

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$1.75 a copy; \$70 a year

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Massachusetts seeks to liquidate two American Mutual affiliates

BOSTON—The Massachusetts Insurance Division is seeking to liquidate American Mutual Liability Insurance Co. and American Mutual Insurance Co. after an actuarial study determined the two insurers together are insolvent by \$469 million.

Based on this estimate, the American Mutual companies would represent the third-largest U.S. insurer insolvency, behind Mission Insurance Group and Transit Casualty Co., both of which are
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FASB fallout

Accounting rules will trigger retiree health plan changes

By JERRY GEISEL

Proposed accounting rules for retiree health care benefits will force employers to redesign their retiree health care plans to eliminate open-ended promises.

The prototype retiree health care plan—under which retirees are eligible for full, unreduced benefits as early as age 55 and with just 10 years of service—will become a dinosaur following implementation of the Financial Accounting Standards Board proposals, benefit experts say.

Companies still want to make a health care commitment to their retirees. But they do not—in the wake of FASB—want that commitment to be open-ended," said Edward J. Davey, a principal with A. Foster Higgins & Co. Inc. in New York.

Proposed FASB rules—which were formally published last week and are virtually identical to earlier drafts—will require com-

panies to accrue as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the employee is eligible for post-employment health care coverage (see story, page 86).

In addition, retiree health care liabilities will appear on corporate balance sheets.

Observers point out that retiree health care plan design often has been relegated to the corporate back burner—with little time or thought given to the programs—since the plans became popular in the last two decades.

But, now, many companies—at last awakened by FASB to the true cost of their retiree health care liabilities—will overhaul their programs in an attempt to protect corporate financial statements.

"The FASB rules will force virtually every
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Drain on profits will depend on company demographics

By DEBORAH SHALOWITZ

Proposed accounting standards for retiree welfare benefits will hurt some companies' bottom lines more than others, corporate finance officials and other experts predict.

According to one estimate, a company's expense for retiree health care liabilities recognized on financial statements could be five to 50 times greater under the proposed accounting standard than under current practices.

Hardest hit by the standard will be companies that have very few retirees relative to active employees, according to some experts, since companies with large retiree populations already are reporting substantial annual retiree health care expenditures under the "pay-as-you-go" accounting system currently used by most

companies.

In addition, the financial impact of the proposed accounting standard, released last week by the Financial Accounting Standards Board, will vary tremendously depending on the level of retiree health care benefits offered by a company and the financial assumptions used in calculating retiree health care liabilities, experts agreed.

Besides lowering corporate profits, implementation of the FASB standard may also jeopardize loan agreements, reduce a company's net worth and cause stock prices to tumble.

However, despite the reduction in reported profits, corporate stock dividends are unlikely to be cut by the proposed standard because a company's cash flow will not change as a result of the accounting standard, experts said.

"It's pretty clear that (the standard) will
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Insurers awaiting Carbide's call for indemnification

By DOUGLAS McLEOD

DANBURY, Conn.—Union Carbide Corp.'s excess liability insurers are expecting to be asked soon to tender their policy limits as part of the chemical giant's \$470 million settlement of claims arising from the 1984 Bhopal gas leak disaster.

As of last week, Union Carbide—which had \$200 million in liability coverage excess of \$2.5 million in underlying limits at the time of the disaster—had not officially notified excess insurers of the settlement or requested that they pay out their limits, representatives for several excess insurers say.

Some insurers have been unhappy with what is described as "presumptuous" treatment by Union Carbide, which has insisted that it handle investigation, defense and settlement of the Bhopal claims, representatives of several insurers note.

However, officials and representatives of several excess insurers agree there are no substantial grounds for challenging the settlement and that a dispute over coverage of Bhopal claims by the excess insurers is unlikely.

A five-member panel of the Indian Supreme Court directed the \$470 million settlement last week during another round of legal arguments between Union Carbide and the Indian government, which represents victims of the disastrous gas leak (BI, Oct. 24, 1988).

More than 2,500 people were killed and 200,000 injured when deadly methyl isocyanate gas spread from the Bhopal pesticide plant on the night of Dec. 3, 1984.

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Aerojet appellate panel seeks to define 'damages' in cleanups

By STACY ADLER

SAN FRANCISCO—A California appellate court now reviewing landmark pollution coverage litigation is grappling to interpret whether the term "damages" in general liability policies encompasses government-mandated hazardous waste cleanup orders.

More than 100 attorneys filled the 1st District Court of Appeals courtroom in San Francisco Thursday to hear the oral arguments in a case pitting Aerojet General Corp. against 55 of its comprehensive general liability insurers.

Policyholders and insurers nationwide are closely watching the Aerojet litigation because the decision will be the first by a California appellate court addressing coverage for government-mandated waste cleanups and is expected to influence state court judges nationwide.

The appeal stems from a May 25, 1988, ruling by San Mateo County Superior Court Judge John J. Bible that the costs incurred by Aerojet in complying with a government-mandated cleanup are not legal damages and, therefore, are not covered by CGL policies (BI, June 13, 1988).

Judge Bible refused to reconsider his ruling, and Aerojet



Photo: Drake Sorey

Attorneys filled the courtroom for arguments in the Aerojet litigation.

appealed to the California appellate court (BI, June 27, 1988).

The opening arguments in the appeal, which lasted less than two hours, began with the three-judge panel taking an unusually active role in the proceedings.

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Update

Insolvency may be third-largest

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estimated to be insolvent by \$1.5 billion.

The fourth-largest insolvency would be Integrity Insurance Co., estimated to be insolvent by \$300 million.

The Tillinghast division of Towers, Perrin, Forster & Crosby Inc. established the insolvency estimate—much higher than the \$80 million reserve shortfall previously estimated—in an actuarial study. Tillinghast found that AMLICO's liabilities as of last Dec. 31 exceeded its assets by \$360 million while AMI of Boston's liabilities exceeded its assets by \$109 million.

The Massachusetts Insurance Division, which placed the two insurers in voluntary temporary receivership last month (BI, Jan. 23), filed its liquidation petition in Massachusetts Supreme Judicial Court for Suffolk County in Boston last Thursday. A hearing has been scheduled for March 8.

Workers compensation and other liability lines accounted for the bulk of the business written by AMLICO and AMI, whose surpluses had eroded severely in the last year as underreserving for prior years' losses came to light.

Meanwhile, Insurance Commissioner Roger M. Singer, acting as temporary receiver for the two insurers under a Jan. 17 court order, laid off 207 of the insurers' 900 field office workers on Feb. 8 and 125 of 600 home office workers in Wakefield, Mass., on Feb. 14. Nine out of 14 senior management jobs also were eliminated, and additional staff cutbacks are planned.

AMLICO and AMI are not related to American Mutual Fire Insurance Co. of Charleston, S.C.

American General sells units

HOUSTON—American General Corp. has agreed to sell its property/casualty insurance operations to Zurich Insurance Co. of Switzerland for \$740 million in cash.

Included in the transaction are Maryland Casualty Co. of Baltimore and eight of its property/casualty subsidiaries, which together generated 1988 gross premium volume of about \$2 billion.

Maryland Casualty, rated A-plus by A.M. Best Co., reported gross written premiums of \$1.8 billion, net premiums of \$1.6 billion and policyholder surplus of \$876 million as of year-end 1988.

The sale, subject to approval by the directors of American General and Zurich and by regulatory authorities, is expected to be completed by June 30.

American General announced plans last August to divest units relying on independent agents and brokers (BI, Aug. 15, 1988).

The acquisition will double the gross premium volume of Zurich's U.S. operations and increase Zurich's position as an insurer of small and medium-sized accounts.

Constellation acquisition eyed

NEW YORK—Great American Insurance Co. is proposing to acquire the assets and liabilities of the defunct Constellation Reinsurance Co.

At Great American's request, a state judge has adjourned until April 19 a hearing on the New York Insurance Department Liquidation Bureau's massive commutation plan for the liquidation of Constellation.

Great American, an American Financial Corp. unit and Constellation's largest creditor and retrocessionaire, plans to ask the court for an order directing the Liquidation Bureau to seek proposals from other insurers—including Great American—for acquiring Constellation's assets and liabilities.

A letter from Ohrenstein & Brown, Great American's New York law firm, suggests that such an acquisition could result in Constellation's creditors receiving 100 cents on the dollar for their claims rather than the roughly 84 cents on the dollar projected by the liquidation bureau under its commutation plan (BI, Feb. 6).

At the hearing last Thursday, Great American requested more time to study the Liquidation Bureau's plan.

Lawyers for the Insurance Department objected to an adjournment if its purpose was to pursue an alternative to the plan, noting that it would be premature for Great American to examine alternatives based on an estimate of its likely recovery under the Liquidation Bureau proposal.

American Financial Corp. was the largest shareholder of the now-insolvent Mission Insurance Co.

Proposition 103 hearing set

SACRAMENTO, Calif.—The California Supreme Court will hear arguments March 7 concerning the constitutionality of Proposition 103, the controversial insurance reform initiative narrowly passed by voters on Nov. 8.

The court last November issued a stay on the most controversial provision of the initiative, which would require a rollback of all property/casualty insurance "charges" to 20% below Nov. 8, 1987, levels (BI, Dec. 12, 1988; Nov. 14, 1988). The court also stayed a provision calling for the establishment of a non-profit consumer protection corporation. The stays were issued in response to a suit by the insurance industry charging that the rollback provisions constitute a denial of due process because they deny insurers an opportunity to make a fair profit.

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Errors & omissions

Only five members of the now-defunct environmental impairment liability reinsurance facility set up by Environmental Risk Assessment Service (International) Ltd. are suing Societe Commerciale de Reassurance (BI, Feb. 6). The five facility members represent 10% of the facility's primary layer. Facility members participating on the first and second excess of loss layers of the facility have no conflict with SCOR.

Stop-loss cover shortage may cut Lloyd's capacity

By STACY SHAPIRO

LONDON—Lloyd's of London's capacity could fall next year for the first time in recent history if syndicate members cannot find affordable personal stop-loss insurance and determine that Lloyd's is no longer a profitable investment.

As of last week, only a handful of the 17,000 Lloyd's members who buy personal stop-loss insurance had been able to renew their coverage for the 1989 underwriting year because of the scarcity of capacity in the stop-loss market.

"None of our names have stop-loss insurance yet," said a Lloyd's members' agent. About 35% of his names normally buy stop-loss coverage.

While the deadline for members to resign from Lloyd's for the 1989 underwriting year has long passed, the lack of affordable stop-loss coverage may prompt many Lloyd's members to resign from Lloyd's in 1990, thereby reducing the market's capacity.

Members' personal stop-loss insurance capacity dried up late last year when leading underwriters of the coverage dropped out of the market and the following market reduced the amount of coverage it would write.

Brokers and agents say the underwriters stopped writing the coverage because of heavy losses.

Several Lloyd's brokers in the last few weeks have made Herculean efforts to organize stop-loss insurance facilities that would provide coverage to members backdated to Jan. 1 for the 1989 underwriting year.

However, Lloyd's members are criticizing the facilities, commenting that the coverage is limited and too expensive.

"A lot of members are concerned about this. They don't want to be without it, and they don't want to pay more," said a spokesman for the Assn. of Lloyd's Members.

Capacity for stop-loss insurance "is very difficult," said Michael Wade, chairman of Holman Wade Ltd., Lloyd's leading stop-loss insurance broker.

Mr. Wade, a member of the Council of Lloyd's, said that 11,000 of the 17,000 Lloyd's members who purchased stop-loss insurance last year were covered under Holman Wade's line slip.

"We are still placing our (stop-loss insurance facility) for 1989," he said. If the slip is completed, "it will go some way to staying members of Lloyd's from resigning in 1990 or 1991."

However, a lack of coverage "may have an impact on resignations for next year psychologically," said a Lloyd's members' agency executive.

The lack of affordable stop-loss insurance for Lloyd's members comes at a time when Lloyd's faces the likelihood of reduced membership anyway, market observers point out.

"But the price of stop-loss insurance could tip the scales," said Richard Godfrey, a stop-loss executive for Lloyd's broker Seacope Insurance Services Ltd.

With or without stop-loss coverage "I think the membership of Lloyd's is going to go down," said

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Alliance, NAI to conduct study of merger feasibility

By MARK A. HOFMANN

CHICAGO—The Alliance of American Insurers and the National Assn. of Independent Insurers may merge if a feasibility study concludes that a merger would be beneficial to both organizations.

"We thought we could really strengthen each other" by joining forces, said Lowell R. Beck, president of the Des Plaines, Ill.-based NAI.

The feasibility study, which will be conducted by an independent consultant, will attempt to determine whether "a pooling of resources of both associations could benefit our members in regard to the public affairs and government affairs activities" now carried out by both groups, according to Franklin W. Nutter, president of the Schaumburg, Ill.-based Alliance.

Although the two associations originally represented different types of insurers, they now find themselves "in almost every instance in Washington and the states very close together," Mr.

Beck pointed out.

NAI and Alliance members have "a community of interest," particularly on such matters as proposal to repeal or modify the McCarran-Ferguson Act.

The two associations "are very compatible in terms of positions," Mr. Nutter agreed.

No one industry-related issue prompted the groups to consider a merger, Messrs. Nutter and Beck said.

"It wasn't just California," Mr. Beck said, referring to the passage of Proposition 103, which has created turmoil in the California property/casualty insurance market (BI, Nov. 14, 1988).

The associations last week began interviewing prospective consultants to study whether the merger is feasible, according to Mr. Nutter.

The feasibility study will be carried out "as expeditiously as possible," and preliminary feasibility reports may be made to the groups' executive committees by late March or early April, Messrs. Beck and Nutter said.

But, both association leaders stressed that a merger was not a certainty. "We may conclude that it is in our members' best interests to remain separate," said Mr. Nutter.

"We want to very carefully evaluate if there is a fit. We have to make sure our cultures do in fact mesh," Mr. Beck said.

If the groups merge, the new association would represent more than 700 property/casualty insurance companies.

The Alliance, which was founded to represent the interests of mutual insurance companies in 1922, currently has about 175 members.

The NAI, founded in 1945 to promote the interests of independent insurers regardless of stock or mutual structure, currently has about 550 members.

Although companies that belong to both groups write both personal and commercial lines of property/casualty insurance, Alliance members tend to be commercial lines-oriented, while NAI members emphasize personal lines insurance.

Inside

✓ High on Congress' list of priorities this session should be legislation to clear up uncertainties in the federal Risk Retention Act, says this week's editorial. **PAGE 8**

✓ Health insurance is midway through a five-year transition process that has rocked the industry. But, in 1989, stability will begin to return, says Russell C. Coile Jr. of Health Forecasting Group in Speaking Out. **PAGE 49**

✓ In Perspectives, Jonathan E. Levin of Mutual of Omaha Cos. presents a means of quantifying the impact of a utilization review program. **PAGE 50**

✓ London's Joint Hull Committee for the first time is allowing underwriters freedom in setting renewal terms for hull insurance. **PAGE 79**

✓ A bank seeks to overturn a jury verdict that Crawford & Co. is not primarily to blame for losses from the bank's investment in a now-insolvent insurer. **PAGE 85**

✓ Raymark Industries Inc. has failed in a second attempt to consolidate all of the asbestos bodily injury claims it faces into a class-action lawsuit. **PAGE 85**

✓ Oil Insurance Ltd., a petroleum industry group captive, says a "preliminary" 50% rate increase is not solely attributable to large claims in 1988. **PAGE 85**

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Vol. 23, No. 7—Business Insurance (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to Business Insurance, Circulation department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 800-992-9970 or 313-446-1611. Copyright 1989 by Crain Communications Inc.



Controlling benefit costs

Insurers, UR firms target rising outpatient claims

By JERRY GEISEL

Insurers and utilization review providers are designing new weapons to tame one of the fastest-rising cost component of employers' health care plans: outpatient claims.

Among the hottest items in employers' growing cost control arsenal are outpatient precertification programs, with new products being unveiled and launched almost every week.

For example, Hartford, Conn.-based Aetna Life & Casualty Co., after a successful pilot program, last month introduced a new outpatient

precertification program that requires employees or their physicians to have certain outpatient procedures reviewed and approved by Aetna nurses or physicians.

"This is a quantum leap in terms of any other outpatient cost control program," said Dr. Constance Winslow, Aetna's medical director and head of medical systems support.

Intracorp, the Berwyn, Pa., managed care unit of CIGNA Corp., now is offering a prospective review program in which up to 27 procedures and tests typically performed on an outpatient basis—like arthroscopy,

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Employers want remedy for drug cost inflation

By DONNA DiBLASE

Employers need a new prescription for managing drug costs under their health care plans, employee benefit experts say.

Annual increases of about 8% in the cost of prescription drugs have made drugs one of the fastest growing types of health care expenses. Drug costs now account for about 10% to 12% of most employers' total health care expenditures, up from about 4% in the early 1970s.

"Prescription drugs are an ever-increasing cost for us. They are the fastest growing cost we have next to

mental health and substance abuse costs," said Jim Proffitt, director of health care for McDonnell Douglas Corp. in St. Louis.

But, while "most employers are interested in doing something about their drug costs, they see it as a relatively small piece of their benefit costs in relation to other costs in their plans," said Dan O'Malley, a principal in the Pittsburgh office of TPF&C, a division of Towers, Perrin, Forster & Crosby Inc.

As a result, "prescription drugs have been one of the least managed areas of benefit plans," said Michael

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10 largest general service utilization review firms

Company (Ownership)	Lives served	Full-time staff			Physicians on retainer
		Total	Physicians	Registered nurses	
Intracorp (CIGNA Corp.)	11,500,000	600	NA	NA	NA
Corporate Health Strategies (Metropolitan Life Insurance Co.)	6,200,000	243	6	228	7
HealthCare COMPARE Corp. (Independent)	5,000,000	433	27	300	NA
Peer Review Analysis Inc. (Privately held)	4,000,000	45	7	16	65
Corporate Health Care Management (EQUICOR Inc.)	3,750,000	236	9	93	23
Cost Care Inc. (Independent)	2,900,000	268	19	136	6
Value Health Inc. (Privately held)	2,800,000	119	5	9	7
The Sunderbruch Corp. (Privately held)	2,683,000	293	2	89	0
Western Medical Review (Non-profit corporation)	2,000,000	40	1	22	50
August International Corp. (Privately held)	1,979,750	230	3	48	45

Source: BI Survey

Chart: Christine Woolsey

UR firms attempt to balance cost, quality of care

By CHRISTINE WOOLSEY

Utilization review providers are walking a tightrope as they attempt the delicate act of balancing health care cost containment with quality of care.

As employers get a better handle on where their health care dollars are being spent, they realize that quality of care cannot be sacrificed to save money, UR experts say.

In response, UR vendors are developing increasingly customized services, like psychiatric and outpatient treatment review and managed care programs, to better advise patients with special needs.

And, to more effectively compete in the increasingly specialized UR market, many UR firms also are becoming more accountable to employers by improving and explaining the methods they use for reporting results.

Moreover, some vendors are carving out other niches, like review of workers compensation cases.

This year, for the first time, *Business Insurance* is ranking the largest general service UR vendors, as well

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Employers seek to control psychiatric treatment costs
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Second surgical opinion programs assume new role in health plans
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Prenatal education programs reduce costs of maternity care
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U.S. spends more on health care than other industrialized nations
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Drug costs

Continued from previous page
J. Barberi, a principal and managing consultant in the San Jose, Calif., office of William M. Mercer Meindinger Hansen Inc.

Most employers—about 65% to 70%—provide coverage for prescription drug purchases through traditional major medical indemnity plans, benefits experts estimate.

These plans often do not contain any prescription drug cost or utilization controls. And, employers often do not receive detailed data on drug costs and claims experience from their insurer or claims administrator even though this information essential to making any cost containment changes, consultants note.

However, some employers have implemented other types of drug benefit programs beside the traditional indemnity approach. These include prescription drug card programs, which provide incentives such as low

copayments for employees to use preferred pharmacies that have agreed to discount prices, and mail-order drug services, which dispense maintenance drugs at wholesale prices.

However, some consultants and drug vendors maintain that the best approach is to develop a customized, multifaceted managed care program using many of those strategies.

"It's very important to realize that it's not just one component that makes a managed prescription drug program work, said Donald Curry, vp of national accounts for Blue Cross of California in Woodland Hills, which implemented such a program last summer.

The rate of increase in the cost of prescription drugs has outpaced that of most other goods and services for several years, according to the U.S. Bureau of Labor Statistics.

For example, in 1988, the prescription drug component of the Consumer Price Index rose at an annual rate of 7.8%, compared with a 6.9%

rise in the medical care component of the CPI and a 4.4% increase in the overall CPI (see chart, page 6).

However, at least one expert warns that the actual increase in drug costs could be even higher than the increase reflected by the CPI.

"The CPI doesn't take into account the utilization rate of prescription drugs. The actual average annual increase in the cost of drugs could be 16% to 18%" when increased prescription utilization is taken into account, said David Karlin, a senior vp with National Prescription Administrators Inc. of Clifton, N.J.

Health care experts attribute the drug cost increases to several factors, including:

- The cost of research and development by the pharmaceutical industry. Pharmaceutical manufacturers spent \$6.5 billion on research and development in 1988 and is expected to spend another \$7.3 billion in 1989, the Pharmaceutical Manufacturers Assn. in Washington, D.C., reports.

- The cost to the pharmaceutical industry of product liability suits and insurance, though observers point out this cost is difficult to estimate.

- Increased price competition among pharmaceutical manufacturers on generic drugs, which increases that price of brand name drugs.

Pharmaceutical companies formerly used revenues from their generic products to hold down the prices of their patented brand name drugs. However, the increase in the number of different manufacturers producing a generic equivalent of a particular drug is forcing lower-priced generics, which cuts the revenue produced from these products.

This, in turn, results in higher prices for brand name drugs as companies try to recoup the research and development costs of these products.

- Increased utilization of prescription drugs as a result of the growing number of elderly people and their increasing need for medication to treat chronic illnesses.

The PMA estimates that there are more than 200 geriatric medications now in development, representing about half of the pharmaceutical industry's research and development expenditures.

- Increased utilization of prescription drugs in lieu of surgical or other inpatient treatments.

For example, the use of drugs known as beta-blockers in preventing second heart attacks have saved as much as \$1 billion a year when compared with the cost of coronary bypass surgeries, said a PMA spokeswoman. A month's supply of beta-blocker drugs costs about \$50 while surgery costs about \$40,000.

The development and increased use of medications for stomach ulcers may have saved more than \$4 billion over the last 10 years, when compared with surgery costs, she said.

In light of these trends, management of prescription drug costs by employers requires a coordinated number of tools and programs, benefits experts say.

First and foremost, employers must have detailed claims information on their drug costs and utilization experience. But this may be easier said than done, experts note.

"Many insurers and claims administrators can't even break out how much an employer is paying for drugs. This is because their claims systems just haven't been set up to capture this data, and it's often reported as a one-line item: Prescription drugs cost you this much this year," explained Gerald Chalfin, chief operating officer of INSURX, a prescription drug benefit plan administrator and consultant in Cleveland.

INSURX provides managed prescription drug programs that include negotiating price with both retail and mail-order pharmacies, electronic-claims filing and processing and a drug UR program. These programs and services can be implemented in conjunction with an employer's major medical plan or prescription drug card program.

BC of California in July implemented a managed care prescription drug program in which INSURX provides claims processing and information, said Mr. Curry.

"A lot of employers are really hesitant about doing major surgery on their benefit plans when they are not comfortable with their data," said Mercer's Mr. Barberi, a leading consultant in prescription drug plan design. He is creating a national practice for Mercer addressing prescription drug plan design.

Along with helping an employer fully realize prescription drug costs, detailed claims information also can be used to perform utilization review and quality assessment, experts say.

Such information has long been used for these purposes by health maintenance organizations, according to one executive.

"In HMOs, more data is collected on prescription drugs. In a managed care system, you know how much and what drugs a patient is taking," commented John Middleton, president of Diversified Pharmaceutical Services Inc., a Minneapolis-based prescription cost management firm.

Diversified, a wholly owned subsidiary of United Health Care Corp., provides managed prescription drug programs to other HMOs, employers and insurers.

Along with more complete claims information and drug utilization review, employers also can use other techniques as part of their managed prescription drug programs, benefits experts say.

For example, prescription card programs—which include PPO arrangements with pharmacies—can be effective, but only if utilization controls and cost sharing by employees are designed as a part of these programs, experts say.

A common criticism of these programs is that since they often require a flat copayment per prescription—

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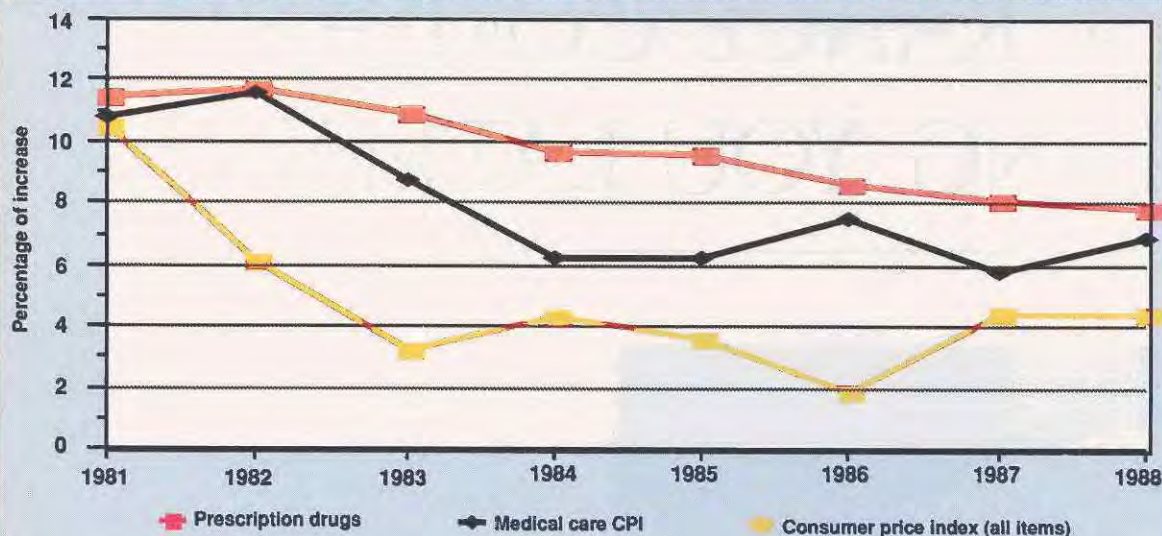
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Drug costs rise faster than other expenses



Source: U.S. Bureau of Labor Statistics

Chart: Holly Seguire

Drug costs

Continued from page 6
usually between about \$3.50 and \$5—that claims frequency and costs can increase because the card program is easier for employees to use than a major medical program.

In addition, the plans can be considerably less expensive for employees to use. Under most major medical plans, employees typically pay a copayment of about 20% of the cost of the drug, as opposed to a flat fee per prescription under a card plan.

However, the flat copayment approach is changing, some say.

"We see a lot more employers that are more willing to put in restrictions on these plans, such as front-end deductibles and copayments," said James Manning, a senior executive vp with Medco Containment Services Inc. of Fair Lawn, N.J. Medco offers both card programs and mail-order programs for maintenance drugs.

"The typical prescription drug card

program years ago was structured so that the covered employee would pay a \$1 or \$2 copayment per prescription. This is pretty much gone today," explained Donald Dahlin, president and chief executive officer of Scottsdale, Ariz.-based PCS Inc. Programs run by PCS, the largest card program vendor, cover about 18.5 million people nationwide.

Today, "there is a trend to increase those copayment levels under the card programs, just as employers have increased their major medical plan deductibles and copayments," said Jim Braun, a consultant in The Wyatt's Co.'s Washington office.

More employers are interested in implementing annual deductibles in addition to copayments under card programs, Mr. Dahlin said.

In addition to increasing copayments under card programs, employers and insurers that provide drug benefit plans also are implementing more aggressive incentives for employees to use generic drugs, which can cost as much as 70% less than their brand name equivalents.

For example, through the use of a higher copayment for brand name drugs, PM Group, the employee benefits division of Newport Beach, Calif.-based Pacific Mutual Life Insurance Co., achieved a generic substitution rate of about 18% for all of its group health plan clients.

Covered individuals were paying a \$2.50 copayment for generic drugs and \$5 copayment for brand name drugs. But, "we thought we were going to force a greater generic substitution rate than that. I think maybe the difference between the copayments was not high enough," explained Haskell Rosenberg, assistant vp of Pacific Mutual's multiple employer trust administration division.

Pacific Mutual contracts with PCS to administer drug benefits for all of the insurer's group health clients.

As of Feb. 1, the insurer now requires covered individuals to pay an additional 30% copayment on brand name drugs, he said. Mr. Rosenberg estimates that the new plan design will help Pacific Mutual save 50% per plan participant.

Mail-order drug programs also can fit into employers' managed prescription drug programs for employees who use maintenance drugs.

"Mail service pharmacies operate as a maintenance drug buying facility for an employer: a corporate pharmacy," said Terry Snyder, vp of marketing and sales for America's Pharmacy of Des Moines, Iowa.

These companies buy bulk quantities of drugs at wholesale prices, then typically bill the employer for the cost of those drugs used by its employees, plus some administrative or operating fee to cover dispensing and mail costs, vendors explained.

Maintenance drugs account for about 70% of the average employer's drug plan costs.

"The trick to seeing savings is to 'incentivize' employees to get their maintenance prescriptions filled out of the company's mail service system instead of in the retail setting," Mr. Snyder said.

America's Pharmacy estimates that it can save employers with major medical drug benefits 29.2%, and employers with drug card programs 27.6%.

But, along with giving employees an incentive to use a mail-order service for maintenance drugs, employers also should be sure that copayments are high enough to share costs with employees, said Kris Gibney, president of the Prescription Service Division of Lincolnshire, Ill.-based Baxter Healthcare Corp.

"Copayments for a 90-day supply of a drug range between \$3 and \$8. But, we recommend employers require toward the higher end, because that's often equal to 20% of the cost of the supply of the drug," she explained.

Baxter has operated the mail-order pharmacy since 1986, when the company introduced the service as a pilot program to its own employees. ■

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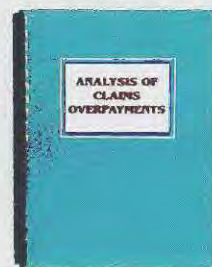
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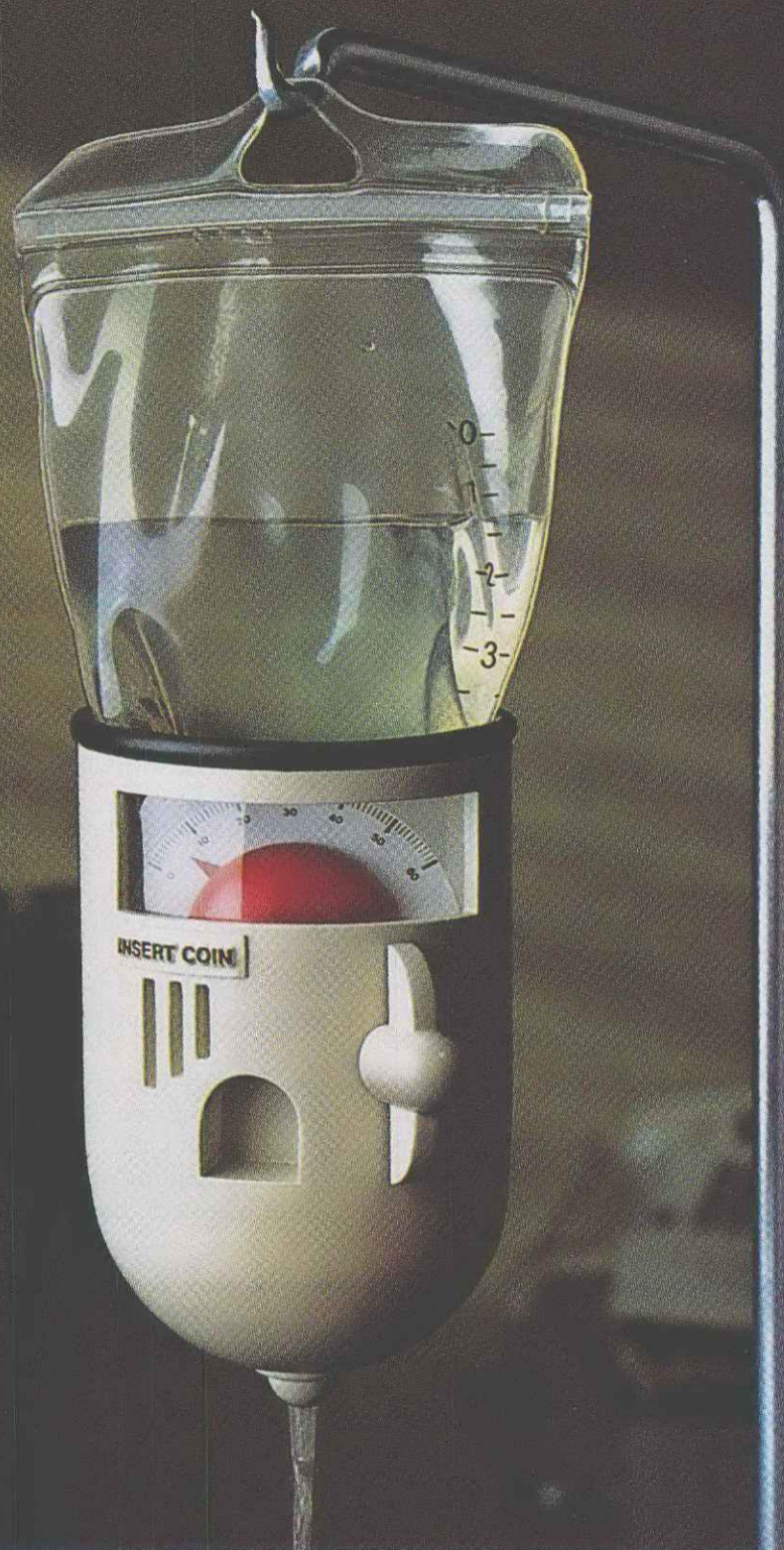
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Opinions

Fix Risk Retention Act

HIGH ON CONGRESS' list of priorities this session should be legislation to clear up uncertainties in the federal Risk Retention Act.

One part of the 1986 amendments to the Risk Retention Act is working well: More than 50 risk retention groups have been established since the amendments were enacted in October 1986.

Those risk retention groups, some of which have already become major market forces, have given businesses, municipalities and professional organizations, a needed and valuable alternative to the commercial liability insurance market.

But the other part of the Risk Retention Act, which allows the formation of risk purchasing groups, is not serving the needs and interests of buyers or regulators. It must be overhauled.

Ambiguities abound in the risk purchasing group provisions. For example, it isn't clear from a reading of the law how many states, if any, can require insurers of purchasing groups to file rate and policy forms.

A New York federal court, in its interpretation of the act, suggested in 1987 that insurers would have to submit rates and policy forms in any state in which a purchasing group has members.

Such a requirement would hit risk purchasing group insurers with major administrative costs and be a blow at the *raison d'être* of the Risk Retention Act: facilitating the group purchase of commercial liability insurance with minimal interference by state regulators.

However, regulators are concerned, with some justification, that ambiguous provisions in the Risk Retention Act have opened the door for quick-buck artists looking to establish thinly capitalized insurance companies to write purchasing group coverage.

In fact, some regulators warn that the collapse of insurers writing purchasing group business is a disaster waiting to happen.

Fortunately, proposals being advanced by U.S. Commerce Department staffers would do much to make purchasing groups attractive to buyers and insurers, while closing the door to shady operators.

One proposal would make clear that only one state—the state that a purchasing group declares as its principal place of business—could regulate rates and policy forms.

That would enormously cut down on administrative costs.

To ease the concern of regulators, risk purchasing group insurers would have to meet a set of objective financial criteria, such as having a certain capital and surplus.

Such a requirement would be a good start to keep out insurers that simply lack the financial resources to write liability insurance for purchasing groups.

Above all, we strongly support the staffers' proposal that purchasing groups be established and controlled by buyers, not insurers.

Such a requirement would avoid situations, now possible, in which an insurer organizes a slew of risk purchasing groups, lures policyholders with cut-rate premiums, cedes most of the risk to unsuspecting reinsurers and rakes in ceding commissions.

At that point, the fate of the risk purchasing group is of little concern to the insurer.

We would hope that Congress soon begins consideration of a legislative package to again amend the Risk Retention Act.

Changes of this importance should not be left to the last frantic closing weeks of a congressional session.

By acting in the months ahead, Congress will help assure that a well-crafted, revised Risk Retention Act will be in place to meet the needs of buyers and allay the concerns of regulators before the liability insurance market begins to harden.

Letters

RIMS speaks out against FSA rules

The following letter was also sent to the commissioner of the Internal Revenue Service.

To the editor: The Risk & Insurance Management Society Inc. strongly objects to rules being developed by the IRS that could gut flexible spending accounts (BI, Jan. 30). As an organization of more than 4,200 corporate, governmental and non-profit sponsors of employee benefit plans, RIMS believes FSAs are of great value to both employees and employers and, thus, worth preserving.

The IRS is preparing to promulgate regulations that would require employers to reimburse employees for all claims against their FSAs, even if an employee has yet to accumulate sufficient funds to cover the claim. This makes employers liable for any shortfall in an FSA.

Clearly, any such rule would act as a significant disincentive toward the creation and maintenance of FSAs. RIMS views this as poor public policy, hurting both employees, who are provided a vehicle for coverage, and employers, which utilize FSAs to help control rising health

care costs. This method of cost control is accomplished with the cooperation and understanding of employees, involving them in the economic realities of our nation's health care delivery system.

As a time when access to affordable health care has become such a critical issue, the IRS' impending regulations on FSAs are clearly contrary to public policy objectives. RIMS therefore urges that the IRS not promulgate restrictive rules.

Howard W. Greene
Associate Legislative Director
Government Affairs
Risk & Insurance Management
Society Inc.
New York

Industry shuns blame for poor public image

To the editor: The insurance industry continues to depict itself as a poor beleaguered industry. This is evidenced by the article in your Nov. 14, 1988 issue, "Insurers Can Improve Image: Lawyer." While claiming to be a victim of politically motivated antitrust suits, the industry continues to refuse to accept responsibility for the image it projects. Prime indications of this ostrich-like behavior are the specific suggestions for improving its image described in your article.

For example, former Florida Supreme Court Justice Frederick Karl, quoted in the article, encouraged insurance companies to adopt strategies such as developing an awareness of and determination to improve their image, doing good deeds and making the public aware of them, and standing up for their rights. These suggestions all conspicuously avoid any

mention of improving the cost and quality of the services and products insurance companies provide to their customers.

A heavy dose of honesty and integrity would go a long way toward cleaning up the tarnished image of the insurance industry. It is not hard to see how insurance companies developed their reputation with business policyholders. In the recent hard market, underwriters abandoned policyholders wholesale. Insurance companies increased premiums as much as 100% for long-standing policyholders who had experienced no change in loss experience. They did all this after years of urging risk managers to establish long-term relationships with their underwriters in the interest of stability.

During the soft market, when they were afraid of losing market share, underwriters pleaded with risk managers to "stick with us during the soft market and we'll stick with you when the market turns." Risk managers who believed that are justified in feeling betrayed and more than a little dismayed about the integrity of the insurance companies since those same underwriters turned their backs on their policyholders when premiums skyrocketed and capacity dried up.

Hyperbole in response to the attorneys general's lawsuits is not going to impress risk managers. Insurance industry customers are looking for "meaty" responses, not "breast beating."

If good faith dealing is lacking, sponsoring a Little League, as suggested by Justice Karl, is not going to help.

Eugene R. Anderson
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Published by Crain Communications Inc., Chicago

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For more information on the comprehensive inpatient and outpatient review services Intracorp can offer your company, call 1-800-345-1075 (In PA, HI

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intracorp

Outpatient UR

Continued from page 3

cataract surgery and allergy testing—are reviewed and certified.

"More than 35% percent of all surgery is done on an outpatient basis. There are very few utilization programs in existence today that effectively monitor the necessity, appropriateness and charges of outpatient procedures," said Doug Leland, Intracorp's vp of product development and management.

Value Health Sciences Inc. of Santa Monica, Calif., is aggressively marketing to insurers and health care management firms a new software program that uses detailed clinical standards, initially developed by researchers at the University of California at Los Angeles and the Rand Corp., to identify the appropriateness of performing various outpatient procedures (see profile, page 15).

The computer programs are to be used by review service nurses who discuss patient information with the attending physician. Precertification for most procedures should be available with one telephone call.

Unquestionably, the boom in precertification programs for outpatient procedures is being fueled by tremendous cost and utilization increases.

For example, hospital revenues from outpatient visits almost tripled over an eight-year period, rising to \$31.5 billion in 1987, up from \$10.4 billion in 1980, according to American Hospital Assn. statistics. By contrast, revenues from inpatient care rose only 88.4% to \$130 billion from \$69 billion during the same period.

At the same time, the number of annual outpatient visits to AHA member hospitals shot up 28.5% to 279 million in 1987 from 217.2 million, while the number of inpatient admissions has declined 10.4% to 33.6 million in 1987 from 37.5 million in 1980.

The Chicago-based AHA, the nation's largest hospital organization, isn't the only group reporting big increases in outpatient utilization while inpatient utilization continues to decline.

Blue Cross & Blue Shield Assn. says the number of outpatient visits per 1,000 subscribers leaped 56.7% between 1978 and 1987, while the number of inpatient admissions fell 28.7%.

Some individual employers report an even bigger surge in outpatient care.

Outpatient expenses at Hewlett-Packard Co. in Palo Alto, Calif., equaled 8% of the company's total health care costs in 1987, up from 2% in 1986.

"Rising outpatient costs clearly is an area that needs a lot more looking into," said Hewlett-Packard Benefit Manager Art Young.

"Outpatient costs have inflated sharply," adds Cathy Corse, assistant vp-employee benefits at Barnett Banks Inc. in Jacksonville, Fla.

Rising outpatient costs, in part, are attributable to advances in technology. Far more medical procedures can be performed on an outpatient basis than a decade ago.

"Surgery has become much safer on an outpatient basis," said Patty Armocida, director of utilization management with the BC/BS Assn. in Chicago.

But employers themselves are partly to blame for soaring outpatient costs, many say.

Companies, in their zeal to keep employees out of high-cost hospitals, redesigned their benefit plans to give employees higher levels of reimbursement for services performed on an outpatient or ambulatory basis.

"Many looked at controlling hospital costs as the magic bullet in controlling health care costs," said

Dr. Robert Becker, chairman of HealthCare COMPARE Corp. of Downers Grove, Ill., a utilization review vendor.

While employers also deployed a variety of techniques like preadmission testing and second surgical opinion programs to control hospital costs, outpatient procedures did not receive the same sort of rigorous scrutiny.

"There was little thought given to how to manage outpatient utilization," said Larry Goelman, president of Cost Care Inc. of Huntington Beach, Calif.

With inpatient procedures held in check through cost management, outpatient utilization took off.

"It's like the Pillsbury Doughboy; you push in one place and something pops out in another place," said Dr. Donald Vickery, president of Travelers Insurance Co.'s Center for Corporate Health Promotion in Reston, Va.

"The employers we deal with un-

animously became concerned that costs have been driven from inpatient to the outpatient side because no programs were in place to control costs," said Jim Sang, general director of managed care with John Hancock Mutual Life Insurance Co. in Boston.

"Physicians recognized that there was no real surveillance on the outpatient side," said James Adams, president of Efficient Health Systems Inc. of Skokie, Ill.

UR vendors are now filling that need.

More than a dozen health care cost management vendors now are offering outpatient precertification review programs, including August International of Orange, Calif.; Cost Care; Efficient Health Systems; HealthCare COMPARE; Intracorp; Peer Review Analysis Inc. of Malden, Mass.; Preferred Health Network of Los Angeles; and Republic RSB Cos. Inc. of Naperville, Ill.

While the outpatient precertification programs now on the market vary somewhat, they share common features.

Typically, an employer and its review organization target a set of outpatient procedures for precertification. Those procedures often costily and are highly utilized.

Procedures subject to precertification often include colonoscopy, cataract removal, knee arthroscopy and upper gastrointestinal endoscopy.

Employees are expected to call a nurse reviewer at the insurer or health care management firm to receive certification when they are told they require one of the listed procedures.

The nurse reviewer then will discuss the case with the employee's attending physician to determine if the procedure is medically necessary based on protocols the review organization has established. Aetna's protocols, for example,

were developed by researchers affiliated with Rand and UCLA.

If the protocols are met, the case is certified and the procedure is performed. If there is a disagreement, the case is bounced to a review physician who contacts the attending physician.

If an agreement still cannot be reached, outside specialists would be contacted for an independent medical examination.

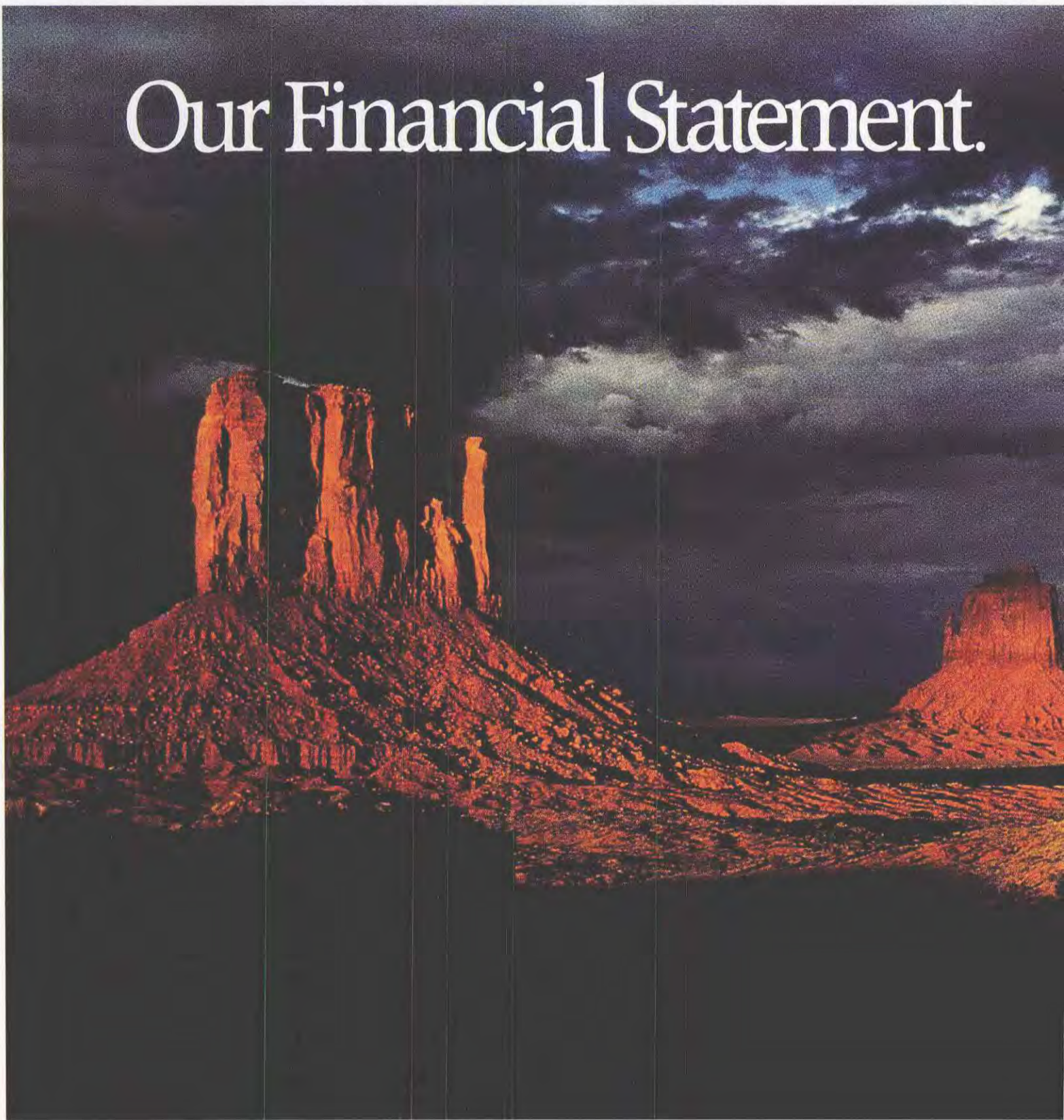
However, even if the review organization refused to certify a procedure as medically necessary, an employee still could opt to have the procedure performed, though he or she might receive little or no reimbursement for the claim.

Similarly, if an employee simply ignored the precertification procedure, he or she would receive either partial or no reimbursement.

Precertification is in everyone's interest, UR experts say.

"It provides us with an opportunity
Continued on next page

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Continued from previous page

nity to review the necessity of service and to establish a relationship with doctors while educating employees in the process and saving employers money," said Intracorp's Mr. Leland.

But the success of outpatient certification programs in eliminating unnecessary procedures will depend in part on the willingness of employers to deny reimbursement if certification procedures are flouted.

"Once you find the aberrant behavior, what are you prepared to do as an employer?" asked Kathryn Kelly, a consultant in the Washington, D.C., office of TPF&C, the benefit consulting unit of Towers, Perrin, Forster & Crosby Inc.

Others are concerned that employers could be potentially liable if they accept a review organization's negative verdict on a procedure and an employee later develops a problem.

"It is more complicated than saying what is the appropriate setting for a procedure. It is saying either yes or no," said Tom Billet, a managing consultant with A. Foster Higgins & Co. Inc. in New York.

While it remains to be seen, what, if any, legal problems develop, some insurers and review organizations are encouraged by the economic results from the first outpatient precertification review programs.

For example, in an Aetna pilot program for a major Midwest employer, some 5% to 7% of outpatient procedures were found to be unnecessary and averted, Dr. Winslow said.

One firm, August International, caught such cost-inflating techniques as roping off a doctor's office and calling it a 'surgery suite,' potentially adding hundreds of dollars to a bill.

In addition, six employers, municipalities and multiemployer plans using a precertification program developed by August International cut expenditures by 4.4% between 1986 and 1987 for 25 procedures.

That program also caught cost-inflating techniques deployed by physicians, such as roping off a doctor's office and calling it a "surgery suite," potentially adding hundreds of dollars to a bill.

"We made it clear (during precertification) that such fees would be inappropriate," said Blayne Lequeux, August International's president and chief executive officer.

While outpatient precertification programs are burgeoning, other techniques have helped to stem the tide of rising outpatient costs. For example:

- Ford Motor Co. of Dearborn, Mich., reduced the volume of foot care services for hourly employees in Southeast Mich-

igan by 50% over an 18-month period between 1983 and 1985 after implementing a preferred provider program established by National Foot Care Program Inc. of Southfield, Mich.

Podiatrists in the program agreed to abide by protocols established by National Foot Care and to have their work continuously reviewed.

The success of the program "tells us that if you use a network of providers, at least for foot care, it can be an effective means of reducing cost escalation as well as a good way to assure quality care," said Jack Dunn, supervisor-insurance programs of employee relations staff at Ford.

- Blue Cross/Blue Shield of Arizona negotiated fixed fees with about a dozen outpatient surgical centers in the Phoenix and Tucson metropolitan areas.

"We achieved a 30% savings compared to the old billed charges," said Dr. Kenneth Smithson, the plan's medical director in Phoenix.

Health care experts, such as Tim Borchert, a consultant with Hewitt Associates in Lincolnshire, Ill., believe that techniques to control outpatient costs are in their infancy.

Ultimately, "the savings produced by these programs may be multiples of their cost while improving the quality of care," said Dr. Paul Frankel, national director of medical management for Corporate Health Strategies, a health care management company in Westport, Conn.

UR firms

Continued from page 3

as the largest psychiatric UR firms based on the number of lives they serviced in 1988.

While many independent review operations number among the Top 10, insurer affiliates remain the largest suppliers of UR services, partly because of their built-in client base and financial backing.

In addition to the profiles of the largest UR firms, a directory of UR vendors begins on page 33.

Increasing media attention on nutrition, fitness and preventive medicine and a growing realization that physicians are not infallible are changing employers' attitudes toward health care purchases, UR experts say.

Health care is now being viewed as a "product" like any other for which employers should comparison-shop to get the most value for the money, said Richard McMaster, chief executive officer of the West Des Moines, Iowa-based Sunderbruch Corp., the eighth-largest general service UR vendor.

"Just getting a discount does not mean you're getting quality" services, he added.

Similarly, employers are beginning to shop around for utilization review. The "off-the-shelf" UR package has gone by the wayside, and employers are seeking more specific analysis of their company's spending, vendors say.

"Off-the-shelf, basic UR components clearly have a place, but employer demographics and philosophies vary too much," says Dr. Roger Taylor, national director for Corporate Health Care Management, a division of EQUICOR Inc. in Nashville, Tenn., and the fifth-largest general service UR vendor.

"UR firms can't just have a vanilla-flavored product. You have to have a vanilla baseline," he said.

Other UR vendors agree. "The most important thing to UR firms is to keep evolving," says Bob Belichick, product manager in the Santa Monica, Calif., office of Health Data Institute Inc., a subsidiary of Baxter Health Care Corp. in Deerfield, Ill. "Products have to shift because medical protocols are changing."

Blayne Lequeux, president and chief executive officer at Orange, Calif.-based August International Corp., warned: "If your firm is not continuing to evolve or spend money on research and development, you're in trouble." August International is the 10th-largest general service UR firm.

The bulk of the evolutionary process is taking place in the outpatient arena, UR vendors say. In light of the increased utilization of outpatient services, UR firms are developing a wide range of techniques to monitor outpatient care (see story, page 3).

Continued on next page



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UR vendors

Continued from previous page

"Initially, ambulatory service was less expensive," explained Dr. Taylor. "But providers were smart enough to shift costs into this area because inpatient procedures were being used less frequently."

The increasing focus on supplying specialized review services is spurring competition among UR vendors, observers say.

In addition to mental health and substance abuse services, which are the fastest growing areas of outpatient review (see story, page 17), UR firms are concentrating on medical case management and workers compensation rehabilitation review.

Dr. Taylor said Corporate Health Care Management's medical case management volume grew by 60% since his company began marketing that product about a year ago.

"The main reason is (that) companies realized a well-run medical

case management program can have a major impact," he explained.

Several vendors predict case management programs will become more prospective in nature, identifying problem areas early, before health care dollars are spent.

"The emphasis will change," predicted David P. Lyle, president of Pittsburgh-based Health Related Services Inc., a subsidiary of Blue Cross of Western Pennsylvania. "There will be more case management, not just for catastrophic illness, but real counseling with patients to explain benefits and suggest alternatives."

"There should be a more concerted effort on preventive care," said Madelon Finkel, president and chief executive officer of Second Opinion Consultants Inc., an independent UR firm in Millwood, N.Y.

Workers compensation case management is an area Richmond-based Blue Cross & Blue Shield of Virginia is developing. The company, which

already manages the medical treatment, is working with providers to return employees to work more quickly, explained Tim O'Shea, director-health care management.

"We're often dealing with gray areas, like back pain, so we need good supportive medical criteria to base our reviews on," he said.

Western Medical Review in Torrance, Calif., also is concentrating on workers compensation cases.

Medical case management following a workplace injury "was handled up to now by workers comp adjusters who aren't medical people," said Victoria Nishioka, review manager at the ninth-largest general service UR vendor. "The money spent on workers comp is unbelievable."

Other UR firms are diversifying into the workers compensation area in different ways.

For example, MedView/CompPro plans to offer on-site safety reviews to employers in addition to traditional UR services, said Polly Jant-

zen, vp-administration at the Farmington Hills, Mich.-based UR firm. "We want to be a company that can provide integrated health care administration from the start."

Observers also point out that benefit consultants are evaluating the various firms for employer clients seeking more accountability from their UR service providers.

For example, employers are showing increasing interest in the quality of reports their UR firms are producing. Some employers never even received reports from their review firms, or, when they did, the data was often confusing or useless, said Health Data Institute's Mr. Belichick.

"People just put up with it now they are becoming more sophisticated," he said.

August International's Mr. Le-Queux agreed. "Clients want to know more facts, they want more accountability; they say, 'Prove to me you made these savings.'"

As a result teaching employers

how to interpret reports is now on UR vendors' agendas.

"Benefits people aren't always the best financial people," so UR firms have to design reports that actually say something, Mr. Belichick said.

"It's tough to measure quality from abstract claims data," Mr. Lyle agreed. "Clients are asking for more agreements with providers ahead of time and requiring more detailed, focused analysis of medical data."

Most misunderstandings occur when a benefit manager continues to watch his or her company's health care costs rise, even after implementing a UR program. But, UR does save money, vendors say.

"Health care costs are going to continue to rise," Mr. Lyle said. "But employers have to realize a 14% increase in costs could have been a 25% increase without UR."

In addition to competition based on products and services, independent utilization review firms continue to run a race with huge, insurer-owned UR companies.

"It's strangely competitive," says Russell Robbins, chairman/director-product development for Malden, Mass.-based Peer Review Analysis Inc., the fourth-largest UR vendor.

"You have joint ventures and buyouts occurring, and you also have big insurance corporations that have an easier sell because of their size," he said.

Size, a built-in client base and plenty of financial support all contribute to the success of insurer-sponsored UR firms.

"It's not easy to be profitable" because UR firms need money to enhance systems and avoid takeovers, says Health Data Institute's Mr. Belichick. "And, you can only hold on if you have deep pockets."

Ms. Nishioka of Western Medical Review agreed. "We can't compete with insurance carriers who say they'll do claims and throw in utilization review for free."

Another reason clients may opt to contract for UR services from their insurers is the advantage of having only one toll-free number to call, UR vendors say.

However, most free-standing UR firms say their clients are committed to having someone besides an insurer or third-party claims administrator conduct utilization review to avoid any possible conflicts of interest.

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

Intracorp

Intracorp, the Berwyn, Pa.-based health care management subsidiary of CIGNA Corp., is the largest general service utilization review firm ranked by *Business Insurance* based on the 11.5 million lives it serviced in 1988.

Intracorp recently increased the possible number of reviews each medical procedure receives to four from three.

The majority of Intracorp's initial utilization reviews are conducted by registered nurses over the telephone. If a question arises concerning the appropriateness or necessity of care during this first stage of review, and a nurse cannot authorize an admission or procedure, an Intracorp physician will discuss the proposed services with the employee's doctor, sometimes suggesting alternatives.

When conflicts persist beyond this second stage of review, an independent physician is consulted for a third review, explained Doug Leland, vp-product development.

And, Intracorp has recently introduced a fourth level of physician review with its new outpatient prospective procedure review service.

The prospective review service, which was introduced in January, reviews the appropriateness and necessity of 27 specific outpatient procedures that Intracorp has targeted as overutilized and highly variable in price, Mr. Leland explained.

Under the new program, Intra-
Continued on next page



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Continued from previous page
corp physicians research the most current medical literature and make their decisions based on criteria set forth by experts. If a review progresses to the fourth level of physician interaction, Intracorp doctors share their information and research with provider physicians and will even send copies to the hospital.

"We've chosen not to negotiate fees, but to share information," Mr. Leland explained.
The outpatient service is available in conjunction with other services or on an unbundled basis.

Another service available to employers is a "fee management option," under which Intracorp determines average fees for various medical procedures and reports them to a company's employees so they can determine what their benefit plans will cover and what may end up coming out of the employee's own pockets.

"We want the employer to know we're trying to educate the employee to become a more prudent purchaser and therefore change utilization behavior," he added.

Intracorp, which was founded in 1970 and began providing utilization review services in 1984, reported 1988 gross revenues of more than \$200 million.

Last year, the company reviewed group health, chiropractic, psychiatric and substance abuse services for 20,200 clients, including corporate and institutional employers, insurance companies, health maintenance organizations, preferred provider organizations and third-party administrators.

Intracorp has a staff of 4,000 employees, of which 600 are professionals. However, the company will not release the number of physicians and registered nurses it has on staff.

In addition to its UR services, Intracorp also offers medical case management, claims auditing services and rehabilitation services for workers compensation cases.

Corporate Health Strategies

Westport, Conn.-based Corporate Health Strategies is the second-largest UR firm based on 6.2 million lives serviced in 1988.

Corporate Health Strategies, a unit of Metropolitan Life Insurance Co. of New York, derived 80% of its 1988 gross revenues from providing UR services to employers, with the remainder coming from providing other services.

CHS describes itself as more than just a UR provider: "Our background is in health care cost containment," said Dr. Paul Frankel, national director-medical management, who added that the roots of the company are based in data analysis services.

"The products we've developed are driven by the data analyzed, and with our computer technology, we've had a real opportunity to be state-of-the-art in UR products," Dr. Frankel said.

Because of a shift in the health care industry to increased use of outpatient procedures vs. inpatient care, CHS developed a computerized UR review system designed to electronically screen all claims submitted for outpatient care. The system compares the procedures to national standards that suggest the maximum expected frequency of certain services based on a patient's diagnosis.

For example, assume that a patient's diagnosis is diabetes and the medical services performed by the provider include an office visit, a blood test and a toe X-ray. When the claim reaches CHS, the firm's computer will scan the matrix of diagnoses and services and will "realize" that the toe X-ray was unnecessary based on the diagnosis, Dr. Frankel explained.

A preliminary computer interpretation to deny payment is always followed up by CHS personnel, he stressed.

The company employs 243 staff members, including six physicians and 228 registered nurses. In addition, seven physicians are available to review services on a retainer basis.

CHS has increased the size of its staff by 33% in the last four to six months, said Dr. Frankel, who attributes the growth, in part, to CHS' ability to retain employees.

"We have a high retention rate because people like the job—they're saving (employers) money and improving the quality" of health care services, he said.

CHS provided UR services to 868 clients last year, including corporate and institutional employers, insurers, HMOs, PPOs and TPAs. CHS reviews

group health, psychiatric and substance abuse services.

The majority of CHS precertification reviews are conducted by telephone. However, on-site reviews also may be conducted in certain medical or psychiatric case management situations.

HealthCare COMPARE Corp.

The third-largest UR firm ranked by BI is HealthCare COMPARE Corp. of Downers Grove, Ill., which serviced 5 million lives last year.

The need for UR services has been exacerbated by hospitals' efforts to fill vacant beds, said Dr. Robert J. Becker, chairman and chief operating

officer, pointing out that many inpatient treatments can be provided on a less-expensive outpatient basis or in a non-hospital setting.

"It's one of the primary reasons the costs of employer-sponsored health care plans are continuing to climb significantly," Dr. Becker said. As a result, outpatient review programs, especially for alcohol and drug abuse, are generally more effective and cost much less, he said.

HealthCare COMPARE employees review and monitor the medical necessity and appropriateness of group health, dental, chiropractic, psychiatric and substance abuse services.

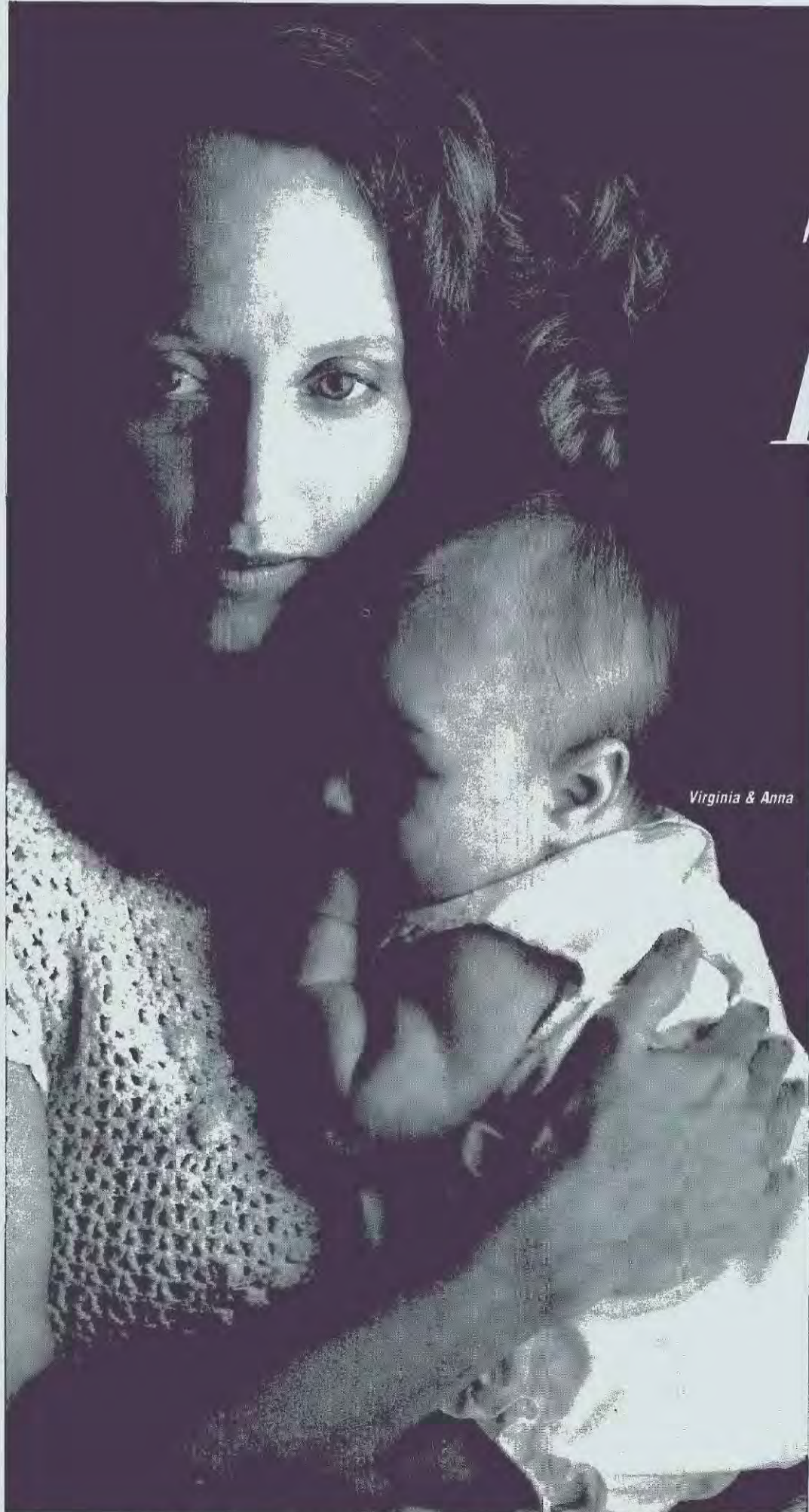
And, in 80% of psychiatric reviews, a psychiatrist will talk to an attend-

ing psychiatrist to discuss treatment plans, delivery and setting, Dr. Becker said.

Of HealthCare COMPARE's 433 staff members, 27 are physicians, 300 are registered nurses, 10 are licensed practical nurses and 15 are medical records technicians. The company uses only trained mental health nurses for psychiatric and substance abuse reviews and employs three full-time psychiatrists.

The independent company reported \$20.8 million in gross revenues in its 1988 fiscal year ended Aug. 31. Those revenues, which represent an 80% increase from 1987 revenues of \$11.6 million, in-

Continued on page 15



Virginia & Anna

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UR vendors

Continued from page 13
clude business from AFFORDABLE Health Care Concepts, a PPO acquired late last year.

HealthCare COMPARE derived 55% of its gross revenues from providing UR services to employers.

HealthCare COMPARE provided UR and cost management services to 12,000 clients in 1988, including insurance companies, TPAs, self-insured employers, government employee groups, multiemployer trusts and Taft-Hartley trusts.

Peer Review Analysis Inc.

Malden, Mass.-based Peer Review Analysis Inc. ranks as the fourth-largest provider of utilization review services, with 4 million lives serviced in 1988.

Peer Review Analysis has shifted its focus from classic utilization review to medical case management, Mr. Robbins explained.

"All of the UR techniques are there, but the major thrust is individual case management from the beginning," he said.

Mr. Robbins stressed the importance of using multispecialty physicians in the UR process, especially in long-term case management.

"Case management shouldn't just have a singular perspective; you have to have an idea of the financial impact and patient and family needs," he explained.

Peer Review is continuing to develop products in this manner, he said. "We said, let's not just develop a cookie-cutter review program."

The UR firm reported 27 total clients in 1988, which included employers, insurers, HMOs, PPOs and TPAs. It derived 0.5% of its \$2.5 million in 1988 gross revenues from UR services provided to employers.

Peer Review employed 45 total staff members last year, including seven physicians, 16 registered nurses and one licensed practical nurse; 65 physicians were on retainer.

Most of the firm's group health and psychiatric/substance abuse care reviews are conducted by telephone.

Corporate Health Care Management

The fifth-largest UR firm is Nashville, Tenn.-based Corporate Health Care Management, a division of EQUICOR Inc.

The UR firm serviced nearly 3.8 million lives in 1988, generating \$17.5 million in gross revenues from providing UR services to employers.

CHCM is moving into review of outpatient services, but in a controlled way, Dr. Taylor said. "A lot of UR firms are jumping onto the bandwagon of outpatient services, but you have to look at the whole picture," he said.

"We've gone into this in a very proactive way," Dr. Taylor said. "We look at claims experience to foresee the impact" outpatient procedures may have on a client's costs.

Another growing area for CHCM is health promotion. Health Choice, a monthly newsletter the UR firm sends to approximately 200,000 employees, helps employees tentatively interpret their symptoms and decide if it is necessary to see a doctor.

Many employers that offer employee assistance programs are buying this product, Dr. Taylor said, adding that access to this information can reduce doctor visits by as much as 20%.

"We are continuing to look at high-impact areas where health promotion can make a difference in the client's bottom line next year," he said.

Of the 600 clients the firm serviced in 1988, nearly all—592—were corporate and institutional employer clients.

CHCM—which reviews group health, dental, chiropractic, psychiatric/substance abuse and podiatric services—employs 236 total staff members, nine of which are physicians and 93 of which are registered

nurses. In addition, 23 physicians are on retainer.

Most CHCM reviews are conducted over the telephone, but a mail system also is available so employees facing elective surgery can send the proper information to the company in advance.

Cost Care Inc.

Cost Care Inc., an independent cost management company based in Huntington Beach, Calif., is the sixth-largest general service UR vendor based on 2.7 million lives serviced in 1988.

Cost Care generated 60% of its 1988 gross revenues from providing UR services to employers, with the remainder derived from providing other services.

While the majority of Cost Care's reviews are conducted by registered nurses over the telephone, all of the decision-making is done by physicians.

This works to clients' advantage because doctors can better evaluate medical necessity, establishing treatment settings and determining adequate lengths of stay, according to President Larry Goelman.

Cost Care has maintained a 30% to 40% annual growth rate since it was founded in 1981, Mr. Goelman said. Initially serving clients for one insurer, the company soon added 11 more insurance organizations and, in 1985, implemented its own sales staff.

"We now market our uniqueness directly to consultants and corporations," Mr. Goelman said.

The company focuses on clinical and diagnostic data rather than on statistical data alone. For example, many UR firms base admission authorization on data bases containing utilization rates for certain age groups or ZIP code areas; they don't take into account the individual patient's symptoms and medical history—a vital part of the decision-making process, he explained.

"We're going to continue to build this data processing ability of analyzing and managing medical episodes," Mr. Goelman said. "Our clients are the lab for us to come up with programs to meet their needs."

The company's 268 staff members include 19 physicians, 136 registered nurses and 10 medical records technicians. Six physicians are available on a retainer basis.

Cost Care reviewed group health, chiropractic, psychiatric and substance abuse services for 6,678 clients in 1988.

Value Health Inc.

The seventh-largest provider of utilization review services is Avon, Conn.-based Value Health Inc., which serviced 2.8 million lives in 1988.

In addition to general UR services, Value Health offers specialty UR services—including review of group health, prescription drug and podiatric services—through its various subsidiaries:

- Value Health Sciences, a subsidiary based in Santa Monica, Calif., offers a clinical standards-based approach to precertifying the medical necessity of high-cost inpatient and outpatient procedures.

Based on research from Rand Corp., the Santa Monica-based think tank, VHS developed software to determine the appropriateness of medical procedures for particular kinds of patients. The company licenses the software to other UR vendors to help them prescreen high-cost medical procedures and then conducts physician reviews based on that prescreening.

"Other UR firms just aim at authorizing the level of treatment—for example, to admit to the hospital or not," said Value Health President Robert E. Patricelli. "This system permits a medical necessity judgment about procedures."

- ValueRx, another unit of Value Health Inc., screens drug claims data to identify people at high risk

Continued on next page



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UR vendors

Continued from previous page for drug-induced illnesses.

The company, based in Arlington, Va., alerts prescribing doctors when it may be necessary to change their prescription patterns.

For example, if a physician isn't aware of additional medication a patient may be taking for other ailments, the drugs they prescribe can exacerbate symptoms or negate the effectiveness of other medication.

"Ten percent to 25% of patients in the population we review are having a drug conflict," he said.

- The National Foot Care Program, based in Southfield, Mich., reviews prospective and retrospective treatment of podiatric procedures.

- American PsychManagement Inc. provides mental health and substance abuse services (see profile, page 26).

Value Health is a "science-based specialty managed care company," said Mr. Patricelli. "We don't operate in a broad managed care world," he said. "We operate in niches."

Value Health employs 119 professional staff members, including five physicians, nine registered nurses and six medical records technicians; seven physicians were on retainer in 1988. The company reported servicing 84 clients last year, 59 of which were corporate and institutional employer clients.

The company derived 10% of its 1988 gross revenues from providing UR services to employers.

The Sunderbruch Corp.

The Sunderbruch Corp., a privately owned UR vendor based in West Des Moines, Iowa, is the eighth-largest UR vendor, servicing 2.7 million lives in 1988.

The company generated 70% of its revenues from providing UR services directly to employers.

Reviews are handled by registered nurses who receive information over the telephone from either the patient or the attending nurse or physician, according to Pam DePriest, director of marketing.

The company only employs registered nurses with at least five years of experience, she said, because "they ask the right questions." Providers appreciate the fact that they are dealing with people who are medically knowledgeable, not just claims-oriented, she added.

"Claims and insurance are financial functions, not health care functions," interjected Richard McMasters, Sunderbruch's chief executive officer. "We believe those functions should be left to those experts, just as medical review is left to our experts."

Mr. McMasters also stressed the importance of establishing a good relationship with providers. Saving employers money is important, but "you have to care about the providers too; if you do they will cooperate and help you plan a cost-effective treatment program," he said.

According to Ms. DePriest, 80% of the calls for preadmission certification are approved by Sunderbruch reviewers. If an admission is questioned, a physician will discuss the situation with the attending doctor and try to work out an alternative.

"We won't let a patient be admitted to the hospital without being seen by a physician," Mr. McMasters said, noting that admissions are administrative in nature, not medical.

Sunderbruch also does not assign a fixed length of stay based on a patient's admission information, though it is easier to do so.

And, because patients with the same symptoms may react quite differently to medical procedures and initial diagnoses are often misleading, Sunderbruch nurses always contact the provider the following day to check a patient's progress, Ms. DePriest explained.

The company never initially certifies an admission for more than three days, regardless of condition severity, Ms. DePriest added.

One of the biggest conveniences for clients is that Sunderbruch's preadmission review program operates 24 hours a day, seven days a week.

"Our national clients feel good about our (availability) because they don't need to worry about time zones in different areas," Ms. DePriest said.

The reports Sunderbruch generates on utilization data do not depict savings in terms of dollars; rather, the client receives information on admitted days and total discharges.

"It's a better way to measure utilization patterns because often it is difficult to determine dollar amounts," Mr. McMasters said.

The company generated gross revenues of \$11.8 million last year from reviewing group health, chiropractic, psychiatric and substance abuse services for 78 total clients, 63 of which were corporate and institutional employers.

Professional staff members at Sunderbruch include two physicians, 89 registered nurses, three licensed

practical nurses and four medical records technicians.

Western Medical Review

The ninth-largest UR vendor is Western Medical Review, based in Torrance, Calif. The company, whose sole business is providing utilization review services, reported servicing 2 million lives last year.

Unlike many UR firms, Western Medical Review conducts all of its concurrent and retrospective reviews on site. "It's labor-intensive and we do it because that's what clients want," explained Victoria M. Nishioka, review manager.

While on-site services cost more, there are clear advantages, she pointed out.

For example, the reviews are more timely because "you have direct access to patients' medical records so you don't have to track down information over the phone," she said. Also, because the reviewers have the medical chart in their possession,

they know which procedures have been done or which are being suggested so reviews are more accurate.

Ms. Nishioka said many UR firms have difficulty tracking down the admitting doctor or nurse, and quite often the provider will not return the reviewer's call in a timely manner.

"You can kill one day trying to track these people down, and the next day the patient may have been discharged so we can't intervene," she said.

Founded in 1977, Western Medical "started as a Medicare professional review organization," Ms. Nishioka said. In 1980, the company started providing private utilization review services and eventually stopped servicing its Medicare business.

The company grew dramatically between 1980 and 1985, Ms. Nishioka said, attributing much of the increase in business to the growing trend for companies to self-insure.

"Those companies were looking for

cost control and decisions on medical necessity became a need for them," she said.

The company was recently contacted by an HMO, so she expects the number of lives Western Medical Review services to increase significantly.

In addition, the company will begin offering new home health review and workers compensation case management products.

Western Medical Review employs 40 total staff members, including one physician, 22 registered nurses, three licensed practical nurses and five medical records technicians; 50 physicians are available on a retainer basis.

The company reviews group health, dental, chiropractic, psychiatric and substance abuse services.

Western Medical Review serviced 350 clients in 1988, 40 of which were corporate and institutional employer clients.

Continued on next page

To A Lot Of Insurance This Was A Stop Sign.

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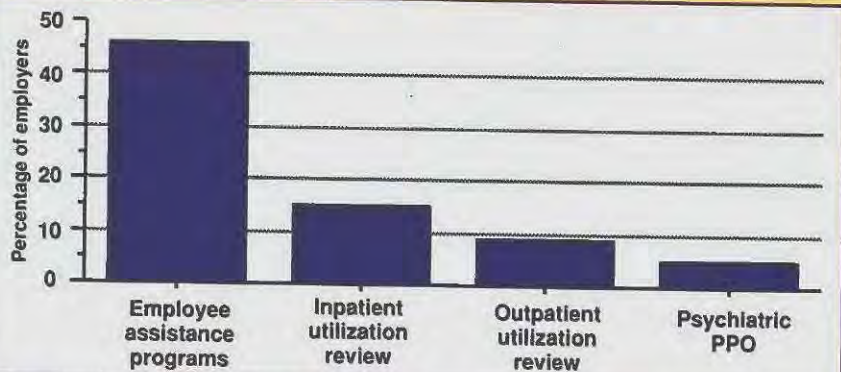
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How employers manage mental health/substance abuse costs



Graphic: Holly Seguire

Source: A. Foster Higgins & Co. Inc.

Employers shift focus to controlling costs of mental health care

By STACY ADLER

As the costs of mental health care charge out of control, employers are attempting to take the bull by the horns.

Among their most dramatic moves to hold down rising mental health care costs, employers are encouraging employees to seek less-expensive forms of treatment and contracting with preferred provider organizations composed solely of mental health care specialists.

In addition, nearly half of the nation's employers already have established employee assistance programs to steer workers toward the most appropriate and cost-effective forms of treatment.

And, a growing number of employers are implementing utilization review programs that specialize in mental illness (see story, page 25).

"With good benefit design, an EAP program, utilization review, case management and mental health care cost controls, employers can realize substantial savings while increasing the quality of care for their employ-

Continued on next page



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UR vendors

Continued from previous page

Gross revenues for the company totaled \$2.4 million, 60% of which were generated from providing UR services directly to employers.

August International Corp.

Orange, Calif.-based August International Corp. is the 10th-largest UR vendor, with just fewer than 2 million lives serviced in 1988.

The privately held company is a consolidation of three services: UR, third-party claims administration and a PPO, according to August's president, Blayne Lequeux.

The company's growth has been explosive, he said. "Every year for four years we've tripled our company's size," he said.

Part of his firm's success with UR comes from the fact that specific individuals at the company take care of certain clients, thereby creating a relationship where potential problems are discovered immediately.

"That's why we retain clients and we're still growing," Mr. Lequeux explained.

Another reason for August's popularity is its integrated data system and the thoroughness and accuracy of the reports generated, said Vp Jeff Merkow.

Benefit managers "are used to getting voluminous documents from other entities," Mr. Merkow said. "Ours are understandable and help them design future benefits plans."

The next area of data analysis the company will focus on is what Mr. Lequeux calls "smart reports."

The system will anticipate what information will be necessary for the reviewer to make a decision on whether to admit a patient. While the system will not actually make the decision, it will tell the reviewer what questions to ask.

"The net result will be that we will truly know whether an admission is medically necessary and what the appropriate treatment will be, because it is getting humanly impossible for one person to know all the facts and ask the right questions," he said.

The company employs 230 staff members. Professional staff members include three physicians and 48 registered nurses. Forty-five physicians are on retainer.

More than 2,000 total clients were reported in 1988, 42 of which were corporate and institutional employer clients.

August International reviews group health, dental, chiropractic, psychiatric and substance abuse services.

About 53% of the company's gross revenues were derived from providing UR services to employ-

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Psychiatric care

Continued from previous page
ees," said Susan Prest, a licensed psychologist and director of managed mental health care at Health Risk Management Inc., a managed care firm in Minneapolis.

Some 20% to 25% of all employer health care expenditures go toward psychiatric and substance abuse treatment, she estimated.

Furthermore, mental health care costs are going up faster than any other medical specialty," Ms. Prest added. "The costs are out of sight."

Psychiatric and substance abuse treatment costs are among the major contributors to the sharply rising medical care component of the Consumer Price Index, agreed Ira Studin, vp of Preferred Health Strategies Inc. in White Plains, N.Y.

A recent survey by benefit consultant A. Foster Higgins & Co. Inc. shows that the cost of providing mental health and substance abuse

benefits grew 27% to an average of more than \$207 per employee in 1988, up from \$163 per employee in 1987.

Psychiatric care expenses, including substance abuse benefits, accounted for 9.6% of employers' overall medical care costs last year, the survey said.

"Psychiatric and substance abuse treatment now accounts for \$38 billion—or 7%—of the nation's annual health care expenditure," added Dr. William N. Werner, medical director for Republic RSB Cos. Inc., a managed care firm in Naperville, Ill.

But, Dr. Werner's estimate doesn't take into account social costs related to treating mental disorders, such as lost workdays and productivity, crime and social welfare programs.

All told, the economic cost to society of mental disorders rose 35.2% to \$73 billion from \$54 billion between 1980 and 1983, according to the most recent statistics available from the U.S. Alcohol, Drug Abuse and Mental Health Administration (BI, Sept. 29, 1986).

The agency is currently compiling its next report, but the data has not been made public.

Among factors contributing to the huge increases in mental health care costs are increased employee stress, increased social acceptability of psychiatric treatment and the increased incidence of treatment of adolescent mental illness, experts say.

Adolescent admissions to hospitals for psychiatric treatment jumped 450% between 1984 and 1987, estimated Ms. Prest of HRM.

In contrast, the incidence of emotional trauma or chemical dependency problems among employees and other dependents did not increase significantly during that time, she pointed out.

The success of medical utilization review programs also is partly to blame for the increasing incidence of mental health expenditures, experts say. Because employees and their dependents are spending fewer days in hospitals for medical problems, hospitals looking for new sources of revenue are emphasizing mental health care.

"Providers use psychiatric care as a way to keep beds filled," said Joan Pearson, a consultant with Towers, Perrin, Forster & Crosby Inc. in Seattle.

Providers also are more aggressively marketing their adolescent psychiatric treatment programs, experts point out.

Treatment programs for adolescent chemical dependency are "a relatively high-profit area for hospitals," explained Michelle Alkon, director of research evaluation for Philadelphia-based TAO Inc., a UR firm specializing in psychiatric and substance abuse services.

In addition, hospitals are launching myriad inpatient psychiatric programs to treat all types of mental disorders ranging from sexual and religious addictions to stress.

"Who benefits from all of these types of programs is the provider—financially," said Ms. Prest.

To prevent abuses in the system, "a lot of employers are taking a look at their mental health care benefits," said Kathy Tennesen, a consultant with Hewitt Associates in Santa Ana, Calif.

"Employers must take a long, hard look at their mental health care benefits," agreed Ms. Prest.

At the start, employers must be careful that their employee benefit plans do not encourage the use of expensive inpatient psychiatric care and discourage the use of less expensive outpatient care, explained Ms. Tennesen of Hewitt.

Ms. Prest agreed: "It tends to be the benefit that drives the treatment. Employers must make alternatives to costly inpatient care available."

Thus, employers should provide equal—if not greater—coverage to employees who seek treatment through outpatient programs, experts say.

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The New PCS

Mental health care

Continued from page 18

The National Assn. of Private Psychiatric Hospitals recommends that coverage "be extended to a full continuum, including outpatient services, partial hospitalization, residential treatment centers, halfway houses and other transitional and community residency programs."

"Outpatient care can be equal to if not better than" inpatient treatment in some cases, according to Dr. Kenneth Kessler, president of American PsychManagement Inc., a psychiatric UR firm in Arlington, Va.

However, "this is not to say inpatient care is inappropriate. . . There is a real role for inpatient programs," he added.

Employers also can cut their mental health care costs by encouraging employees to use selected mental health care providers that have agreed to discount their services, experts say.

Already, some 5% of employers are offering psychiatric PPOs to their employees, according to the A. Foster Higgins survey.

In a psychiatric PPO, the patient begins by calling a toll-free number to talk to a psychiatric nurse or doctor. The nurse or doctor then refers the patient to the appropriate type of practitioner for care.

For example, an employee with marital problems might be referred to a psychiatric social worker, while someone who is severely depressed might be referred to a psychologist or a psychiatrist.

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

Employers that are considering contracting with a psychiatric PPO should look for one that has a proven track record as well as a diversified and high-quality staff, Dr. Werner of Republic RSB recommends.

In addition, employers should study both the inpatient and outpatient services offered by the PPO, as well as the types of utilization review controls applied, he added.

However, Dr. Werner warns employers to be very careful when communicating to employees a switch to a PPO-type of arrangement. "PPOs are often perceived by employees that they are losing their freedom of choice," he explained.

While psychiatric PPOs are proliferating, employee assistance programs remain the most popular method used by employers to curb employee and dependent mental health care costs.

Forty-six percent of the employers surveyed by A. Foster Higgins reported having an EAP up and running, while another 8% plan to create an EAP by 1990.

An EAP usually involves an in-house licensed psychologist who acts as the gatekeeper. Patients contact the EAP director, who can offer the employee some limited care or refer the employee to a more appropriate provider.

The biggest advantage of an EAP is that it helps employers identify employees' psychiatric problems in the early stages, experts say. A drawback, however, is that an EAP often can

lead to increased utilization of psychiatric services by employees.

"Employers should make certain to coordinate their EAP programs with any kind of case management they are doing," warns Jack Newstrom, president and chief executive officer of United Behavioral Systems Inc. in Minneapolis, a managed care unit of United Health Care Systems.

"If left to run wild, EAPs can increase costs," he said. "However, if they are managed, EAPs can reduce costs by identifying problems in the workplace."

William Maloney, executive director of psychPACER Utilization Review/MCC Cos. Inc. of Minneapolis, agrees.

"As a defensive measure, an EAP needs a managed care back-up," he said. The use of UR services allows EAPs "to continue to do what they do best," he added.

While more employers have EAPs in place, a growing number are contracting with utilization review providers that specialize in psychiatric treatment to monitor outpatient and inpatient treatment of mental disorders.

In fact, in 1988, 15% of employers used a psychiatric UR firm to review inpatient care, and 9% used specialized UR for outpatient care, according to the A. Foster Higgins survey.

Among the services provided by psychiatric UR firms are: preadmission review, concurrent review, discharge planning, case management and outpatient review.

Assistant Copy Editor Jacqueline LaSota contributed to this report.

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Mental health costs Insurer tests plan on own employees

By STACY ADLER

Mutual of Omaha Insurance Co. is implementing a bold, new plan to bring down the high costs of mental health care for its 8,000 employees nationwide.

"We saw a trend within our own employee group that mental health care costs were outpacing medical/surgical costs," explained Al Wagner, vp-group managed health care for the Omaha, Neb.-based insurer.

For example, by studying its own employees' claims, the insurer found that its employees were admitted to the hospital for psychiatric care or filed medical claims for psychiatric care more frequently than the general claim population.

Specifically, the company found that between Jan. 1, 1988, and Oct. 1, 1988, 11.7% of all of its employees' hospital admissions were for mental health care or substance abuse.

On the other hand, when the company surveyed its policyholders' claims, it found that only 10.9% of all hospital admissions were for psychiatric care.

And by looking at policyholder claims data dating back to 1985, the insurer realized that both the number of hospital admissions related to psychiatric care and the number of claims related to psychiatric care were rising sharply.

Furthermore, the company found that between Jan. 1, 1988, and Oct. 1, 1988, 6.2% of the psychiatric care claims consumed 44% of the total claims dollars spent on psychiatric care for Mutual of Omaha employees.

"We realized that if we managed only 6% of the claimants we were managing a sizable amount of dollars," Mr. Wagner said.

To curb this "alarming trend" within its own house, Mutual of Omaha formed a task force to study the problem, Mr. Wagner explained. The task force, which was composed of representatives from the benefits, personnel, underwriting and group operations departments, recommended a three-prong strategy to reduce costs.

First, the company redesigned its employee benefit plan to encourage employees to use managed mental health care.

The company dramatically decreased its coverage for employees who received their mental health care coverage from providers that did not

Continued on page 22

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Mutual of Omaha plan

Continued from page 20
belong to the company's own Mutually Preferred provider organization.

Employees who went outside the Mutual of Omaha PPO saw their deductibles jump to \$250 for individuals and \$500 for families per year, from a \$150 deductible for individuals and \$300 deductible for families per year.

Similarly, employees who went outside the PPO saw their copayment rise to 50% from 20% of the cost of office visits.

Mutual of Omaha also modified psychiatric care coverage for employees who used the company's own PPO.

Prior to Jan. 1, 1988, employees using the PPO had a 20% copayment on the cost of their office visits with no deductible. However, after Jan. 1, 1988, employees' office visits were subject to a \$100 deductible for individuals and a \$200 deductible for families, both with a 20% copayment.

In addition, employees using the PPO for inpatient treatment saw their copayments rise to 10% from 5%, and their deductible increase to \$100 for individuals and \$200 for families from

In an unusual move, Mutual of Omaha will tie the UR firm's compensation to the amount of psychiatric cost savings that are produced by the firm.

zero.

Mutual of Omaha also instituted new limits on the amount of chemical dependency treatment employees could receive.

Prior to Jan. 1, 1988, employees could receive up to 30 days of treatment for chemical dependency in any 365-day period. There was a lifetime limit of two such confinements regardless of length of stay.

After Jan. 1, 1988, employees could receive up to \$10,000 of coverage per year and a lifetime maximum of \$30,000.

The insurer also launched a health maintenance organization in mid-1988 that is available to employees for either medical/surgical or psychiatric care.

The second phase of the company's three-pronged plan involved implementing a comprehensive utilization review program with United Behavioral Systems Inc. of Minneapolis, a unit of United Health Care Systems.

In an unusual move, Mutual of Omaha will tie the UR firm's compensation to the amount of psychiatric cost savings produced by the firm.

Any cost reductions of more than 20% to 24% will result in increased income for the UR firm. Any reductions below 20% to 24% will result in decreased income for the UR firm.

However, the amount of increased income the UR firm can achieve tapers off after psychiatric costs are reduced by 35% to 40% in order to prevent the company from "squeezing too much," explained Mr. Wagner.

The third prong of Mutual of Omaha's plan involves the company's employee assistance program.

Mutual of Omaha has a licensed psychologist on staff who "acts as a traffic cop," directing employees to the most appropriate type of psychiatric care, explained Mr. Wagner.

"We want our employees to receive the appropriate treatment and the right level of care," he said.

How to pick psychiatric UR providers

By STACY ADLER

More and more employers are selecting specialized utilization review firms to help control the costs of mental health care.

But, choosing the best company can be difficult. According to utilization review experts, employers should choose a psychiatric utilization firm based on several criteria:

- Training and background of medical staff.

Susan Prest, director of managed mental health care at Health Risk Management Inc. in Minneapolis, suggests that the UR firm's staff should be specialists in mental health and chemical dependency treatment. In addition, the staff should be multi-disciplinary, including psychiatrists, psychologists and psychiatric social workers, she said.

- Guidelines used to recommend appropriate care.

Ira Studin, vp of Preferred Health Strategies Inc. in White Plains, N.Y., warns employers against choosing utilization review firms that "downplay everything."

He says the firm should be willing to recognize a serious problem and instruct the employee to receive the appropriate care.

Ms. Prest agreed, saying it is imperative that the UR have "up-to-date criteria for making treatment decisions."

In addition, the UR firm should be able to explain to the employer how it arrived at its criteria, she said.

Dr. William Werner, medical director at Republic RSB Cos. in Naperville, Ill., said the UR firm should have an established procedure for how disagreements between the UR firm and the provider are resolved.

- Track record.

Dr. Werner suggests that employers judge utilization firms by their track record in servicing employees with proper treatment. He said employers should pay careful attention to the number of times employees are re-admitted for the same illness.

- References.

Ms. Prest of HRM suggested that employers should check the references of the utilization review firm. Employers should talk to current clients as well as former clients of the firm. It is important to find out why former clients left the UR firm, she explained.

- Data analysis.

Find out if the UR firm can provide data analysis reports—quarterly, if possible—documenting employee treatment and review services provided, suggests Michelle Deverich, director of promotion and development for Advanced PsychSystems in Washington, D.C.

Typical information to which the employer should have access includes utilization rates by employees, demographic data and information on work in progress, she added.

- Cost of services.

The experts warned against picking a utilization review firm based solely on cost.

"The more progressive employers are not going to be looking for the cheapest utilization review firm, but the most effective," said Mr. Studin of Preferred Health Strategies.

Ms. Prest agreed: "Employers should be careful of UR firms that are simply cutting all services in order to reduce costs."

Assistant Copy Editor Jacqueline LaSota contributed to this report.

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Growth in psychiatric services spurs call for utilization review

By JACQUELINE LaSOTA

Increasing use of psychiatric and substance abuse treatment is creating a business boom for psychiatric utilization review services.

One of the biggest growth areas for these firms is review of adolescent substance abuse programs, often the largest dependent care expense paid under employers' mental health care benefit plans.

While many general service UR firms provide such services as part of their overall review packages, many specialty UR firms are sprouting up that exclusively provide psychiatric UR services.

This year, *Business Insurance* for the first time has ranked the largest providers of psychiatric UR services based on number of lives serviced.

Among the largest psych UR providers are Advanced PsychSystems, a Washington, D.C.-based unit of the American Psychiatric Assn.; Preferred Health Care Ltd. of Wilton, Conn.; TAO Inc., a subsidiary of Independence Blue Cross of Philadelphia; psychPACER Utilization Review/MCC Cos. Inc., a CIGNA Corp. unit based in Minneapolis; and American PsychManagement Inc. of Arlington, Va. (see chart).

These specialized UR firms, many of which are linked to psychiatric hospitals or associations, claim they are better equipped to manage psychiatric and substance abuse treatment than general service UR firms that conduct mostly medical treatment reviews.

For example, because of its affiliation with the American Psychiatric Assn., Advanced PsychSystems can call on any of the more than 33,000 association members in any area of expertise to determine the appropriate treatment.

General service UR firms will "never be as good as we (specialized UR firms) are," asserts William R. Maloney, executive director of psychPACER, the fourth-largest psychiatric UR firm.

PsychPACER services its 1.3 million lives through clinics operated through preferred provider organizations owned by MCC Cos. Inc., a unit of CIGNA Corp. (*BI*, Jan. 23).

PsychPACER also provides psychiatric case management, employee assistance programs, crisis intervention and inpatient and outpatient counseling (*BI*, Feb. 15, 1988).

American PsychManagement, the fifth-largest psychiatric UR firm, also provides mental health care services through a preferred provider organization established in 1983 (*BI*, Sept. 29, 1986).

"Our goal is to modify the treatment plan to arrive at cost-effective and appropriate treatment," explained Dr. Kenneth Kessler, president of American PsychManagement.

Although some employers are reluctant to hire a second vendor to provide psychiatric UR, "they've tried alternatives and come to us," said Dr. Kessler. "Half of our business is take-away business."

The most common service provided by psychiatric UR firms today is adolescent mental health and chemical dependency treatment review.

Among the factors contributing to growth in this area of practice are an increase in the number of specialized, hospital-based adolescent chemical dependency treatment programs and the diminishing stigma associated with receiving psychiatric care.

Chemical dependency programs

for adolescents are very profitable for hospitals, according to Michelle Alkon, director of research evaluation for TAO, the third-largest provider of psychiatric UR services. TAO specializes in case management for inpatient mental health and chemical dependency treatment.

"The aggressive marketing of hospital chains... is falling on fertile ears," noted Dr. Kessler of American PsychManagement.

Working parents are more willing to put their children in a health care facility because the stigma that was once associated with psychiatric care is dissipating, he noted.

"In general, the guilt for leaving a child (in a health care facility) is not as great as it was, and hospitals are catering to that," agreed Mr. Maloney of psychPACER.

Continued on next page

5 largest psychiatric utilization review firms

Company (Ownership)	Lives serviced
Advanced PsychSystems (American Psychiatric Assn.)	12,250,000
Preferred Health Care Ltd. (Publicly held)	5,250,000
TAO Inc. (Independence Blue Cross of Philadelphia)	2,300,000
psychPACER Utilization Review/MCC Cos. Inc. (CIGNA Corp.)	1,310,000
American PsychManagement Inc. (Value Health Inc.)	1,200,000

Source: *BI* survey

Chart: Christine Woolsey

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Because adolescent treatment programs "have longer lengths of stay"—especially for substance abuse—there is a need for utilization review, explained Michelle Deverich, director of promotion and development of Advanced PsychSystems, the largest provider of psychiatric UR services.

Adolescents are "the biggest users—once they get in they stay forever," said TAO's Ms. DeHart. To keep these treatment costs in line, "we red-flag adolescents," she said.

However, adolescents are not the only ones being treated for chemical dependency. Employers also are discovering increasing drug and alcohol abuse among employ-

ees.

Chemical dependency "is what employers are most concerned about," said TAO's Ms. DeHart.

A recent study conducted by TAO of its Blue Cross group subscribers showed that in 1986 and 1987 admissions for alcohol and drug abuse were greatest in the 20-to-34 age bracket. In addition, the greatest proportion of admissions for both types of treatment was for male employees.

The increase in employee substance abuse has forced employers to take a closer look at how to manage treatment costs, UR providers say.

"The biggest buyers of UR services are in the corporate market," said Ms. DeHart.

"There's a whole corporate market in the '90s that's becoming aware" of the need to control these costs, she added.

Following are profiles of the five largest UR firms that specialize in psychiatric treatment review:

Advanced PsychSystems

Washington, D.C.-based Advanced PsychSystems is the largest psychiatric and substance abuse utilization review firm ranked by *Business Insurance*, with 12.3 million lives serviced in 1988.

Advanced PsychSystems, which began providing UR services in 1979, obtained 95% of its 1988 gross revenues from providing psychiatric UR services to employers. Five percent of gross revenues re-

sulted from services provided to other entities like insurers, preferred provider organizations and health maintenance organizations.

The UR firm is a subsidiary of the American Psychiatric Assn.

Recently, Advanced PsychSystems began the dissolution of a joint venture with Intracorp, a health care management subsidiary of CIGNA Corp., that was started in 1985. American PsychSystems performed prospective review work for approximately 25,000 Intracorp clients as part of the exclusive joint venture.

The mutual termination of the joint venture will initially result in fewer lives serviced, Ms. Deverich said. But, "we are confident we are going to get (back) the clientele,"

she added.

Advanced PsychSystems is the sole psychiatric UR firm for CHAMPUS, the Department of Defense health care program that covers dependents of armed forces members. Additionally, the firm provides psychiatric retrospective review services for 37 insurance companies.

One of its products under development, which is scheduled to be introduced later this year, will measure the impact of the utilization review process on quality care, according to Ms. Deverich. This service "will be very much in demand," but "it's got to be done responsibly," she said.

Advanced PsychSystems provides preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient service predetermination and case management. Occasionally, Advanced PsychSystems provides disability review and workers compensation services.

Advanced PsychSystems employed 75 professional staff members in 1988, including 9 psychiatrists, 45 registered psychiatric nurses, 20 social workers and one medical records technician. The company also employs 900 professionals that are compensated on a per-case basis.

Principal officers in addition to Ms. Deverich include: Dr. Melvin Sabshin, medical director-American Psychiatric Assn.; Dr. John Hamilton, deputy medical director for psychiatric services-American Psychiatric Assn.; and Norman Penner, director, office of quality assurance-Advanced PsychSystems.

Preferred Health Care Ltd.

Wilton, Conn.-based Preferred Health Care Ltd. ranked second among companies providing psychiatric and substance abuse UR services, based on 5.3 million lives serviced in 1988.

Preferred Health Care, which was founded in 1983, began providing UR services in 1985.

Preferred Health Care generated 1988 gross revenues of \$13.3 million, with 57%, or \$9.1 million, generated by UR services to employers. The remaining 43% of gross revenues was from services provided to other companies.

The UR firm offers preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, on-site case management and family support services. Preferred Health Care occasionally provides retrospective review and hospital bill audits.

Preferred Health Care employed 149 people in 1988, including five physicians, eight psychologists and seven registered nurses.

The firm serviced 81 clients, 21 of which were corporate and institutional employer clients.

Preferred Health Care officers include Dr. Jay Reibel, chairman; David McDonnell, chief executive officer; and Paul Litwak and Steve White, executive vps.

TAO Inc.

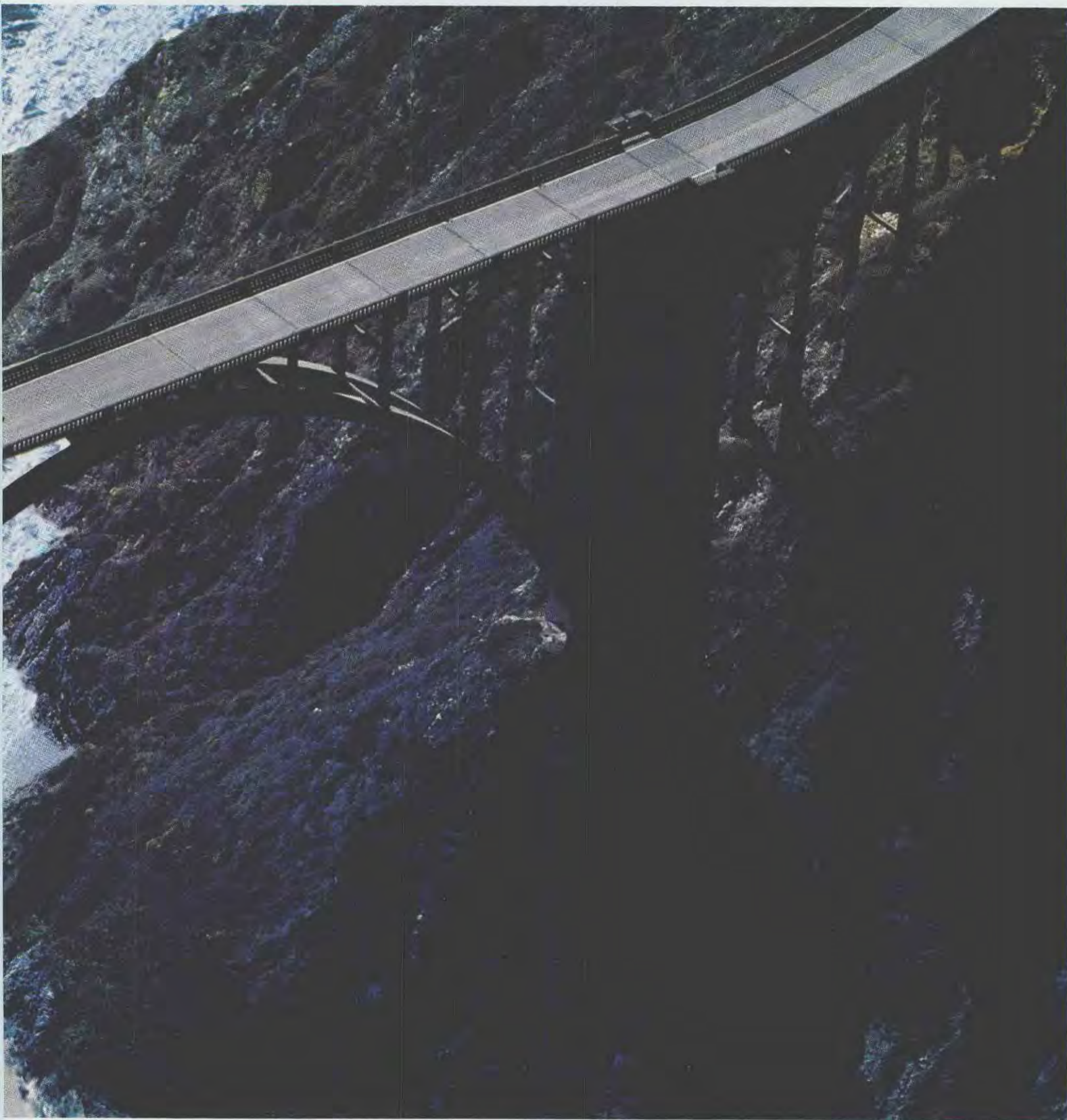
TAO Inc. of Philadelphia ranked No. 3 in *BI's* survey of psychiatric and substance abuse UR firms by servicing 2.3 million lives in 1988.

The company, a subsidiary of Independence Blue Cross of Philadelphia, began providing UR services in 1985.

Total gross revenues in 1988 were \$3.8 million, of which 6%, or \$210,000, was generated by services provided directly to employers. Ninety-four percent of revenues were derived from services provided to other companies.

Continued on next page

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Psychiatric UR

Continued from previous page

TAO specializes in case management for inpatient mental health and chemical dependency treatment.

It also has begun offering outpatient review as a free-standing service to clients.

Other services TAO provides include preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, and outpatient psychiatric and substance abuse services.

The UR firm occasionally provides retrospective review and hospital bill audits.

In the second quarter of 1989, TAO expects to introduce a new insurance benefit product called PsychSystems in conjunction with Independence Blue Cross.

This new service will be offered as an alternative to an employer's

'We have such a large population concentration in one area (Philadelphia),' that when TAO offers a new product line it can 'iron out problems locally,' said Ms. DeHart. The result is a national product that is fully functioning much faster, she added.

basic psychiatric benefit package available, said Donna E. DeHart, vp-marketing.

Under the program, the insurer provides each employee with a "bank" of inpatient psychiatric care days per year, said Ms. DeHart.

An inpatient day would hold a certain value and could be traded for other necessary treatment. For instance, a person could trade one inpatient day to receive two days of residential treatment.

When an employee decides he needs psychiatric treatment, he

calls a participating provider. The provider then performs a pre-care assessment review according to TAO guidelines. From this mandatory assessment, the employee is diagnosed and treatment commences.

TAO's PsychSystems will not require that a patient begin treatment with inpatient care, as do some mental health care packages, Ms. DeHart said. After the mandatory pre-care assessment the patient is diagnosed for the most effective care, which may only require residential or outpatient

treatment.

After refining the product on a local level, TAO expects to take the program nationwide.

This local refinement is something TAO practices with all its products.

"We have such a large population concentration in one area (Philadelphia)," that when TAO offers a new product line it can "iron out problems locally," said Ms. DeHart.

The result is a national product that is fully functioning much faster, she added.

The TAO staff includes 38 full-time members, including administrative and clerical workers. Of 18 professional staff members in 1988, three were physicians, 14 registered nurses and one medical records technician. One physician is on retainer.

In addition to Ms. DeHart, principal officers are: Anthony F. Panzetta, president and chief execu-

tive officer; and Barry Davis, vp and chief operating officer.

psychPACER Utilization Review/MCC Cos. Inc.

Ranking No. 4 in the BI survey is psychPACER Utilization Review/MCC Cos. Inc., a unit of CIGNA Corp. The Minneapolis-based psychiatric and substance abuse UR firm serviced 1.3 million lives in 1988.

Gross revenues totaled \$32 million in 1988, 99% of which was derived from providing services to companies other than employers.

PsychPACER, which was founded in 1974, provides services through preferred provider organizations owned by MCC Cos. Inc. Some 900,000 lives are reviewed by psychPACER personnel at local clinics in the PPOs to determine necessary treatment. The remaining 400,000 clients are reviewed over the phone.

Often, reviewers will go into the hospitals to conduct concurrent treatment reviews with patients and providers.

PsychPACER also offers services for preadmission certification, length of stay determination, discharge planning, retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services and case management.

The UR firm employed 350 staff members in 1988, including 160 professionals and 16 physicians on retainer.

The UR firm serviced 150 total clients, including 125 corporate and institutional employers.

Principal officers include Terence Wills, president; J. Randall Cox and Joseph Strahan, vps-operations; William R. Maloney, executive director; Mark Tidgewell, vp-finance; Greg Heineemann, vp-marketing; Dr. John Bartlett, corporate medical director; and Carol Staples, director-development.

American PsychManagement Inc.

American PsychManagement Inc. holds the No. 5 spot in BI's ranking of psychiatric UR firms, servicing 1.2 million lives in 1988.

Since beginning operations in 1983, the most frequent service provided by American PsychManagement has been concurrent hospital treatment review.

The UR firm also conducts preadmission certification, length of stay determination, discharge planning, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services and case management.

It also may provide third-opinion and workers compensation review services.

Value Health Inc., a group health service UR provider in Avon, Conn., is a major shareholder of American PsychManagement.

The company employed 81 people in 1988, including administrative and clerical staff. Of that number, 54 were professionals and 10 were physicians on retainer.

Although 1988 gross revenues will not be released until March, the company reports that 12% of 1988 revenues came from UR services for employers. Eighty-eight percent of revenues were derived from services provided to other companies, including insurance companies and PPOs.

Thirty of the firm's 57 total clients in 1988 were corporate and institutional employers.

American PsychManagement operates a branch office in Alameda, Calif., which provides managed care services only.

Officers are Dr. Kenneth A. Kessler, president; Dr. Daniel Patterson, vp-medical affairs; and Dr. Peter T. Stanton, vp-marketing. ■



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Role of second opinions is evolving: Experts

By JUDY GREENWALD

Despite recent moves by two large insurers to drop their second surgical opinion requirements, the practice is not becoming passe, health care utilization review experts say.

Instead, the role of the second opinion as a cost-containment device is evolving, observers say.

Rather than dropping second surgical opinion programs, many employers are making them optional for certain procedures or using non-surgeon reviewers to determine whether a second opinion is necessary.

Other employers are touting the programs as an added employee benefit that can ease an employee's anxieties when he or she is facing a major medical procedure.

Still others are restructuring their second surgical opinion programs as part of an overall managed care program that also includes such elements as precertification and discharge planning.

"There is no question you can't just drop in a second opinion program and expect to solve all your problems," said Bill Danish, a consultant with Kwasha Lipton in Fort Lee, N.J.

"We look at second opinions as basically an educational tool," said John Shattuck, senior vp of Chicago-based Blue Cross & Blue Shield of Illinois.

When second-opinion programs first gained popularity 10 to 12 years ago, they essentially involved presenting employees with a set list of 20 to 30 surgical procedures and telling them they had to get a second doctor's OK if they needed such an operation.

But, too often, employers, insurers and utilization review firms found that the 'second doctors' opinions echoed those of the first, with confirmation rates running at 90% or more.

As a result, employers often found themselves saddled not only with the expense of an unnecessary second opinion—at an average cost of about \$100—but also with the expense of having to pay for the operation anyway.

"In the early days, the incidence of surgery actually increased," said Dr. Richard Cooper, a Franklin, Tenn.-based independent managed care consultant. People who were hesitant about elective procedures were actually encouraged by second opinions to go ahead, he explained.

In response, some health care payers dropped their second opinion programs altogether.

New York Life Insurance Co., for example, cited a study showing a confirmation rate of 92% as a factor in its decision to drop its mandatory second surgical opinion program last year (*BI*, March 28, 1988).

And, New York-based Borden Inc. dropped its second opinion program Jan. 1, said Vicki Fortman, manager of employee benefits administration for the self-insured Columbus, Ohio-based company.

The company found that not only was it not saving any money, but its employees resented having to go through the process of obtaining another opinion, said Ms. Fortman, who is now focusing on ways to reduce outpatient expenses.

But instead of following the lead of New York Life and Borden, the overwhelming majority of health care payers instead are choosing to revise their programs to make them more effective, observers say.

"There certainly is no trend to discontinue second opinion programs. New York Life is standing pretty much alone," said Bob Pol-

lock, principal at William M. Mercer Meidinger Hansen Inc. in Los Angeles.

"None of our carriers have dropped it," said Louis R. Morgan, vp of DataMed, based in Northbrook, Ill.

Major changes employers are implementing include:

- Giving utilization review firms the authority to waive second opinions where there is clearly no doubt surgery is necessary.

- Specifically directing patients to non-surgeon physicians such as neurologists and cardiologists who are less likely to recommend surgery.

"I think there's generally a tendency to be more flexible. There should be no hard and fast rule," said Mr. Pollack.

For example, many employers are giving their utilization review firms greater discretionary authority to waive second opinions if they consider them redundant.

In these cases, the decision to grant a waiver is generally made by a nurse or other qualified medical personnel working at a utilization review firm who determines whether alternative procedures to surgery have been adequately explored.

For example, fluid in the inner ear is a common childhood problem, noted Bruce Taylor, employee insurance manager at GTE Corp. in Stamford, Conn. Traditionally, the pediatrician tries antibiotics. If that doesn't work, the next accepted step would be a surgical procedure, called a myringotomy.

"Asking for a second opinion at that point in time doesn't make a lot of sense. Obviously, the medical need has been established," said Mr. Taylor, whose firm has adopted a program where second opinions can be waived.

Milwaukee-based Bucyrus-Erie Co., a mining equipment manufacturer that introduced a waiver program less than a year ago, so far is pleased with the results.

"It's based on the facts and circumstances of each case. I think the new program is more effective," said Jerry Thorne, manager of benefits and compensation. Health insurance for the firm's 300 to 400 employees is written by Principal Mutual Life Insurance Co., based in Des Moines, Iowa.

Pepsico Inc., based in Purchase,

N.Y., which is self-insured, introduced a waiver program for 20,000 employees as of Jan. 1, said Shan Burchenal, manager of benefit planning.

Unlike a 1986 program that is still in place for its remaining 45,000 employees, the new program has no set list of surgeries that require second opinions, said Ms. Burchenal. "We're trying the no-list approach vs. the list approach to see whether it works better," she said.

"Why require a second opinion when the first may clearly tell the situation?" she asked. Noting the new program has only been introduced to about one-third of its employees so far, Ms. Burchenal said, "We intuitively feel it's the right

Continued on next page

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Second opinions

Continued from previous page
way to go, but we just didn't want to jump that way without testing it."

If everything else has been tried, "it's really silly to get a second surgical opinion," commented Sharon Cacciobondo, vp of utilization management at Efficient Health Systems, a UR firm in Skokie, Ill.

With the waiver approach, "they're saving the cost of the second opinion, but they are obtaining that leverage to refer somebody if it's really necessary," she added.

Observers say that while second opinion programs may be flawed, the basic concept behind them remains sound.

"Second opinion programs offer the weakest tool in cost containment among our bag of tricks," concedes Patrick J. Kearse, president of Health Management Re-

'There's still a lot of unnecessary surgery taking place,' says Mercer's Mr. Pollock. Confirmation rates may exceed 90% but, 'If you stop 10% of unnecessary operations in this country, that would be worth billions of dollars,' he says.

sources in Binghamton, N.Y. But it can nevertheless be valuable, he stressed.

For example, if a second opinion contradicts the first, "most people would think twice about getting something done," said Ms. Cacciobondo.

"There's still a lot of unnecessary surgery taking place," said Mercer's Mr. Pollock. Confirmation rates may exceed 90%, said Mr. Pollock. But, he added, "If you stop 10% of unnecessary operations in this country, that would be worth billions of dollars, without

question."

And, the 90% confirmation rates can be misleading, said DataMed's Mr. Morgan. The fact that a program exists "frequently acts as a deterrent for (the original) physicians when there is an 'either/or' situation."

Knowing that their opinions will be second-guessed makes doctors reluctant to recommend surgery in borderline cases in the first place, he said.

In addition, calling for second opinions only in marginal procedures avoids forcing the patient to

go through the aggravation of another examination, increases the likelihood of a non-confirmation and is less costly as well, said F. Jerome Coquillard, president of CareAmerica Inc., a Barrington, Ill.-based UR firm.

As an example, Mr. Kearse of Health Management Resources told of one young boy who had a peaked, rather than a flat, breast bone. A doctor had recommended surgery to correct the deformity.

In the course of arranging the second opinion, however, Health Management learned it was the boy's mother who was the impetus behind the planned surgery.

She was worried the deformity would cause her son psychological problems once he entered adolescence. The boy, it turned out, though, "really didn't feel that way."

Subsequently, the second doctor pointed out the surgery would mean a long, drawn-out recupera-

tion process involving a lot of pain as well as the risk of numbness in his limbs. The decision was made to forgo the surgery, said Mr. Kearse.

As a result, not only did the plan save money, but more importantly, "the trauma of the surgery wasn't inflicted on the child," said Mr. Kearse.

Among the procedures that are most frequently referred for second opinions are second Caesarean sections, coronary bypasses and back operations, said Dr. Jeff Harris, associate director of FOCUS Healthcare Management, based in Brentwood, Tenn.

Doctors often automatically order Caesarean sections for women giving birth a second time if the first delivery was by Caesarean, although it may not be necessary, said Dr. Harris.

Coronary bypasses often can be avoided by choosing treatment with medication, and back surgery cannot only cause significant side effects but is often ineffective, experts say.

Dr. Harris noted FOCUS has a program in which the second opinion can be rendered by having a second doctor just talk to the first on the phone, without seeing the patient. "It costs a lot less to work on the phone than it does to meet someone," he said.

There also is a growing trend toward sending patients to non-surgeons for second opinions as well, observers note.

"You're much more likely to get a different view" when a second opinion is obtained from a non-surgeon, said Barbara Levine, assistant vp with the Alexander Consulting Group in New York.

"I think that approach has a lot more validity than just getting a second surgical opinion," she said.

A cardiologist, for instance, is more likely to recommend an angioplasty, which uses a balloon to clear arteries, rather than the coronary bypass a heart surgeon is likely to recommend, said Ms. Levin. And, a gastroenterologist is more likely to recommend medication for a gall bladder problem than surgery, she added.

Prudential Insurance Co. of America in Newark, N.J., recently revised its list of doctors to whom it sends its policyholders for second opinions, and although it cut its overall list to 15,000 physicians from 31,000, it added non-surgeons, including family practitioners, said Dr. Dan Dragalin, vp-group medical services.

This was accomplished "to help render second opinions on procedures that might be amenable to medical therapy," Dr. Dragalin said.

"There's no self-indulgence" when a non-surgeon renders the second opinion, said DataMed's Mr. Morgan. "They can truly give an opinion based on medical necessity" that removes any doubt.

Another problem challenging the validity of second opinions is the lack of hard data showing precisely how much the programs save, observers point out.

"It's very, very difficult to say whether it saves costs or not," said Anna Maria Azzara, an associate benefits consultant for Buck Consultants based in Secaucus, N.J.

Ray Werntz, assistant vp of human resources at the Chicago-based Whitman Corp., agreed.

"It's really hard these days to talk about savings or price reductions" because of price pressures in the health care system overall, Mr. Werntz said.

Data collected in this area also does not reflect when a second opinion recommends against gall bladder surgery, but it eventually has to be done anyway, pointed out Mercer's Mr. Pollock.

"I don't think it's possible, period," to truly substantiate the cost

Continued on next page

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Continued from previous page savings from a second opinion program, given the complexity of factors involved, said Jules Yancey, client services manager for Corporate Healthcare Management, a UR firm based in Pittsburgh.

Clients will not be convinced to take on second opinion programs on the basis of the statistics that are available either, he said. "They've gotten far too sophisticated to take something that doesn't have a lot of substance to it and believe it."

As a result, many employers are touting second opinion programs as an employee benefit rather than as a cost-containment device, observers note.

Corporate Healthcare's sales force is among those trying to refocus its second opinion program as an additional employee benefit, Mr. Yancey said.

"I really think that's the perspective you've got to talk about," he said.

Others agree. A second opinion "certainly increases the employees' awareness of health care costs as well as educates him to the options of health care," said Buck's Ms. Azzara.

PepsiCo's involvement in a second opinion program is not motivated purely by economic factors, said Ms. Burchenal. "It's really to have a better outcome for the individual."

"In all probability, a plan might wind up saving money if it did not require a second surgical opinion," said Richard Valeri, assistant superintendent for administrative services for the Schuyler-Chemung-Tioga Board of Cooperative Educational Services, an Elmira, N.Y.-based agency that serves six school districts. "It's not a cost-containment factor."

"We're not sure whether this is a cost savings to us or not," said Jack Herron, assistant benefits director of the Illinois Bell Telephone Co. in Chicago, which offers its 23,000 active employees and 6,000 of its retirees a program called Med-Call. "We're weighing the cost factor very carefully," he said, but are still not certain.

"The employees like it," he said, though. "It gives them a certain amount of comfort."

"It's been a positive thing from the employee side," he said. Illinois Bell is self-insured, but works with BC/BS of Illinois on its managed care program.

To be effective, second opinion programs must be part of an overall umbrella cost-containment program, observers stress.

"It's not going to save a lot of money unless it's part of a larger cost-containment program," said BC&BS of Illinois' Mr. Shattuck.

It should be included along with other programs such as precertification and concurrent review, he said. "As a stand-alone program, it's not going to be very productive."

There is "not a whole lot of demand for" second opinions as a stand-alone product, said Efficient Health's Ms. Cacciobondo.

Second opinion programs will continue to evolve to meet employers' and employees' needs, say observers. "They're going to continue to be focused," said GTE's Mr. Taylor. Programs in the future will concentrate on areas that have been subject to abuse, he said.

One current Prudential

project is to develop questionnaires that would closely question its panel of second doctors on their opinions, instead of just asking "what do you think," said Dr. Dragalin.

With this approach, certain indications would have to be present for surgery to be approved. "We're asking for something concrete."

Prudential also is becoming active in small area analysis, which involves examining the rates of certain surgical procedures to see whether they are in line with the rates in other segments of the country.

This analysis could, for example, lead to the insurer asking for a second opinion if a particular procedure is recommended in Connecticut, but not in Vermont, said Dr. Dragalin.

"This is the appropriate approach," said Dr. Dragalin of second opinions. "It just needs revision." ■

Communicating UR benefit key to cutting health costs

By KARI BERMAN

Communicating utilization review programs as an improvement to employee benefits can increase employee compliance and ultimately give employers more ammunition in their war on rising health care costs, benefit consultants say.

But, getting across the message to employees that UR is a bonus can be difficult, consultants agree, especially because most employees view basic UR procedures such as hospital precertification, second surgical opinions and concurrent review as inconveniences.

While a variety of communication tools are available, employee benefit consultants and UR providers suggest employers use a combination of printed material, meetings and videos to describe UR objectives and compliance rules to employees.

Among the tactics benefit experts suggest employers use to communicate to employees that UR is an added

benefit—not a take-away—are to:

- Explain the merits of a UR program, emphasizing that it can improve quality of care while reducing health care costs.

- Establish a spirit of cooperation by making employees feel they are on the employer's team in its battle against rising health care costs.

- Make UR compliance a mandatory condition for coverage.

- Offer employees financial incentives for compliance, or disincentives when they don't use the UR programs.

Because employees are often suspicious and fearful of losing coverage, it is important that they understand both the merits of UR and their employer's legitimate need to control medical care costs, consultants stress.

"Communication between employer and employee is the key to a successful UR program that is both

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Communication

Continued from previous page
accepted by the employees and is cost-effective," says Al Schlachtmeyer, manager of communication for the eastern region at Hewitt Associates in Rowayton, Conn.

UR should be explained to employees as "trimming the fat off of the system," but leaving the meat so that medical benefits are healthier for employees, explained Constance Winslow, medical director and head of medical systems support at Hartford, Conn.-based Aetna Life Insurance Co.

"Unnecessary surgery or medical treatment is dangerous and nobody wants to be in the hospital if they can be at home," she added.

"Employers should tell employees that they want them to have the best medical care at the highest quality, but that unnecessary treatment or hospitalization are unhealthy expenses that drive up health care costs," said Linda Trainor, a principal at consultant William M. Mercer Meidinger Hansen Inc. in Los Angeles.

And, employers shouldn't beat around the bush when they explain their UR programs to employees, consultants warn.

"Employers need to be direct and up-front with employees and not try to kid them," said Richard Bevan, vp at consultant Towers, Perrin, Forster & Crosby Inc. in New York.

"They (employees) should be aware of medical health care inflation and understand that employers want to meet their benefit needs but that they need to help by following the utilization review procedures," he added.

Honest and direct content is crucial for successful UR communication, Mr. Bevan said.

The "UR message should be treated seriously and not lost in an elaborate communication design," he said. "You don't need a glitzy book to communicate UR to employees."

Among the messages an employer can send to its employees to boost UR compliance is that they want to work together to ensure they are getting the best care for the least cost, consultants suggest.

"Creating a feeling of partnership with employees so that they feel a part of the medical cost-control effort" is helpful in gaining employee compliance, said Hewitt's Mr. Schlachtmeyer.

To communicate this message, Mr. Schlachtmeyer said that employers use "a variety of media that hit all angles." He suggested the use of educational videos and face-to-face meetings between employees, employers and UR specialists where personal questions can be answered.

Cost Care Inc. uses one such team approach to help its employer clients explain UR to employees.

Along with printed brochures, posters and payroll stuffers, Huntington Beach, Calif.-based Cost Care explains UR to employees through an educational video that takes them on a tour of the UR process and Cost Care's facilities.

In addition, Cost Care representatives will "go to the workplace and meet with employees to discuss our program, procedures and benefits," said Dave Brisbin, manager of communications.

Another tactic an employer can use to boost participation in its UR program is to make compliance a mandatory condition for coverage under the employer's health care plan, consultants and UR vendors suggest.

"Getting employees to call and precertify before going to the hospital is sometimes difficult because it is an additional procedure that they have to go through when they just want to get treated," according to Douglas Leland, vp of medical review service at Intracorp, a

Eerwyn, Pa.-based medical case management firm and subsidiary of CIGNA Corp.

"Because employee participation in UR programs is unpredictable and less effective if left optional, employers will usually make it mandatory by imposing financial penalties for non-compliance," Ms. Trainor said.

For example, employers can threaten to cut reimbursement to 50% from 80% if UR rules are ignored.

This is the tactic used by many employers, including San Francisco-based Bank of America.

Bank of America has used Intracorp's UR services for its 22,000 employees since 1986 and has achieved 100% employee compliance, said Joan Ardoin, vp and manager of employee insurance plans.

"When we first introduced UR we had the expected negative employee response complete with hate

mail and threats, but after a year everything was fine," she said.

Bank of America's employee benefit department, with Intracorp's help, used pamphlets and newsletters to explain UR to employees.

Beatrice/Hunt-Wesson reduces the company's 85% copayment to 50% if employees do not precertify before entering the hospital or receiving extensive treatment, said Joe Deacon, director of employee benefits at the Fullerton, Calif.-based food product manufacturer.

Beatrice/Hunt-Wesson commissioned Hewitt Associates to help launch its UR program in 1986, he said.

"We held group meetings, distributed explanatory step-by-step UR kits and sent pamphlets to help our 4,000 employees understand the need for UR," Mr. Deacon said.

Beatrice's UR plan has "universal" compliance and is administered through Metropolitan Life

Insurance Co.'s Met Review UR product in San Francisco.

Another company, which Ms. Trainor declined to identify, was even more creative in its UR incentive program: It tied UR compliance to employees' annual cost-of-living increases.

"The employers explained the rising health care cost problem and told employees that if they used UR properly and controlled health care costs, their annual pay increases would be as usual. However, if they did not comply and costs went up, then money to fund the added cost would come from their raises," he explained.

Ms. Trainor said that the tactic was effective and the company was satisfied with results.

Employers also can use positive reinforcement to encourage employee participation in UR programs, consultants suggest.

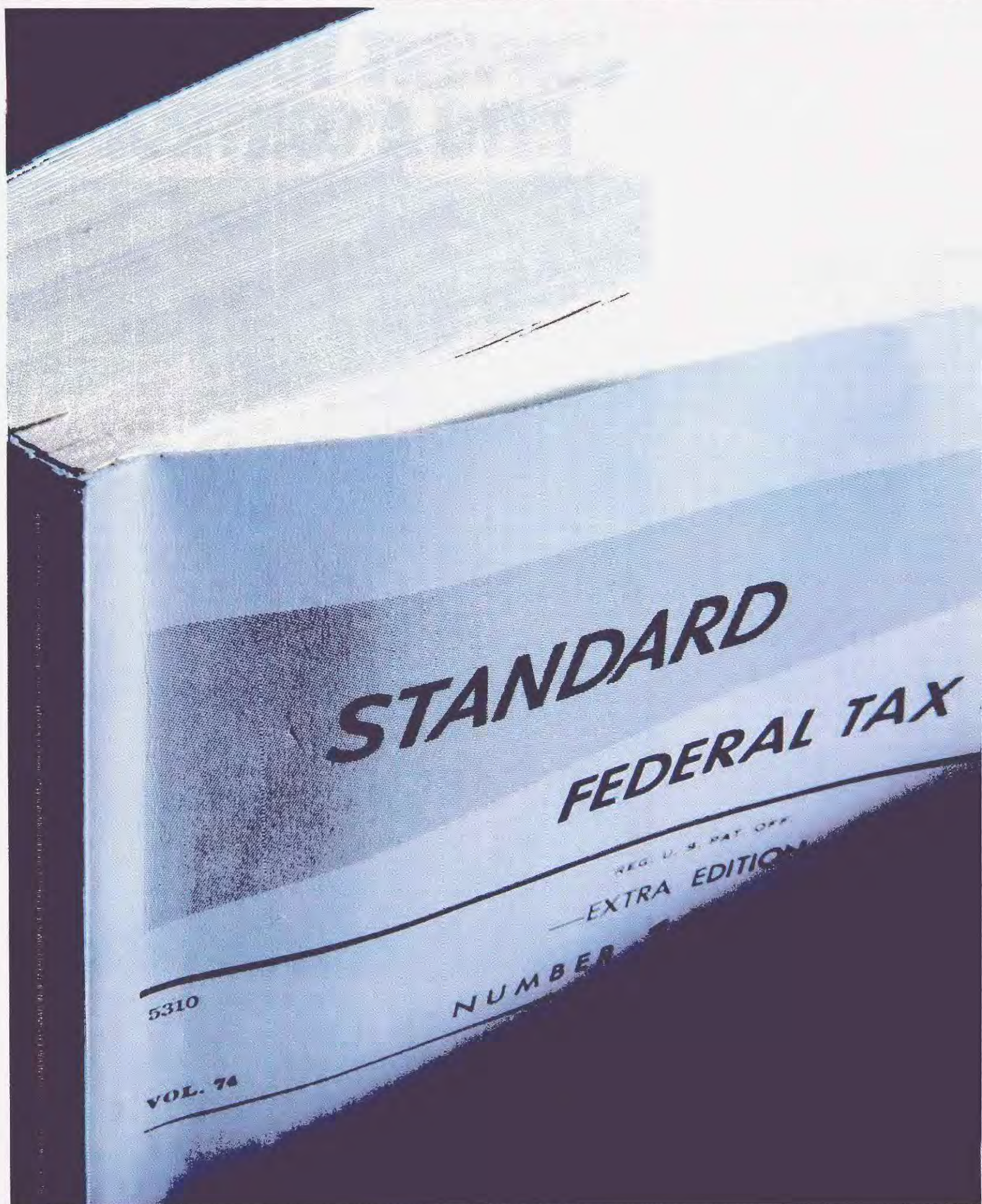
For example, an employer could increase its copayment to 90% from

80% for employees who precertify, explained John Galleazzi, a consultant at C&B Consulting Group in St. Louis, a subsidiary of Corroon & Black.

Many benefit experts support the use of positive reinforcement to encourage UR participation.

"Employers shouldn't threaten to slash 80% medical benefit copays for compliance failure. Instead, they should turn it around and say that they are offering a 50% copay but will increase it to 80% if employees follow UR rules," said TPF&C's Mr. Bevan.

"Even if UR is in their best medical interest, employees don't tend to react well when threatened with copay penalties for non-compliance. We see positive incentives as being more beneficial for long-term compliance," said Paul Frankel, national director of medical management at Corporate Health Strategies in Westport, Conn., a subsidiary of Metropolitan Life. ■



Directory of utilization review providers

A

Acorn PsychManagement Corp.

Robert Morris Building, 17th & Arch Streets, Philadelphia, Pa. 18103; 800-223-7050

Year founded: 1975; began providing utilization review services in 1981.

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, outpatient service predetermination, outpatient

psychiatric and substance abuse services, case management; 30% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: 14 total staff members.
Clients: 87 total clients; 84 employer clients; 15% with fewer than 500 employees, 30% with 500-999 employees, 18% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 7% with more than 5,000 employees. 250,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Fee for service or capitation.

Principal officers: Dr. Mel S. Goldsmith, president/chief executive officer; Dr. Dorothy Harrison, vp/director-clinical services; Dr. Mel Wondolowski, vp-corporate relations; Barbara Caroll, senior vp/chief

operating officer.

Action Health Care Inc.

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

Year founded: 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, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, on-site concurrent hospital treatment management, workers compensation case management.

Services reviewed: Group health

services, dental services, psychiatric and substance abuse services, chiropractic services.

Staff: 10 total staff members; seven professional staff members, including five physicians, two medical records technicians. More than 12 physicians and more than 400 nurses on a retainer basis.

Clients: 15 employer clients; 60% with fewer than 500 employees, 33% with 500-999 employees, 7% with 2,500-4,999 employees. 18,000 total lives serviced in 1988.

Branch offices: San Francisco.

1988 gross revenues: Not reported.

Charges: Per employee, 75 cents-\$2.50; per case, \$100-\$250; percent of savings.

Principal officers: Ruth Smith, president; Stella VanNess, vp-operations; David K. Stewart, vp-marketing.

Advanced PsychSystems

1400 K St. N.W., Suite 610, Washington, D.C. 20005; 202-371-1211; 800-243-7526

Year founded: Began providing utilization review services in 1979.

Parent company: American Psychiatric Assn.

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, case management; occasional disability review, workers compensation review; 5% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: 75 professional staff members, including nine psychiatrists, 45 registered psychiatric nurses, 20 social workers, one medical records technician. 424 physicians, 56 psychiatric nurses, 256 psychologists and 156 psychiatric social workers on a retainer basis.

Clients: 25,000 total clients, 12.3 million lives serviced in 1988.

Branch offices: Anaheim, Calif.; Norcross, Ga.; Denver.

1988 gross revenues: Not reported.

Charges: In-patient: per employee per month, 19 cents-25 cents; per case, \$225-\$300; flat annual fee per employee, \$2.28-\$3. Out-patient: per employee per month, 32 cents-40 cents; per case, \$195-\$250; flat annual fee per employee, \$3.84-\$4.80.

Principal officers: Dr. Melvin Sabshin, medical director-American Psychiatric Assn.; Dr. John Hamilton, deputy medical director for psychiatric services-American Psychiatric Assn.; Norman Penner, director-quality assurance; Michele Deverich, director-promotion/development.

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% 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, diagnostic review, rehabilitation review, hospice review; 89% of gross revenues from other services.

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

Staff: 1,200 total staff members; 101 professional staff members, including 75 registered nurses, 16 licensed practical nurses, 10 medical records technicians. 45 physicians on a retainer basis.

Clients: 298 employer clients; 27% with fewer than 500 employees, 46% with 500-999 employees, 16% with 1,000-2,499 employees, 7% with 2,500-4,999 employees, 4% with more than 5,000 employees. 750,000 total lives serviced in 1988.

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

1988 gross revenues: \$58 million total, \$6 million from utilization review services for employers.

Charges: Per employee, per case.

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

Continued on next page

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Alternative Care Management Systems Inc.

Suite 100, 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, 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, psychiatric and substance abuse services, chiropractic services.

Staff: 10 total staff members; three professional staff members who are registered nurses. Five physicians on a retainer basis.

Clients: 14 employer clients; 71.4% with fewer than 500 employees, 14.3% with 500-999 employees, 14.3% with 2,500-4,999 employees. 22,950 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee.

Principal officers: John O. Micha, president.

American Benefit Plan Administrators Inc.

2999 W. Sixth St., Los Angeles,
Calif. 90020; 213-386-2703

Year founded: 1952; began providing utilization review services in 1987.

Parent company: TPA of America Inc.

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.

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EMPLOYEE BENEFITS BULLETIN: COST-SAVING LTD SERVICES FROM CNA

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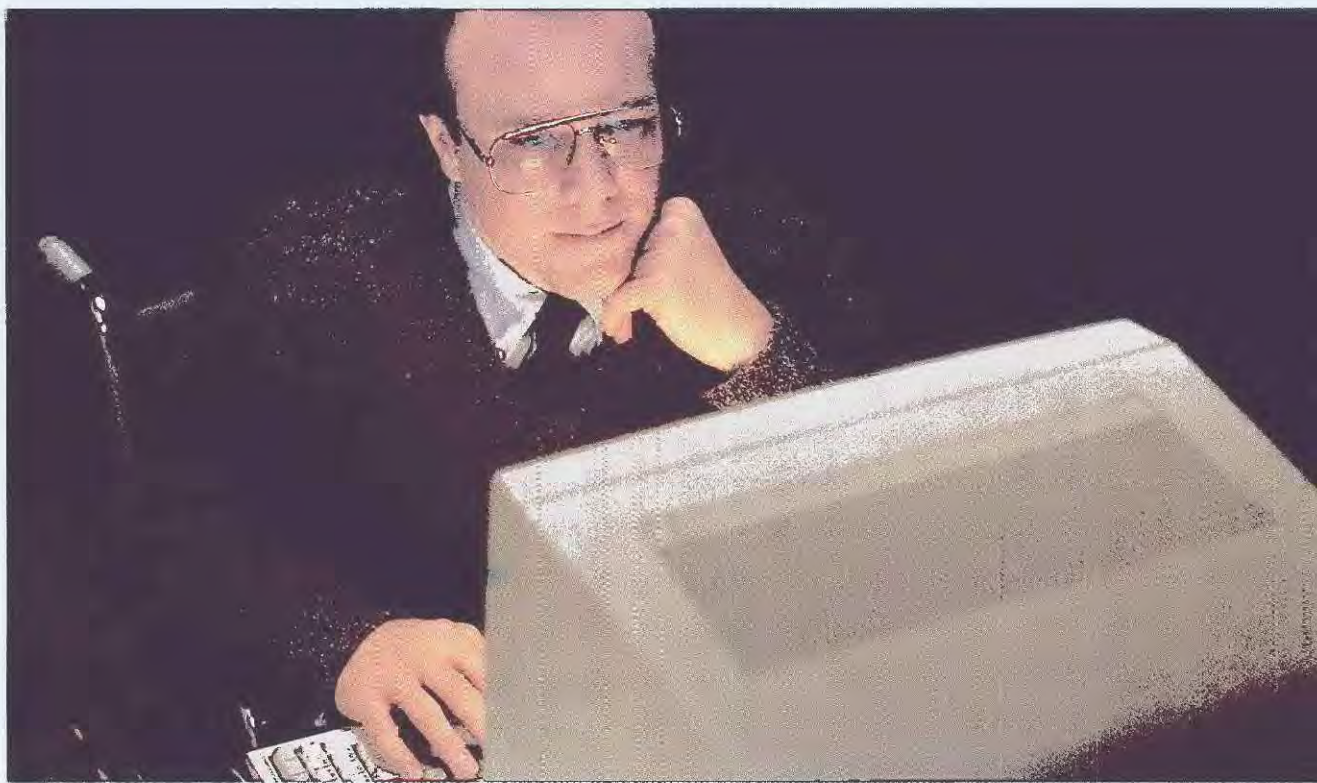
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How to use directory

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

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

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

The percentage of 1988 gross revenues generated from providing utilization review services to employers is noted, followed by specific programs the company provides. Also listed is the percentage of 1988 revenues generated from other services, including utilization review for insurers, PPOs, HMOs and third-party claims administrators.

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

Number and size of clients and the total number of lives serviced in 1988 follow. Locations of branch offices are listed; 1988 gross revenues are included when supplied by the company.

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

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

The directory is published as an editorial service; there is no charge for companies to be included. If you would like to be listed in the 1990 directory of utilization review service providers, please write Christine Woolsey, Associate Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590.

Continued from previous page
discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services, case management; occasional outpatient service predetermination; 98% of gross revenues from other services.

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

Staff: 10 total staff members; professional staff members include one physician, two registered nurses, one medical records technician.

Clients: Four total clients; 5% with 2,500-4,999 employees, 95% with over 5,000 employees. 40,000 total lives serviced in 1988.

1988 gross revenues: \$24 million total, \$600,000 from utilization review services for employers.

Charges: Per employee, \$1-\$1.50; per case, \$70-\$200; flat annual fee, \$6,500-\$27,000.

Principal officers: Arthur R. McGimsey, president/chief executive officer; Richard A. Boespflug, senior vp; Jan Marie Smith, director-claims.

Charges: Per employee per month, 34 cents-68 cents; per case, \$250-\$400.

Principal officers: Dr. Kenneth A. Kessler, president; Dr. Daniel Patterson, vp-medical affairs; Peter T. Stanton, vp-marketing.

Associated Medical Review Services Inc.

2821 Richland Ave., Metairie, La. 70002; 800-325-9754

Year founded: 1985.

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; occasional hospital bill audit, outpatient service predetermination; 10% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric

and substance abuse services, chiropractic services.

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

Clients: 107 total clients; 105 employer clients; 60% with fewer than 500 employees, 33% with 500-999 employees, 7% with 1,000-2,499 employees. 38,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, 90 cents-\$1.80; per case, \$25-\$75.

Principal officers: Katherine Belchic, president; Pamela Chauff, vp; Vincent Varisco Jr., secretary.

Associates for Health Care

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

Year founded: 1984.

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, case management, home health care, durable medical equipment; 50% of gross revenues from other services.

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

Staff: 20 total staff members.

Clients: 1,000 total clients; 900 employer clients; 91% with fewer than 500 employees, 5% with 500-999 employees, 3% with 1,000-2,499 employees, 1% with 2,500-4,999 employees. More than 100,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1.60-\$2; by the hour for bill audits, \$50.

Principal officers: Richard M. Blomquist, president; George W. Coffman, vp.

Association for Organizational & Human Development

1701 Lake Ave., Glenview, Ill. 60025; 312-729-9280

Year founded: 1986.

Services provided: Utilization review services include 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.

Services reviewed: Psychiatric and substance abuse services.

Staff: Two professional staff members, including one physician, one psychologist, 10 physicians and four nurses on a retainer basis.

Clients: Three total clients; 230,000 total lives serviced in 1988.

Branch offices: Skokie, Ill.

1988 gross revenues: Not reported.

Charges: Per employee, 29 cents-
Continued on next page

American Health Network Inc./Florida Health Network

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

Year founded: 1983.
Parent company: American General Corp.

Services provided: Utilization review services to employers include 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.

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

Staff: 53 total staff members; professional staff members include four physicians, 49 registered nurses. 42 physicians on a retainer basis.

Clients: 1,648 total clients; 94.5% with fewer than 500 employees, 2.2% with 500-999 employees, 2.1% with 1,000-2,499 employees, 0.9% with 2,500-4,999 employees, 0.3% with more than 5,000 employees. 833,007 total lives serviced in 1988.

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

1988 gross revenues: Not reported.

Charges: Per employee.

Principal officers: Howard Korn, chief executive officer/president-American General Group Insurance Co.; Frank Greaney, president-American Health Network Inc.

American PsychManagement Inc.

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

Year founded: 1983.
Parent company: Value Health Inc.

Services provided: 12% 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; third opinion review service, workers compensation review; 88% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: 81 total staff members; 54 professional staff members, including three physicians, 16 registered nurses, 10 physicians on a retainer basis.

Clients: 57 total clients; 30 employer clients; 23% with fewer than 500 employees, 10% with 500-999 employees, 13% with 1,000-2,499 employees, 13% with 2,500-4,999 employees, 41% with more than 5,000 employees. 1.2 million total lives serviced in 1988.

Branch offices: Alameda, Calif.
1988 gross revenues: Not reported.

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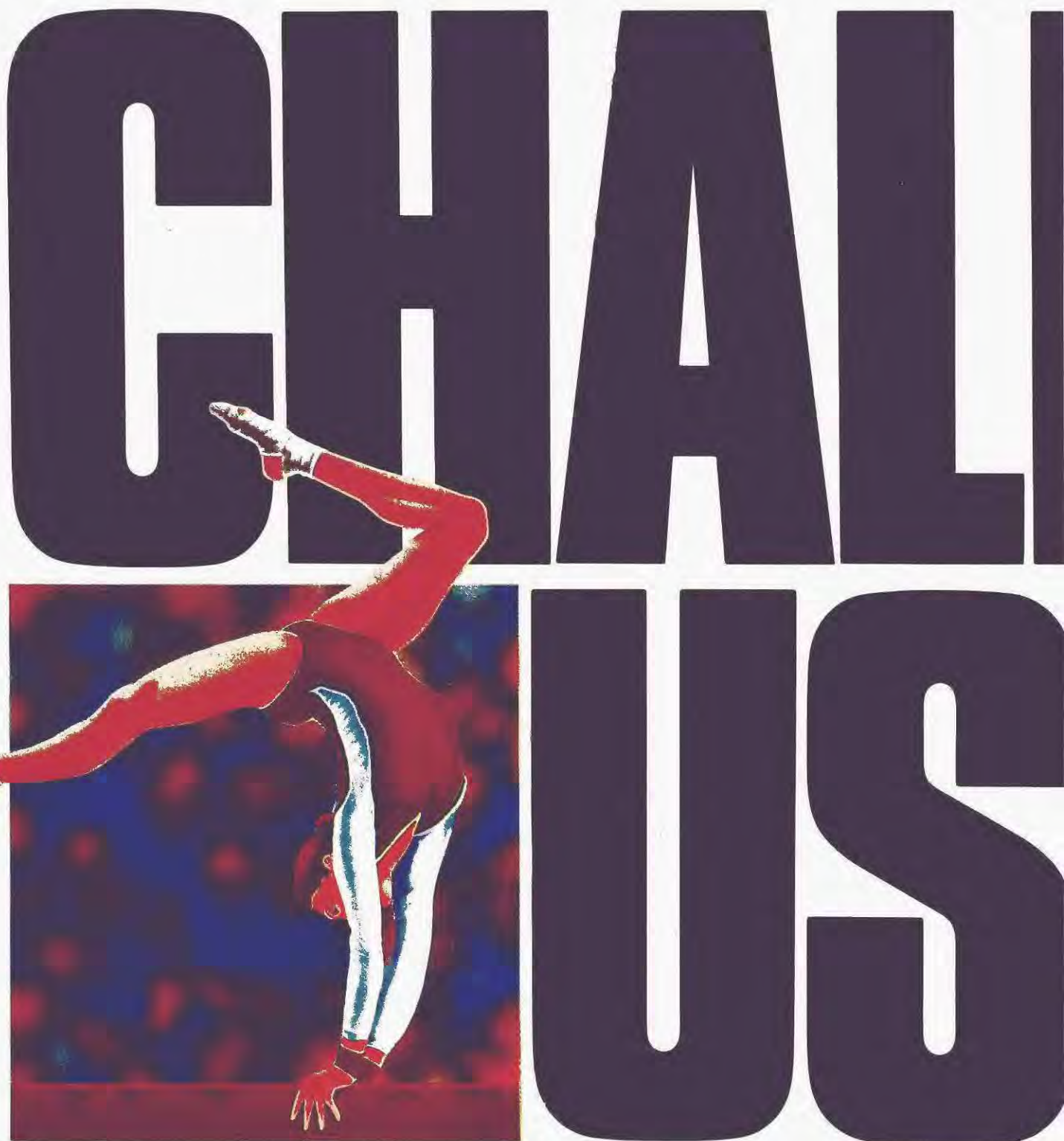
Spotlight report

Continued from previous page

41 cents; per case.

Principal officers: Dr. Ronald L. Kirschner, president.**August International Corp.**One City Blvd. W., Suite 1000,
Orange, Calif. 92668;
714-938-2600**Year founded:** 1985.**Services provided:** 53% 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, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, reporting and analysis of health care data, employee education programs; 47% of gross revenues from other services.**Services reviewed:** Group health services, dental services, psychiatric and substance abuse services, chiropractic services.**Staff:** 230 total staff members; 53 professional staff members, including three physicians, 42 registered nurses, 47 professionals on a retainer basis, including 45 physicians.**Clients:** More than 2,000 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. 2 million total lives serviced in 1988.**Branch offices:** Olympia, Wash.; Dallas.**1988 gross revenues:** Not reported.**Charges:** Per employee; per case; percent of bill per hour, 2%-3%.**Principal officers:** Blayne Lequeux, president/chief executive officer; Kenneth Aaron, vp-managed care; George Bregante, vp-marketing/sales; Charles Cressman, vp-sales; Dr. William Thompson, national medical director.**AXIOM Review**33 Bleeker St., Millburn, N.J.
07041; 201-379-6300**Year founded:** Began providing utilization review services in 1978.**Parent company:** The AXIOM Group.**Services provided:** Utilization review services include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, DRG validation; occasional preadmission hospital review, hospital bill audit, outpatient psychiatric and substance abuse services, case management.**Services reviewed:** Group health services, psychiatric and substance abuse services, chiropractic services.**Staff:** 235 total staff members; 100 professional staff members, including three physicians, 58 registered nurses, five licensed practical nurses, four medical records technicians, 125 physicians and 10 nurses on a retainer basis.**Clients:** 16 total clients.**1988 gross revenues:** \$7.1 million total.**Principal officers:** Dennis J. Duffy, president; Dr. Edgar V. Santoro, chairman.**B****Beech Street Inc.**2 Ada, Irvine, Calif. 92718;
714-727-1353**Year founded:** 1951; began providing utilization review services in 1982.**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, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, workers compensation case manage-

ment and back to work programs; occasional retrospective review; 30% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, chiropractic services.**Staff:** 40 total staff members; 35 professional staff members, including 16 registered nurses, two licensed practical nurses, 17 medical records technicians. Four physicians on a retainer basis.**Clients:** 555 total clients; 333 employer clients; 50% with fewer than 500 employees, 10% with 500-999 employees, 20% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 10% with more than 5,000 employees. 1.5 million total lives serviced in 1988.**Branch offices:** Houston.**1988 gross revenues:** Not reported.**Charges:** Per employee, 95 cents-\$1.50; per case, \$85-\$150; percent of billed charges, 2%-3%.**Principal officers:** Mac Crawford, president; Jan Lindbloom, vp-utilization review; Catherine L. Cather, senior vp-marketing.**Behavioral Health Group**2714 Union Ave. Extended, Suite
210, Memphis, Tenn. 38112;
901-327-4664**Year founded:** 1987.**Services provided:** Utilization review services include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, outpatient psychiatric and substance abuse services, case management; occasional hospital bill audit; alternative treatment identification, psychiatric diagnostic validation.**Services reviewed:** Psychiatric and substance abuse services.**Staff:** 11 total staff members; five professional staff members, including one physician, two registered nurses.**Clients:** Seven total clients; 560,000 total lives serviced in 1988.**1988 gross revenues:** \$231,716 total.**Charges:** Per employee, 20 cents-40 cents; per case, \$350 and up.**Principal officers:** Jim Rout, president; Phil Prosser, senior vp; Debbie Bateman, controller.**Bethesda Provider Organization**5200 DTC Parkway, Suite 51C,
Englewood, Colo. 80111;
303-771-4258**Year founded:** 1984.**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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review; 70% of gross revenues from other services.**Services reviewed:** Psychiatric and substance abuse services.**Staff:** Five total staff members; professional staff members include one physician, one registered nurse. One physician and one nurse on a retainer basis.**Clients:** 14 total clients; five employer clients; 80% with fewer than 500 employees, 20% with 500-999 employees. 60,000 total lives serviced in 1988.**1988 gross revenues:** Not reported.**Charges:** Per employee, per case.**Principal officers:** William van Doorninck, chairman; Dr. William Scholten, medical director; Dianne Lacy, acting operations director.**Biotrak Marketing Group Inc.**Building 600, 1 Kendall Square,
Cambridge, Mass. 02139;
617-577-8110**Year founded:** 1984; began providing utilization review services in 1988.**Services provided:** Utilization review services include preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical*Continued on next page*

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Continued from previous page
opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, disability management.

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

Staff: 14 total staff members; 12 professional staff members, including four physicians, eight medical records technicians. Two physicians on a retainer basis.

Clients: 100 total clients. 100,000 total lives serviced in 1988.

Branch offices: Minneapolis.

1988 gross revenues: \$2.25 million total.

Charges: Per employee, \$2-\$3.

Principal officers: Donald D. Gilligan, president; Thomas H. Ulfelder, vp.

Blue Connection

25A-288 Vreeland Road, Florham Park, N.J. 07932; 201-593-5103

Year founded: 1932; began providing utilization review services in 1977.

Parent company: Blue Cross & Blue Shield of New Jersey Inc.

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, patient advisory service, inpatient psychiatric review services.

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

Staff: 24 total staff members; professional staff members include five physicians, 18 registered nurses, one licensed practical nurse. 35 physicians on a retainer basis.

Clients: 400 employer clients; 80% with fewer than 500 employees, 10% with 500-999 employees, 5% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 1% with more than 5,000 employees. 300,000 total

lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee.

Principal officers: Kathleen Pasantino, vp-managed care division; Taplynn Dugan, cost containment product manager.

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

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

Year founded: 1986.

Parent company: Blue Cross & Blue Shield United of Wisconsin.

Services provided: Utilization review services include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, case management, home health care preauthorization; occasional retrospective review, outpatient psychiatric and substance abuse services.

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

Staff: 23 total staff members; 20 professional staff members, including one physician, 19 registered nurses. Three physicians on a retainer basis.

Clients: 213 total clients; one employer client. 92% of all clients with fewer than 500 employees, 3% with 500-999 employees, 4% with 1,000-2,499 employees, 1% with more than 5,000 employees. 151,356 total lives serviced in 1988.

1988 gross revenues: \$370,000 from utilization review services for employers.

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.

Blue Cross & Blue Shield of Virginia

P.O. Box 27401, Richmond, Va. 28279; 804-756-2105

Year founded: 1938; began providing utilization review services in 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, outpatient psychiatric and substance abuse services, case management; occasional hospital bill audit, outpatient service predetermination; 1% of gross revenues from other services.

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

Staff: 131 total staff members; 96 professional staff members, including four physicians, 89 registered nurses, three licensed practical nurses. 35 physicians on a retainer basis.

Clients: 20,000 total clients; 16,200 employer clients; 99% with fewer than 500 employees, 0.3% with 500-999 employees, 0.7% with more than 1,000 employees. 1.8 million total lives serviced in 1988.

Branch offices: Norfolk, Roanoke, Charlottesville, Fredericksburg and Petersburg, Va.

1988 gross revenues: \$1.4 billion total.

Charges: Per employee, \$1.50; per case for case management, \$55 per hour.

Principal officers: Dr. Richardson Grinnan, chief health care management officer; Tim O'Shea, director-health care management; Gerry Good, president-Blue Cross & Blue Shield of Virginia.

Blue Shield of California

2 North Point, San Francisco, Calif. 94133; 415-445-5000

Year founded: 1939; began providing utilization review services in 1966.

Services provided: Utilization review services include preadmission 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, dental services, psychiatric and substance abuse services, chiropractic services.

Branch offices: Los Angeles.

1988 gross revenues: Not reported.

Principal officers: Thomas C. Paton, chairman/chief executive officer; Charles W. Stewart, president/ chief operating officer; James N. Geiger, executive vp; Larry Parcell, senior vp-marketing.

Business Health Services Inc.

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

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

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, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, workers compensation injury management; 50% of gross revenues from other services.

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

Staff: Five total staff members; professional staff members include one physician, four registered nurses, 13 physicians and one nurse on a retainer basis.

Clients: Two employer clients.

1988 gross revenues: Not reported.

Charges: Per employee, 30 cents-\$2.50; per case, \$125-\$600; by the hour.

Principal officers: Dr. E. Scott Rosenbloom, president.

Continued on next page

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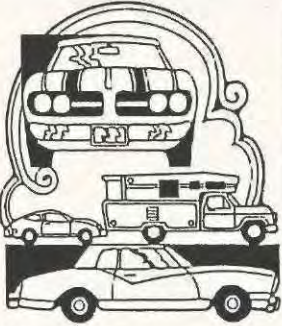
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Physical Damage by
Motors Insurance
The Insurance People from
General Motors

Continued from previous page

C

CAPP CARE Inc.

17390 Brookhurst, Suite 280,
Fountain Valley, Calif. 92708;
714-963-8035

Year founded: 1982; began providing utilization review services in 1984.

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

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

Staff: 170 total staff members; 60 professional staff members, including three physicians, 27 registered nurses, 30 medical records technicians.

Clients: 27,000 total clients; 20 employer clients; 90% with fewer than 500 employees, 10% with 500-999 employees. 1.4 million lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee.

Principal officers: Dr. Edward Zalta, chairman/chief executive officer; Michael E. Henry, president/ chief operating officer.

CareAmerica Inc.

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

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, d:s-

charge planning, retrospective review, outpatient service predetermination, case management.

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

Staff: 10 total staff members.

Clients: Total clients not reported; 2% with fewer than 500 employees, 1% with 500-999 employees, 6% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 61% with more than 5,000 employees.

1988 gross revenues: Not reported.

Charges: Per employee, per case, flat annual fee.

Principal officers: F. Jerome Coquillard, president.

CarreFour

7930 State Line Road, P.O. Box
8208, Prairie Village, Kan. 66208;
913-341-1215

Year founded: Began providing utilization review services in 1986.

Parent company: Managed Healthcare Resources/Blue Cross & Blue Shield of Kansas City.

Services provided: 2% of gross revenues from providing utilization review services to employers, including frequent discharge planning, outpatient service predetermination, case management; occasional concurrent hospital treatment review, length of stay determination, retrospective review; 98% of gross revenues from other services.

Services reviewed: Group health services.

Staff: Nine professional staff members, including eight registered nurses, one medical records technician. One physician on a retainer basis.

Clients: 16 total clients; 10 employer clients; 95% with fewer than 500 employees, 4% with 500-999 employees, 1% with 1,000-2,499 employees. 275,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, per case, flat annual fee, by the hour.

Principal officers: Gail A. Shaf-ton, chief executive officer.

Coast Medical Review Inc.

12235 Beach Blvd., Suite 9,
Stanton, Calif. 90680;
714-895-3044; 213-493-2568

Year founded: 1981.

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, hospital bill audit, outpatient service predetermination, case management, workers compensation case management; occasional second surgical opinion, outpatient psychiatric and substance abuse services; 50% of gross revenues from other services.

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

Staff: Seven total staff members professional staff members include one registered nurse. 87 physicians and 28 nurses on a retainer basis.

Clients: 33 total clients; 10 employer clients; 3% with fewer than 500 employees, 5% with 500-999 employees, 10% with 1,000-2,499 employees, 38% with 2,500-4,999 employees, 44% with more than 5,000 employees.

1988 gross revenues: Not reported.

Charges: Per employee, \$1-\$4; per case; percent of savings, 25%.

Principal officers: Larry Gallant, president.

CoMed Management Inc.

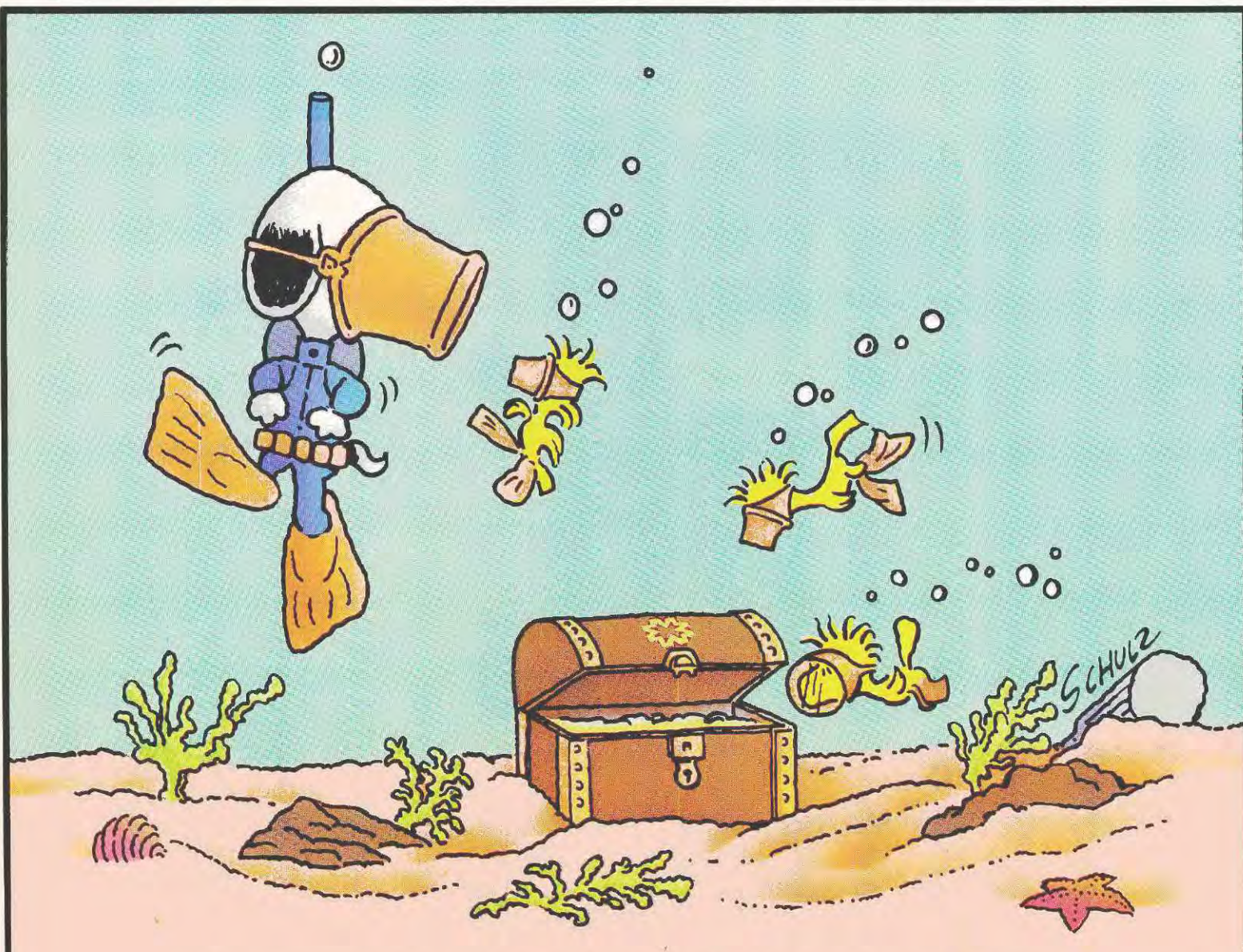
525 Metro Place N., Suite 300,
Dublin, Ohio 43017; 614-766-0061

Year founded: 1982.

Parent company: New York Life Insurance Co.

Services provided: 21% 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 management, disability case management; occasional retrospective re-

Continued on next page



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AND AFFILIATED COMPANIES

Continued from previous page view; 79% of gross revenues from other services.

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

Staff: 96 total staff members; 46 professional staff members, including one physician, 44 registered nurses, one licensed practical nurse, 40 professionals on a retainer basis.

Clients: 77 total clients; 10 employer clients; 30% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 40% with more than 5,000 employees. 800,000 total lives serviced in 1988.

1988 gross revenues: \$3.3 million total; \$600,000 from utilization review services to employers.

Charges: Per employee per month, \$1.20-\$1.45; per case, \$75-\$85.

Principal officers: Jay Wendt, chief executive officer; Janice Spillane, president/chief operating officer; Dudley Briggs, medical director.

Conservco

3903 Northdale Blvd., Suite 200, Tampa, Fla. 33624; 813-969-0701

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

Parent company: The Travelers Insurance Co.

Services provided: 18% 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, ambulatory surgery; 82% of gross revenues from other services.

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

Staff: 800 total staff members; one physician on a retainer basis.

Clients: 1,000 total clients; 100 employer clients; 10% with 500-999 employees, 35% with 1,000-2,499 employees, 40% with 2,500-4,999 employees, 15% with more than 5,000 employees.

Branch offices: 160 locations.

1988 gross revenues: \$43 million total.

Charges: Per employee, \$1.20-\$1.50; per case, \$40-\$50; volume discounts.

Principal officers: Dennis Huffman, president; Larry Mattingly, executive vp; Cathy Johnson, Jack DeMumbrum, Tim Mooney and Terry Oetting, vps.

Coordinated Rehabilitation Services Inc.

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

Year founded: 1981; began providing utilization review services in 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, case management; occasional retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services; 90% of gross revenues from other services.

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

Staff: 22 total staff members who are professionals, including one physician, 15 registered nurses, one licensed practical nurse, five medical records technicians. Three physicians and 28 nurses on a retainer basis.

Clients: 53 total clients; seven employer clients; 2% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 68% with more than 5,000 employees. 350,000 total lives serviced in 1988.

Branch offices: Detroit and St. Joseph, Mich.; Akron, Ohio.

1988 gross revenues: \$920,000 total.

Charges: Per employee, 46 cents-75 cents; per case, \$70 per hour.

Principal officers: Kathleen M. Etienne, president; Daniel L. Geczi, vp.

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 1983.

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

Continued on next page

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State Insurance Regulations

- Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, Commonwealth of Puerto Rico

Other Important Regulatory Information*

- Alabama Bulletins and Fire Marshal Regulations, Alabama Selected Attorney General Opinions, Alaska Bulletins and Orders, Alaska Selected Attorney General Opinions, Arizona Circular Letters, Arizona Selected Attorney General Opinions, Arkansas Bulletins and Directives, Arkansas Rules of Practice and Procedure, California Bulletins, Colorado Notices, Colorado Selected Attorney General Opinions, Connecticut Bulletins, Connecticut Selected Attorney General Opinions, Delaware Bulletins and Circular Letters, Delaware Selected Attorney General Opinions, Florida Bulletins and Fire Marshal News, Florida Selected Attorney General Opinions, Georgia Bulletins and Directives, Georgia Selected Attorney General Opinions, Hawaii Selected Attorney General Opinions, Idaho Bulletins, Idaho Selected Attorney General Opinions, Illinois Credit Life and Credit Accident Bulletins, Illinois Selected Attorney General Opinions, Indiana Bulletins, Indiana Selected Attorney General Opinions, Iowa Bulletins and Directives, Iowa Selected Attorney General Opinions, Kansas Bulletins, Kansas Selected Attorney General Opinions, Kentucky Bulletins and Miscellaneous References, Kentucky Selected Attorney General Opinions, Louisiana Directives, Louisiana Rules of Practice and Procedure, Louisiana Department of Public Safety Rules, Louisiana Special Letters of the Rating Commission, Louisiana Selected Attorney General Opinions, Maine Bulletins, Maine Selected Attorney General Opinions, Maryland Notices and Orders, Maryland Memorandum and Guidelines, Massachusetts Selected Attorney General Opinions, Michigan Bulletins, Michigan Selected Attorney General Opinions, Minnesota Bulletins and Circular Letters, Minnesota Selected Attorney General Opinions, Mississippi Bulletins and Circular Letters, Mississippi Selected Attorney General Opinions, Missouri Selected Attorney General Opinions, Montana Bulletins, Montana Selected Attorney General Opinions, Nebraska Bulletins

- Nebraska Selected Attorney General Opinions, Nevada Bulletins, Nevada Selected Attorney General Opinions, New Hampshire Securities Laws and Regulations, New Hampshire Selected Attorney General Opinions, New Jersey Circular Letters and Bulletins, New Mexico Advice of the General Counsel, New Mexico Selected Attorney General Opinions, New York Circular Letters, New York Opinions of General Counsel, North Carolina Selected Attorney General Opinions, North Dakota Bulletins, North Dakota Selected Attorney General Opinions, Ohio Bulletins, Ohio Selected Attorney General Opinions, Oklahoma State Board for Property and Casualty Rates Regulations, Oklahoma Selected Attorney General Opinions, Oregon Bulletins, Oregon Selected Attorney General Opinions, Pennsylvania Bulletins, Notices and Orders, Pennsylvania Selected Attorney General Opinions, South Carolina Bulletins and Orders, South Carolina Selected Attorney General Opinions, South Dakota Bulletins, South Dakota Selected Attorney General Opinions, Tennessee Selected Attorney General Opinions, Texas Selected Attorney General Opinions, Utah Bulletins, Vermont Bulletins, Vermont Selected Attorney General Opinions, Virginia Administrative Letters, Virginia Selected Attorney General Opinions, Washington Bulletins and Fire Marshal Regulations, Washington Selected Attorney General Opinions, West Virginia Informational Letters, West Virginia Selected Attorney General Opinions, Wisconsin Selected Attorney General Opinions, Wyoming Selected Attorney General Opinions, Commonwealth of Puerto Rico Circular Letters

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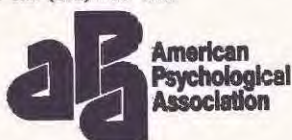
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Continued from previous page
and substance abuse services, case management, workers compensation rehabilitation services; 10% of gross revenues from other services.

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

Staff: 13 total staff members; nine professional staff members, including one physician, five registered nurses, two licensed practical nurses, one medical records technician. Two physicians and 11 nurses on a retainer basis.

Clients: 20 total clients; nine employer clients; 33% with fewer than 500 employees, 22% with 500-999 employees, 33% with 1,000-2,499 employees, 12% with more than 5,000 employees. 11,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, per case, by the hour.

Principal officers: Dr. John F. Spring, chairman; Patrick J. Kearse, president.

Corporate Health Care Management

1801 West End Ave., P.O. Box 1115, Nashville, Tenn.
37202-1115; 615-320-7608

Year founded: 1983.

Parent company: EQUICOR Inc.

Services provided: 82% 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, health advisory and promotion services; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 18% of gross revenues from other services.

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

Staff: 238 total staff members; 102 professional staff members, including nine physicians, 93 registered nurses. 23 physicians on a retainer basis.

Clients: 600 total clients; 592 employer clients. 3.8 million total lives serviced in 1988.

Branch offices: Pittsburgh; Brea, Calif.

1988 gross revenues: \$22 million total; \$17.5 million from utilization services to employers.

Charges: Per employee, by the hour.

Principal officers: Dr. Roger Taylor, national director.

Corporate Health Strategies

276 Post Road W., Westport, Conn. 06880; 203-454-6100

Year founded: 1982.

Parent company: Metropolitan Life Insurance Co.

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, outpatient psychiatric and substance abuse services, case management, high-risk pregnancy services, ambulatory review; 20% of gross revenues from other services.

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

Staff: 243 total staff members; professional staff members include six physicians and 228 registered nurses. Seven physicians on a retainer basis.

Clients: 868 employer clients; 56% with fewer than 500 employees, 18% with 500-999 employees, 12% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 9% with more than 5,000 employees. 6.2 million total lives serviced in 1988.

Branch offices: 20 locations in the United States.

1988 gross revenues: Not reported.

Charges: Per employee, by the hour.

Principal officers: Robert A. Chernow, president/chief executive officer; Leon I. Hyman, senior vp/ chief operating officer; Dr. Paul Frankel, medical director.

Cost Care Inc.

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

Year founded: 1981.

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, workers compensation, disability management; 40% of gross revenues from other services.

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

Staff: 268 total staff members; 165 professional staff members, including 19 physicians, 136 registered nurses, 10 medical records technicians. Six physicians on a retainer

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Continued from previous page basis.

Clients: 6,678 total clients; 2.9 million total lives serviced in 1988.

Branch offices: New York; Chicago; Houston and Irving, Texas; Memphis and Chattanooga, Tenn.; Tampa and Jacksonville, Fla.; Pasadena, Calif.

1988 gross revenues: Not reported.

Charges: Per employee, per case, flat annual fee.

Principal officers: Larry Goelman, president; Hugh Cone, senior vp; Ray Foose, vp-marketing.

Cost Containment Management

5401 W. Kennedy Blvd., Suite 271, Tampa, Fla. 33609; 813-286-2778

Year founded: 1973; began providing utilization review services in 1981.

Parent company: Adjustco 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, second surgical opinion, hospital bill audit, case management, workers compensation case management; occasional retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services; 10% of gross revenues from other services.

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

Staff: 100 total staff members; 84 professional staff members, including 35 registered nurses. Eight physicians and three nurses on a retainer basis.

Clients: 350 total clients; 315 employer clients; 5% with fewer than 500 employees, 60% with 500-999 employees, 10% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 15% with more than 5,000 employees.

1988 gross revenues: \$4.9 million total.

Charges: Per employee, per case, percent of savings.

Principal officers: Leonard Russo, chief executive officer; Jack Holton, senior vp-operations; Grace Armstrong, senior vp-cost containment management division; Louise Herbert, director-medical review.

Cost Management Technologies

4435 Main St., Suite 810, Kansas City, Mo. 64111; 816-531-6300

Year founded: 1986.

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, second surgical opinion, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 75% of gross revenues from other services.

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

Staff: Seven total staff members; four professional staff members who are registered nurses. 36 physicians on a retainer basis.

Clients: 250 total clients; 25 employer clients; 95% with fewer than 4,999 employees, 5% with more than 5,000 employees. 98,125 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Patrick A. Thompson, president; John Hatfield, vp.

Crawford & Co. Health Management Services

P.O. Box 5047, Atlanta, Ga. 30302; 404-256-0830

Year founded: 1941; began providing utilization review services in 1981.

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, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, workers compensation review; occasional retrospective review; 30% of gross revenues from other services.

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

Staff: 50 total staff members; 37 professional staff members, including five physicians, 24 registered

nurses, six licensed practical nurses, two medical records technicians. One physician on a retainer basis.

Clients: 2,000 total clients; 5% with fewer than 500 employees, 20% with 500-999 employees, 20% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 25% with more than 5,000 employees. 350,000 total lives serviced in 1988.

Branch offices: Savannah, Ga.; Columbia, S.C.

1988 gross revenues: Not reported.

Charges: Per employee, \$1-\$2.50.

Principal officers: P.A. Bollinger, executive vp; G. Berk Lynch II, vp; Jeff V. Aycock, assistant vp.

D

DataMed Inc.

650 W. Dundee Road, Northbrook, Ill. 60062; 312-291-0742

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

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 re-

view, second surgical opinion, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 5% of gross revenues from other services.

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

Staff: 30 total staff members; 15 professional staff members, including nine physicians, six registered nurses, two medical records technicians. Four physicians and two nurses on a retainer basis.

Clients: 60 total clients; 54 employer clients; 84% with fewer than 500 employees, 10% with 500-999

Continued on next page

1988 Results

RLI

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Consolidated Statutory Financial Information

RLI Insurance Company and Mt. Hawley Insurance Company

STATUTORY SURPLUS

(000 Omitted)

1983 - \$12,238
1984 - \$16,739
1985 - \$37,037
1986 - \$53,063
1987 - \$57,243
*1988 - \$64,951

COMBINED RATIO

1983 - 94.9
1984 - 97.0
1985 - 99.7
1986 - 84.1
1987 - 84.2
*1988 - 93.9

5 YEAR
COMBINED RATIO: 89.8
(1983-1987)

ASSETS

(000 Omitted)

1983 - \$ 35,156
1984 - \$ 48,719
1985 - \$105,993
1986 - \$159,568
1987 - \$168,859
*1988 - \$173,861

LOSS RESERVES

(000 Omitted)

1983 - \$ 4,985
1984 - \$ 9,150
1985 - \$22,784
1986 - \$46,243
1987 - \$59,712
*1988 - \$63,544

*Six months results ended June 30, 1988

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For Specialty Insurance Coverages

Spotlight report

Continued from previous page employees, 6% with 1,000-2,499 employees, 26,670 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, 50 cents-\$2.30.

Principal officers: Louis R. Morgan, vp.

E

Efficient Health Systems Inc.

5215 Old Orchard Road, Suite 360, Skokie, Ill. 60077; 312-967-7800

Year founded: 1984; began providing utilization review services in 1985.

Services provided: 53% 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 programs, workers compensation case management; 47% of gross revenues from other services.

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

Staff: 108 total staff members; 68 professional staff members, including seven physicians, 60 registered nurses, one medical records technician, 20 physicians on a retainer basis.

Clients: 1,000 total clients; 32 employer clients; 40% with fewer than 500 employees, 15% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 30% with more than 5,000 employees. 496,000 total lives serviced in 1988.

Branch offices: New York and Atlanta.

1988 gross revenues: \$5.8 million total.

Charges: Per employee per month, \$1.35-\$2.30; by the hour, \$100-\$125.

Principal officers: Harve A. Ferrill, chairman/chief executive officer; James E. Adams, president/chief operating officer; Sharon Cacciabondo, vp-utilization management; Stephanie L. Kramer, vp-development; Dr. Donald E. Casey Jr., vp/medical director.

F

Focus Healthcare Management Inc.

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

Year founded: 1986.

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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, workers compensation management; occasional hospital bill audit; 15% of gross revenues from other services.

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

Staff: 60 total staff members; 25 professional staff members, including four physicians, 19 registered nurses, one licensed practical nurse and one medical records technician.

Clients: 200 total clients; 170 employer clients; 50% with fewer than 500 employees, 38% with 500-999 employees, 10% with 1,000-2,499 employees, 2% with 2,500-4,999 employees. More than 400,000 total lives serviced in 1988.

1988 gross revenues: \$2 million total; \$1.7 million from utilization review to employers.

Charges: Per employee, \$1-\$1.05; per case, \$125-\$275; by the hour, \$50-\$60.

Principal officers: Stryker Warren Jr., president; David Iskowe and Mark Kishe., executive vps.

G

Great-West Life Assurance Co./Health Care Review Service

5505 E. Orchard Road, Englewood, Colo. 80111; 303-889-3000

Year founded: 1892; began providing utilization review services in 1985.

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, case management, outpatient surgery; occasional outpatient service predetermination, outpatient psychiatric and substance

abuse services.

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

Staff: 243 total staff members; 142 professional staff members, including two physicians, 108 registered nurses, 15 physicians on a retainer basis.

Clients: 1,790 employer clients; 95% with fewer than 500 employees, 3% with 500-999 employees, 2% with 1,000-2,499 employees. 517,556 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee.

Principal officers: Alan MacLennan, senior vp-group insurance; James D. Motz, vp-group insurance; David Grapko, manager-health care management.

GreenTree Health Services Inc.

P.O. Box 1005, Delaware, Ohio 43015; 800-999-688C

Year founded: 1987; began pro-

viding utilization review services in 1988.

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; 80% of gross revenues from other services.

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

Staff: Nine total staff members; five professional staff members who are registered nurses. One physician on a retainer basis.

Clients: 65 total clients; 60 employer clients; 100% with fewer than 500 employees. 540,000 total lives serviced in 1988.

Charges: Per employee, \$1-\$1.50.

Principal officers: Patrick Travis, president; Ginny Leitch, director-utilization review services.

H

John Hancock Managed Health Care

P.O. Box 111, Boston, Mass. 02117; 617-572-7104

Year founded: 1984.

Parent company: John Hancock Financial Services.

Services provided: 95% 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, employee advisory services; 5% of gross revenues from

Continued on next page



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Continued from previous page
other services.

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

Staff: 142 total staff members who are professionals, including 10 physicians, 69 registered nurses, 1,000 physicians available through a physician advisory network.

Clients: 396 total clients; 395 employer clients; 53.9% with fewer than 500 employees, 16.2% with 500-999 employees, 16.5% with 1,000-2,499 employees, 4.5% with 2,500-4,999 employees, 8.5% with more than 5,000 employees. 1.7 million total lives serviced in 1988.

Branch offices: San Francisco; Dallas; Detroit; Schaumburg, Ill.; Lynnfield, Mass.

1988 gross revenues: \$7.5 million total.

Charges: Per employee, \$1-\$2.15.

Principal officers: James Sang, general director; Nancy Buckman, product development consultant; Aileen Montour, director-managed health services; Jan Settele, manager-case management services.

Clients: 216 total clients; 214 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. 675,000 total lives serviced in 1988.

1988 gross revenues: \$1.7 million total; \$1.6 million from utilization review services to employers.

Charges: Per employee, 95 cents-\$1.25; by the hour.

Principal officers: Jerry Boyer, vp/chief operation officer; Elizabeth A. Galitski, program administration director; Susan Bunting Bianchi, information systems director.

HealthCare COMPARE Corp.

3200 Highland Ave., Downers Grove, Ill. 60515-1223; 312-719-9000

Year founded: 1982.

Services provided: 55% of gross revenues from providing utilization review services to employers, includ-

Health Benefits Management Inc.

P.O. Box 8125, Camp Hill, Pa. 17089; 800-441-2330 in Pennsylvania; 800-441-2333 outside Pennsylvania

Year founded: 1984.

Parent company: Pennsylvania Blue Shield and Capital Blue Cross.

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, second surgical opinion, outpatient service predetermination, disability certification; occasional discharge planning, retrospective review, case management; 5% of gross revenues from other services.

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

Staff: 21 total staff members who are professionals, including two physicians, 16 registered nurses. One physician on a retainer basis.

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, workers compensation and disability management, medical information hotline; occasional hospital bill audit; 45% of gross revenues from other services.

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

Staff: 433 total staff members; professional staff members include 27 physicians, 300 registered nurses, 10 licensed practical nurses and 15 medical records technicians.

Clients: 12,000 total clients; more than 5 million total lives serviced in 1988.

Branch offices: Sacramento, San Francisco and Los Angeles, Calif.; Portland, Ore.

1988 gross revenues: \$20.8 million total.

Charges: Per employee, per case.

Principal officers: Dr. Robert J. Becker, chairman/chief operating officer; James C. Smith, president/chief executive officer; Daniel Brunner, president-Affordable Health Care Concepts.

Health Care Evaluation Inc.

1212 W. Robinhood Drive, Suite 3-D, Stockton, Calif. 95207; 209-951-6711

Year founded: 1968.

Services provided: 64% 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; 36% of gross revenues from other services.

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

Staff: 52 total staff members; 30 professional staff members, including 22 registered nurses, two licensed practical nurses, six medical records technicians. 150 physician consultants on a retainer basis.

Clients: 74 total clients; 72 employer clients; 27% with fewer than 500 employees, 12% with 500-999 employees, 37% with 1,000-2,499 employees, 11% with 2,500-4,999 employees, 13% with more than 5,000 employees. 1.1 million total lives serviced in 1988.

Branch offices: Bakersfield, Sacramento, Fresno and San Francisco, Calif.

1988 gross revenues: \$2.2 million total; \$1.5 million from utilization review services to employers.

Charges: Per employee, \$1-\$2.40; per case, \$38-\$75.

Principal officers: Dr. John W. Kellar, medical director; Elaine Hislop, executive director; Bernice Wahler, president.

Health Cost Consultants Inc.

10201 Lee Highway, Fairfax, Va. 22030; 703-591-7800

Year founded: 1983.

Parent company: Inova Health-Care 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; 80% of gross revenues from other services.

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

Staff: 10 total staff members who are professionals, including one physician, six registered nurses. 50 physicians on a retainer basis.

Clients: Not reported.

Branch offices: Atlanta.

1988 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Debbie L. Scheff, president; Dr. Louis J. Pugsley, vp/medical director.

The Health Data Institute-Managed Care Division

900 N. State Parkway, Suite 325, Schaumburg, Ill. 60173-5135; 312-240-1111

Year founded: 1981.

Parent company: Baxter Health-care Corp.

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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, disability management; occasional hospital bill audit; 50% of gross revenues from other services.

Services reviewed: Group health

Continued on next page

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Continued from previous page
services, psychiatric and substance abuse services.

Staff: 180 total staff members.

Clients: More than 100 total clients; more than 60 employer clients; 5% with fewer than 500 employees, 10% with 500-999 employees, 20% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 45% with more than 5,000 employees. 825,000 total lives serviced in 1988.

Branch offices: Lexington, Mass.; Elmhurst, Ill.; Detroit; Santa Monica and Laguna Hills, Calif.

1988 gross revenues: Not reported.

Principal officers: Richard Daly, president; Shelli Williamson, vp/general manager-managed care division.

Health Economics Corp.

1300 W. Mockingbird Lane, Suite 300, 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, 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-determination, outpatient psychiatric and substance abuse services, case management; 80% of gross revenues from other services.

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

Staff: 230 total staff members; 41 professional staff members, including two physicians, 27 registered nurses, nine licensed practical nurses, three medical records technicians. One physician on a retainer basis.

Clients: 71 total clients; 64 employer clients; 44% with fewer than 500 employees, 25% with 500-999 employees, 17% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 10% with more than 5,000 employees. 350,000 total lives serviced in 1988.

Branch offices: Oklahoma City, Houston, Atlanta.

1988 gross revenues: \$10.2 million total; \$2 million from utilization review services to employers.

Charges: Per employee, \$1.25-\$2.75; per case, \$50-\$75.

Principal officers: Stephen F. Coady, president/chief executive officer; Richard D. Starkweather, vp-operations; Nancy Coleman, vp-claims.

Health International Inc.

1840 Century Park E., Suite 670, Los Angeles, Calif. 90067;
213-551-1840; 800-333-3760

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, case management; 20% of gross revenues from other services.

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

Staff: 20 total staff members; 11 professional staff members, including two physicians, eight registered nurses, one medical records technician. 18 physicians on a retainer basis.

Clients: 268 total clients; 85% with fewer than 500 employees, 8% with 500-999 employees, 5% with 1,000-2,499 employees, 1% with 2,500-4,999 employees, 1% with more than 5,000 employees. 250,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1.75.

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: 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 pre-determination, outpatient psychiatric and substance abuse services, case management.

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

Staff: 12 total staff members who are registered nurses. One physician and one nurse on a retainer basis.

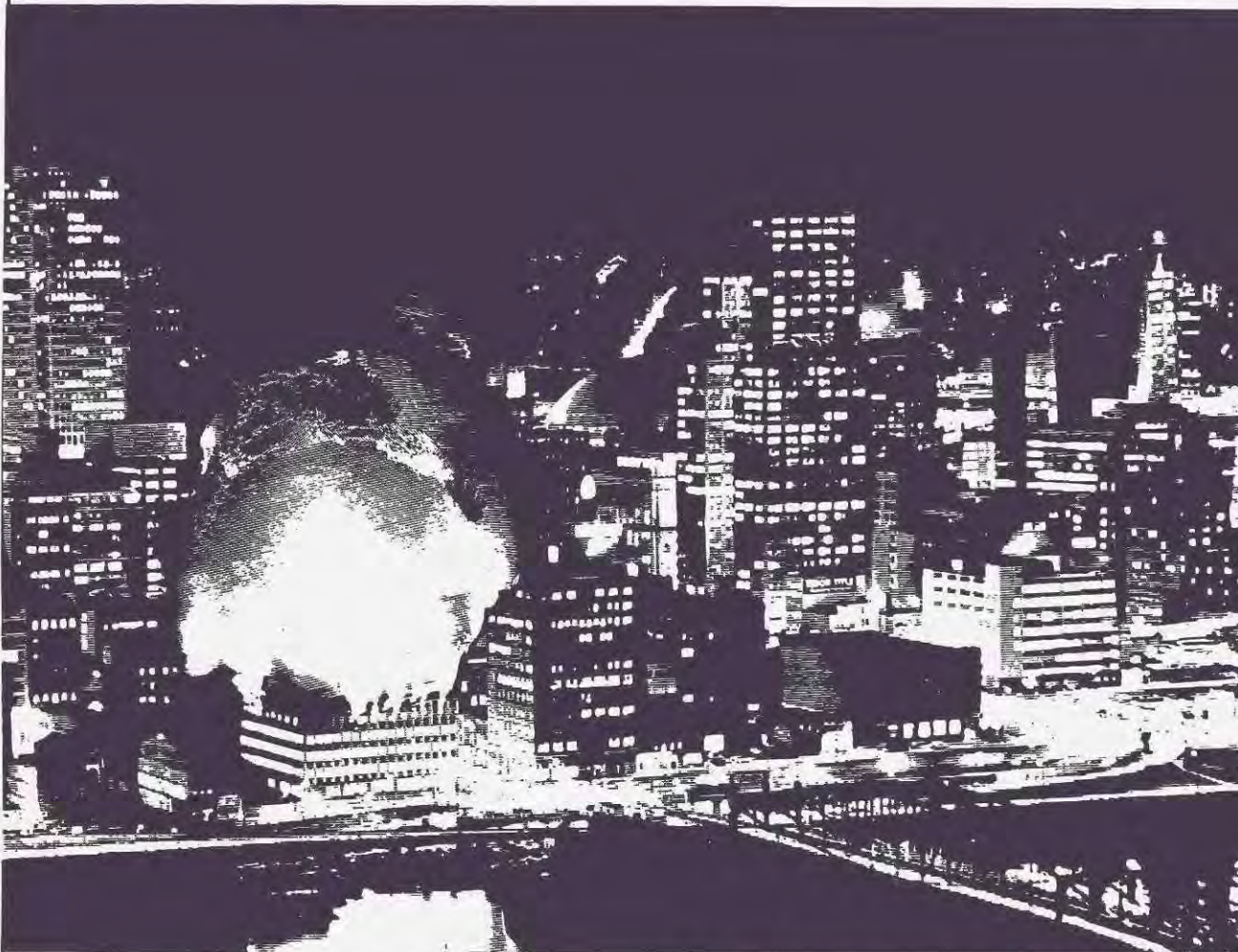
Clients: 500 total clients; 99% with fewer than 500 employees, 0.5% with 500-999 employees, 0.5% with 1,000-2,499 employees. 38,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1.50-

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Continued from previous page
\$2.35; per case, \$75-\$150 per hour.
Principal officers: Jane Esenwein
McCreary, president.

Health Management Strategies International Inc.

1301 Pennsylvania Ave. N.W.,
Suite 800, Washington, D.C.
20004; 800-624-6472

Year founded: 1985.
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, pre-natal review; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 50% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 70 total staff members; 37 professional staff members, including two physicians, 35 registered nurses. 30 physicians on a retainer basis.

Clients: 277 total clients; 268 employer clients; 76% with fewer than 500 employees, 9% with 500-999 employees, 4% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 7% with more than 5,000 employees. 1.5 million total lives serviced in 1988.

1988 gross revenues: \$3.9 million total.

Charges: Per employee, per case.
Principal officers: E. Seton Shields, president; Dr. Alan B. Zients, senior vp/medical director; Daniel J. Klein, vp-marketing; William R. Vandervennet Jr., vp-corporate operations.

Health Related Services Inc.

301 Fifth Ave. Building, Pittsburgh,
Pa. 15222; 412-765-1444

Year founded: 1984; began providing utilization review services in 1985.

Parent company: Blue Cross of Western Pennsylvania.

Services provided: 80% of gross revenues from providing utilization review services to employers, including frequent preadmission 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; 20% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 236 total staff members; 138 professional staff members, including three physicians, 135 registered nurses. 85 physicians on a retainer basis.

Clients: 13,750 total clients; 610 employer clients; 15% with fewer than 500 employees, 5% with 500-999 employees, 10% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 55% with more than 5,000 employees. 1.8 million total lives serviced in 1988.

Branch offices: Erie and Johnstown, Pa.

1988 gross revenues: \$18 million total; \$14 million from utilization review services to employers.

Charges: Per employee, \$1.75-\$3.10; per case, \$70-\$100 plus expenses.

Principal officers: David P. Lyle, president; Roy S. Thomas Jr., vp-marketing/communications; David M. O'Brien, vp-cost management services.

Health Risk Management Inc.

8000 W. 78th St., Suite 270,
Minneapolis, Minn. 55435;
612-829-3500

Year founded: 1977; began providing utilization review services in 1984.

Services provided: 75% of gross revenues from providing utilization 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, inpatient and outpatient psychiatric and substance abuse services, case management, workers compensation; 25% of gross revenues from other services.

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

Staff: 220 total staff members; 68 professional staff members, including 16 physicians, 41 registered nurses, six licensed practical nurses, five medical records technicians. Four nurses on a retainer basis.

Clients: 125 total clients; 115 em-

ployer clients; 1% with fewer than 500 employees, 3% with 500-999 employees, 9% with 1,000-2,499 employees, 7% with 2,500-4,999 employees, 80% with more than 5,000 employees. 1.3 million total lives serviced in 1988.

Branch offices: Phoenix, Ariz.
1988 gross revenues: Not reported.

Charges: Per employee per year, \$7-\$38; per case, \$32-\$184.

Principal officers: Dr. Gary T. McIlroy, chief executive officer/chairman; Marlene Travis, president/chief operating officer; Tim Temple, vp; Bruce Kelley, vp-analytical services; Kenneth Diamond, vp-Care-PASS PPO; Al Pertuz, vp-operations; Walter Conley, vp-corporate resource planning; Al Gourley, executive vp; Terry Booth, vp-sales.

Health Service Review

6730 Roosevelt, Suite 304,
Franklin, Ohio 45005;
513-422-0063

Year founded: 1983.

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

Services reviewed: Group health

services, psychiatric and substance abuse services, chiropractic services.

Staff: 13 total staff members, eight professional staff members. 31 professionals on a retainer basis.

Clients: 172 total clients; 143 employer clients; 43% with fewer than 500 employees, 38% with 500-999 employees, 11% with 1,000-2,499 employees, 6% with 2,500-4,999 employees, 2% with more than 5,000 employees. 135,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1.05-\$2.20.

Principal officers: Thomas Wiley, president; Karen Mehl, William D. Stief and Donald Barker, vps.

Continued on page 54

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Services provided: 75% 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, inpatient and outpatient psychiatric and substance abuse services, case management, workers compensation; 25% of gross revenues from other services.

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

Staff: 220 total staff members; 68 professional staff members, including 16 physicians, 41 registered nurses, six licensed practical nurses, five medical records technicians. Four nurses on a retainer basis.

Clients: 125 total clients; 115 employer clients; 1% with fewer than 500 employees, 3% with 500-999 employees, 9% with 1,000-2,499 employees, 7% with 2,500-4,999 employees, 80% with more than 5,000 employees. 1.3 million total lives serviced in 1988.

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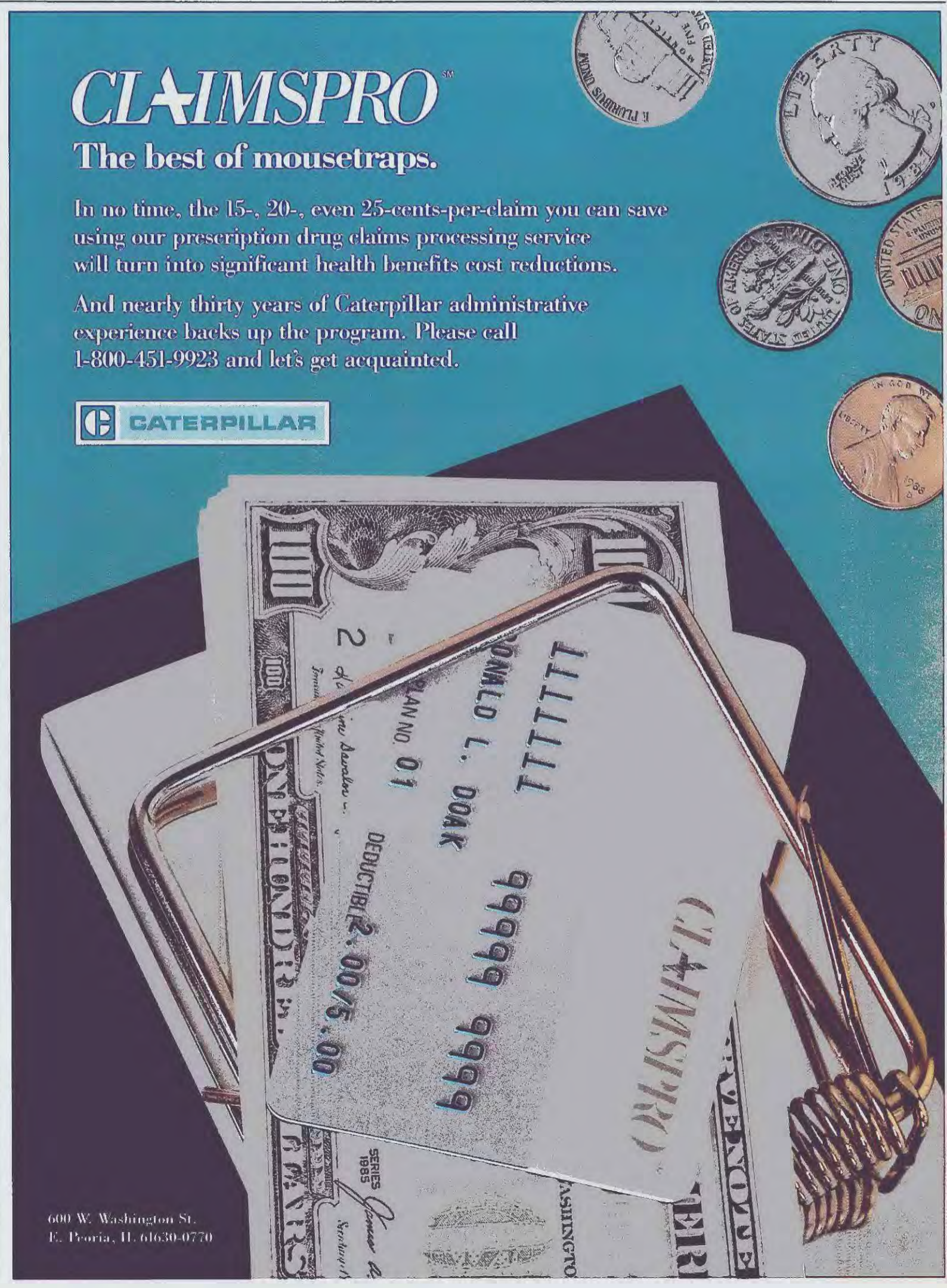
Health Risk Management Inc.

8000 W. 78th St., Suite 270,
Minneapolis, Minn. 55435;
612-829-3500

Year founded: 1977; began providing utilization review services in 1984.

Services provided: 75% of gross revenues from providing utilization review services to employers, includ-

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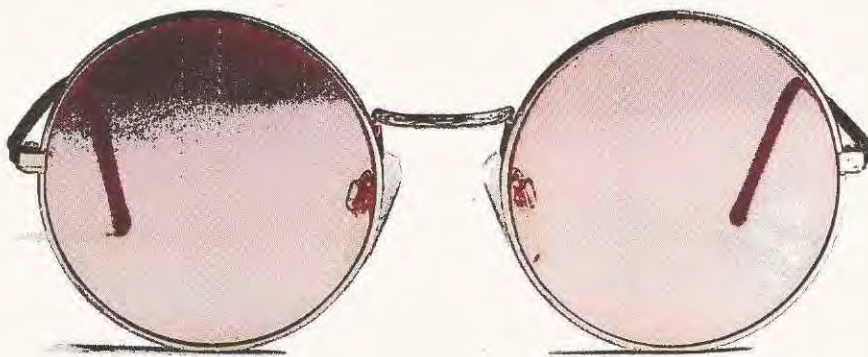
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Positive prognosis

Managed care to stabilize health insurance market

By Russell C. Coile Jr.

HEALTH INSURANCE is midway through a five-year transition process that has rocked the industry. But in 1989, stability will begin to return.

The business outlook for health insurance is improving and some insurance companies should see profitability in health care returning in the year ahead. Forecasting health industry trends is hardly a precise science, but 1989 holds promise to be a better year than 1988, with rising revenues and declining losses.

It is still a time of transition for health insurance and 1989 is only the midpoint. The underlying trend for this five-year period is the shift to managed care. The "insurance" concept in health care is extinct. By 1992, more than 60% to 70% of health insurance plans will be managed care plans, with the remainder surviving as "managed indemnity" plans.

What follows is an examination of the driving forces in health insurance in 1989.

One such trend is that the cost push spiral should ease. Group health insurance premiums should increase at rates of 20% to 25%, depending upon the insurer and the insured group, as medical care inflation returns to double-digit levels. This will continue the pattern of cost-push inflation for health insurance that took off in 1987, until further controls are put in place. A three-year cost-push spiral began in 1988.

Most major health insurers are planning more increases, but are moderating from the 40% to 50% hikes some implemented in 1988.

In 1989, the root causes of insurance company cost woes will be:

- ✓ Cost-shifting to private insurance by hospitals and physicians hard-pressed by declining Medicare reimbursement.

- ✓ Increased use of ambulatory services by consumers and doctors.

- ✓ Innovative "gaming the insurance system" by both consumers and providers.

- ✓ Aging of the population, with more chronic disease and higher use rates for inpatient and ambulatory care.

- ✓ An upward trend in inpatient utilization driven by the bottoming-out of hospital stays and the growing elderly population in the United States.

- ✓ Lack of effective provider controls and inadequate screening in provider selection.

- ✓ Higher operating costs for hospitals and physicians, driven by labor shortages and wage boosts of 8% to 15% nationally.

Declining losses also will impact health insurers in 1989. In the short term, America's health insurers should be prepared for more rough sledding, at least for the first two quarters of

1989.

Given the \$8 billion to \$9 billion in losses experienced by the health insurance industry in 1987, and continuing deficits in 1988 by many health insurers and a third of all health maintenance organizations, the pattern of declining losses will be welcome news. Most of the financial improvement will be due to premium increases. Costs to health insurers are only beginning to come under control and it will take at least another two years to rein them in.

Fewer plans and fewer options will also affect the health insurance industry. Soaring health care costs still are not under control, and major employers are resisting premium inflation. Buyers will respond by dumping higher-cost plans and limiting employee health options. This should be fertile ground for benefit consultants in assisting major employers to reduce the number of

soaring costs and disappointing enrollments in the past 18 months. HMO membership is climbing again, but only at 1% to 2% annual rates, as of mid-1988. As the difference between HMO and indemnity insurance costs becomes apparent to buyers in 1989, expect HMO growth to return to 10% to 12%, or about half of the rate during the high growth period in the mid-1980s. Total national HMO enrollment will top 35 million by 1990.

HMOs will continue to increase premiums, tighten controls and screen out high-cost providers. The focus will continue on more profit per enrollee instead of market share growth, helping HMOs return to profitability in 1989, but with low margins.

Will national firms dominate and affiliated firms disappear? Not by 1990. The race is far from over. One-third of national HMOs lost money in 1987, while only 21% of local

employees make the choice to use lower-cost HMO providers or pay the difference out-of-pocket.

In addition, the niche players are flourishing and will make inroads in the year ahead. Think of them as single-business HMOs.

The hottest managed care niches will be mental health, alcohol/drug abuse and dental care. Watch the development of niche plans in rehabilitation, stroke, obstetrics and cardiac care. The market is quickly broadening from major employers to other insurers that are downloading their risk to subcontractors. For example, Blue Cross of California contracted 1 million enrollees for mental health benefits to Orange County-based LifeLink.

The dental managed care market is growing, as dental costs have doubled since 1980. Managed care dental plan premiums rose only 4% to 5% in 1988, compared with 9% to 11% for standard group dental plans. Both HMO and PPO variations of managed dental care will compete. This is a huge potential market. A William M. Mercer Meidinger Hansen Inc. study showed 85% of a sample of major employers offered dental benefits; a similar survey by Hewitt Associates found that 96% of employers provided dental insurance.

Also in the year ahead, major employers will put retiree health care on the front burner and give it top priority. The trend is not driven by the potential impact of Financial Accounting Standards Board rules on corporate balance sheets (see story, page 1). More directly, the issue is soaring retiree health costs. Worse yet, most retirees are in indemnity plans and Medigap policies.

Take General Motors Corp.: More than 60% of GM's salaried workforce is enrolled in managed care plans, as are 40% of the hourly workers, while only 13% of GM's retirees picked managed care options. GM's retiree health costs are soaring, as its worker-to-retiree ratio drops.

Some companies are thinking of mandating HMOs for retirees, and a few employers are offering to cash out new retirees' health care benefit liability with a lump sum of \$15,000 to \$25,000 in lieu of coverage.

More experiments like Allied-Signal Corp.'s well-publicized deal with CIGNA Corp. are likely in 1989.

Major employers, Taft-Hartley plans and even state and local governments are primed for innovative

Continued on page 52

Speaking out

The underlying trend for this five-year period is the shift to managed care. The 'insurance' concept in health care is extinct. By 1992, more than 60% to 70% of health insurance plans will be managed care plans, with the remainder surviving as 'managed indemnity' plans.

insurance plans and HMOs offered to employees.

Not all companies will be equally hard hit. Self-insured employers with effective cost containment policies will benefit by lower health care cost increases—in the range of 12% to 17%. Most companies have imposed substantial cost shifting, and many employees are shifting to flexible benefit plans.

What's next? Mandated HMO enrollment. A few employers, like First Interstate Bank of Oakland, Calif., are experimenting with mandatory HMO enrollment, at least for new hires, and there won't be many HMO options.

Also having an impact will be the continuing trend of consolidation, as companies leave the market or are acquired. The wave of consolidation should hit the health insurance beach in the year ahead.

As employers reduce health insurance/HMO/preferred provider organization options, this should hasten the departures and acquisitions of small, marginal plans and those with limited market share.

"Brand-name" health plans should benefit; they have the deep pockets to buy out competitors.

Some national firms may exit the volatile health field, too, like Travelers Corp., which sold its health insurance book of business in late 1988.

Meanwhile, the future is brightening for the nation's HMOs, battered by

HMOs were losers, according to InterStudy, an Excelsior, Minn.-based HMO research organization.

Long-range prospects are promising for the ultimate dominance of national HMO firms, if only because their large insurance company sponsors have deeper pockets to ride out loss years and acquire weaker competitors.

Few new HMOs will form in 1989; their numbers are slowly declining.

Another managed care development is PPOs' victory in the managed care war last year, surging to 36 million to 40 million members, compared with 32 million HMO enrollees. In California, 7 million HMO enrollees were topped by 11 million PPO members. PPOs will be the dominant form of managed care plan in the future, with an enrollment advantage of 2-to-1 over HMOs.

What is happening now is that health insurers are becoming PPOs with an HMO option. As 1989 turns the corner into the 1990s, the distinctions between HMOs and PPOs will blur.

In the bellwether Twin Cities of Minneapolis-St. Paul, the "open-ended HMO" is the fastest growing form of HMO, according to InterStudy. Its gain is primarily at the expense of traditional HMO plans. Prudential's Pru-Plus plan gained 18.4% in the second quarter of 1988, eclipsing HMO enrollment increases. Employees like the point of service flexibility in the open-ended plans, while employers are pleased that

Russell C. Coile Jr. is president of The Health Forecasting Group in Alameda, Calif.



Assessing utilization review

Employers can quantify the impact of programs on health care expenses

By Jonathan E. Levin

UTILIZATION REVIEW has become an increasingly pervasive health care cost-containment strategy among U.S. employers. A recent survey of 100 large employers conducted by the research firm of Schulman, Ronca & Bucuvalas indicated that 80% have hospital admission and continued stay review, second surgical opinion and case management programs.

However, when asked to evaluate the impact of UR programs on their health care costs, employers find themselves challenged to quantify the programs' results. Published evaluations of employers' assessments of UR impact usually remain in the realm of opinion, not fact. Phrases such as "somewhat positive," "not too confident" and "very important" characterize responses to surveys on employer satisfaction with utilization review.

We present here a straightforward means of quantifying the impact of a UR program. It provides a simple method of evaluating utilization review and can be conducted within a reasonable amount of time by one person in possession of a few specific facts.

Here is how it works.

The following information is required for analysis of hospital utilization review programs. This data should be available for either a company's group health insurer or its UR vendor:

- The number of hospital admission requests.
- The number of admissions denied.
- The number of days of care requested by provider.
- The number of days approved by the UR vendor.
- The average charge per hospital day.
- The average room-and-board charge.
- The average length of stay.
- The cost of the UR program.

Using this information, an employer may derive the following data:

- The number of admissions certified equals requests reviewed minus admissions denied.
- The number of days saved equals number of days requested by provider minus the number of days approved by the UR provider.
- Average charge per admission equals average length of stay multiplied by average charge per hospital day.

Once you have this data, conduct the following calculations:

- Subtract room-and-board charges from the average charge per day. The result represents ancillary charges.

When a day of hospitalization is saved, the employer saves 100% of the room-and-board charges, but only a portion of the ancillary charges. This is because some portion of ancillary charges will be shifted to the remainder of the inpatient stay or to the outpatient or physician office setting. In the absence of an empirically derived rate, it is assumed that 30% of the ancillary charges will be shifted to other settings, while 70% of the charges will be saved.

Thus, multiply the ancillary charges by 0.7 to derive ancillary charges avoided.

- Add ancillary charges saved back into room-and-board charges to identify potential savings per day.
- Multiply potential savings per day by the number of days saved to estimate savings from total

days saved.

- To ensure that your results are conservative, it may be wise to adjust the estimate of savings to reflect the fact that the calculation days saved is an artifact of the interaction between the physician and the review methodology.

For example, assume Dr. A and Dr. B are each calling to admit patients with identical characteristics. The average length of stay for this illness/procedure is, for our purpose, seven days. Dr. A asks for 10 days, but only seven are certified. Dr. B asks for six days, and six days are certified. On the sixth day, Dr. B asks for a three-day extension and, based on the patient's condition, two days are certified. On the seventh day, Dr. A asks for four additional days, and two are approved.

Days saved from these two review episodes might be calculated as follows:

✓ Dr. A: Initial request, 10 days; initial approval, seven days; initial days saved, three days.

✓ Dr. B: Initial request, six days; initial approval, six days; initial days saved, zero days.

✓ Dr. A: Extension request, four days; extension approval, two days; extension days saved, two days.

✓ Dr. B: Extension request, three days; extension approval, two days; extension days saved, one day.

✓ Dr. A: Total days saved, five days.

✓ Dr. B: Total days saved, one day.

When Dr. A requested 10 days, did he intend to keep the patient in the hospital for 10 days, or was he aiming for seven or eight days? The patient actually used nine of the initial 10 days requested. Isn't one day a more accurate count of days saved than five days?

Some review vendors may present the higher numbers in their reports. You may want to make a downward adjustment in estimated savings or days saved. In this example, we reduce savings by 15% to derive a subtotal to which we will add savings from admissions denied in their entirety.

- As with days saved, some portion of the cost of admissions denied in their entirety will be shifted to other settings. To be conservative, we assume 40% of charges related to denied admissions are shifted elsewhere.

We therefore multiply the average charge per admission by 0.6 to determine savings related to each denied admission.

- Add the amount related to days saved to the amount associated with denied admissions. This represents the gross savings of the UR program.
- Subtract program costs from gross savings to determine the UR program's net savings.

To test how this procedure works, consider the following example:

In a given year, an employer has 360 reviews performed. Six admissions are denied, while 354 are certified. In total, 2,085 days of hospitalization are proposed, while only 1,785 days are certified for a savings of 301 days. The average length of stay is five days, while the average charge per day is \$839 and the average daily room-and-board cost is \$262. The average charge per admission is \$4,103.

To determine the savings produced by the UR program, you would:

- Subtract average room-and-board charges from average charge per day to determine ancillary charges (\$839 - \$262 = \$577).
- Multiply ancillary charges by 0.7 to determine ancillary charges avoided (\$577 × 0.7 = \$404).
- Add room-and-board charges avoided to ancillary charges to determine potential savings per day (\$404 + \$262 = \$666).
- Multiply potential savings per day by the number of days saved to determine potential savings

(\$666 × 301 = \$200,466).

- Multiply this number by 0.85 to take into account the 15% "gaming" factor (\$200,466 × 0.85 = \$170,396).

• Calculate the savings produced by the six denied admissions. (\$4,103 × 0.6 × 6 = \$14,772).

• Add this savings to the subtotal (\$170,396 + 14,772 = \$185,168).

• Subtract the cost of the UR program to determine the net savings (\$185,168 - \$35,736 = \$149,432).

With a net savings of \$149,432, approximately \$4 were returned for every dollar of program cost. While this does not match the 8-1 return suggested by some UR vendors, it does suggest that the program had a positive impact.

A similar test can be used to analyze the cost-effectiveness of second surgical opinion programs. The following information is needed to conduct this test:

- The number of second opinion cases subject to review.
- The number of second opinions waived due to apparent medical necessity.
- The number of second opinion requests initiated but not completed due to cancellation of plans for surgery,

sudden need for emergency surgery or other similar reasons.

- The number of second opinions obtained.
- The number of confirming second opinions rendered.

• The number of surgeries performed without required second opinions or performed despite adverse second opinions. A penalty usually is assessed to the patient in such scenarios.

- The penalty formula.
- The average cost of a second opinion consultation. (Health Insurance Assn. of America data for 1987 suggest \$75 as an average second opinion consultation fee).
- The average cost for a surgery. (An average inpatient surgical episode costs \$5,290 based on 217,000 Illinois cases.)

To run the test, complete the following calculations:

- Subtract the number of waivers and canceled opinions from the number of cases to derive the number of opinions required.
- Subtract from the number of opinions required the number of opinions obtained to determine the number of penalty situations for failure to obtain a second opinion (if the surgery was indeed performed).
- Subtract from the number of confirming opinions from the number of opinions performed to determine the number of opinions not confirmed.
- Subtract the number of surgeries performed without a second opinion from the number of opinions not confirmed to derive the number of surgeries successfully avoided.
- Multiply the number of waivers by the average second opinion fee to derive waiver savings. Waiver savings may be considered second opinion program savings or merely avoided program costs, depending on how conservative one wishes the analysis to be.
- Multiply the number of surgeries not confirmed and not performed (surgeries avoided due to intervention of the second opinion program) by the average charge for a surgery to derive the savings attributable to avoided surgeries.
- Multiply the number of penalty situations by the amount of the penalty.
- Add waiver savings, avoided surgery savings and penalty amounts.

Continued on page 52

Jonathan E. Levin is cost and utilization analysis manager at Mutual of Omaha Cos. in Omaha, Neb.

'As with days saved, some portion of the cost of admissions denied in their entirety will be shifted to other settings.'

'We present a means of quantifying the impact of a UR program by providing a method of evaluating utilization review.'

awns.
house;
origin

[Gr. *axia*.] a leguminous plant having an
ax-shaped.

ax'i-a, *n.* [Gr. *axia*. s.f.]

1. value, merit.
2. thing or quality having intrinsic worth.

Syn.—excellence, virtue.

See Gr. *axios*, worthy.

ax-i-al, *a.* 1. of, pertaining to, or like an axis.
2. revolving about an axis.

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Work-related stress caused heart attack

A WORKERS COMPENSATION claimant in a heart attack case must show, by a preponderance of evidence, that work-related stress or exertion precipitated the employee's heart attack, according to the Supreme Court of New Hampshire.

William J. O'Sullivan was a part-owner and general manager of an auto dealership. On Oct. 10, 1984, he died while en route to an automobile auction. The cause of his death was cardiac arrest brought on by acute cardiac arrhythmia. Testimony indicated that he suffered prolonged stress because of the dealership's financial difficulties and the difficulty of maintaining an adequate inventory of Toyotas in the face of import restrictions.

Prior to his death, Mr. O'Sullivan's stress became so severe that he underwent personality changes. He had a prior heart attack and a myocardial infarction in 1979. He was being treated for heart disease at the time of his death. His widow filed for and was awarded compensation.

On appeal, the employer argued that there was no evidence to support the finding that Mr. O'Sullivan's work-related stress was greater than encountered in normal non-employment life. The appellate court disagreed. According to the court, there was evidence that the dealership was having financial difficulty immediately prior to his death. His condition had deteriorated noticeably at that time and the effects were evident in his personality changes, the court said. The court was satisfied that Mr. O'Sullivan's work-related stress was greater than normally encountered in non-employment life and affirmed the award.

Legal briefs

Cheshire Toyota/Volvo Inc. vs. O'Sullivan, Supreme Court of New Hampshire, Aug. 24, 1987 (BI/02/Sept.-\$10).

Wrongful termination award upheld

The Supreme Court of Mississippi has upheld a \$100,000 punitive damage award to a policyholder under a group health insurance policy for the insurer's denial of a claim and wrongful termination of coverage.

On Oct. 1, 1984, Kathy Maas was hospitalized for surgery. Her husband, Stanley, an employee of Raleigh Forest Products, was covered under the employer's group health plan issued by Blue Cross & Blue Shield of Mississippi. On Dec. 3, 1984, the employer's bookkeeper paid the October premium of \$913.93 to BC/BS and remitted a separate check for \$127.77 as prepayment of an additional employee. As the amount received was in excess of invoice, BC/BS referred the matter to its reconciliation department.

Meanwhile, on Oct. 13, 1984, Mr. Maas quit his job with Raleigh Forest Products. The bookkeeper sent BC/BS a termination card for Mr. Maas on Oct. 15, removing him from the policy effective Oct. 31. However, acting on an Oct. 16 note that Mr. Maas had quit, the source of which was not established, BC/BS canceled his coverage as of the "pay-to-date," Oct. 1, 1984, according to company procedure.

The medical bills received by BC/BS for Mrs. Maas were rejected. Although Mr. Maas inquired about the claim, BC/BS never responded. Mr. Maas sued BC/BS seeking actual and punitive damages.

On Jan. 14, 1985, BC/BS began an investigation into the matter that took about 2½ weeks to complete. A bill submitted from Mrs. Maas' doctor received by BC/BS was also rejected. On March 11, 1985, BC/BS tendered checks to the Maases totaling \$1,766.40. At trial, BC/BS employees readily conceded that they had made a mistake. A jury awarded the Maases \$1,820 in actual damages and \$100,000 in punitive damages.

On appeal, BC/BS maintained that it investigated Mr. Maas' coverage after he had filed suit and remitted payment once it had found the error. The court said that punitive damages are recoverable where a breach of contract results from an intentional wrong, insult or abuse as well as for gross negligence as constitutes an independent tort. The court said that the Maases had proven gross negligence indicative of a wanton and willful disregard of their rights by BC/BS that supported the award of punitive damages.

Blue Cross & Blue Shield of Mississippi vs. Maas, Supreme Court of Mississippi, Dec. 9, 1987, rehearing denied, Jan. 6, 1988 (BI/05/Sept.-\$10).

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a \$10 check payable to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

Health care forecast

Continued from page 49

arrangements that reduce costs and shift risks to insurers and providers. Many of these non-traditional arrangements will cut out middlemen, restrict choice to a handful of exclusive providers and receive below-market prices. Providers will eagerly sign up in exchange for volume guarantees.

Another trend ripe for expansion is case management. Blue Shield of California began in 1987 to experiment with case management for AIDS patients, and in 1988 expanded the program to other terminally ill patients.

The innovation is that Blue Shield's case managers can use and pay non-plan providers, depending upon whoever provides the most appropriate, cost-effective care.

The focus on quality will heat up in 1989. The new term for quality assurance is "outcomes management." Employers will want documentation of effective outcomes from insurance companies—not on the process of caring, but the actual outcome of care.

Self-insured employers and their consultants will screen claims to see if the injured employees achieved desired outcomes from their treatment.

The Joint Commission on Accreditation of Healthcare Organizations will continue to expand the criteria for quality care, including outcome measures, as they develop standards for 18 clinical services by 1991-92. Health insurers may expand the domain of their utilization managers to include outcome criteria. It will be the coming thing, demanded by employers, government, consumer groups and all major health insurance customers in the 1990s.

The future will bring surprises as well as the predictable. Futurists call them "wild cards." Imagine these three scenarios:

✓ Foreign competition. Here is a longshot possibility: the invasion of foreign firms, buying into the U.S. insurance industry.

It follows a global pattern of the internationalization of finance, which began with banking and is rapidly

expanding into stockbrokerage, marketing and real estate. Insurance could be next. With their huge financial reserves, large-scale investments and broad customer bases, U.S. insurance companies could be prime targets for foreign investment.

✓ "Motel 6" prices for health insurance. Just when the insurance industry believes that discounting and the price wars of the mid-1980s are over, along comes cut-rate health insurance.

High-deductible plans are becoming available. Other plans focus on narrow niche groups, with discount premiums. Blue Shield of California is offering a health plan for children of workers without family health coverage. In Rochester, N.Y., Blue Cross will offer a new plan, "Value-Med," to the uninsured with low and moderate incomes of no more than 200% of New York's Medicaid income standard. The premium will be 50% of the standard rate, with limited benefits.

✓ "Proposition 103" for health insurance. With consumer activists

gathering steam after rolling back insurance rates by 20% in California, a proposition similar to 103 could be put on the California ballot to reduce health insurance premiums.

Already, one consumer organization, Health Access, is planning a petition drive in California. Other state legislatures could expand the trend of insurer-bashing to include health insurance in the coming year. The supporters for rolling back health insurance prices could include major employers, chambers of commerce and government officials, who would like to cut their own health care costs.

One last thought: Take all predictions with a grain of salt!

Forecasts are only assumptions. Every forecast needs to be filtered through the experience of each firm and its market. The "microclimates" for trends vary by region. California and the Twin Cities are unique, but so is every marketplace. Think of these predictions as a second opinion on your forecast of the forces that will drive health insurance and your business in 1989.

Evaluating utilization review

Continued from page 50

• Subtract program costs to derive the net impact of the second surgical opinion program.

As an example, take a company with 176 cases subject to second opinions. Eight waivers are granted, and there are 13 aborted opinions. Of the 75 second opinions obtained, 73 are confirming opinions, and no employees have surgery performed despite a non-confirming second opinion.

Finally, the employer assesses a \$125 additional deductible as a penalty for not obtaining a second opinion.

According to the formula:

• Subtract the number of waivers and aborted opinions from the total number of cases to calculate the number of opinions required (176 - 80 - 13 =

83).

• Subtract the number of opinions obtained from the number of opinions required to determine the number of penalty situations (83 - 75 = 8).

• Subtract the number of confirming opinions from the number of second opinions obtained (75 - 73 = 2).

• Subtract the number of surgeries performed despite a non-confirming second opinion from the number of non-confirming second opinions (2 - 0 = 2).

• Multiply the number of waivers obtained by the \$75 second opinion fee (80 × \$75 = \$6,000).

• Multiply avoided surgeries by the average charge for a surgery (2 × \$5,290 = \$10,580).

• Multiply the number of penalty situations by

the penalty amount (8 × \$125 = \$1,000).

• Add the products of the three previous steps to determine gross savings (\$6,000 + \$10,580 + \$1,000 = \$17,580).

• Subtract the cost of the program to determine net impact (\$17,580 - \$25,491 = -\$7,911).

In this analysis, program costs exceed the savings, even if waivers are considered as savings rather than simply avoided program costs. Such a finding may serve as a basis for modifying the program, terminating it or negotiating lower vendor prices.

Utilization review programs may outlive their usefulness. It is important to be able to discern when that point has been reached to redeploy cost-containment dollars to more rewarding activities.

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A Professional Service Organization

Continued from page 45
Healthcare Review Corp.
9200 Shelbyville Road, Suite 215,
Louisville, Ky. 40222;
502-426-4888

Year founded: 1986.
Services provided: 60% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, nursing home review, ambulatory surgery procedure review; 40% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, chiropractic services.
Staff: 17 total staff members; nine professional staff members, including three physicians, five registered nurses, one licensed practical nurse. One physician and seven nurses on a retainer basis.

Clients: 50 total clients; 12 employer clients; 67% with fewer than 500 employees, 8% with 500-999 employees, 25% with more than 5,000 employees. 167,122 total lives served in 1988.
1988 gross revenues: \$915,069 total; \$551,531 from utilization review services to employers.
Charges: Per employee, 75 cents-\$3.50; \$50-\$150 per hour for some services.
Principal officers: James C. Rogers, president; Dr. Barbara Freeman, medical director; Dr. Alvin B. Ortner, vp.

HealthCare Strategies Inc.
9841 Broken Land Parkway, Suite 105, Columbia, Md. 21046;
301-381-5430
Year founded: 1984.
Parent company: TPA of America Inc.

Services provided: 100% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, maternity services, medical information hot line; occasional hospital bill audit.

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

Staff: 45 total staff members; 20 professional staff members, including six physicians, nine registered nurses, two medical records technicians. Three physicians on a retainer basis.

Clients: 63 total clients; 62 employer clients; 5% with fewer than 500 employees, 10% with 500-999 employees, 10% with 1,000-2,499 employees, 55% with 2,500-4,999 employees, 20% with more than 5,000 employees. 450,000 total lives served in 1988.

1988 gross revenues: \$1.7 million total, all from utilization review services to employers.

Charges: Per employee, \$1.25-\$2.60; \$35-\$500 per hour for maternity services review; \$115-\$125 per hour for large case management.

Principal officers: Janice K. Albert, president; William P. Keenan, vp.

Healthmarc Inc.
5601 Smetana Drive, Suite 400,
Minnetonka, Minn. 55343;
612-936-1205

Year founded: 1983.
Parent company: United Health Care 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, second surgical opinion, case management; occasional retrospective review, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, workers compensation management services; 20% of gross revenues from other services.

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

Staff: 75 total staff members; professional staff members include two physicians, 45 registered nurses, four medical records technicians. 24 professionals on a retainer basis.

Clients: 324 total clients; 300 employer clients; 25% with fewer than 500 employees, 20% with 500-999 employees, 25% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 15% with more than 5,000 employees. 500,000 total lives served in 1988.

Branch offices: Pasadena, Calif.
1988 gross revenues: Not reported.

Charges: Per employee, \$1.50-\$2.50; per case, \$112-\$150.

Principal officers: Mark Tierney, president; Carol Hampton, vp-group operations; Glenda Garrard, vp-workers compensation.

HealthNetwork Inc.
1420 Kensington Road, Suite 203,
Oak Brook, Ill. 60521-2106;
312-954-2900; 800-345-7848

Year founded: 1985.
Continued on next page

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A HEALTHY DIFFERENCE.

Continued from previous page

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, retrospective review, second surgical opinion, outpatient surgery review; occasional hospital bill audit, outpatient psychiatric and substance abuse services, case management; 60% of gross revenues from other services.

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

Staff: Nine total staff members; five professional staff members who are registered nurses. Two physicians and two nurses on a retainer basis.

Clients: 195 total clients; 90 employer clients; 97.8% with fewer than 500 employees, 2.2% with 1,000-2,499 employees. 40,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1.45-\$1.80; percent of billed charges for bill audits; \$67 per hour for case management.

Principal officers: George C. Phillips Jr., president/chief executive officer; Donna M. Wolak, vp/financial officer.

Healthpro Inc.

10 Mechanic St., Worcester, Mass. 01608; 508-757-5440

Year founded: 1975; began providing utilization review services in 1976.

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; 10% of gross revenues from other services.

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

Staff: 65 total staff members; 36 professional staff members, including one physician, 35 registered nurses. 50 physicians on a retainer basis.

Clients: 10 total clients; seven employer clients; 10% with 1,000-2,499 employees, 90% with more than 5,000 employees. 750,000 total lives serviced in 1988.

1988 gross revenues: \$3 million total.

Charges: Per employee, \$1.25-\$1.75; per case, \$125 per hour.

Principal officers: Michele Stranger-Hunter, president; Gary N. Lapidus and Barbara Ladon, vps.

Health Resources Ltd.

P.O. Box 246, 3 N. Lancy St., Pittsfield, Maine 04967; 207-487-5135

Year founded: 1979; began providing utilization review services in 1985.

Services provided: 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 and waiver option, hospital bill audit, outpatient service predetermination, case management; occasional outpatient psychiatric and substance abuse services; 50% of gross revenues from other services.

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

Staff: 10 total staff members; nine professional staff members, including seven registered nurses, two licensed practical nurses. One physician on a retainer basis.

Clients: Not reported.

1988 gross revenues: Not reported.

Charges: By the hour, \$42-\$48.

Principal officers: Mary E. Orloski, president; Lynne S. Parkhurst, vp-review services.

The Holman Group

6900 Owensmouth Ave., Canoga Park, Calif. 91303; 800-824-2932; 800-321-2843 in California

Year founded: 1979.

Services provided: 15% of gross revenues from providing utilization review services to employers, including preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, hospital bill audit, outpatient psychiatric and substance abuse services, case management; 85% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: 63 total staff members.

Clients: 53 total clients; 41 employer clients; 10% with fewer than 500 employees, 5% with 500-999 employees, 60% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 10% with more than 5,000 employees. 400,000 total lives served in 1988.

Branch offices: Bakersfield, Del Mar, Downey, Glendale, Los Angeles, Oxnard, Palmdale, Pasadena, Pomona, Riverside, San Diego, Santa Monica, Torrance, Tustin and Westminster, Calif.; Las Vegas.

1988 gross revenues: Not reported.

Charges: Per employee, 25 cents-\$3.50; per case, \$160-\$400.

Principal officers: Ron Holman, president; Marilyn Kingston, senior vp; Judy Hunt, vp-professional services.

Humana Health Care Plans

500 W. Main St., P.O. Box 1438, Louisville, Ky. 40201-1438; 502-580-1000

Year founded: 1983.

Parent company: Humana Inc.

Services provided: Utilization review services include 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.

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

Clients: Not reported.

1988 gross revenues: Not reported.

Principal officers: Wayne Smith, president-group health division; W. Larry Cash, senior vp-finance; Philip B. Garmon, senior vp-operations; C.

Roger Collins, vp-western region; Dr. Ronald S. Lankford, vp-medical affairs; Daniel J. Moen, vp-Health Care Plans of Florida; John H. Morse, vp-development; Joseph E. Shiprek, vp-administration; Karen A. Sholtis, vp-Health Care Plans of Kentucky; Thomas D. Stroud, vp-sales.

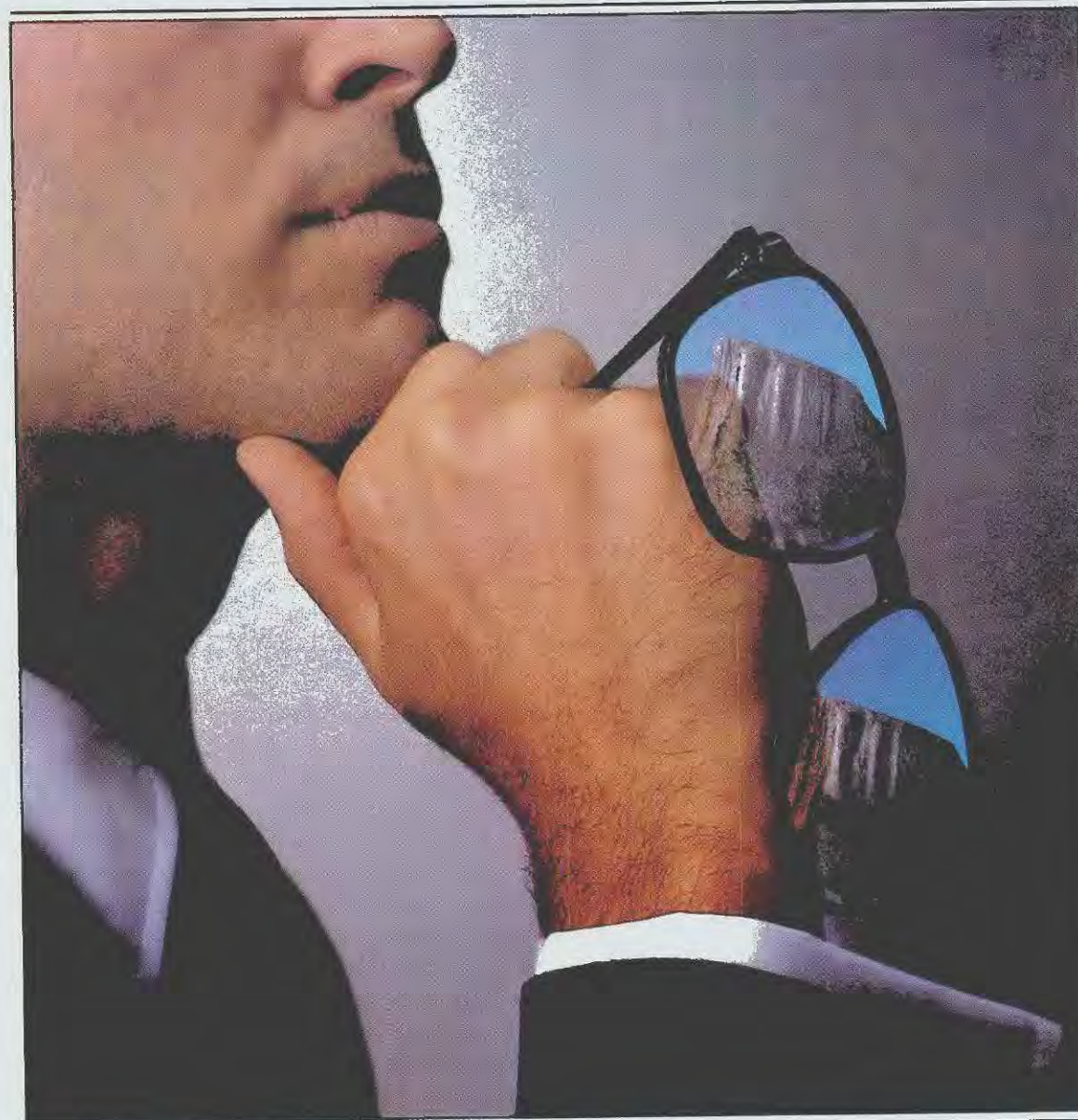
Independent Dental Consultants

301 N. Harrison St., Building B, Suite 173, Princeton, N.J. 08540; 201-286-9210

Year founded: 1988.

Continued on next page

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Continued from previous page

Services provided: 75% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, second surgical opinion, outpatient service predetermination, case management, second opinion clinical examinations, alternative benefits review; occasional concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, hospital bill audit; 25% of gross revenues from other services.

Services reviewed: Dental services.

Staff: Six total staff members who are professionals, including four dentists, one registered nurse, one hygienist, 150 dentists on a retainer basis.

Branch offices: Philadelphia and New York.

Charges: Percent of premium, percent of claims, percent of savings.

Principal officers: Dr. Kenneth O'Connor, president.

Integrated Health Systems Inc.

119 Dillmont Drive, Worthington, Ohio 43085 514-858-2223

Year founded: 1986.

Parent company: Health Matrix Corp.

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, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional hospital bill audit; 95% of gross revenues from other services.

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

Staff: Four total staff members who are professionals, including one physician, three registered nurses.

Clients: Three total clients; one employer client. 36,000 total lives

serviced in 1988.

1988 gross revenues: Not reported.

Principal officers: Bradley Engel, chairman/chief executive officer; Jonnie Geis, president/chief operating officer; Robert M. Fox, vp.

Intracorp

1295 Westlakes Drive, Berwyn, Pa. 19312; 215-889-2600

Year founded: 1970; began providing utilization review services in 1984.

Parent company: CIGNA Corp.

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.

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

Staff: 4,000 total staff members; 600 professional staff members.

Clients: 20,200 total clients; 11.5 million total lives serviced in 1988.

Branch offices: Offices in the United States, Canada and Australia.

1988 gross revenues: \$200 million total.

Charges: Per employee, per case.

Principal officers: Warren D. Fuller, president; Richard Anderson, executive vp; Gregory Reidi, senior vp-marketing.

IPRO National Medical Review

95-25 Queens Blvd., 10th Floor, Rego Park, N.Y. 11374; 718-896-7230

Year founded: 1983.

Services provided: 50% 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; 50% of gross revenues from other services.

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

Staff: 160 professional staff members, including 87 registered nurses, 12 medical records technicians, 550 physicians, 10 nurses and 10 medical records coding specialists on a retainer basis.

Clients: 30 total clients.

1988 gross revenues: Not reported.

Charges: Per employee, per case.

Principal officers: Theodore O. Will, executive vp.

K

Kepple & Co. Inc.

1811 W. Altorfer Drive, Peoria, Ill. 61615; 309-692-7330

Year founded: 1982; began providing utilization review services in 1986.

Services provided: 16% 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 on non-compliance, second surgical opinion, case management; 84% of gross revenues from other services.

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

Staff: Five total staff members who are professionals, including one physician, three registered nurses, one medical records technician.

Clients: 28 total clients; 26 employer clients; 82% with fewer than 500 employees, 11% with 500-999 employees, 7% with 1,000-2,499 employees. 24,000 total lives serviced in 1988.

1988 gross revenues: \$1.6 million total; \$280,500 from utilization review to employers.

Charges: Per employee, \$1.75-\$2.50; by the hour, \$50.

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; 800-367-4207; 317-298-6600

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

Parent company: The Associated Group/Blue Cross & Blue Shield of Indiana.

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 psychiatric and substance abuse services, case management; occasional retrospective review, second surgical opinion, workers compensation case management; 60% of gross revenues from other services.

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

Staff: 110 total staff members; professional staff members include 68 registered nurses. Four professionals on a retainer basis, including one physician.

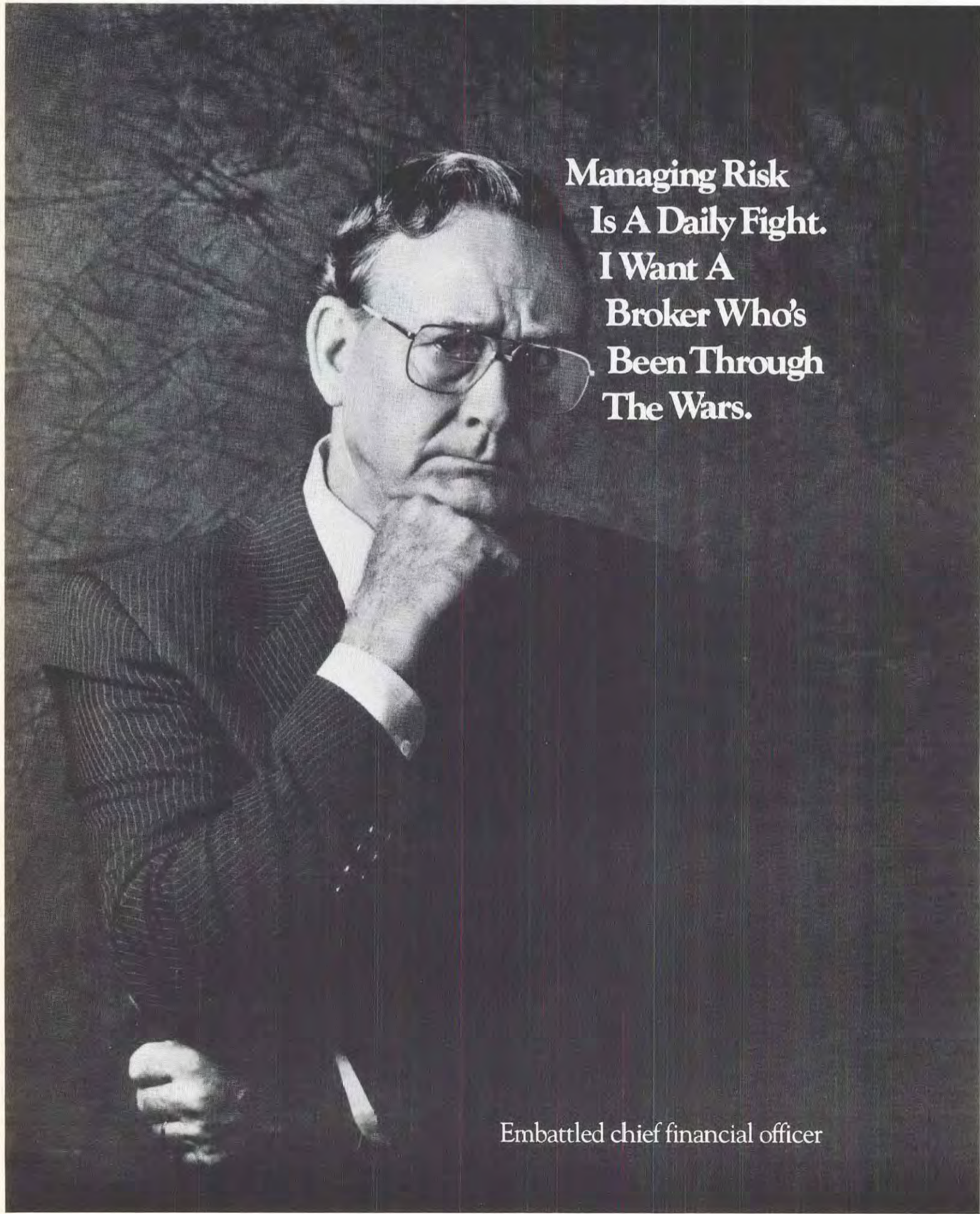
Clients: 1,000 total clients; 32% with fewer than 500 employees, 26% with 500-999 employees, 27% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 5% with more than 5,000 employees. 1.5 million total lives serviced in 1988.

1988 gross revenues: \$7.5 million total.

Charges: Per employee, 23 cents-\$2; per case, \$200-\$3,000; percent of savings.

Principal officers: Erick E. Hanson, president/general manager.

Continued on next page



**Managing Risk
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 Been Through
 The Wars.**

Embattled chief financial officer

Continued from previous page

M

Managed Care Administrators

12651 High Bluff Drive, Suite 203,
San Diego, Calif. 92130;
619-259-1933

Year founded: 1988; began providing utilization review services in 1989.

Services provided: Utilization review services 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: 14 total staff members; professional staff members include two physicians, two registered nurses, one licensed practical nurse, two medical records technicians, 15 physicians and two nurses on a retainer basis.

Charges: Per employee, \$1.25-\$2; per case, \$55-\$85.

Principal officers: Raymond E. Hughes, chairman/chief executive officer; Edward M. Bosanac, president/ chief operating officer.

Massachusetts Peer Review Organization (MassPRO)

300 Bear Hill Road, P.O. 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: Less than 1% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, outpatient service predetermination; occasional second surgical opinion, hospital bill audit, outpatient psychiatric and substance abuse services; more than 99% of gross revenues from other services.

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

Staff: 100 total staff members; 86 professional staff members, including five physicians, 67 registered nurses, 14 medical records technicians, 150 physicians on a retainer basis.

Clients: Three total clients, 800,000 total lives serviced in 1988.

Branch offices: West Springfield and Middleboro, Mass.

1988 gross revenues: \$6.3 million total.

Charges: Per employee, per case, flat annual fee.

Principal officers: Dr. Brenda E. Richardson, president; Dr. Francis D. Cogliano, vp; Dr. Eugene V. LaLancette, clerk; Dr. Gunter Spanknabel, treasurer.

Medcost Inc.

2150 Country Club Road, Suite
160, Winston-Salem, N.C. 27014;
919-721-1844

Year founded: 1983; began providing utilization review services in 1984.

Services provided: 48% 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, case management; 52% of gross revenues from other services.

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

Staff: 15 total staff members; professional staff members include five registered nurses, 30 physicians on a retainer basis.

Clients: 62 total clients; approximately 15 employer clients. 350,000 total lives serviced in 1988.

Branch offices: Charleston, S.C.
1988 gross revenues: Not reported.

Charges: Per employee, \$1-\$1.50.
Principal officers: Otto W. Mueller, president; Billie J. Davis, vp.

Medical Claims Review Services Inc.

7315 Wisconsin Ave., Suite 500W,
Bethesda, Md. 20814;
301-469-3080

Year founded: 1984.

Services provided: 10% of gross revenues from providing utilization review services to employers, including frequent retrospective review, case management, medical claim surveys and analysis; occasional preadmission certification, concurrent hospital treatment review, length of stay determination, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services; 90% of gross revenues from

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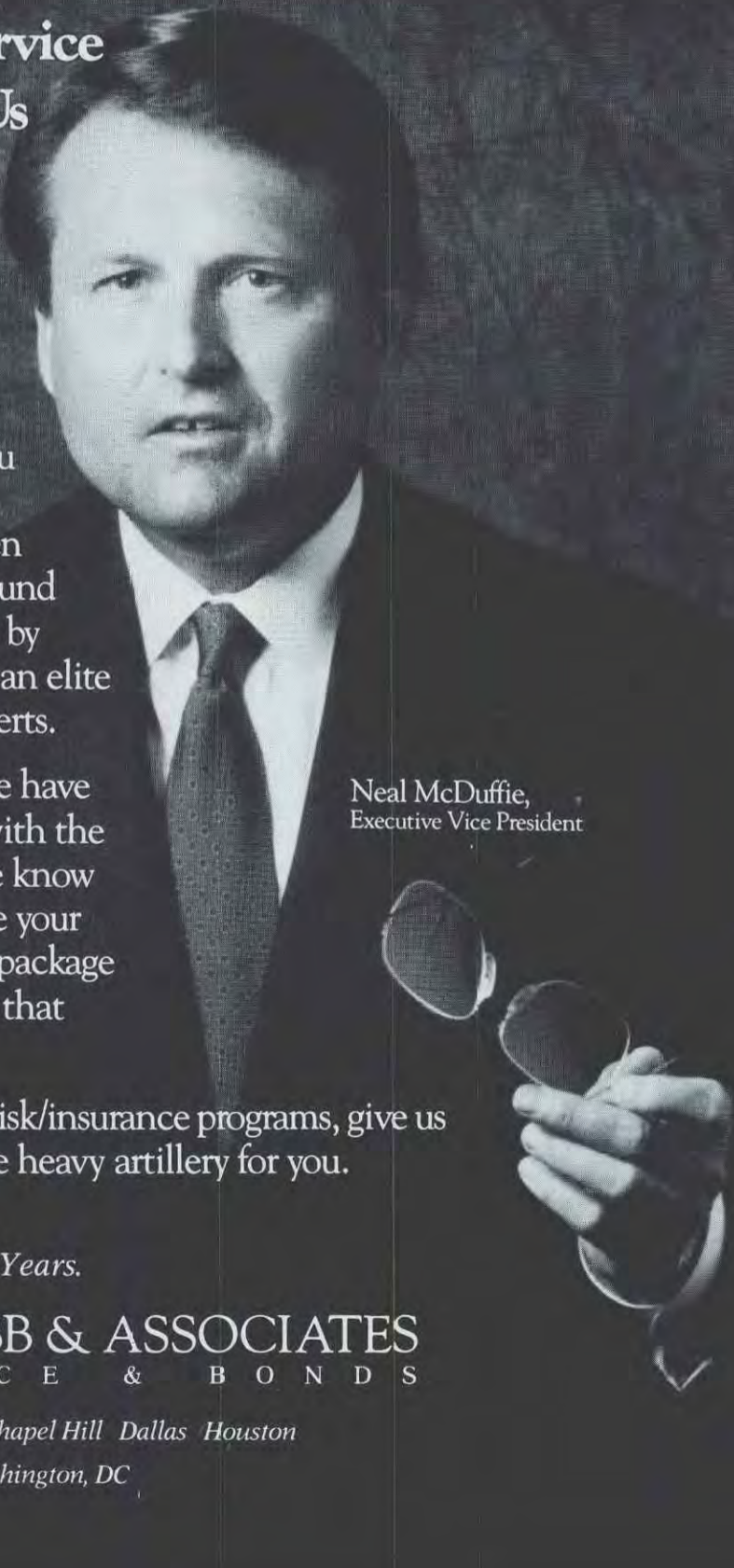
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Neal McDuffie,
Executive Vice President

Continued from previous page
other services.

Services reviewed: Dental services, psychiatric and substance abuse services, chiropractic services, surgery, physical therapy services.

Staff: 41 total staff members; 26 professional staff members, including four physicians, four registered nurses, 18 medical records technicians, 20 physicians and 30 nurses on a retainer basis.

Clients: 150 total clients; 10 employer clients; 1% with fewer than 500 employees, 3% with 500-999 employees, 3% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 90% with more than 5,000 employees.

Branch offices: Van Nuys, Calif.
1988 gross revenues: \$2.5 million total, \$500,000 from utilization review services for employers.

Charges: \$1.50-\$1.90 per billing line, \$60-\$175 per hour.

Principal officers: Ronald E. Gots, president; Thomas C. McCarthy, executive vp; John J. Madigan, vp-development; Jack V. Casbolt, vp-marketing; Eric Wissel, director-case management.

Medical Cost Management Corp.

122 S. Michigan Ave., Suite 1200, Chicago, Ill. 60603; 312-341-0217

Year founded: 1986.

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, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, case management; occasional discharge planning, outpatient psychiatric and substance abuse services; 40% of gross revenues from other services.

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

Staff: 15 total staff members; professional staff members include four physicians, four registered nurses, one licensed practical nurse, 300 physicians and 40 nurses on a retainer basis.

Clients: 120 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. 65,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, 80 cents-\$1.45; per case.

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., Miami, Fla. 33166; 305-593-0404

Year founded: 1973.

Services provided: 80% of gross revenues from providing utilization review services to employers, including preadmission certification, concurrent hospital treatment review, length of stay determination, dis-

charge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 20% of gross revenues from other services.

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

Staff: 50 total staff members; 40 professional staff members, including seven physicians, 30 registered nurses, three medical records technicians. Seven physicians and three nurses on a retainer basis.

Clients: 200 total clients; 150 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 employees, 5% with more than 5,000 employees.

1988 gross revenues: Not reported.

Charges: Per employee, 70 cents-\$1.15; per case, \$50-\$75; retrospective review, \$40 per hour.

Principal officers: John Sforza,

executive director; Lois Osman, director-operations; Richard N. Dietrich, director-marketing.

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: 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, second surgical opinion, hospital bill audit, case management; occasional retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services; 40% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance abuse services, chiropractic services, physical therapy services, nursing services.

Staff: Not reported.

Clients: Total clients not reported; 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.

1988 gross revenues: Not reported.

Charges: \$1.10-\$2 per employee; \$65-\$185 per case; \$55-\$125 per hour.

Principal officers: M. Allen, chairman/chief executive officer; P. Stalker, vp.

Medical Review Institute of America

525 E., 100 S., Suite 300, Salt Lake City, Utah 84102; 800-654-2422

Year founded: 1982.

Services provided: 20% of gross revenues from providing utilization review services to employers, including frequent retrospective review, outpatient service predetermination, outpatient medical and dental claims review; 80% of gross revenues from other services.

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

Staff: 17 total staff members; 155 physicians on a retainer basis.

Clients: 480 total clients; employer clients; 15% with 1,000-2,499 employees, 35% with 2,500-4,999 employees, 50% with more than 5,000 employees.

1988 gross revenues: Not reported.

Charges: Per case, \$48-\$350.

Principal officers: Diane Hoyle, executive vp/general manager; William W. Low, president; Dr. Robert K. Maddock, medical director.

Med-Services Management Co.

1 Bala Ave., Suite 4C, 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; occasional case management; 50% of gross revenues from other services.

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

Staff: 20 total staff members.

Clients: 60 total clients.

1988 gross revenues: \$1.5 million total.

Charges: Not reported.

Principal officers: Robert Bauer, chief executive officer; Marie Constance-Lewis, vp; Mary Kay Dunne, director-health care cost management.

MedTrac Inc.

2550 University Ave., Suite 240N, St. Paul, Minn. 55114; 612-646-2848; 800-328-8181

Year founded: 1969.

Parent companies: Corroon & *Continued on next page*

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Black Corp./The Foundation for Health Care Evaluation.

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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, workers compensation review; occasional hospital bill audit; 70% of gross revenues from other services.

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

Staff: 41 total staff members; 26 professional staff members who are registered nurses. 700 physicians on a retainer basis.

Clients: 526 total clients; 115 employer clients; 85% with fewer than 500 employees, 5% with 500-999 employees, 5% with 1,000-2,499 employees, 2.5% with 2,500-4,999 employees, 2.5% with more than 5,000 employees. 492,000 total lives serviced in 1988.

Branch offices: Nashville, Tenn.
1988 gross revenues: Not reported.

Charges: Per employee, \$1.10-\$1.60; per case, \$55-\$85.

Principal officers: Ronald G. Cameron, president/chief executive officer; Patricia L. Hanson, vp; Gregory G. McNair, national sales manager; Neil Collins, vp/regional director-Nashville office.

MED-VALU by MHC

6200-D Avery Road, Dublin, Ohio 43017; 800-447-3459

Year founded: 1987.

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, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, physicians' office utilization review; occasional retrospective review, second surgical opinion; 90% of gross revenues from other services.

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

Staff: 23 total staff members; 17 professional staff members, including two physicians, 15 registered nurses. 10 physicians on a retainer basis.

Clients: 15 total clients; five employer clients; 2% with fewer than 500 employees, 8% with 500-999 employees, 10% with 1,000-2,499 employees, 80% with more than 5,000 employees. 170,000 total lives serviced in 1988.

1988 gross revenues: \$1 million total, \$750,000 from utilization review services for employers.

Charges: Per employee, 95 cents-\$1.10; monthly fee.

Principal officers: Michael Linde, president; Frank Anzelmo, vp-systems; Mary Ellen O'Grady, vp-sales.

MedView/CompPro

30057 Orchard Lake Road, Farmington Hills, Mich. 48018; 313-851-0700

Year founded: 1983; began providing utilization review services in 1984.

Services provided: 65% 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, workers compensation; 35% of gross revenues from other services.

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

Staff: 30 total staff members; professional staff members include two physicians, 20 registered nurses, four licensed practical nurses, four medical records technicians. 40 physicians and 20 nurses on a retainer basis.

Clients: 1.9 million total lives serviced in 1988.

Branch offices: Chicago and Los Angeles.

1988 gross revenues: Not reported.

Principal officers: Robert J. Mackey, president; Dr. David S. Segel, executive vp.

Member Service Administrators

1437 S. Boulder, Tulsa, Okla. 74119; 918-586-7700

Year founded: 1984.

Parent company: Blue Cross & Blue Shield of Oklahoma.

Services provided: Utilization review services include frequent

preadmission certification, concurrent hospital treatment review, retrospective review, hospital bill audit, case management; occasional length of stay determination, second surgical opinion.

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

Staff: 11 total staff members; six professional staff members who are registered nurses.

Clients: Two total clients. 60,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee per month, \$1-\$4.

Principal officers: Ralph S. Rhoades, chairman/chief executive officer; Richard D. McCutchen, se-

nior vp.

Memphis Business Group on Health Inc.

2714 Union Extended, Suite 200, Memphis, Tenn. 38112; 901-323-1808

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

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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional

retrospective review, second surgical opinion, hospital bill audit; 10% of gross revenues from other services.

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

Staff: Nine total staff members; seven professional staff members, including one physician, six registered nurses.

Clients: 14 employer clients; 21% with fewer than 500 employees, 16% with 500-999 employees, 28% with 1,000-2,499 employees, 21% with 2,500-4,999 employees, 14% with more than 5,000 employees. 125,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1.50; per

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This program is trimming the cost of medical care to my injured employees without sacrificing quality. This is important to me because the cost of medical treatment is used in determining basic workers' comp rates and my experience modification. Both are primary factors affecting the amount of premium I pay.

Here's how the program works:

State Fund claims adjustors refer injured workers to contracted medical facilities meeting high quality standards to insure that your injured worker gets the best medical care at the lowest possible rates.

State Fund monitors drug prescriptions to guard against drug abuse and to check for possible billing errors.

State Fund reviews all medical reports and bills to guard against any treatment unnecessary to the recovery of your employee, and to make sure that charges are not greater than that to which the provider is entitled.

What it comes down to is State Fund watches their expenses, just like I do with my business. They've saved policyholders over \$37.9 million dollars since they started the Medical Cost Containment Program in 1985. I appreciate that. And so do the other State Fund policyholders.

If you would like to be sure your injured employees are getting the best medical care at the lowest cost, you should be talking to State Fund.

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STATE
COMPENSATION
INSURANCE
FUND

Spotlight report

Continued from previous page
case, \$55.

Principal officers: Gordon C. Smith, president; Donna Miller, executive vp.

Metrocare Administrative Services Inc. (ValuTrac)

1815 S.W. Marlow, Suite 210,
Portland, Ore. 97225;
503-297-3806

Year founded: 1986.

Parent company: Metrocare National 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, retrospective review, second surgical opinion, outpatient psychiatric and substance abuse services, case management,

home health care review, rehabilitation review; occasional hospital bill audit, outpatient service predetermination; 30% of gross revenues from other services.

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

Staff: 58 total staff members; 50 professional staff members who are registered nurses.

Clients: 2,000 total clients; 70% with fewer than 500 employees, 17% with 500-999 employees, 5% with 1,000-2,499 employees, 5% with 2,500-4,999 employees, 3% with more than 5,000 employees. 530,000 total lives serviced in 1988.

Branch offices: Bloomington, Minn.; Bellevue, Wash.; Troy, Mich.; Charlotte, S.C.; King of Prussia, Pa.; Linwood, N.J.

1988 gross revenues: \$2 million total.

Charges: Per employee, \$1.20-\$1.80; per case, \$75-\$150; per nurse, \$5,000-\$6,500.

Principal officers: Joan Copeland, executive vp; Steve Gregg, chief executive officer; Dale White.

Metrolina Medical Foundation

3000 Charlottetown Center,
Charlotte, N.C. 28204;
704-373-1545

Year founded: 1975.

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; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 65% of gross revenues from other services.

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

Staff: 31 professional staff members, including one physician, 26 registered nurses, two licensed practical nurses, two medical records technicians. 140 physicians and four nurses on a retainer basis.

Clients: 12 total clients; six em-

ployer clients; 33% with 500-999 employees, 17% with 1,000-2,499 employees, 50% with more than 5,000 employees. 216,000 total lives serviced in 1988.

1988 gross revenues: \$2.1 million total.

Charges: Per employee per year, \$7.50-\$10.

Principal officers: Dr. Richard Kevecman, president; Dan Carrigan, executive vp; Dr. Dewey Dorsett, secretary.

Mutual Health Services Co.

1240 Huron Road, Cleveland, Ohio
44115; 216-687-8500

Year founded: 1972; began providing utilization review services in 1983.

Parent company: Blue Cross & Blue Shield of Ohio.

Services provided: 23% 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, case management; occasional hospital bill audit; 77% of gross revenues from other services.

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

Staff: 61 total staff members; 55 professional staff members, including 54 registered nurses and one medical records technician. 32 physicians on a retainer basis.

Clients: 66 total clients; 60 employer clients; 66% with fewer than 500 employees, 11% with 500-999 employees, 8% with 1,000-2,499 employees, 3% with 2,500-4,999 employees, 12% with more than 5,000 employees. 1.2 million total lives serviced in 1988.

Branch offices: Salem, N.H.

1988 gross revenues: \$15 million total, \$3.5 from utilization review services for employers.

Charges: Per employee, \$1-\$1.60.

Principal officers: James W. Harless, president/chief executive officer; Jerome W. Rogers, secretary; Robert A. Bauer, treasurer; David G. Bick, director-sales/marketing.

Mutual of Omaha Insurance Co./United of Omaha Insurance Co.

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 include frequent preadmission certification, concurrent hospital treatment review, length of stay determination, retrospective review, second surgical opinion, case management.

Services reviewed: Group health services.

Staff: 36 total staff members assigned to utilization review; professional staff members include two physicians, 18 registered nurses. Seven physicians on a retainer basis.

Clients: 7,694 total clients; 99.78% with fewer than 500 employees, 0.08% with 500-999 employees, 0.09% with 1,000-2,499 employees, 0.01% with 2,500-4,999 employees, 0.04% with more than 5,000 employees. 165,000 total lives serviced in 1988.

1988 gross revenues: \$1.8 billion total.

Charges: Per employee, \$1.20-\$1.50.

Principal officers: Thomas J. Skutt, chairman; John W. Weekly, president-Mutual of Omaha Insurance Co.; William J. Hetzler, president-United of Omaha Life Insurance Co.

N

National Chiropractic Review Service Inc.

600 Cramer Building, Route 38,
Mount Holly, N.J. 08060;
609-267-3838

Year founded: 1974.

Services provided: 50% of gross revenues from providing utilization review services to employers, including prospective and retrospective chiropractic review; 50% of gross revenues from other services.

Services reviewed: Chiropractic services.

Staff: 54 total staff members; 15 professional staff members, including 15 physicians, one registered nurse. 550 chiropractic examiners on a retainer basis.

Clients: 500 total clients.

1988 gross revenues: Not reported.

Charges: Per case, \$115.

Principal officers: Dr. Lawrence Wolther, president/chiropractic director; Barbara Gutstadt, vp.

National Health Services Inc./CareReview

12300 W. Center St., Milwaukee,
Wis. 53222; 414-778-5151

Year founded: 1984.

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, hospi-

Continued on next page

High-Performance Utilization Review



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27	FEB 15		

MARCH

6	FEB 22		AGENT/BROKER TOPICS: Agency-Insurer Relations/ Preferred Agents
13	FEB 28*	RISK MANAGEMENT SERVICES Directory: Risk Management Consultants Distribution: International Captive & Reinsurance Forum	
20	MAR 8		INSURER TOPICS: Insurer-Agency Relations

New York: 212 210-0228 Chicago: 312 649-5276 Los Angeles: 213 651-3710

Continued from previous page
 tal bill audit, outpatient medical/surgical service review, case management; occasional outpatient service predetermination, outpatient psychiatric and substance abuse services; 70% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 31 total staff members; 18 professional staff members, including 11 physicians, seven registered nurses. Physicians and nurses are contracted on a retainer basis.
Clients: 416,533 total lives serviced in 1988.
Branch offices: Dallas.
1988 gross revenues: \$1.5 million total, \$450,000 from utilization review services for employers.
Charges: Per employee, \$1-\$2.20; by the hour plus expenses.
Principal officers: Mark W. Williams, president; Donald L. White, executive vp-marketing.

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 other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 18 total staff members; 11 professional staff members, including one physician, eight registered nurses, one licensed practical nurse, 30 physicians and 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. 500,000 total lives served.
Continued on next page

O

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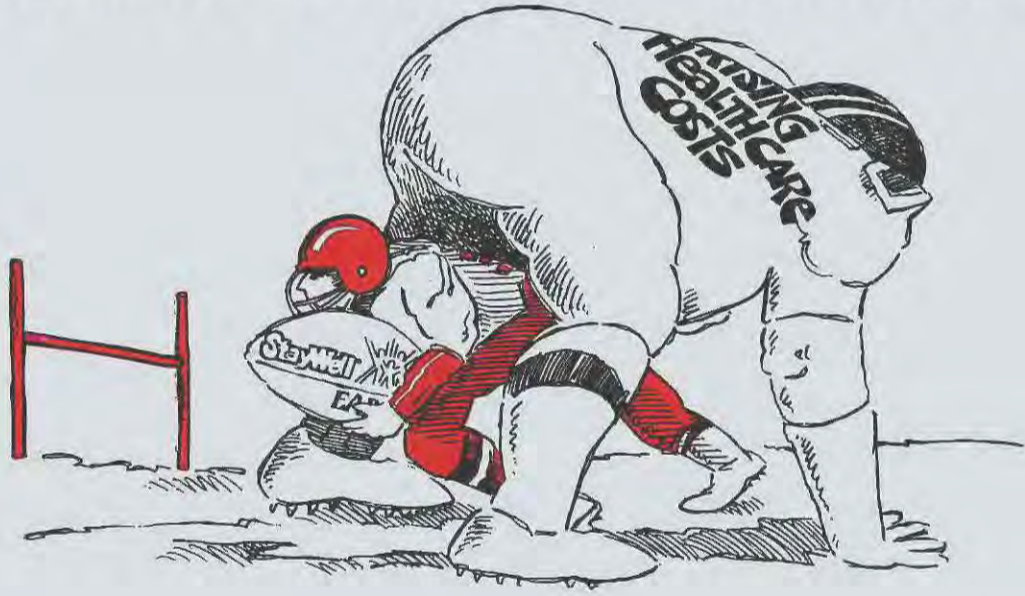
Year founded: 1981; began providing utilization review services in 1984.
Services provided: 30% of gross revenues from providing utilization review services to employers, including preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, workers compensation services; 70% of gross revenues from other services.
Services reviewed: Group health services, dental services, psychiatric and substance abuse services, chiropractic services.
Staff: 48 total staff members; 37 professional staff members, including 10 registered nurses; one medical records technician; 27 rehabilitation counselors and psychologists. 25 physicians and three nurses on a retainer basis.
Clients: 18 total clients; five employer clients; 10% with 1,000-2,499 employees, 30% with 2,500-4,999 employees, 60% with more than 5,000 employees. 800 total lives serviced in 1988.
1988 gross revenues: \$1.8 million total.
Charges: Per employee per hour, \$45-\$70; per case, \$250.
Principal officers: Joseph M. McCabe, president; Antonia L. Scarlata, secretary/treasurer.

P

PCC/Drug Data Systems Inc.
 828 Hollywood Way, Burbank, Calif. 91505; 818-843-8551
Year founded: 1969.
Services provided: 40% of gross revenues from providing utilization review services to employers, including frequent retrospective review, hospital bill audit, outpatient psychiatric and substance abuse services; occasional concurrent hospital treatment review; workers compensation services; 60% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: Eight total staff members; seven physicians and three nurses on a retainer basis.
Clients: 1,800 total clients; 600 employer clients; more than 1 million total lives serviced in 1988.
1988 gross revenues: Not reported.
Principal officers: Dr. Alvin Saldiner, president.

Pacific Peer Review Inc.
 6230 Claremont Ave., Oakland, Calif. 94618; 415-547-7841
Year founded: 1983.
Services provided: 60% of gross

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Spotlight report

Continued from previous page
viced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, per case, by the hour.

Principal officers: Dr. Thomas Forde, president; Margaret M. Kelly, executive director.

Pacific Review Services

5995 Plaza Drive, Cypress, Calif.
90630-0848; 714-220-3700

Year founded: 1983; began providing utilization review services in 1984.

Parent company: Pacificare Health Systems Inc.

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, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, case management; occasional outpatient psychiatric and

substance abuse services; 60% of gross revenues from other services.

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

Staff: 60 total staff members; professional staff members include two physicians, 17 registered nurses, five medical records technicians. Three physicians on a retainer basis.

Clients: 420 total clients; 100 employer clients; 28% with fewer than 500 employees, 31% with 500-999 employees, 17% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 9% with more than 5,000 employees. 450,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1.30-\$2.25.

Principal officers: Vicki Merrill, chief operating officer.

Parkside Health Management Corp.

205 W. Touhy, Park Ridge, Ill.
60068; 312-698-4800

Year founded: 1980; began pro-

viding utilization review services in 1981.

Parent company: Lutheran General Health Care Services Corp.

Services provided: 88% 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, disability management; occasional hospital bill audit, disability review; 12% of gross revenues from other services.

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

Staff: 160 total staff members; professional staff members include three physicians, 70 registered nurses. 19 physicians on a retainer basis.

Clients: More than 200 total clients; 100 employer clients; 10% with fewer than 500 employees, 64% with

500-999 employees, 10% with 1,000-2,499 employees, 6% with 2,500-4,999 employees, 10% with more than 5,000 employees. 1.1 million total lives serviced in 1988.

Branch offices: Toledo and Cleveland, Ohio; Chicago; Atlanta.

1988 gross revenues: \$8 million total.

Charges: Per employee, 68 cents-\$2.50; per case, \$50-\$150.

Principal officers: Marsha L. Ballard, president; Jenifer Cline, vp-operations; Dr. Steve Tiwald, president-Path PPO; Robert Coburn, president-Commons Data Services.

Peer Review Analysis Inc.

380 Pleasant St., Malden, Mass.
02148; 617-322-6400

Year founded: 1984.

Services provided: 0.5% 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, outpatient psychiatric and

substance abuse services, case management; occasional retrospective review, hospital bill audit, outpatient service predetermination; 95.5% of gross revenues from other services.

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

Staff: 45 total staff members; 24 professional staff members, including seven physicians, 16 registered nurses, one licensed practical nurse. 65 physicians on a retainer basis.

Clients: 27 total clients; three employer clients; 100% with fewer than 500 employees. 4 million total lives serviced.

1988 gross revenues: \$2.5 million total.

Charges: Per employee, \$1.25-\$1.60; Per case, \$55-\$75; by the hour, \$125-\$175.

Principal officers: Dr. Barry Manuel, chairman; Russell Robbins, vice chairman; Eric Spitzer, president; Charles Smith, treasurer.

Physical Therapy Review Services Inc.

P.O. Box 69, Woodlyn, Pa. 19094;
215-874-1248

Year founded: 1986.

Services provided: 10% of gross revenues from providing utilization review services to employers, including retrospective review, outpatient service predetermination, concurrent review, physical therapy review; 90% of gross revenues from other services.

Services reviewed: Physical therapy services.

Staff: Four professional staff members who are physical therapists. 40 physical therapists on a retainer basis.

Clients: 200 total clients, 12 employer clients.

1988 gross revenues: Not reported.

Principal officers: David W. Clifton Jr., president/chief executive officer; Susan L. Michlovitz, vp/director-operations; Leslie Buksar Clifton, business manager.

Preferred Health Care Ltd.

15 River Road, Wilton, Conn.
06897; 203-762-0993

Year founded: 1983; began providing utilization review services in 1985.

Services provided: 57% 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, on site case management, family support services; 43% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: 149 total staff members; professional staff members include five physicians, seven registered nurses, eight psychologists, 57 social workers.

Clients: 81 total clients; 21 employer clients; 5% with 1,000-2,499 employees, 10% with 2,500-4,999 employees, 85% with more than 5,000 employees. 5.3 million total lives serviced in 1988.

Branch offices: Detroit; Irvine, Calif.; Chicago.

1988 gross revenues: \$13.3 million total.

Charges: Per employee, 29 cents; per case, \$550; percent of savings.

Principal officers: Dr. Jay Reibel, chairman; David McDonnell, chief executive officer; Paul Litwak and Steve White, executive vps.

psychPACER Utilization Review/MCC Cos.

1401 W. 76th St., Suite 400,
Minneapolis, Minn. 55423;
612-861-9565

Year founded: 1974.

Parent company: Connecticut General Life Insurance Co.

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, outpatient

Continued on next page

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Continued from previous page
psychiatric and substance abuse services, case management; 99% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: 350 total staff members; 160 professional staff members, including 30 registered nurses, 28 medical records technicians. 16 physicians on a retainer basis.

Clients: 150 total clients; 125 employer clients; 84% with fewer than 500 employees, 8% with 500-999 employees, 4% with 1,000-2,499 employees, 4% with more than 5,000 employees. 1.3 million total lives serviced in 1988.

1988 gross revenues: \$32 million total, \$500,000 from utilization review services for employers.

Charges: Per employee, 25 cents-65 cents; per case, \$350-\$500; flat annual fee.

Principal officers: Terence Wills, president; J. Randall Cox and Joseph Strahan, vps-operations; William R. Maloney, executive director; Mark Tidgewell, vp-finance; Greg Heine-mann, vp-marketing; Dr. John Bartlett, corporate medical director; Carol Staples, director-development.

Q

Quality Care Review Inc.
100 Roscommon Drive, Middletown, Conn. 06457; 203-632-2008

Year founded: 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 predetermination, workers compensation and disability case management, workers compensation service review; 80% of gross revenues from other services.

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

Staff: 28 total staff members; professional staff members include two physicians, 14 registered nurses, one medical records technician. One physician and one chiropractor on a retainer basis.

Clients: Four total clients; three employer clients; 25% with 500-999 employees, 75% with 2,500-4,999 employees. 70,000 total lives serviced in 1988.

1988 gross revenues: \$800,000 total.

Charges: Per employee, per case.

Principal officers: Dr. Edward A. Kamens, president; Marcia K. Petrillo, executive vp.

Quality Health Services Inc.
2500 Dekalb Pike, Norristown, Pa. 18951; 215-277-3540

Year founded: 1983; began providing utilization review services in 1984.

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, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, predetermination of physician fees, DRG validation and fee determination; 62% of gross revenues from other services.

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

Staff: 39 total staff members; 16 professional staff members, including one physician, 13 registered nurses, two medical records technicians.

Clients: 27 total clients; nine employer clients; 41% with fewer than 500 employees, 7% with 500-999 employees, 15% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 22% with more than 5,000 employees. 200,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1.10-\$2.25; by the hour, monthly.

Principal officers: Roger B. Hiser,

president/chief executive officer; Jeanne M. Kennedy, executive vp/ chief operating officer; Robyn S. Walsh, executive vp/chief financial officer; Winifred S. Hayes, executive vp/chief marketing officer; Jan Lipas, medical director.

R

RMSCO Management Services Inc.

651 W. Washington Blvd., Chicago, Ill. 60606-2193; 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 other services.

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

Staff: Three total staff members, including one physician, two licensed practical nurses. One physician on a retainer basis.

Clients: 35 total clients; 52% with

fewer than 500 employees, 30% with 500-999 employees, 18% with 1,000-2,499 employees. 17,000 total lives serviced in 1988.

1988 gross revenues: \$803,000 total, \$200,750 from utilization review services for employers.

Charges: Per employee.

Principal officers: Robert M. Schrayner, president; Richard A. Freeman and Max R. Schrayner II, senior vps; Karen Z. Vacko, executive vp.

Republic-RSB Cos. Inc.

1717 Park St., Naperville, Ill. 60540; 312-420-6800

Year founded: 1964; began providing utilization review services in 1983.

Services provided: 24% 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, workers compensation claim review, rehabilitation management; 76% of gross revenues from other services.

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

Staff: 455 total staff members; 210

Continued on next page

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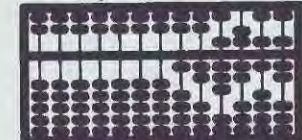
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Hazlehurst & Associates, Inc./400 Perimeter Center Terrace/Suite 850/Atlanta, Georgia 30346/(800) 476-6633/(404) 395-9880.

Spotlight report

Continued from previous page professional staff members, including six physicians, 196 registered nurses, eight medical records technicians. Six physicians on a retainer basis.

Clients: 5,140 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. 1.2 million total lives serviced in 1988.

Branch offices: Atlanta; Houston; Los Angeles; Parsippany, N.J.

1988 gross revenues: \$21.5 million total, \$5 million from utilization review services for employers.

Charges: Per employee, \$1.10-\$1.90; per case, \$95-\$125.

Principal officers: Richard E. Mandel, president; Steven E. Nelson, senior vp; Deanna Sirtaut, vp.

Rush Contract Care

910 W. Van Buren, Chicago, Ill. 60607; 312-942-8270

Year founded: Began providing

utilization review services in 1983.

Parent company: Rush Presbyterian St. Luke's Medical Center.

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, case management; occasional retrospective review, hospital bill audit, outpatient service predetermination; 95% of gross revenues from other services.

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

Staff: 17 professional staff members, including four physicians, six registered nurses, one medical records technician. Eight physicians on a retainer basis.

Clients: 1,400 total clients; 99% with fewer than 500 employees, 1% with 1,000-2,499 employees. 97,879 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$2.50.

Principal officers: Dr. Jerome Hahn, president.



SA Care

P.O. Box 6123, Salt Lake City, Utah 84106; 801-272-8811

Year founded: 1976; began providing utilization review services in 1986.

Services provided: 100% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, length of stay determination, retrospective review, outpatient psychiatric and substance abuse services; occasional concurrent hospital treatment review, discharge planning, second surgical opinion, hospital bill audit, outpatient service predetermination, case management.

Services reviewed: Group health services, dental services, psychiatric

and substance abuse services, chiropractic services.

Staff: 10 total staff members; professional staff members include four registered nurses, one licensed practical nurse, five medical records technicians.

Clients: 40 total clients; 35 employer clients; 80% with fewer than 500 employees, 11% with 500-999 employees, 6% with 1,000-2,499 employees, 3% with more than 5,000 employees. 20,000 total lives serviced in 1988.

1988 gross revenues: \$100,000 total.

Charges: Per employee, \$1.25-\$2.75; per case, \$35-125.

Principal officers: Richard L. Smith, chief executive officer; Wesley C. Argyle, attorney; Tony Thompson, controller.

SCM Associates Inc.

9315 Vista Bonita, Cypress, Calif. 90630; 714-220-0815

Year founded: 1986; began providing utilization review services in 1988.

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, retrospective review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 60% of gross revenues from other services.

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

Staff: 28 total staff members who are registered nurses; 15 physicians and six nurses on a retainer basis.

Clients: 23 total clients; 75% with fewer than 500 employees, 15% with 500-999 employees, 10% with 1,000-2,499 employees. 30,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Principal officers: Suzanne A. Moore, president; Marlys A. Severson, vp-management systems; Julie A. Ferguson, vp-medical systems; Nadya M. Thomas, vp-sales/marketing.

Sagamore Health Network Inc.

11555 N. Meridian St., Suite 400, Carmel, Ind. 46032; 312-573-2900

Year founded: 1984; began providing utilization review services in 1985.

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 review, second surgical opinion, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 35% of gross revenues from other services.

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

Staff: Professional staff members include two physicians, five registered nurses.

Clients: 793 total clients; 96% with fewer than 500 employees, 3% with 500-999 employees, 1% with 1,000-2,499 employees. 110,000 total lives serviced in 1988.

Branch offices: Mishawaka and East Chicago, Ind.

1988 gross revenues: Not reported.

Charges: Per enrollee per month. **Principal officers:** Barry J. Sullivan, chief executive officer/president.

Sanus Preferred Services

6611 Kenilworth Ave., Suite 300, Riverdale, Md. 20737; 301-927-4300

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

Parent company: Sanus Corp. Health Systems.

Services provided: 100% of gross revenues from providing utilization 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 second surgical opinion, hospital bill audit.

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

Staff: 15 total staff members; professional staff members include one physician, 13 registered nurses, one licensed practical nurse.

Clients: 22 total clients, all of which are employer clients; 90% with fewer than 500 employees, 5% with 500-999 employees, 5% with more than 5,000 employees. 20,000 total lives serviced in 1988.

1988 gross revenues: \$26,000 total, all from utilization review services to employers.

Charges: Per employee, \$2-\$3.50; per case, \$50-\$75.

Principal officers: Joseph Lynaugh, president; Jeff Emerson, vp; Doug Hoffman, marketing director; Nannette Grenon, finance director.

Continued on next page

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RETIREE HEALTH BENEFITS & THE NEW FASB RULING—

DEFUSING THE TIME BOMB

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The
HealthWays
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Continued from previous page

Second Opinion Consultants Inc.
P.O. Box 621, Millwood, N.Y.
10546; 800-446-4606;
800-446-4626 in New York

Year founded: 1984.
Services provided: 20% of gross revenues from providing utilization review services to employers, including second surgical opinion, hospital bill audit, disability review, physician claims review; 80% from other services.
Services reviewed: Group health services, chiropractic services.
Staff: 15 total staff members; professional staff members include one physician, five registered nurses, five licensed practical nurses, two medical records technicians.
Clients: Not reported.
1988 gross revenues: Not reported.
Charges: Per employee, \$75 per claim reviewed; per case, \$155; flat annual fee.
Principal officers: Madelon Lubin Finkel, chief executive officer/president; David J. Finkel, chief financial officer; Dr. Norman Mazza, medical consultant.

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, case management, hospital quality review and assessment; occasional hospital bill audit; 30% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services, chiropractic services.
Staff: Professional staff members include two physicians, 89 registered nurses, three licensed practical nurses, four medical records technicians.
Clients: 78 total clients; 63 employer clients; 23% with fewer than 500 employees, 16% with 500-999 employees, 21% with 1,000-2,499 employees, 15% with 2,500-4,999 employees, 25% with more than 5,000 employees. 2.7 million total lives serviced in 1988.
Branch offices: St. Louis; Lincoln, Neb.
1988 gross revenues: \$11.8 million total.
Charges: Per employee, \$1.25-\$1.50.
Principal officers: Richard McMaster, chief executive officer; Rebecca A. Hemann, vp-operations; Pam DePriest, director-marketing; James A. Roberts, director-operational programs.

T

TAO Inc.
P.O. Box 58655, Philadelphia, Pa.
19102; 800-344-1255

Year founded: 1985.
Parent company: QCC Inc., a subsidiary of Independence Blue Cross.
Services provided: 6% 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, hospital bill audit; 94% of gross revenues from other services.
Services reviewed: Psychiatric and substance abuse services.
Staff: 38 total staff members; 18 professional staff members, including three physicians, 14 registered nurses, one medical records technician. One physician on a retainer basis.
Clients: Five total clients; two employer clients; 50% with 2,500-4,999 employees, 50% with more than 5,000 employees. 2.3 million total lives serviced in 1988.
1988 gross revenues: \$3.8 million

total, \$210,000 from utilization review services for employers.
Charges: Per employee, per case.
Principal officers: Anthony F. Panzetta, president/chief executive officer; Donna E. DeHart, vp-marketing.

U

UMP
1718 Peachtree St. N.W., Suite 552,
Atlanta, Ga. 30309-2405;
404-875-5875

Year founded: 1983; began providing utilization review services in 1985.
Parent company: Atlanta Healthcare Alliance.
Services provided: 30% 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, second surgical opinion, outpatient service predetermination, case management; occasional retrospective review, outpatient psychiatric and substance abuse services, outpatient surgical review, home health care review; emergency telephone service; 70% of gross revenues from other services.
Services reviewed: Group health services, psychiatric and substance abuse services.
Staff: 13 total staff members; eight professional staff members who are registered nurses. Two physicians and one nurse on a retainer basis.
Clients: 88 total clients, 79 employer clients. 80,000 total lives serviced in 1988.
1988 gross revenues: Not reported.
Charges: Per employee, 95 cents-\$1.22.

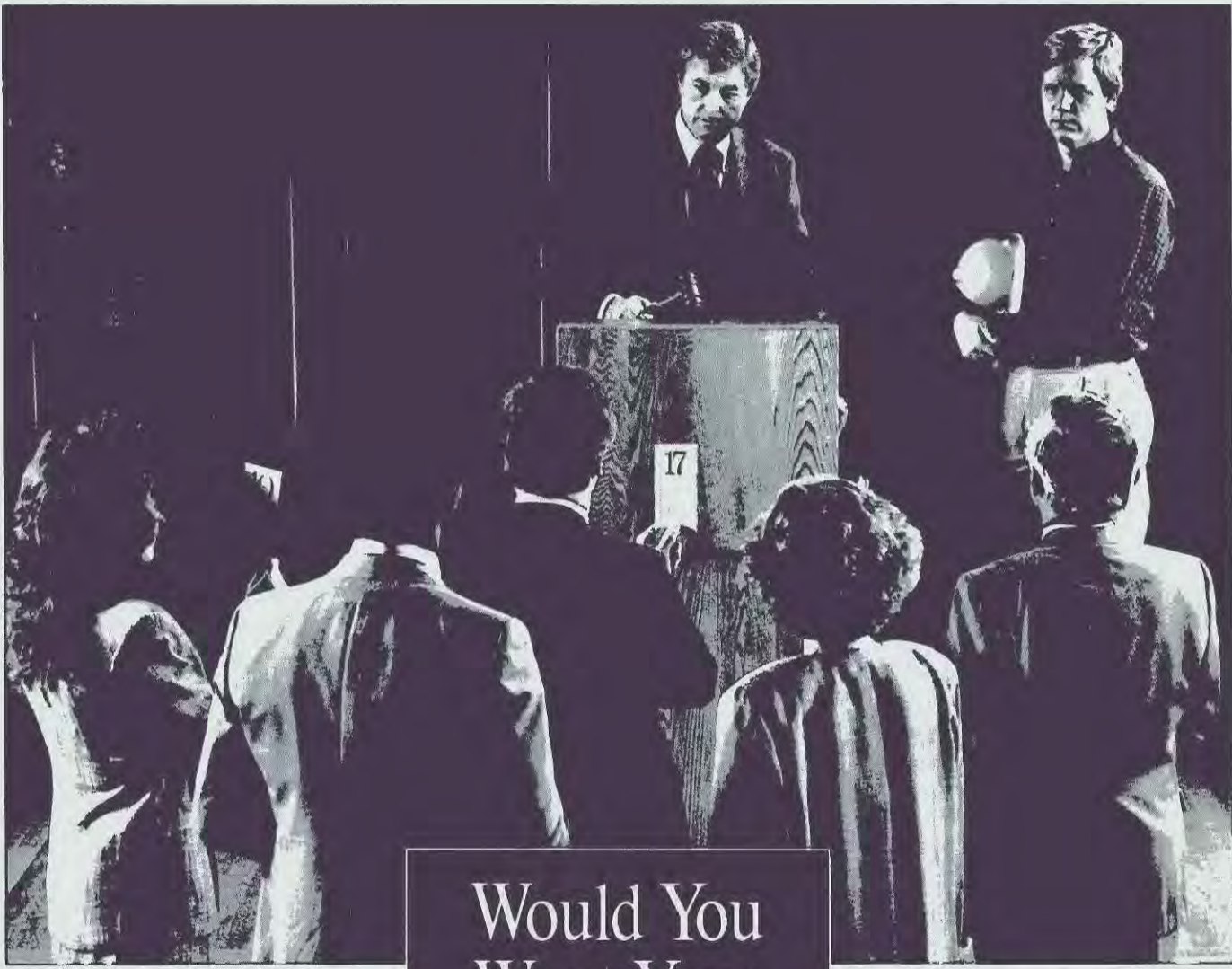
Principal officers: S. Walker McCune, executive vp; Adele Cohen, vp-program development; Jody A. Hunter, vp-program management.

United Behavioral Services Inc.
3600 W. 80th St., Suite 630,
Minneapolis, Minn. 55431;
612-830-3171

Year founded: 1985; began providing utilization review services in 1988.
Parent company: United Healthcare Corp.
Services provided: 0.2% 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; 99.8% of gross revenues from other services.
Services reviewed: Psychiatric and substance abuse services.
Staff: 80 total staff members; professional staff members include two physicians; two registered nurses; 76 psychologists, social workers and drug abuse counselors.
Clients: 17 total clients; two employer clients; 100% with 1,000-2,499 employees. 400,000 total lives serviced in 1988.
Branch offices: Omaha, Neb.
1988 gross revenues: \$6.8 million total; \$200,000 from utilization review to employers.
Charges: Per employee per month 27 cents-40 cents; per case, \$150-\$225; by the hour, \$65.
Principal officers: Jack Newstrom, president/chief executive officer; Charles Sherman and Glenn Andis, operations directors.

Continued on next page



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Spotlight report

Continued from previous page

United HealthCare Inc.

2811 Lord Baltimore Drive,
Baltimore, Md. 21207;
301-265-6033

Year founded: 1964; began providing utilization review services in 1982.

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, disability and workers compensation services; 85% of gross revenues from other services.

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

Staff: 239 total staff members.

Clients: 128 total clients; 68% with fewer than 500 employees, 9% with

500-999 employees, 6% with 1,000-2,499 employees, 6% with 2,500-4,999 employees, 11% with more than 5,000 employees. 600,000 total lives serviced in 1988.

Branch offices: Atlanta.
1988 gross revenues: Not reported.

Charges: Capitation.
Principal officers: William H. Slavin, chief executive officer; Dr. Oscar B. Camp, chairman.

U.S. Administrators Inc.

3540 Wilshire Blvd., Los Angeles,
Calif. 90010; 213-383-1100

Year founded: 1962; began providing utilization review services in 1972.

Parent company: Crownx; acquisition by ALTA Health Strategies Inc. pending

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, 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 other services.

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

Staff: 800 total staff members; 102 professional staff members, including two physicians, 100 registered nurses. 10 physicians on a retainer basis.

Clients: 35 total clients; 34 employer clients; 14% with fewer than 500 employees, 14% with 500-999 employees, 7% with 1,000-2,499 employees, 14% with 2,500-4,999 employees, 51% with more than 5,000 employees. 252,000 total lives serviced in 1988.

Branch offices: Los Angeles, Calabasas and North Hollywood, Calif.; Pittsburgh.

1988 gross revenues: \$41.6 million total, \$2.4 million from utilization review services for employers.

Charges: Per employee, \$1.25-\$2.50.

Principal officers: Geoff Wood,

president/chief executive officer; Ted White, senior vp-operations; Paul Kral, senior vp-client services; Martin Thorpe, senior vp-information systems; Sam Kaplan, chairman.

Universal Managed Care Inc.

70 N. Main St., Wilkes-Barre, Pa.
18711; 800-346-6149;
800-752-1919 in Pennsylvania

Year founded: 1985.

Parent company: Blue Cross of Northeastern Pennsylvania.

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, hospital bill audit, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional retrospective review, second surgical opinion; 93% of gross revenues from other services.

Services reviewed: Group health services, psychiatric and substance

abuse services, chiropractic services.

Staff: 31 total staff members; 24 professional staff members, including one physician, 23 registered nurses.

Clients: 26 total clients; 20 employer clients; 57% with fewer than 500 employees, 22% with 500-999 employees, 9% with 1,000-2,499 employees, 12% with 2,500-4,999 employees. 630,000 total lives serviced in 1988.

1988 gross revenues: \$1.3 million total, \$91,000 from utilization review services for employers.

Charges: Per employee, 50 cents-\$2; per case, \$62 per hour.

Principal officers: Gilbert Tough, chairman; Thomas Ward, executive vp.

V

VPS Case Management Services Inc.

4335 Cox Road, Glen Allen, Va.
23060; 804-273-1999

Year founded: 1975.

Services provided: 100% of gross revenues from providing utilization review services to employers, including discharge planning, hospital bill audit, outpatient psychiatric and substance abuse services, case management, workers compensation.

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

Staff: 195 total staff members; professional staff members include 120 registered nurses.

Clients: Not reported; 5% with fewer than 500 employees, 15% with 2,500-4,999 employees, 80% with more than 5,000 employees.

Branch offices: Cherry Hill, N.J.; Baltimore, Md.; Vienna and Richmond, Va.; Raleigh and Charlotte, N.C.; Atlanta; Orlando, Fort Lauderdale and Tampa, Fla.

1988 gross revenues: Not reported.

Charges: By the hour, \$60.

Principal officers: Mary F. Gambosh, president; Frank L. Gambosh, secretary/treasurer.

Value Health Inc.

22 Waterville Road, Avon, Conn.
06001; 203-677-4101

Year founded: 1987.

Services provided: 10% 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, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; 90% of gross revenues from other services.

Services reviewed: Group health services, prescription drug services, podiatric services.

Staff: 119 total staff members; professional staff members include five physicians, nine registered nurses, six medical records technicians. Seven physicians on a retainer basis.

Clients: 84 total clients; 59 employer clients; 2% with fewer than 500 employees, 3% with 500-999 employees, 12% with 1,000-2,499 employees, 28% with 2,500-4,999 employees, 55% with more than 5,000 employees. 2.8 million total lives serviced in 1988.

Branch offices: Southfield, Mich.; Santa Monica, Calif.; Arlington, Va.

1988 gross revenues: Not reported.

Charges: Per employee, per case, flat annual fee.

Principal officers: Robert E. Patricelli, president; William J. McBride, executive vp; Rick Lee, vp-sales; Steven J. Shulman, senior vp.

W

Wayne & Associates Inc.

Suite 1166, Medical Arts Building,
Louisville, Ky. 40217; 502-451-8262

Year founded: 1981; began providing utilization review services in 1987.

Services provided: 25% of gross

Continued on next page

IN 1971, THE AMERICAN PSYCHIATRIC Association took the lead in promoting medical cost containment by establishing psychiatric utilization criteria. Why? For one excellent reason: to safeguard patient access to effective care. With few third party payers providing coverage for mental health services, treatment for numerous serious conditions was available only to the privi-

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Psychiatric care shouldn't be a blank check.

leged few. Despite the fact that then, as now, over one in five adults suffer from mental illnesses, such as depression, anxiety disorders and others, during their lifetime. (When you add substance abuse, the figure rises to more than one-third of the population.) We believed objective criteria could and should be developed to make it feasible for insurers to provide coverage for the treatment of conditions that diminish time and productivity on the job, as well as the quality of life for employees and their families.

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Continued from previous page
revenues from providing utilization review services to employers, including frequent preadmission certification, outpatient psychiatric and substance abuse services; occasional concurrent hospital treatment review, length of stay determination, discharge planning, outpatient service predetermination, case management; 75% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: Nine total staff members.

Clients: 30 total clients; 28 employer clients; 35% with fewer than 500 employees, 40% with 500-999 employees, 25% with more than 5,000 employees. 20,000 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Not reported.

Principal officers: James S. Wayne, president; Thomas A. Wanemuehler, vp-utilization review.

Western Medical Review

23840 Hawthorne Blvd., Torrance, Calif. 90505; 213-378-2248

Year founded: 1977.

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, workers compensation case management.

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

Staff: 40 total staff members; 31 professional staff members, including one physician, 22 registered nurses, three licensed practical nurses, five medical records technicians. 50 physicians on a retainer basis.

Clients: 350 total clients, 40 employer clients; 2 million total lives serviced in 1988.

1988 gross revenues: \$1.2 million total.

Charges: Per employee, 85 cents-\$1.95.

Principal officers: Donald P. Balzano, executive director; Victoria M. Nishioka, review manager; Ronald Kaufman, medical director.

Z

Zenith Administrators

111 Massachusetts Ave. N.W., Washington, D.C. 20001; 202-682-7915

Year founded: 1984.

Parent company: ULLICO 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, case management, home health precertification; occasional outpatient psychiatric and substance abuse services; 20% of gross revenues from other services.

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

Staff: 24 total staff members; 22 professional staff members, including two physicians, 17 registered nurses, three licensed practical nurses. Two physicians on a retainer basis.

Clients: 70 total clients; 15% with fewer than 500 employees, 20% with 500-999 employees, 25% with 1,000-2,499 employees, 20% with 2,500-4,999 employees, 20% with more than 5,000 employees. 200,000 total lives serviced in 1988.

1988 gross revenues: \$10 million total.

Charges: Per employee per month, \$1.50; per case by the hour, \$74-\$150.

Principal officers: Daniel O'Sullivan, president/chief executive officer; James Luce, senior vp; Gary Eng, vp; Thomas Kiely, director-marketing.

Information on the following companies was received too late to be included in alphabetical order in the directory of utilization review firms.

Admar Corp. HealthWatch

850 Town & Country Road, Orange, Calif. 92668; 714-953-9600; 800-422-0294

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

Parent company: The Admar Group 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, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management; occasional hospital bill audit; 45% of gross revenues from other services.

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

Staff: 26 total staff members who are professionals, including 24 registered nurses, two medical records technicians.

Clients: 15,385 employer clients; 89% with fewer than 500 employees, 7% with 500-999 employees, 2% with 1,000-2,499 employees, 1% with 2,500-4,999 employees, 1% with more than 5,000 employees. 1.4 million total lives serviced in 1988.

1988 gross revenues: \$5.3 million total, \$2.9 million from utilization review services for employers.

Charges: Per employee, by the hour for case management, percent of savings, percent of billed charges.

Principal officers: Richard Toral, chairman/chief executive officer; Virginia Pascual, executive vp/chief operating officer; Roger Ellis Lightholder, vp/general counsel.

Comprehensive Review Technology Inc.

455 E. Mound St., Columbus, Ohio 43215; 614-464-9481

Year founded: 1985.

Services provided: 10% 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, workers compensation case management; 90% of gross revenues from other services.

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

Staff: 35 total staff members, including 17 registered nurses. Eight physicians on a retainer basis.

Clients: 35 total clients; 10 employer clients; 15% with fewer than 500 employees, 10% with 500-999 employees, 25% with 1,000-2,499 employees, 20% with 2,500-4,999 employees.

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Spotlight report

Continued from previous page
employees, 30% with more than 5,000 employees.

1988 gross revenues: Not reported.

Charges: Per employee, 25 cents-\$1.50; per case, \$125; by the hour, \$50-\$85; percent of savings.

Principal officers: William R. Heiss, chairman; James E. Huston, chief financial officer; John R. Williford, assistant secretary.

C.U.R.B.**Associates**

150 E. Harmon Ave., Suite 228,
Las Vegas, Nev. 89109;
702-731-6688

Year founded: 1985.

Parent company: MEGA Inc.

Services provided: 75% of gross revenues from providing utilization review services to employers, including preadmission certification, con-

current 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; 25% of gross revenues from other services.

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

Staff: 26 total staff members, including seven physicians, three registered nurses, 16 medical records technicians.

Clients: 22 total clients; 32% with fewer than 500 employees, 27% with 500-999 employees, 27% with 1,000-2,499 employees, 9% with 2,500-4,999 employees, 5% with more than 5,000 employees. 45,400 total lives serviced in 1988.

Branch offices: Reno, Nev.

1988 gross revenues: Not reported.

Principal officers: Dr. Elias F. Ghanem, president.

**Healthlink
Review Corp.**

6278 N. Federal Highway, Suite
155, Fort Lauderdale, Fla. 33308;
305-753-2874

Year founded: 1988.

Parent company: Healthlink Corp.

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, case management; 80% of gross revenues from other services.

Services reviewed: Group health services.

Staff: 10 total staff members; seven professional staff members, including five physicians, two registered nurses.

Clients: Two employer clients, 100% with more than 5,000 employ-

ees. 500 total lives serviced in 1988.

1988 gross revenues: Not reported.

Charges: Per employee, \$1-\$2; percent of savings.

Principal officers: Marlene Mahle, executive director.

**Mental Health
Management**

7950 N.W. 53rd St., Suite 204,
Miami, Fla. 33166; 305-592-2872

Year founded: 1988; began providing utilization review services in 1989.

Parent company: Managed Care of America Inc.

Services provided: 40% 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; 60% of gross revenues from other services.

Services reviewed: Psychiatric and substance abuse services.

Staff: Seven total staff members; five professional staff members, including one physician, one registered nurse. Three physicians on a retainer basis.

Clients: Four total clients, 100% with more than 5,000 employees.

1988 gross revenues: Not reported.

Charges: Per employee, \$1-\$2; per case, \$250-\$500.

Principal officers: Dr. Julio Avello, president; Marlene Mahle, executive director.

**National
Medical Audit**

3 Embarcadero Center, Suite 1250,
San Francisco, Calif. 94111;
415-393-5660

Year founded: 1983; began providing utilization review services in 1984.

Parent company: William M. Mercer Meidinger Hansen Inc.

Services provided: Services include review of utilization review service companies for employers, insurers, claims administrators.

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

Staff: 46 total staff members; including seven physicians, three registered nurses, four medical records technicians. 120 physicians on a retainer basis.

Clients: 50 total clients; 35 employer clients; 10% with 2,500-4,999 employees, 90% with more than 5,000 employees.

1988 gross revenues: Not reported.

Charges: Per project.

Principal officers: Dr. Arnold Milstein, president; Dr. Michael J. Martin, director-project design. ■

**UR receives
recognition
from AMA**

By MARK A. HOFMANN

VENICE, Fla.—The American Medical Assn. is recognizing utilization review as a specialized field of medicine by granting the Venice, Fla.-based American College of Utilization Review Physicians a seat in the AMA's House of Delegates.

By welcoming ACURP into its fold, the AMA has designated utilization review as a separate body of knowledge that requires its own education and expertise, explained Betty J. Hamman, ACURP's executive director.

"The AMA has recognized UR as a specialty," she said.

The new designation gives ACURP the higher platform its members have been seeking to better promote professional and public education about the role of UR in cost containment and the assurance of quality medical care, Ms. Hamman added.

Promoting UR education is just one of several goals pursued by the American College of Utilization Review Physicians. Other aims of ACURP include:

- Encouraging specialization in UR.
- Elevating the standards of UR specialists by fostering and encouraging research and study in the field of medicine, its delivery, mode and quality of care.
- Elevating standards of post-graduate education for qualifying as a UR specialist.
- Editing and publishing books and journals on the subject.
- Providing continuing education for physicians and others engaged in UR.
- Encouraging better public understanding of UR so that cost containment can be achieved.

The college, which was incorporated in 1973, offers three classes of membership: full, affiliate and institutional.

Full membership in the college is available to doctors of medicine, osteopathy or dentistry. These physicians pay annual dues of \$155. Members who remain active in ACURP for two years and who achieve certification in quality assurance and utilization review from the Port Charlotte, Fla.-based American Board of Quality Assurance and Utilization Review Physicians are eligible to become fellows of the college.

Affiliate membership in ACURP is open to other health professionals, such as doctors of chiropractics, podiatry and optometry; registered nurses; and pharmacists. Associate membership is also open to hospital administrators, administrators of third-party payers and the executive directors of peer review organizations. Affiliate members pay annual dues of \$75.

In addition, ACURP offers institutional membership to hospitals and other corporations involved in utilization review services. Institutions that pay annual dues of \$400 are allowed to designate two physician members and four affiliate members from their staff to be ACURP members.

"The primary benefit of the college is an educational one," explained William Werner, a member of ACURP since 1981 and medical director for Republic-RSB Cos. Inc., a Naperville, Ill.-based utilization review service provider.

Like Ms. Hamman, Dr. Werner noted that utilization review and medical quality assurance are taught neither in medical school nor during residency. As a result,

Continued on next page

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**DENTAL BENEFIT
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Prenatal care gives birth to reduced costs

By LINDA J. COLLINS

Prenatal care and education are two of the most effective tools employers can use to curb the growth of maternity-related health care expenses, benefits experts say.

Unfortunately, few cost-containment programs address maternity care because employers do not recognize the problems and pregnancy is such a sensitive issue.

But maternity care costs compose a significant portion of employee and dependent health care expenses, according to estimates by insurers, employers and consultants.

Among the factors fueling the growth in maternity care costs are the high cost of caring for premature and low birth weight babies, and a tremendous increase in the rate of Caesarean sections performed over the last two decades.

"Maternity benefits cost 10% of the total medical benefits paid under a commercial

'We've seen anywhere from 10% to 49% of the total costs of employers' medical programs relating to maternity costs. . . Insurance companies are saying to us that 20% to 25% of their medical costs are related to maternity care,' says Suzanne Peck of Towers, Perrin, Forster & Crosby Inc.

insurance policy on an average country-wide," said a spokesman for the Health Insurance Assn. of America in Washington, D.C.

Combined, the costs related to normal pregnancies and to neonatal conditions arising from premature births represented "9.5% of our total medical charges in 1988," said Robert E. Garren, manager of group benefits for Burlington Industries Inc. in Greensboro, N.C.

"Pregnancy runs between 8% and 10% of the total benefits claims made in a calendar year" for employers, depending upon "the demographics of the employee population," estimated Dr. John J. Mahoney, director of the Health Strategies Group at Alexander & Alexander Services Inc. in Westport, Conn.

"We've seen anywhere from 10% to 49% of the total costs of employers' medical programs relating to maternity costs. . . Insurance companies are saying to us that 20% to

25% of their medical costs are related to maternity care," observed Suzanne Peck, a consultant with Towers, Perrin, Forster & Crosby Inc. in Chicago.

Among the weapons employers can use to combat rising maternity-related health care costs among their employees and dependents, are:

- Providing in-house prenatal education programs to promote healthy lifestyles and prompt pregnant women to take greater control of their pregnancies.

- Focusing utilization review or educational efforts on limiting the use of Caesarean section deliveries to medical emergencies (see story, page 74).

- Engaging the help of utilization review and/or case management companies to identify and monitor high risk pregnancies, question certain medical procedures and reduce some hospital stays following delivery

Continued on next page

UR recognition

Continued from previous page

most physicians have learned utilization review on the job, he said.

"The college brings some formal educational process" to learning UR and quality assurance," Dr. Werner said. The college's seminars and publications allow physicians and others involved in UR to add to their knowledge.

The addition of the college to the AMA's House of Delegates adds to the group's mission, he said.

"It represents a voice for physicians who do this sort of work who did not have that voice before," Dr. Werner said. AMA recognition gives ACURP more visibility, thus bolstering its efforts to explain UR to both medical professionals and the public at large, he said.

"I think the college is poised now to play a bigger role in education," Dr. Werner said. He stressed that both ACURP and the American Board of Quality Assurance and Utilization Review Physicians are "primarily physician-oriented."

One of ACURP's educational endeavors is the publication of a study guide in quality assurance and utilization review to help physicians prepare for the certification examination administered by the American Board of Quality Assurance and Utilization Review Physicians. More than 2,000 people have received board certification since the program began in 1978, said John Hamman, executive director of the board.

"Preparing for the exam alone makes them more specialized," Dr. Hamman said, adding that achieving certification engenders peer respect and allows certificate holders to appear as expert witnesses.


In addition, the board currently offers four one-year fellowship residencies to physicians who have practiced for at least five years.

ACURP currently has about 1,300 full members and roughly 300 affiliate members, said Susan M. Plomski, the group's membership coordinator. Approximately 35 organizations currently hold institutional memberships as well.

ACURP currently has 11 regional affiliates, she said.

In addition to publishing the annual study guide for physicians seeking board certification in UR, ACURP publishes a quarterly journal and a monthly newsletter. The group sponsors national and regional seminars on UR-related topics and provides tapes and transcripts of seminar addresses.

Further information is available from the American College of Utilization Review Physicians, Southbridge Park, 1521 S. Tamiami Trail, Suite 304, Building 3, Venice, Fla. 34292; and the American Board of Quality Assurance and Utilization Review Physicians at 1777 Tamiami Trail, Suite 205, Box 12, Port Charlotte, Fla. 33948. ■



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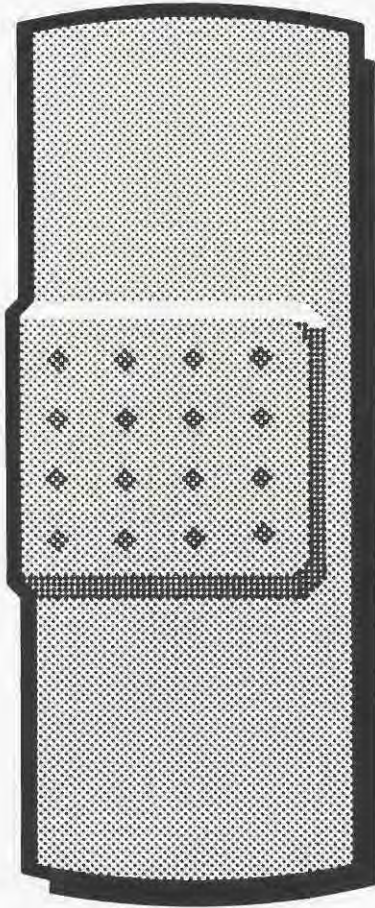
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UR/Sagamore
HEALTH NETWORK

Maternity costs

Continued from previous page (see story, page 72).

• Providing oral or written information on maintaining healthy pregnancies, alternative birthing options or substance avoidance during pregnancy to employees through in-house medical professionals, company newsletters or pamphlets and brochures available through a variety of sources (see story, page 75).

By far the most effective step to reducing maternity costs is to reach the employee or dependent either before conception or early in the pregnancy, statistics show.

For example, a study published by the Children's Research Institute of California in 1987 showed that babies of mothers receiving adequate prenatal care are five times more likely to live and one-and-a-half times more likely to be born at adequate birth weight than are babies whose mothers received no prenatal care.

A study by the Michigan Department of Public Health in 1984 estimated that for every \$1 spent on prenatal care, \$6.12 could be saved in newborn intensive care costs.

And, statistics published by the March of Dimes Birth Defects Foundation in White Plains, N.Y., show that the risk of having a low birth weight baby decreases to 2% for a woman who has the recommended series of 13 to 14 prenatal doctor visits, compared with 9% for a woman who has no prenatal care.

Taking the precautions is particularly important because premature births are expensive, consultants say.

"Companies I work with frequently report medical costs of up to \$250,000 due to premature birth-related problems," said Miriam Jacobson, director of the Prevention Leadership Forum of the Washington Business Group on Health. "The dollars scream for the effectiveness of prenatal programs."

While the threat of acquired immune deficiency syndrome alarms many employers, "a low birth weight premature infant is often more costly than an AIDS patient," said Dr. Mahoney of Health Strategies Group. He estimated the average cost of caring for a premature infant at about \$55,000, but

added that adequate prenatal care and proper nutritional habits can "bring those costs down."

Burlington Industries' Mr. Garren estimated that the initial charges for neonatal cases among his employees and their dependents averaged \$35,000 each in 1988 and reach about \$2.5 million annually. Out of 28,000 employees, in 1988 "we had 20 neonatal cases in excess of \$10,000," he said.

Burlington has had four to six neonatal cases in which medical costs have exceeded \$300,000 and one case that exceeded \$500,000, Mr. Garren added.

Unfortunately, few employers are focusing attention on controlling maternity and delivery costs, consultants note.

"We have not had a tremendous amount of interest on the part of employers. Typically an employer who would focus on prenatal care and education is one who has been burned," said Linda C. Ruth, group benefits consultant for Hewitt Associates in Lincolnshire, Ill.

"If our clients see an unusually high claims experience in this area, then they will attempt to address this issue," agreed Angelo M. Nardi, area president and employee benefit sales manager for Arthur J. Gallagher & Co. in Rolling Meadows, Ill.

One of the problems is that while the cost impact of a utilization review program, an expectant mother might have at any point in the pregnancy, will immediately send a packet of educational material describing the company's maternity program and providing information on pregnancy-related issues, Mr. Garren said.

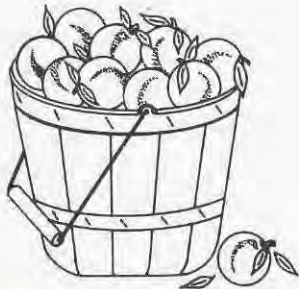
And, if the woman does not already have a physician, Burlington will refer her to one. After a physician is located, the company sends the doctor a check directly each month to pay for the woman's prenatal visits so that she does not have to bother with filing claims or paying for care up-front.

"We are trying to remove the financial barrier," Mr. Garren explained.

The program is promoted in brochures, employee meetings and in the company benefit booklet. Some of the company's nurses are also trained in a March of Dimes prenatal education program and hold classes for expectant mothers in

Continued on next page

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Continued from previous page their area, Mr. Garren added.

The March of Dimes educational program is available free of charge to employers in several parts of the country and literature is available nationwide, explained its National Director of Health Promotion Programs, Irene McKirgan (BI, Oct. 24, 1988).

The foundation will train someone within a company to teach the program or arrange for a volunteer health care practitioner to come to the company and teach the program to employees at no charge, she explained.

A series of classes on such subjects as nutrition, substance avoidance, different types of birth-related complications, birthing options, exercise, stress, teen-age pregnancies and pregnancies for women over 35 are offered, Ms. McKirgan said.

For example, Karen Zalewski, prenatal health coordinator for First National Bank of Chicago and a registered nurse, was trained to teach the March of Dimes program. In addition, the bank is waiving the medical deductible for the first year of the newborn's life for employees or dependents who attend three of these prenatal programs within the first four months of their pregnancy.

Women who are contemplating becoming pregnant can also attend and later receive the deductible waiver, Ms. Zalewski added. The courses are promoted in the company's wellness newsletter, and table cards in the cafeteria list upcoming classes.

The formal program was introduced late last year, but informal classes were taught prior to that. Don Hoy, the bank's director of benefits, estimated that pregnancy costs have historically averaged between 15% to 18% of the bank's total medical costs.

First Bank System in Minneapolis also uses the March of Dimes prenatal education program, said Lorraine M. Iversen, manager of health services and a registered nurse. It offers six classes over a two-week period twice a year and employees "can pick and choose the classes they want," she said. Classes also are videotaped for employees who are unable to attend.

"I piloted the program several years ago because I found I was getting so many questions from the pregnant employees I counsel. These classes really answer a lot of questions...and the instructors are top notch," Ms. Iversen said. The classes, which are taught by March of Dimes volunteers, are promoted in a health bulletin that is distributed to all employees. Spouses are also invited to attend.

TPF&C began marketing a prenatal education program to employers late last year that combines a videotape, a workbook and classroom instruction "to raise the consciousness of employees in a positive way" to the advantages of proper prenatal care and the importance of educated choices in medical care, said Diane Kastiel, an associate at TPF&C (BI, Oct. 24, 1988).

She noted that the program was developed in response to employers that found employees "were not getting the right care, buying too much care or not aware of how to shop for the proper care."

The "Expect the Best" program can be customized to a particular employer and includes information on what benefits are provided under the group medical program, Ms. Kastiel noted.

Chicago-based Illinois Bell Telephone Co. began offering the TPF&C program to its employees and their dependents late last year. It is taught in six one-hour sessions. The first is an introductory course that can be taken separately. There is a "nominal fee" for those who elect to attend the last

'A low birth weight, premature infant is often more costly than an AIDS patient,' Dr. Mahoney says.

five sessions "for commitment purposes," said Bill Watson, director of benefits.

Yvonne Eberle, manager of preventive health care for the phone company, said that the class materials and videotape also are available for employees in remote locations who are unable to attend the classes. The program is announced through the company's internal health bulletin.

Mr. Watson stressed that for an employer to see any reduction in its maternity costs, "this has to

Continued on next page

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Maternity costs

Continued from previous page
be a continuing program," but he added that the company has "never tried to sell the cost savings" to employees in its wellness activities.

For employers that want to educate their employees but are not prepared to offer ongoing prenatal education programs, other options are available.

For example, General Mills Inc. in Minneapolis "has a fully staffed medical department where employees can go for answers to questions," and it also has brochures and a library available with information on health issues, including pregnancy, said occupational health nurse Marilyn Rydland.

And, Johnson & Johnson Products Inc. in New Brunswick, N.J., has a Healthy Pregnancy manual that it gives to all pregnant employees along with a child development publication it markets called "Your Baby—The First Wonderful Year," explained Jeff Harten, wellness administrator.

The 124-page manual addresses medical care during pregnancy, body changes, nutrition, exercise, birthing options, substance avoidance and nutrition, stress management and postpartum issues. Mr. Harten noted.

Johnson & Johnson also is considering offering prenatal education seminars as part of an expanded focus on wellness issues, he said.

'If the infant is born healthy...the costs of medical care will be less,' says Dr. Catz.

And, Gallagher's Mr. Nardi said that one of his clients has begun to offer a dollar incentive to its employees who seek prenatal care in their first trimester. The employer also furnishes employees with booklets on pregnancy in Spanish as well as English because it has many Spanish-speaking employees.

Whatever an employer does to educate employees and their dependents will probably benefit the employer in reduced maternity costs and increased employee morale, observers contend.

"If the infant is born healthy, the mother will be able to return to work earlier and the costs of medical care will be less," said Dr. Charlotte Catz, head of pregnancy and perinatology for the National Institute of Child Health and Human Development in Bethesda, Md.

"There is some perception by employees that there is a balance to providing beneficial programs to them as well as implementing cost control measures" to their benefits programs, Illinois Bell's Mr. Watson observed. ■

Case management reduces high-risk pregnancy costs

By LINDA J. COLLINS

Case management programs are arriving in the maternity ward, as insurers, utilization review firms and independent health care practitioners focus on monitoring high-risk pregnancies and minimizing prenatal hospital stays.

Case management can include home visits and/or homemaking assistance to new mothers who elect to shorten their hospital stays after delivery.

Such programs were developed to monitor the health of the mother and child, while combating the high costs of hospital maternity care.

"These are very tangible services with a known benefit to the patient. You don't need empirical data to see the benefits," said James E. Adams, president and chief operating officer of Efficient Health Systems Inc. in Skokie, Ill. The company's new maternity services program is designed to reduce premature births and complications during delivery.

"Managed care at home is much less disruptive (for the family) and much cheaper," stressed Lorene Reed, executive director of professional services for Affordable Skilled Nursing, a unit of Affordable Home Healthcare Inc. in Akron, Ohio.

High-risk maternity case management programs may include:

- Providing expectant mothers with a phone consultation service through which they can receive advice from physicians or registered nurses.
- Referring patients to local physicians who are experienced in dealing with problem or high-risk pregnancies.
- Providing in-home nursing care or home nursing visits.

Even though a variety of vendors now are offering maternity case management programs, 'only the most progressive companies have begun to look at this issue,' Affordable Skilled Nursing's Ms. Reed and others stress.

• Providing homemaker services to new or expectant mothers who would otherwise be hospitalized.

• Equipping expectant mothers with in-home devices that monitor the fetus' and/or the mother's medical condition to alert them to any potential complications. This also avoids hospitalization.

Even though a variety of vendors now are offering maternity case management programs, "only the most progressive companies have begun to look at this issue," Affordable Skilled Nursing's Ms. Reed and others stressed.

Many "employers are missing the boat. The private sector is the ultimate payer and the ultimate saver," Ms. Reid added.

A case management program can produce a substantial cost savings in high-risk pregnancy cases, agreed Mary Abramowski, a registered nurse and manager-medical case management for the appropriate care and treatment program of Northwestern National Life Insurance Co. in Minneapolis.

For example, the insurer's case management program arranged a home health care alternative for an expectant mother of triplets in her 20th week of pregnancy whose doctor had prescribed strict bed rest in the hospital.

"The mother delivered three healthy girls and the cost comparison showed a claims dollar savings of over \$23,000," Ms. Abramowski

said.

Northwestern National began offering this program in October 1986 to its group policyholders nationwide. Ms. Abramowski and five other case managers provide case management services for high-risk pregnancies and premature births, she said, noting that four of the six case managers are registered nurses with neonatal intensive care backgrounds, one is a medical technician and one is a psychologist.

"Our services could entail providing home monitoring equipment or evaluating the woman's care to make sure the physician is skilled with high-risk pregnancies and is affiliated with a high-skill-level hospital," she said.

"We could also provide attendant or homemaking care to assist the mother. We take a very individualized approach, depending on what is available within their community," Ms. Abramowski noted.

Northwestern National policyholders that use the insurer's utilization review services can enroll in the program for an additional charge.

Health Risk Management Inc. in Minneapolis also offers employers utilization review services and case management programs for pregnant employees or dependents, according to a spokeswoman.

Through its UR program, HRM negotiates fees with hospitals and determines the necessity of procedures like Caesarean sections.

If the utilization reviewer finds that a woman is a high-risk candidate, "a nurse is assigned to follow the case through the pregnancy and afterward," the spokeswoman said.

About 12 case managers based in Minneapolis provide services nationwide and can arrange for local service providers to visit or assist the woman, if needed.

The HRM program saved employers an average of 9% in doctor fees and 12% in hospital charges last year, the spokeswoman added.

Republic RSB Cos. Inc. in Naperville, Ill., recently began offering a high-risk pregnancy screening service as part of its preadmission review service.

Dr. William N. Werner, medical director for Republic RSB, said that in examining its high-risk pregnancies, "we recognized that those problems could have been reduced if the woman had received proper prenatal care."

In addition, "home monitoring of women who would otherwise have to be hospitalized could reduce costs without putting the mother at risk," he said.

After recognizing these potential areas for risk reduction and cost control, the company "researched medical literature to identify factors that would determine that a woman was at risk," Dr. Werner noted. Such factors include a history of preterm babies, a very young woman or a woman older than 35, smokers or women who have medical conditions like high blood pressure or diabetes, he said.

Republic RSB then designed a questionnaire for a registered nurse to administer to pregnant

Continued on next page

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Maternity care information available

Continued from previous page
 women who call a toll-free telephone number. This allows nurses to identify high-risk candidates and design an appropriate prenatal care program for them, Dr. Werner explained.

"We don't automatically start the case management process. That is done with the claims payer's approval," Dr. Werner said.

If the company is appointed as case manager, Republic RSB then consults with the treating physician or provides a physician referral.

The company also might attempt behavior modifications, provide home monitoring equipment or arrange home care for the expectant mother, he said. Services are provided on a per-hour cost basis that varies depending upon the services required.

Efficient Health Systems began providing maternity case management because preterm births and neonatal intensive care treatment costs reach an estimated \$5 billion a year nationwide, Mr. Adams said.

"The medical community has methods available to interfere with preterm delivery and help mothers deliver closer to term, but the information they receive from their obstetricians needs to be reinforced," Mr. Adams explained.

For example, many expectant mothers are not aware that their alcohol consumption during pregnancy can lead to infant retardation, he pointed out. Or if the mother has medical problems like diabetes or hypertension, "we alert them to the additional health concerns associated with those pregnancies," he said.

EHS case managers—registered nurses with clinical experience—monitor pregnancies, supported by a group of physicians.

An expectant mother can call the case manager any weekday or Saturday with questions; the case managers also contact the expectant mother at least twice a month.

The program is available to employers or insurers in the 48 contiguous states through Efficient Health Systems' offices in Skokie, Ill., New York, Atlanta and Los Angeles.

Local assistance or home monitoring can be arranged if necessary, Mr. Adams noted.

Affordable Skilled Nursing was established three years ago to provide prenatal and postpartum home nursing visits and live-in homemaker care. It also offers prenatal education courses for employees.

While the program is marketed to both insurers and self-insured employers, no employers have yet purchased the service, said Ms. Reed.

However, the program does offer a definite cost savings, she noted. Ms. Reed cited a case involving an expectant mother of triplets who would otherwise have required hospitalization.

Affordable Skilled Nursing's program allowed the woman to stay home until one week before her delivery at a cost of less than \$150 per day.

The total cost savings to Blue Cross & Blue Shield of Ohio, which contracted for the services, was "at least \$15,000," Ms. Reed said.

"The cost differences were definitely worthwhile," agreed Rita Williams, supervisor of medical review for BC/BS of Ohio in Cleveland. "Employers could also use home nursing services for post delivery as a perk if a mother is discharged early," Ms. Williams observed.

While Affordable Skilled Nursing's home visits currently are only available in Northeastern Ohio, Ms. Reed will consult with employers in other parts of the country that are interested in finding out more about the program.

Blue Cross & Blue Shield of Rhode Island's Maternity Home Care program provides nurse and pediatrician home visits and homemaking services to women who elect to leave the hospital early, if agreed upon by the mother, the obstetrician and the pediatrician, a spokesman explained.

Women in the program who deliver vaginally must leave the hospital 24 hours after delivery and women who have Caesarean sections must leave after four days, barring complications, he said.

These women and their babies receive 100% coverage for 14 days after discharge for three visits by a nurse, one pediatrician home or office visit, any laboratory tests, up to 20 hours of home health aid services and up to nine hours of homemaker services, the Blue Cross spokesman explained.

The program, which began in October 1984, is available to employer groups. ■

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CAN TELEVISION PREVENT AIDS?

This month on PBS, television brings you an insightful look at the plague that may put you out of business: AIDS.

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guidelines you establish today for determining the insurability of HIV-positive applicants may not hold up in court tomorrow.

Yet in spite of its serious consequences to America's health care and life insurance industries, much of the information available on AIDS has been wrapped in a numbing blur of statistics and outright sensationalism. That is why PBS is broadcasting *The AIDS Quarterly*, with its premiere broadcast anchored by Peter Jennings of ABC News. The new hour-long series is devoted to an up-to-the-minute look at the effect of AIDS upon America and its institutions.

Presented by WGBH Boston, producers of the award-winning *Nova* and *Frontline* programs, *The AIDS Quarterly* has assembled a team of noted international journalists to sift through the information and report on the latest and most relevant developments of this unprecedented terror.

Right now, knowledge is our primary weapon against AIDS.

In this historic series, presented once a quarter through a major grant from the Robert Wood Johnson Foundation, the AIDS nemesis will be examined far beyond its emotional impact.



In its first installment, anchored by Peter Jennings, to be seen on February 28th, *The AIDS Quarterly* will take an exacting look at the federal government's response to the AIDS crisis. Future segments will cover the ethical problems of the epidemic, the biochemistry of AIDS and the financial and political implications of the disease.

This makes *The AIDS Quarterly* a program not just for you, your work force and your insureds, but for everyone. Because once they see the ramifications of AIDS as shown in this provocative and intelligent presentation, they'll understand the real urgency facing all America.

Watch *The AIDS Quarterly* February 28th on your PBS station. Check local listings for time and station.



The Robert Wood Johnson Foundation of Princeton, New Jersey, has been since 1972 the nation's largest private philanthropy dedicated to health care. Currently it provides more financial support for AIDS-related programs than any other private-sector organization.

The Robert Wood Johnson Foundation is proud to add WGBH Boston to its list of local, regional and national organizations working to improve the health and health care of Americans. For the homeless, the elderly, the uninsured, the mentally ill and others, the Robert Wood Johnson Foundation is seeking to make a difference.

The AIDS Quarterly, February 28th on PBS.

Caesarean births

Continued from previous page
 sanean, according to a spokesman in Providence.

Blue Cross & Blue Shield of Illinois has adopted a similar flat compensation schedule for physicians under its preferred provider organization, said Bradford A. Buxton, vp-health care services in Chicago.

"We also put together a C-section brochure for expectant mothers" with the help of Dr. Gleicher and another area physician, he said.

In addition, Mr. Buxton said BC/BS of Illinois examines the Caesarean rate of hospitals in its marketing area every quarter and visits those with high rates to make sure the procedures are medically necessary.

There are also things that employers can do to lower the Caesarian rate, experts say.

For example, Yvonne Eberle, manager of preventative health care for Illinois Bell Telephone Co. in Chicago, said that the company presents a Caesarean section videotape to employees or their dependents who attend their prenatal education courses. Handout materials on surgical deliveries also are distributed, and a physician is available to answer employee questions.

The company's director of benefits, Bill Watson, added that the issue is also discussed in the employee newsletter.

Karen Zalewski, prenatal health coordinator for First National Bank of Chicago and a registered nurse, said that in addition to adding a mandatory second surgical opinion requirement for prearranged Caesarean sections under its health care plan, the bank also

'You can't and shouldn't prevent emergency C-sections,' Ms. Friedman says.

discusses Caesareans in its prenatal education classes for employees and discusses the issue in its wellness newsletter.

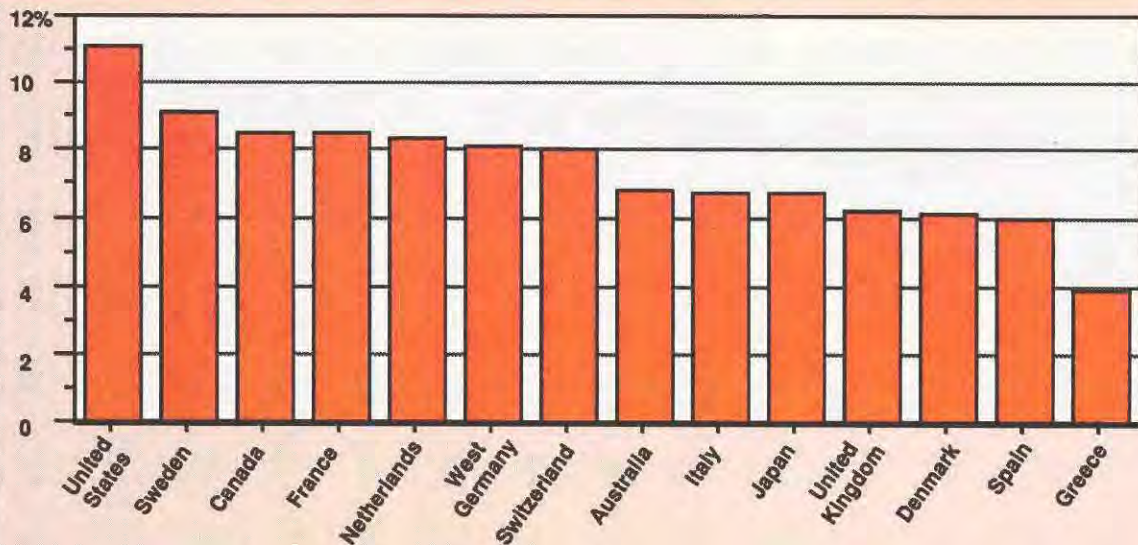
The ACOG spokesman suggested that employers that want to reduce the rate of Caesareans among their employees start by informing employees about vaginal deliveries. Information is available from the ACOG and other sources (see story, page 75).

The ACOG spokesman also pointed out that not only is a Caesarean more costly and cause for a lengthier hospital stay, it can also result in greater complications to both the mother and child. For example, the procedure subjects both the mother and baby to anesthesia, which carries with it an increased health risk. Surgery also poses a greater risk of infection to the mother, the spokesman noted.

Ms. Friedman explained that she and others are simply "trying to reduce the number of preplanned elective C-sections. You can't and shouldn't prevent emergency C-sections," Ms. Friedman said, expressing concern that systems could be set up to deny necessary Caesarean sections for economic reasons.

But "C-sections should be viewed as a serious surgical procedure to be used when all other methods have failed. We have to take this procedure more seriously," Ms. Friedman said. ■

Percentage of GNP spent on health care in 1986



Source: Organization for Economic Cooperation and Development

Chart: Holly Seguire

Lack of government control boosts U.S. health care costs

By DEBORAH SHALOWITZ

The United States spends more on health care than any other industrialized nation primarily because the government does not control health care costs or utilization, experts say.

Also contributing to the higher U.S. health care bills is a bigger appetite for health care and more expensive high-technology treatments and tests.

The U.S. health care system is burdened by hidden costs, too,

such as the cost of medical malpractice insurance—something providers in many other countries do not face.

Furthermore, because individuals who receive care directly pay for only about 25% of U.S. health care expenditures, they have little incentive to keep health care costs down, according to one expert.

In terms of gross national product, the United States spent 23.3% more on health care than the next highest health care spender in 1986, the latest year for which figures are available, according to the Paris-based Organization for Economic Cooperation and Development (see chart).

The United States spent 11.1% of its GNP on health care in 1986, while Sweden spent 9%. Canada spent 8.5% of its GNP on health care and the United Kingdom spent only 6.2%.

Furthermore, the federal Health Care Financing Administration predicts that by the year 2000, U.S. health care spending will reach 15% of GNP.

Per-capita expenditures on

health care in the United States also far surpassed those of other industrialized nations in 1986, according to OECD. The United States' \$1,926 per-capita expenditure for health care in 1986 was 40.6% greater than Canada, which ranks second with a per-capita expenditure of \$1,370.

Per-capita health care expenditures in other countries include \$1,217 in Switzerland, ranked third; \$1,195 in Sweden, ranked fourth; and \$711 in the United Kingdom, which ranks 19th.

The most significant factor contributing to the high U.S. health care bill is the lack of government control of health care pricing, according to experts. The governments of almost all other industrialized nations have a significant amount of control—and in many cases complete control—over health care costs, experts noted.

"It is easier for the government to impose cost controls" in other countries than it is for insurers or employers, which typically are left to control costs in the United

Continued on page 78

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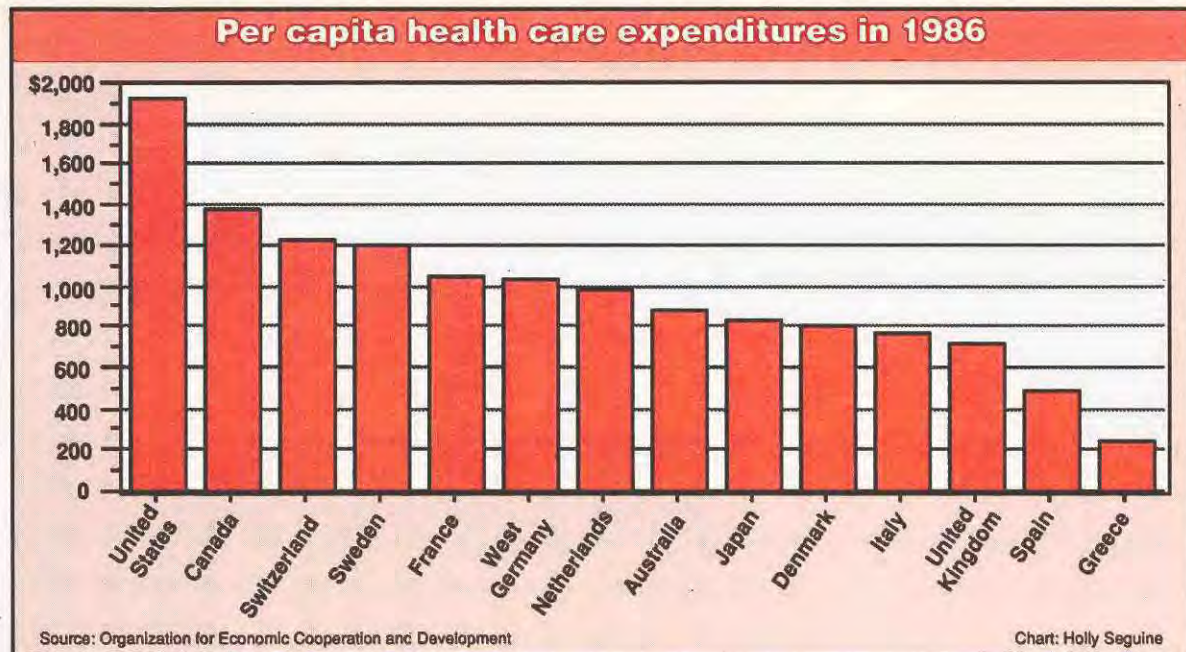
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U.S. health care

Continued from page 76

States, said Sam Bernstein, a consultant with Hewitt Associates in Lincolnshire, Ill.

For example, Canadian and U.S. spending on health care "was running neck-in-neck" during the 1960s when the Canadian health care system was privately controlled, said Dr. Robert Kane, dean of the School of Public Health at the University of Minnesota in Minneapolis.

According to the OECD, in 1960 the United States spent 5.2% of GNP on health care while Canada spent 5.5% of GNP. In 1965, the United States spent 6.0% of GNP on health care while Canada spent 6.1%. By 1970, U.S. health care spending had increased to 7.4% of GNP and Canadian health care spending had increased to 7.2% of GNP.

However, Canada's health care spending fell off the U.S. pace after 1972, when Canada instituted a national health care program, Dr. Kane explained.

In 1975, U.S. health care spending grew to 8.4% of GNP while Canadian health care spending inched up to only 7.3% of GNP, according to the OECD. And in 1980, while the United States was spending 9.2% of GNP on health care, Canada was spending only 7.4% of GNP on health care.

By 1985, U.S. health care spending had jumped to 10.7% of GNP while Canada's spending had risen to only 8.4% of GNP, according to the OECD.

Each of Canada's 10 provinces and two territories individually determine how to finance health care expenses. Currently, three different funding methods are in use: direct premiums from citizens; payroll taxes paid by employers; or general tax revenues.

Health care is provided by private physicians and not-for-profit hospitals. Each provincial government negotiates fees annually with doctors and hospitals, according to Dr. Kane.

"The rate of increase in (health care) costs in Canada is controlled better than here in the United States" because Canada has "one powerful negotiator able to set" prices, said Donald Davis, chairman of The Stanley Works, a diversified manufacturer based in New Britain, Conn.

The differences in health care expenditures in the two countries are "a result of a controlled system vs. a market system," Mr. Davis continued.

One company experiencing these differences in health care expenditures is Chrysler Corp. Chrysler's health care expenditures per U.S. employee are about three times greater than its per Canadian employee cost, noted Walter Maher, director of employee benefits for the Highland Park, Mich.-based automaker.

In addition to controlling health care costs, the governments in many other industrialized nations control—at least to some extent—utilization of health care, experts noted.

For example, the United Kingdom limits elderly patients' access to certain medical procedures like kidney dialysis, pointed out Sylvester Schieber, director of research for The Wyatt Co.'s Research and Information Center in

Washington, D.C.

In comparison, Medicare in the United States pays about \$30,000 per patient per year for kidney dialysis for any beneficiary, without age limitations, Mr. Schieber said.

"Limiting access to certain technologies" affects total costs, he pointed out.

Americans also have a particularly hearty appetite for health care, experts pointed out.

"The medical profession has gotten society at large to take the Hippocratic oath," Mr. Schieber said, referring to a physician's obligation to provide the best medical care possible to patients.

"There isn't this insistence on immediate attention to non-emergency situations" in other countries, Mr. Schieber said.

And, "supply creates its own demand," he said.

"Our system just uses more resources in the treatment of patients than other countries," said Chrysler's Mr. Maher. "We have a cultural appetite for health care," he observed.

Experts also noted that U.S. health care providers use more high-tech treatments and tests than do health care providers in other industrialized nations.

"We do have probably more extravagant and wide-ranging technologies in this country than in other countries," Mr. Schieber said.

There also is "better government control of acquisition of very expensive technology" in other countries, pointed out Hubert Valdemoro, an international benefits consultant in the Dallas office of William M. Mercer Meidinger Hansen Inc.

Technology is "more readily available" in the United States than elsewhere, agreed Hewitt's Mr. Bernstein.

For example, Mr. Bernstein noted that most doctors in the United Kingdom do not have X-ray machines in their offices, while most U.S. doctors do.

The hidden costs of medical malpractice and private health care insurance also push up the cost of U.S. health care.

"The incredible cost of malpractice insurance here has caused medical prices to increase," Mr. Bernstein pointed out. "Built into the doctor's fee is an insurance premium which is higher in the United States than in other countries.

"In the United States you can sue at the drop of a hat," Mr. Bernstein added. "And the size of the awards can be way out of proportion to the actual damages."

"In some other countries doctors would see patients without a fear of malpractice," said Mercer's Mr. Valdemoro.

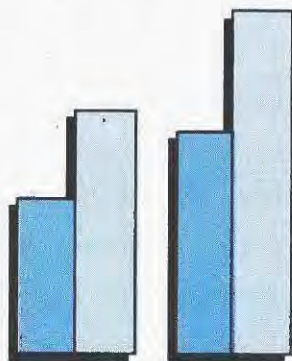
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Insurer Topics

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Not so soft market

Competitive environment places major demands on underwriters

By MARK A. HOFMANN

A soft market can signal hard times for commercial property/casualty insurance underwriters.

Whipsawed by an increasingly violent insurance cycle, underwriters face stress unknown only a decade ago. For instance, many insurance industry experts maintain that the soft market adds to underwriters' insecurities, leading to "underwriter burnout," a professional malaise for which there is no certain cure (see story, page 78E).

"Generally speaking, an underwriter would much rather write business than not. It's a lot more fun," summed up Michael R. Mitchell, vp-underwriting operations for Morristown, N.J.-based Crum & Forster Inc.

"I think there's no question it's a lot more frustrating and difficult for an underwriter to be working in a soft market, provided they're working for a disciplined company," added Michael A. Goldberg, vice chairman of Berkshire Hathaway Inc. in Omaha, Neb.

Mr. Goldberg said underwriters working for insurers that hold the line on pricing during a soft market find that, after awhile, brokers simply stop sending business their way.

"The submissions drop dramatically," he said, adding that underwriters find themselves with little to do.

On the other hand, underwriters may find themselves caught in a very difficult situation if the insurer says one thing and does another as the market softens, Mr. Goldberg said, referring to insurers that

say they want to achieve underwriting profit while insisting that underwriters meet production goals.

Underwriters caught in that sort of crossfire are under considerable stress, he said. "You try not to do anything that sends the wrong signal to underwriters."

The soft market does present insurers with an opportunity to enhance their underwriters' professional skills. Berkshire Hathaway affiliates encourage underwriters to use slow times to further their education, he said.

In addition, underwriters from one Berkshire Hathaway unit are assigned to audit the underwriting practices of another unit. "We hope they're getting smarter and growing professionally," Mr. Goldberg said.

Paul Springman, vp-underwriting for Evanston, Ill.-based underwriting manager Shand, Morahan & Co. Inc., agreed the soft market presents great opportunities for underwriters to sharpen their skills.

The soft market is a period of intense educational efforts, including seminars and job rotation for underwriters at the professional liability specialist (see story, page 78A).

"We have to give them challenges," said Mr. Springman. "Because of the highly specialized nature of our business, we can't afford to lose good people."

"Underwriters really earn their money in a soft market," said James S. Davis, vp and director of

Continued on next page

Insurers follow different courses to teach novices

By MARK A. HOFMANN

There are virtually as many approaches to educating underwriters as there are insurance companies.

Many insurers recruit new underwriters from college campuses, seeking out graduates with business-related degrees. Others encourage promotion from within their ranks, offering underwriting opportunities to personnel in all departments—including the mailroom. And, other insurers seek out only experienced underwriters.

In-house underwriting training can last years, with trainees often working under the wing of an experienced underwriter. In addition, trainees generally must attend in-house courses on the insurer's products, negotiation techniques and personal computer usage. And many insurers encourage underwriters to continue their education by earning professional designations or earning a master's degree in a business field.

The emphasis on both introductory and continuing education depends on corporate culture, recruiting patterns and the types of risk underwritten.

The variety of underwriting education techniques used by insurers may stem from a historical disagreement about whether underwriting is a teachable skill or an art that must be learned through experience, pointed out Everett D. Randall, assistant vp with

Continued on next page

Insurer topics

Cycle tough on underwriters

Continued from previous page

underwriting in standard lines for Zurich-American Insurance Cos. in Schaumburg, Ill. Competition for business puts underwriters under more stress than usual, he said.

Zurich-American's philosophy is that risk selection should not change because of market cycles, Mr. Davis noted.

"We keep communicating that our overall priority is profit and not growth. We want them to make underwriting decisions, not business decisions," Mr. Davis said.

But some property/casualty insurance companies become "fanatic" about cutting their transaction costs—including underwriting—during soft markets, said Gerald D. Stephens, president and chief executive officer of Peoria, Ill.-based RLI Insurance Co. He makes no secret that he regards such cost-saving maneuvers to be counterproductive.

Mr. Stephens, who also is president of the Malvern, Pa.-based Society of Chartered Property & Casualty Underwriters, said that during the soft market of the early 1980s some companies encouraged experienced underwriters to take early retirement in an effort to hold down expenses.

Underwriter training

Continued from previous page

the Insurance Institute of America in Malvern, Pa.

"It's all over the lot as to what people do in regard to education," said Mr. Randall, who is the director of two of the IIA's underwriting and premium audit continuing education programs. The institute also plans to introduce an introduction to underwriting course in about a year (see story, page 78D).

Mr. Randall explained that traditional wisdom has held that underwriters learn their craft by sitting at the elbow of more experienced personnel and that the craft is handed down from generation to generation like a guarded family recipe. An underwriter could serve an apprenticeship for decades.

"Underwriter education through experience is the most expensive course you can take; it can cost millions. Unfortunately, it is probably also among the best," said Angus Robinson, president and chief executive officer of Minneapolis-based NWNL Reinsurance Co., a subsidiary of Northwestern National Life Insurance Co.

Mr. Robinson said underwriters who cost their companies large sums do indeed learn from their mistakes; their superiors remind them of the errors for years.

However, like most other insurance industry executives, Mr. Robinson stressed the importance of formal underwriter education as opposed to seat-of-the-pants instruction.

Despite a certain degree of nostalgia for learn-by-doing underwriting, a common thread now runs among insurers regarding continuing education: Virtually every insurer encourages its personnel to take professional courses offered by the IIA or to pursue a Chartered Property & Casualty Underwriter designation.

"There's tremendous opportunity for trained technical people," said Gerald D. Stephens, president and chief executive officer of Peoria, Ill.-based RLI Insurance Co. and the current president of the Society of CPCU. To assure that the training exists, RLI relies "heavily" on IIA courses, he said.

RLI plans to prepare its underwriters during the current soft property/casualty insurance marketplace for the challenge of the next hard market, Mr. Stephens pointed out.

The IIA offers a series of specialized courses leading to professional designations.

While the IIA and CPCU courses appear to represent a standard of professional education accepted by the insurance industry, many companies have instituted their own—sometimes elaborate—internal education programs as well.

The education process can take more than two years, according to John P. Coonan, assistant vp and assistant national director of the Executive Protection Division of Warren, N.J.-based Chubb Corp. The division underwrites directors and officers liability, fiduciary liability, commercial crime and kidnap/ransom coverages.

The division tends to recruit underwriters straight from college, with about half of the recruits holding business or finance degrees.

"What we're really looking for are bright people who have good personal qualities and who are motivated to learn new things," Mr. Coonan said.

To become an underwriter in the Executive Protection Division, a trainee must complete a rigorous education. Hireses spend a month in an assigned branch office, completing written assignments that give them a better understanding of insurance, before going to a large regional office for a week of

Doing so was one of the worst mistakes the property/casualty insurance industry has ever made, Mr. Stephens said during the CPCU annual meeting in October, (BI, Oct. 24, 1988).

Transaction costs may account for 15% of a company's costs, while claims costs account for perhaps 70%, he explained in an interview. Managements that zero in on transaction costs and insist on a 10% cut in their transaction costs realize a reduction of only 1.5% in their total costs. However, an insurer achieving a 10% reduction in claims cost would cut expenses by 7%, he said.

Still, some insurers find the temptation to slash underwriting training budgets during a soft market irresistible. "In my opinion, some of the insurance industry's major failings have been caused by a lack of respect for these people," Mr. Stephens said, noting that the lack of stature for underwriters does not go unnoticed by those on the receiving end.

"During a soft market, we as an industry tend to lose some of our most talented people," Mr. Stephens said. As a result, when the market contracts, insurers have to make do with inexperienced underwriters who have little idea how to price a risk realistically, he said.

what Mr. Coonan called "intense orientation," about Chubb and its goals.

After two weeks in the branch office, trainees go to Chubb's headquarters for a three- to four-week insurance school.

About 50 trainees attend the school on any one time. Senior managers from all underwriting departments address the trainees and introduce the company's products.

After a brief return to their branches, the trainees pay another visit to corporate headquarters for classes in writing specialty risks, such as directors and officers liability, Mr. Coonan said.

The length of the study program varies by specialty, with most specialized underwriting schools lasting two to three weeks.

The specialty schools emphasize interaction between the students and their instructors, with students encouraged to question what they are being taught, he said.

There is "constant testing" during the courses, which emphasize financial analysis of risk, Mr. Coonan said.

"It's of benefit to the individual to learn where his or her weak spots are," he explained, adding that one or two of 50 trainees may wash out.

Once specialty school is over, the trainees return to their branches for 24 months of on-the-job training. In addition to following self-study guides and interacting with managers and experienced underwriters, the trainees "learn through work about real-life accounts," Mr. Coonan said.

Even after formal training, underwriters are encouraged to pursue continuing education courses, either through the IIA and CPCU or through college night classes in related disciplines, he said.

Underwriter trainees at Wausau Insurance Cos. participate in a five-phase education program, explained Jerry Bellin, casualty underwriting training director for the Wausau, Wis.-based unit of Nationwide Insurance Co.

Trainees, who are generally recruited from college ranks but who may also come from other positions within Wausau, spend their first three or four months in the regional office to which they have been assigned. There, trainees must complete a series of pre-program courses on subjects like workers compensation experience rating, automobile insurance rating, an overview of commercial underwriting and principles of insurance.

Novice underwriters also work on specific accounts with more experienced underwriters assigned as their trainers.

In the second phase of the training, new underwriters spend three weeks at the home office for more intense training before beginning a third phase of on-the-job training back at their branches.

During the 18-to-20-month third phase, trainees are assigned to work with producers, gain familiarity with underwriting procedures and underwrite accounts with supervision, Mr. Bellin said.

In the fourth phase of their education, trainees return to Wausau for a week-long underwriting course. Although much of the emphasis during this week is on technical training, the week in Wausau also serves as a "morale booster," Mr. Bellin noted.

Members of the underwriting class can "swap experiences and relate how they deal with problems in their regions," he said. The sharing of knowledge during this fourth phase of training continues into the fifth phase: continuing education.

Continuing education takes many forms,

Mr. Bellin said. The home office suggests "emphatically" that regional managers conduct training sessions, he said. To aid the effort, the home office has developed materials ranging from leaders' guides to support material on individual topics.

For example, Wausau recently prepared a package on underinsured motorists, he said.

In addition, Wausau encourages its underwriters to pursue the CPCU designation or take IIA courses. "I think if an individual does not partake in continuing education, he or she will be left behind," he said.

An insurer that does not offer continuing education opportunities also may be left behind in the competition for qualified recruits, said William Davenport, second vp in the national accounts group of Hartford, Conn.-based Travelers Insurance Co.

"If you're going to compete with the GEs, the Procter & Gambles and the Citicorps, you're going to have to offer more than a few weeks of introductory education," asserted Mr. Davenport, who is responsible for training in his division, which handles accounts that generate an annual premium of more than \$250,000.

"We tell our people that 'we want you to be in the top 15% or 20% of everybody that's playing this game,'" he said.

All entry-level underwriters hired for his division attend a 15-week school at the insurer's Hartford headquarters.

Much of the introductory course is devoted to explanation of products. In addition, trainees are instructed in what Mr. Davenport calls "the underwriting thought process—exposure, identification, analysis and pricing." Case studies illustrate underwriting skills such as negotiation.

Trainees also must enroll in the IIA's Associate in Risk Management designation program, he said. "We use the ARM because it has a little more focus on large accounts" than some other designation programs, Mr. Davenport said. Completing the course also is "a good resume builder," he added.

Novice underwriters also must participate in a five-year program, during which underwriters spend time in other departments to learn about loss control and other facets of the business, he said. "We want them to get a view of the business as a business."

In addition, underwriters can sharpen their speaking and negotiating skills by attending optional classes at the home office, Mr. Davenport said.

Travelers also encourages its underwriters to pursue advanced degrees, particularly masters of business administration degrees.

Although most of Travelers' underwriter trainees are recruited out of college, some are recruited from within. In fact, some of Travelers' best underwriters have been claims department personnel, Mr. Davenport said. And it is not unheard of for administrative support personnel to become underwriters and eventually managers.

Travelers does not require underwriter trainees to hold undergraduate degrees, Mr. Davenport said. However, he stressed a college degree is preferred, and trainees who lack degrees are encouraged to attain them.

"It's tough without one," because most of an underwriter's peers will hold either bachelor's or graduate degrees, he said.

More than one path also leads to the underwriting departments of Crum & Forster Inc.'s commercial insurers, said Michael R. Mitchell, vp-underwriting operations.

One can begin on a college campus, while the other can begin in the corporate

"It's a crime" when agents and brokers cannot find a knowledgeable underwriter who can handle a hard-to-place risk during a hardening market, Mr. Stephens said.

Although Mr. Stephens expressed frustration with the softening market, he said that RLI is not going to use the market as a rationale for purging its underwriting ranks.

"We're still in the black, but last year we had a disappointing 99% combined ratio compared to an 87% ratio the previous year," Mr. Stephens said, adding that RLI has posted combined ratios worse than 100% only three times since 1965 and has never posted a ratio worse than 102%.

"We believe in using the soft market to improve our infrastructure," Mr. Stephens continued. In an attempt to cut expenses, RLI is attempting to increase its productivity, he said. The insurer is undergoing a companywide examination of its automated systems and recently conducted an in-house "leadership school" to prepare its managers for the next hard market.

But the insurer has not cut its underwriting staff to reduce expenses, said Mr. Stephens. In fact, maintaining an adequately trained underwriting and claims handling staff is "the key to our future," he said. ■

mailroom, he said.

Crum & Forster likes to recruit college graduates who have taken insurance and risk management courses at The College of Insurance in New York or other colleges and universities, Mr. Mitchell said. Although the insurer tends to favor students with a business education, it does not limit itself to those candidates, he said.

Like Travelers, Crum & Forster also encourages promotions from within, he said. "We will recognize job experience in lieu of education," although the job experience must be with Crum & Forster, he said.

Fledgling underwriters go through a year-long internship that is "basically home-grown" with an emphasis on hands-on training, he said.

Underwriters are hired into field offices rather than the home office. After attending a two-week "core program," which covers the basics of insurance, trainees begin their branch office duties, Mr. Mitchell said. There, they complete company-issued correspondence courses, receive desk-side training from established underwriters.

Trainees spend about half of their first year dealing with casualty insurance and the other half with property insurance issues.

Each six-month training period is bolstered by a week-long classroom course. At the end of a year, the new underwriters receive their permanent assignments.

At PHICO Insurance Co., a Mechanicsburg, Pa.-based insurer that specializes in medical malpractice and other liability coverages for health-related risks, hireses also undergo a year of training.

However, Matthew B. Townsend, vp-underwriting, noted that entry-level employees are not earmarked for a particular job until they have completed their first year.

"We're trying to hire someone right out of college and put them through a comprehensive program," Mr. Townsend said.

Under a program launched last summer, PHICO trainees work in the underwriting, loss control, claims and client services departments during their first year, he said.

"The idea is to give those individuals an idea of how the entire company operates," he said. At the end of the year, the trainees are assigned to departments.

Mr. Townsend said one of the most important factors in creating the program was the company's location in central Pennsylvania, more than 100 miles west of Philadelphia and about 200 miles east of Pittsburgh, which makes recruiting experienced underwriters somewhat difficult, he said.

But even if PHICO were located in a bigger city, the company still would face the problem of having a very small pool of experienced talent from which to recruit, he pointed out. Training recent college graduates, particularly those with degrees in insurance, business and economics, helps fill that pool, he said.

PHICO has no continuing education requirement for its underwriters because of the specialized nature of PHICO's business, though the insurer "strongly encourages" underwriters to enroll in IIA and CPCU courses, he explained.

"It's difficult to even find seminars dealing with medical malpractice," he said.

"There are very few courses of technical bent available" for specialty lines property/casualty insurance underwriters, agreed Ralph Quigley, senior vp with Chicago-based Crum & Forster Managers Corp. of Illinois.

Continued on next page

Training

Continued from previous page

To fill spots in its D&O and professional E&O underwriting departments, CFMC (Ill.) recruits recent college graduates.

The company also seeks experienced underwriters from other companies. However, CFMC (Ill.) underwriters are heavily recruited by other insurers, he noted. "We are the largest single supplier of D&O underwriters for the industry," Mr. Quigley said.

However, CFMC (Ill.) does not train inexperienced people to underwrite its excess property/casualty business, Mr. Quigley said. These underwriters must have at least three years experience. "They have to understand primary before they can do the excess."

Evanston, Ill.-based underwriting manager Shand, Morahan & Co. draws most its underwriters from the ranks of the experienced, said Paul Springman, senior vp-underwriting. Hires usually have five to seven years experience with a primary insurer or one or two years of experience with another specialty company, he said.

Shand, Morahan believes that a soft market is the time to further hone underwriting experience and is pursuing "a formal five-prong program" for its underwriters, Mr. Springman said.

In one effort, many underwriters are temporarily relieved of day-to-day duties and assigned to pure research and development projects within their field of expertise, he said. For example, one architects and engineers liability underwriter has been assigned to research the possibility of introducing the coverage in several geographic regions in the near future.

Other underwriters have been assigned to develop new products. Mr. Springman said that while about nine out of 10 new product ideas are dismissed, Shand, Morahan hopes that underwriters assigned to a separate product development unit during the soft market will be able to design three or four products that be introduced when the cycle turns.

Another educational effort currently under way involves rotating a limited number of underwriters out of their specialties, he said. For example, an architects and engineers liability underwriter may be placed temporarily in the lawyers liability underwriting unit, while a lawyers' underwriter will move to product liability.

Mr. Springman said the program broadens underwriters' experience while exposing them to possible new ways of underwriting the risks with which they are experienced.

The fourth prong is an increased budget for travel, conventions and promotion, Mr. Springman said. Shand, Morahan believes that the soft market is an ideal time to bolster client contacts, he said.

The fifth prong is an increased budget for professional education. Mr. Springman said the budgets for both internal and external seminars have been increased by about 25% to 30%.

The enhanced education budget pays for instruction in marketing trends, financial analysis and specialized endeavors. For example, architects liability underwriters might attend a convention of safety engineers as part of their education, Mr. Springman said.

Three to five years of experience in primary property/casualty insurance underwriting is the usual prerequisite for joining the underwriting staff of Princeton, N.J.-based American Reinsurance Co., said Harold Swann, senior vp and head of the facultative division.

However, American Re, a unit of Aetna Casualty & Surety Co., launched a pilot in-house training

program last year, noted Peter Turner, vp-training and communications. Four people, drawn from administrative support positions or recruited directly from college, are currently in the program.

The underwriter trainees are assigned to branch underwriting departments. For the next two to three years, they will act basically as support for experienced underwriters but will be granted some underwriting authority, Mr. Turner said. On-the-job training will be supplemented by in-house seminars in Princeton.

Mr. Turner said he considers the fact that senior managers serve as trainers as one of the strengths of the education programs, because trainees can draw upon the expertise of senior staff, he said.

In addition, the company offers tuition assistance for continuing education. ■

News video gives pulse of insurer

SCHAUMBURG, Ill.—The management of one insurer is using a televised newscast format to deliver information to its branch office personnel.

During "Z-A Video Pulse," two anchorman introduce excerpts from the quarterly management meeting that Zurich-American Insurance Cos. has conducted for the past seven years.

The program, which condenses the 2½-hour management meetings into 15- to 20-minute segments, represents a refinement of a longer format introduced in 1986, explained E.K. Loughridge, manager of corporate communications for the Schaumburg, Ill.-based insurance company.

Originally, the insurer used its industrial television operation, launched in 1985, to tape the meetings in their entirety.

An on-site television facility made taping the information meetings a logical way to disseminate senior management's observations and concerns to the branch offices, Mr. Loughridge explained.

The facility primarily was used to make tapes for

internal employee consumption as well as a few loss control videos for clients (IT, Oct. 24, 1988).

The first tapes of "Senior Management Report," went to branch offices in late 1986.

"It was a good first step to go from a written piece of paper to video. You could capture personalities as well as information," said Mr. Loughridge.

But the surveys that accompanied the tapes to the branch offices came back with a common complaint: "Senior Management Report" was simply too long. Mr. Loughridge noted that the tapes could run as long as 1½ hours, and were literally edited recordings of the meetings. He also noted that even a 1½-hour tape of an entertainment event can leave an audience squirming.

Fred E. Dabney II, vp-corporate communications, called a meeting in late 1987 to discuss how the format could be changed. Suggestions included a relatively informal, "PM Magazine"-style report or a straight news program reporting on what had happened during the quarterly meeting.

Continued on next page



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Insurer topics

IIA to launch new program for underwriter education

MALVERN, Pa.—The Insurance Institute of America plans to launch an introductory underwriting program within the next year in an effort to get beginning underwriters off on the right foot.

The overwhelming majority of property/casualty insurers—regardless of whether they offer their own specialized training—encourage new and experienced underwriters to pursue continuing professional education by taking courses offered by the IIA or the Society of Chartered Property & Casualty Underwriters, both based in Malvern, Pa. (see story, page 78A).

However, many beginning underwriters have tackled the IIA's premier underwriting program, which leads to an Associate in Underwriting designation, unaware that it is designed for experienced underwriters, pointed out Everett D. Randall, an IIA assistant vp who directs the AU program.

Students must pass four courses to attain the AU designation: "Principles of Property & Liability Underwriting," "Personal Lines Underwriting," "Commercial Liability Underwriting" and "Com-

The institute is designing the course to fill the void in introductory underwriting education, says Everett D. Randall. 'It will by no means make someone an underwriter. But it will help them if they're sitting next to an experienced underwriter.'

mercial Property & Multiple-Lines Underwriting."

By midyear 1988, about 28,000 examinations had been administered and about 2,700 people earned an AU designation, he said.

"Generally, people look at the principles course and think it's an intro. That is not the case," he said. In fact, the principles course is probably the most difficult of the four courses required for the AU designation, he added.

Not surprisingly, many would-be underwriting students failed, Mr. Randall said.

To fill the void in introductory underwriting education, the institute is designing the introductory course, Mr. Randall said.

"It will by no means make someone an underwriter. But it will help them if they're sitting next to an experienced underwriter," Mr. Randall said.

The course, which will probably last about eight weeks, is aimed primarily at two segments of underwriting personnel, he said.

One group is underwriter trainees hired straight out of college. The program is designed to give these trainees "an idea of what they can expect to be doing" in their underwriting career, Mr. Randall said.

The other group targeted for the

course consists of clerical workers in an underwriting department. For these employees, the course is designed as "an aid to communication" so that they will better understand underwriters' jobs.

Mr. Randall said the institute is preparing a six-chapter textbook for the course. The book's first two chapters will explain what underwriting consists of and what underwriters do, he explained.

Subsequent chapters will examine underwriting personal lines, commercial lines coverages and underwriting management, which examines how insurers set underwriting guidelines, Mr. Randall said.

By way of contrast, the IIA's AU designation coursework includes risk management, financial analysis, insurance pricing and underwriting trends and issues, as well as underwriting case studies.

Because the course is an introduction to underwriting, no requirements for the AU or CPCU designations will be waived for students who successfully complete the new program, he said.

Those who earn an AU designation can waive one of 10 courses—"Insurance Company Operations"—required to attain the CPCU designation.

—By Mark A. Hofmann

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INSURER TOPICS

Zurich video

Continued from previous page

Mr. Dabney chose the latter approach and presented the idea to senior managers, including Zurich-American Insurance Cos. President William H. Bolinder and Victor N. Daley, senior vp-corporate development, whose responsibilities include overseeing corporate communications. The senior managers supported the more formal approach as well.

Mr. Loughridge said everyone agreed that the purpose of "Z-A Video Pulse" was to provide business information to its employees, not to serve as entertainment.

"Z-A Video Pulse's" producers followed the philosophy that they should aim at reaching 80% of their audience: 10% would find anything other than the most technical presentation too simplistic, 10% at the other extreme would find anything other than pure entertainment unsatisfying. The newscast format appeared likely to best reach that 80% target audience, said Mr. Loughridge.

Under the format adopted, Messrs. Dabney and Loughridge serve as anchormen, introducing film clips from the information meeting. Mr. Bolinder and other senior managers give their observations on the company's direction and performance during the quarter being discussed.

The chief executives of each of the insurer's five business divisions—standard lines; special risk; international; personal lines; and excess, surplus and specialty—also provide some information on each division's performance over the previous quarter.

The anchormen also occasionally offer commentary or explanations of technical subjects.

About midway through the program, Meg Studer, the company's sales promotion specialist, hosts a brief feature called "Did You Know?" that deals with facts about the company rather than straight reporting. For example, in a recent "Video Pulse," she pointed out that the company has had only nine chief executive officers in 75 years, and that seven of the eight most recent branch managers were promoted from within.

Mr. Loughridge stressed that the "Did You Know?" segment, while somewhat less formal than the newscast, is still business-oriented. "It allows us to promote information that we think is important in a somewhat different way," he said.

Different people find different parts of the video useful, Mr. Loughridge said. "Even if the entire 15 minutes isn't vital to everyone, there's a piece of 'Video Pulse' that is valuable to everyone who's seeing it," he said.

Reaction to the new format has been very favorable, he said. The company also believes the approach is a cost-effective means to reach its branches. Ninety-five percent of the production work is done at Zurich-American's own facilities; only duplication of the master tape to roughly 40 videocassettes for distribution to the branches must be done by an outside supplier.

Despite the positive reaction, Mr. Loughridge said that he and Mr. Dabney are seeking ways to keep the quarterly news program fresh. "We know if we do the same thing every time, people will grow bored," he said.

—By Mark A. Hofmann

Insurers fighting underwriter burnout

By MARK A. HOFMANN

Underwriter burnout is a real problem, not a figment of underwriters' collective imagination, insurers report.

And, as the property/casualty insurance market continues to soften, underwriter burnout is growing worse, they say.

The recommended remedy varies from company to company.

For some insurers, enhanced training is a way to short-circuit underwriter malaise by assuring that an intellectual challenge remains. Other insurers stress frequent communication with the branch office underwriters to reassure them of their value. Still others provide challenge through performance-based financial incentives.

Underwriter burnout is "a management and motivation issue," said John P. Coonan, assistant vp at Chubb Corp. and assistant national director of the Warren, N.J.-based insurer's Executive Protection Division.

"To me, underwriter burnout is a condition where underwriters have worked themselves into a situation where they've lost enthusiasm for the job," he said. The malady also can manifest itself in hampered "ability to be civilized" in dealings with brokers and clients.

Stress is the root of underwriter burnout, explained Angus Robinson, president and chief executive officer of Minneapolis-based NWNL Reinsurance Co., a subsidiary of Northwestern National Life Insurance Co.

During the past three or so years, stress has been fueled by "dramatically changing" policy forms, Mr. Robinson said.

Also, some companies have become insolvent, while financial problems have forced others to lay off employees. "Cutbacks have happened," which have fueled underwriter insecurity, noted Mr. Robinson.

Harold S. Swann, senior vp and head of the facultative division of Princeton, N.J.-based American Reinsurance Co., a unit of Aetna Casualty & Surety Co., agrees that underwriters are suffering from increased demands and reduced job security.

'There wasn't a lot of pressure in regard to (job) security issues' a decade or so ago, says Harold S. Swann. 'Underwriters are being asked to do too much to some extent. Support isn't keeping up with the amount of work they have to handle.'

tions were less favorable than they had been, Mr. Coonan said.

In the soft market, underwriters have to work hard at "trying to communicate with your brokers and customers why they should stay with you" rather than switch to an insurer with a seemingly better price, he added.

"Other underwriters are trying to write more business. As a consequence, they're trying to shoot at your book," Mr. Coonan said.

One of the best tactics for easing underwriter stress is making sure the underwriters know that management is not out to second-guess them, said Mr. Swann of American

Re.

Managers need to make frequent visits to branch offices, he said, adding that "our people are close to our field." Face-to-face contact with the underwriters is invaluable, he said.

Giving underwriters a greater financial stake in their job is one way to combat burnout, according to Fred G. Marziano, president of the agency and brokerage groups of New York-based Continental Corp.

Last year, Mr. Marziano launched a new program that makes underwriters part of "business teams that pair underwriters with marketing officials." He hopes to have the plan fully imple-

mented within three to five years, he said.

Under the Continental Corp. plan, an underwriter and a marketing representative work together on a business plan so that they will share common objectives. In many cases, both the underwriter and the marketing representative will visit producers.

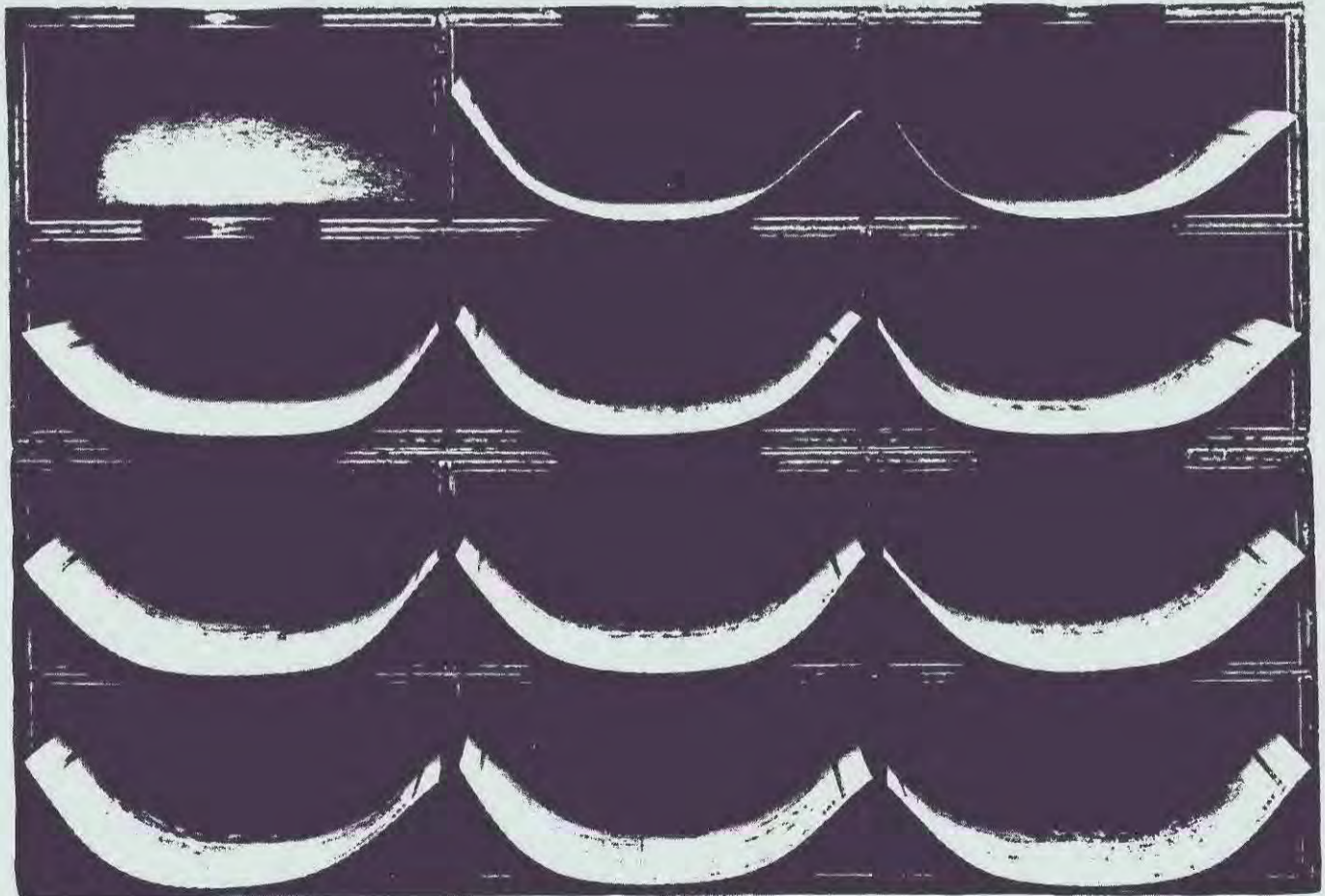
But Mr. Marziano made clear that marketing is not synonymous with a slick sales pitch. Marketing means addressing opportunities, he said. "This is not a glad-handing sales person" approaching a producer, he said.

Under the plan, underwriters are encouraged to write business with

Continued on next page



Pacesetter



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Insurer topics

Underwriter burnout

Continued from previous page

which they feel comfortable, he said. It should be business that can be supported with claim and loss-control expertise as well as underwriting knowledge.

Mr. Marziano said that through this approach, Continental is "trying to resurrect the professionalism in underwriting. I think it's gone by the wayside in the past decade or so."

In addition, Continental wants to develop "a significant profit-sharing program" for underwriters, he said. Each year, underwriters would be eligible for a larger share of the profits for which they were responsible, he said. After three years, a cap would be put on their shares, probably at twice their annual salary.

The profit-sharing program "ties them closely to the objectives of the corporation," he said. If underwriters have the opportunity to remain underwriters rather than having to become managers to advance, the company will benefit in several ways, Mr. Marziano said.

The underwriters become increasingly familiar with their territories and their specialties, Mr. Marziano said. The increased familiarity leads to a heightened understanding of their office's book of business, he added.

Better understanding of the book of business, in turn, leads to better retention rates, which can mean greater profitability, he said.

At the same time, Continental profits by not having to train as many new underwriters as might be expected because experienced underwriters have a direct finan-

cial incentive for remaining in their field of expertise rather than deserting it for a climb up the corporate ladder, Mr. Marziano said.

But he made clear that underwriters who choose to share in the profits through bonuses must also accept the risk of failure. Those who do not achieve their goals face loss of bonus, reassignment or even termination, he said.

"I'm saying we have a career position open to you. If you can make profitable decisions, you can share in the profits," Mr. Marziano said.

He made clear, though, that with responsi-

By developing a profit-sharing program for underwriters, Continental will be able to retain experienced underwriters who have a direct financial incentive for remaining in their field of expertise rather than deserting it for a climb up the corporate ladder, says Fred G. Marziano.

bility comes accountability. "If they are going to be professionals, they have to be accountable for the results," Mr. Marziano said.

Despite these risks, the response to the program has been "terrific" among underwriters, Mr. Marziano said, adding that turnover already has been reduced.

Schaumburg, Ill.-based Zurich-American Insurance Cos. began researching its Field Office Commercial Underwriting System—or FOCUS—in 1986 in an effort to reduce underwriters' daily frustrations and improve their efficiency and professionalism, said James S. Davis, vp and director of under-

writing in standard lines.

The program began when Mr. Davis and other home office managers visited and interviewed branch office underwriters to learn how the productivity of underwriters could be improved.

Mr. Davis did not like what he found: Underwriters appeared to be spending 80% to 85% of their time filling out forms or gathering information on their accounts rather than making underwriting decisions. "Our goal is to turn those percentages around," he said.

Although FOCUS is an ongoing project,

some reforms have been instituted since the research was completed in late 1987.

An attempt has been made to cut down the volume of paper with which an underwriter must deal. For example, Mr. Davis said that underwriters formerly had to complete as many as nine pricing forms for a single piece of business. That has been reduced by at least half, he said, through pricing form consolidation.

The company also has made underwriting information, like loss control reports, easier for underwriters to access through electronic data systems, Mr. Davis said.

A new employee orientation program also

has been introduced. "We didn't have a fool-proof acclimation system," he explained. The program is designed to have new employees learn their employer's business process before they become deeply entrenched in their routines, he said.

Such enhanced efficiency should reduce the chances of underwriter burnout, Mr. Davis said, noting that burnout flares when an underwriter is asked to always be "in a stressful mode." During a soft market, underwriters especially think they are under constant stress while being overworked, he said.

One means of combating burnout is to assure that staffing is adequate, Mr. Davis said. If underwriters' workloads are too heavy, assignments can be shifted or extra staff allocated to a given branch office, he said.

William Davenport, second vp of the national accounts group for Travelers Insurance Co. of Hartford, Conn., said that while he has not seen any cases of underwriter burnout recently, he saw plenty during the last soft market.

Insurers must accept the blame for that, he said.

"We tried to send a conflicting message—grow and do so profitably," he said. The task proved to be impossible.

"Now, we want to keep these people focused on underwriting," Mr. Davenport said.

"What we try to say to them is not to lose confidence in their decisions," he said. "In some cases, an underwriter will not be able to manage an account in a way that is acceptable" to him or her, Mr. Davenport added, explaining that underwriters must be made to understand that losing such an account is not a sign of professional failure. ■

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Personal visits crucial to relations between insurer, branch offices

By MARK A. HOFMANN

When the property/casualty insurance market begins to soften, communication between an insurer's home office and its branches becomes particularly critical, insurance underwriting executives agree. But as Marshall McLuhan once wrote, the medium can be as important as the message.

For example, as the current soft market became pronounced last year, many insurers relied on automated management information systems to monitor branch office underwriting results on a branch-by-branch, line-by-line and, in some cases, even an underwriter-by-underwriter basis (IT, March 28, 1988).

Company executives, who generally had not had access to such systems during the soft market of the early 1980s, found themselves able to pinpoint problem areas and deviations from company underwriting guidelines.

However, insurers insist that even the best automated system cannot replace the personal touch; no amount of electronic mail can replace visits by managers.

"Our senior management travels to our field offices on a regular basis," said Michael Mitchell, vp-underwriting operations for the Morristown, N.J.-based Crum & Forster Inc.'s commercial insurance companies. "It gives the folks out there the feeling they can communicate with the ivory tower."

The hierarchical structure of many insurance companies discourages effective communication between home offices and branches. The more layers a message must filter through, the more likely communication will falter, said Harold Swann, senior vp and head of the facultative division of Princeton, N.J.-based American Re-Insurance Co., a unit of Aetna Casualty & Surety Co.

"Keep the lines of communication as short as possible. The more you string them out, the more the underwriters become isolated from the policy makers," Mr. Swann said.

To achieve what he called a "hands-on approach" to communication between home office and branch office, Bruce P. Berthelsen, senior vp and Eastern zone executive for Novato, Calif.-based Fireman's Fund Insurance Co., logged about 250,000 airline miles in 1988.

Mr. Berthelsen, who is responsible for 20 branch offices in the Eastern Seaboard states plus Indiana, Kentucky, Michigan and Ohio, said Fireman's Fund's zone executives comprise the main channel of communications between the insurer's home office and branches.

"There isn't any broad form of communications that issues out of San Marin daily," he said, referring to the home office's address: 777 San Marin Drive in Novato. Instead, each branch runs as an independent profit center, he said.

"We look at each operation by itself; things are different all over the country," Mr. Berthelsen said.

"I spend a lot of time with as many people as I can, both producers and staff," he added. He estimated that he spent perhaps as much as 80% of his work time on the road last year.

Zurich-American Insurance Cos. uses a variety of communication methods, said James S. Davis, vp and director of underwriting in standard lines for the Schaumburg, Ill.-based insurer. The company has an electronic mail system through which it sends periodic bulletins on underwriting issues and underwriting officials make personal visits to branch and regional offices.

"Even if we go out to an office for a different purpose, we make sure we take time to talk to the underwriters," he said. ■

Business Insurance

Long-term care tests underwriting skills

By ALISON KITTRELL

Life/health insurers entering the growing market for long-term care insurance face a major challenge: How to underwrite the coverage.

Long-term care insurance generally is triggered when a person is unable to care for himself and requires home health care, adult day care or nursing home care. But, determining when a person has lost "functionality" is very different from other life and health insurance decisions.

"This is a whole new area, and you want to make sure you are not excluding people who are not really at risk for functional dependency," says JoAnn Mathieu, director of long-term care for Aetna Life Insurance Co. in Hartford, Conn.

Insurers are taking basically similar approaches to underwriting long-term care insurance—with a few twists.

Aetna, for example, has offered group coverage that can be purchased by active employees or retirees since June 1987.

Ms. Mathieu said that active employees who sign up when they first become eligible for the coverage do not undergo any health screening. "From a risk standpoint, they are not the high risk," she explained. But employees who do not sign up when they first become eligible—as well as retirees who wish to purchase the coverage—must fill out a health screening underwriting form.

Aetna has turned down about 25% of the 15,000 long-term care coverage applications it has received since July, she noted.

The 14-question form is designed to "target things that render people functionally dependent," Ms. Mathieu said. Aetna conducted extensive research to formulate the questions, using some 50 outside medical and social service consultants.

The completed forms are evaluated by registered nurses on Aetna's medical underwriting staff. If the nurses have a question about an applicant's answers, they can request additional medical information from the applicant to assess whether coverage should be written.

Ms. Mathieu also said that part of Aetna's underwriting philosophy for long-term care is its computerized data tracking.

"Every single person that makes an application is entered into the computer," she said. "Then, every three months or so, we go in and look at this data base and say, 'How many people have been declined for this certain condition? Are we declining for the right reasons?'"

The computerized tracking also lets Aetna catch cheaters—rejected applicants who reapply for the coverage with changed answers. But the program primarily allows Aetna to observe loss experience and make needed changes, she said.

"After all," Ms. Mathieu said, "the objective of underwriting is to get in the broadest base you can... it is not to exclude people."

Hartford-based Travelers Corp. also offers long-term care insurance to active workers, retirees, spouses, parents and parents-in-law, ages 18 to 79. The company has offered the program since late 1986.

An eight-question application was devised by a doctor and a medical underwriter in Travelers medical underwriting department, with the aid of employee benefits experts at Travelers, the spokesperson said.

Regarding the long-term care questionnaire, "Our underwriting philosophy basically is, 'What is the future potential of a condition to affect an individual's ability to perform the activities of daily living.'"

The forms are evaluated by Travelers' medical underwriters. If questions arise, the underwriters request an attending physician's statement.

"What it comes down to is their (applicant's) ability to function," the spokeswoman said.

Metropolitan Life Insurance Co. in New York is planning to offer a group-sponsored long-term care program later this year. The plan will be available to active employees, spouses, retirees, parents and parents-in-law.

Met Life has been offering long-term care coverage for retirement communities since 1985, however, and is using that knowledge to underwrite the employer-sponsored coverage, said James B. Weil, vp of

senior services.

All applicants for the retirement community coverage were "fully underwritten," he said, meaning they filled out a questionnaire, submitted a physician's statement and underwent a medical exam before policies were written.

"The purpose of that was to be better able to understand the reliability of the information we get," Mr. Weil said.

Applicants for Met Life's employer-sponsored coverage will be asked to fill out a short questionnaire. Based on their answers, applicants then may be asked to provide a physician's statement or undergo an exam.

The short form represents more

than a year of work, Mr. Weil said.

First, Met Life staffers studied all types of medical diagnoses and evaluated their risk of causing the need for long-term care. "We then evaluated over several dozen other conditions having to do with lifestyle... as well as personal history, and we attempted to put point counts on how much of a risk each of these conditions presented in terms of needing long-term care," he said, adding that applicants could acquire both positive and negative points.

Met Life then asked outside geriatrics specialists to evaluate the questionnaire. As a result of this process, Mr. Weil said, "We have what we think is a very, very comprehensive and very fair evaluation system."

UNUM Life Insurance Co. in Portland, Maine, also is preparing to offer an employer-sponsored group long-term care plan early this year. The plan will be available only to active employees and their spouses, not to retirees or parents of employees.

"We are targeting active work-age people, and our medical questions are not targeted to the elderly," said Edward F. Reed, product manager.

But applicants for UNUM's program will have to undergo an individual underwriting process, filling out a short-form questionnaire about family history and current medical condition. The form was developed by UNUM's medical department, drawing heavily on the company's LTD insurance expertise. ■

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Business Insurance

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Joint Hull Committee permits independent renewal rates

By CAROLYN ALDRED

London

LONDON—The Joint Hull Committee, which includes Lloyd's of London and London company marine underwriters, for the first time is allowing underwriters freedom in setting renewal terms for hull insurance.

Previously, under part of the London marine market's Joint Hull Understandings, underwriters needed to obtain permission to set any renewal rate below the committee's minimum renewal terms.

The minimum renewal rating was introduced earlier this century to prevent excessive competition.

However, the continued worldwide softening of marine insurance rates during the last few years has made it impracticable to restrict rate reductions, observers say.

The old system also was politically sensitive and raised concern among officials at the European Commission responsible for competition within the Common Market, sources say.

The Joint Hull Understandings were amended earlier this month so that renewal terms need only be agreed to by the two leading Lloyd's and two leading company underwriters on each policy.

However, "if the terms for renewal are outside the guidelines of the graph, it is strongly recommended that the four leaders should consult before any quotation is made and the result of their deliberations reported to the Joint Hull Committee by the slip leader," the new understanding reads.

"In the event of disagreement between the leaders over the renewal terms, the case should be submitted to the Joint Hull Committee for adjudication," it states.

"The impact of this change means that leaders of hull policies now carry the total responsibility to negotiate renewal terms without the moderating influence of the Joint Hull Committee," the committee said in a statement.

Italian business

Lloyd's of London underwriters hope to double the amount of Italian insurance business they write with the establishment of a unique facility formed by two Lloyd's brokers and nine leading Italian brokers.

The nine Italian insurance brokers have formed a company called Consulenze e Servizi Assicurativi to help administer a binding authority delegated to the brokers by Lloyd's underwriters.

London-based brokers Alexander Howden Group Ltd. and Willis Faber P.L.C. are responsible for placing the non-marine and marine line slip and the binding authority agreement in London.

Under the binding authority

agreement, the Lloyd's underwriters will write property insurance, liability insurance, personal accident insurance, construction risk coverage, marine cargo/goods in transit insurance, financial/political risks insurance, bankers blanket bonds, jewelers block insurance, contingency risk insurance, professional liability insurance, and directors and officers liability insurance.

As part of the agreement, "substantially higher limits may be bound on behalf of Lloyd's underwriters where the facility is used in respect of coinsurance participations on policies on which established Italian insurance companies lead the coinsurance schedule," according to a statement issued by Alexander & Alexander Europe P.L.C.

CSA plans to have offices in Genoa and Milan by mid-April. The company's chairman will be Renzo Savigni, formerly managing director of Mutua Maritima Nazionale in Genoa.

The additional premium revenues likely to flow into Lloyd's initially "will double the premium currently received by Lloyd's on direct Italian business, estimated at approximately 4 billion lira (\$2.96 million)," said A&A Europe.

Outhwaite summons

Lloyd's of London underwriter Richard Outhwaite is asking a London High Court judge to disqualify London law firm Herbert Smith & Co. from representing another Lloyd's underwriter in an action against Mr. Outhwaite.

In a summons filed in London's Commercial Court, Mr. Outhwaite, underwriter for syndicate 661, seeks "an order directing the (law firm) to cease to act for J.M. Bazell and all other members of syndicate number 90 at Lloyd's in an arbitration commenced by J.M. Bazell against (Outhwaite) and all other members of syndicate 661."

The arbitration is being held to settle a dispute surrounding a runoff reinsurance policy ceded to Mr. Outhwaite by syndicate 90.

Mr. Outhwaite claims that lawyers at the firm had access to "privilege or confidential information (that) was communicated during the course of (Outhwaite's) retainer of" Herbert Smith.

German representative

Lloyd's of London's first general representative in West Germany began work this month in Frankfurt.

Wolfram Kausche "will assist the Lloyd's market to develop its business in West Germany (and) be

responsible for ensuring that Lloyd's activities comply with West Germany's insurance regulations, Lloyd's said.

Currently, Lloyd's West German premium revenues total about 100 million pounds (\$174 million) and are produced through West German intermediaries.

However, "Lloyd's is awaiting formal approval for its application to transact non-marine business," the Lloyd's statement said.

Health centers

British United Provident Assn., Britain's largest medical and health insurer, is setting up 17 regional occupational health centers throughout Britain.

The centers will provide advice and consultation on employee health matters to companies on a fee basis, said a BUPA spokesman.

"The plans will assist many companies to cut down on absenteeism, eliminate health hazards at work and generally improving working conditions," said Lord Wigoder, BUPA's chairman.

Persian Gulf losses

A U.S. Supreme Court decision has dashed London marine underwriters' hopes of using a New York Court of Appeals decision in a similar case to recover massive shipping losses sustained during the seven-year war between Iran and Iraq.

The Supreme Court ruled Jan. 23 that the owners and charterers of an oil tanker destroyed by Argentinian military aircraft in the 1982 Falkland Islands War cannot claim compensation from Argentina for the loss.

The Supreme Court decision overturned a New York Court of Appeals ruling in favor of the plaintiffs, which was filed under the U.S. Alien Tort Act, a statute enacted in 1789 that provides jurisdiction in any civil action by an alien for a tort "committed in violation of the law of nations or treaty of the United States."

Donald O'May, a leading London maritime lawyer who died in December, last year advised London war risk underwriters of the possibility of suing Iran and Iraq on similar grounds if the New York appellate decision was upheld (*BI*, May 23, 1988).

However, the Supreme Court last month ruled that the original New York state court considering the case "correctly dismissed the action, because the Foreign Sovereign Immunities Act of 1976... does not authorize jurisdiction over a foreign state in this situation." ■

Health care costs

Continued from previous page

Kingdom "it would be very, very rare to sue a doctor," according to Mr. Bernstein.

Other hidden costs in the U.S. health care system include insurers' profits and marketing costs, pointed out Dr. Kane of the University of Minnesota. Countries that provide nationalized health insurance do not incur those costs, he noted.

Further inflating U.S. health care costs is the fact that individuals lack incentives to contain health care consumption because they directly pay for only about one-quarter of their health care costs, according to Wyatt's Mr. Schieber.

According to HCFA, direct patient payments accounted for 25% of total health care expenditures in 1987. Insurers and self-funded employers paid for 34% of the expenditures, and government programs, such as Medicare and Medicaid, paid for the remaining 41% of health care expenditures.

"We've taken the price decision out of the consumption choice," Mr. Schieber said. "Over the years what we've done is we've structured a market where people can buy fairly extravagant kinds of health care" without having to foot the bill for it, he explained.

Additionally, in the United States those who determine treatment—physicians primarily—have a financial stake in patients receiving the most treatment, observed Mr. Davis of The Stanley Works.

A minor factor contributing to greater U.S. health care spending than other countries is demographic differences, noted Mr. Bernstein of Hewitt.

For example, in Japan several generations of a family living together still is very prevalent, he said. Younger people in the household provide medical care for older people, which does not show up as a health care expenditure, he explained.

This phenomenon also is true in Europe but to a lesser degree, Mr. Bernstein added. ■

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Union Carbide

Continued from page 1

Hundreds more have died from the effects of their exposure since the accident, with the Indian government placing the death toll at more than 3,300.

Lawyers for Union Carbide and the Indian government quickly agreed to the \$470 million settlement, which is to be paid as a lump sum by March 31 into an account controlled by the court.

Under the settlement terms, Union Carbide will pay \$425 million, less \$5 million in emergency relief funds the company contributed to the Indian Red Cross in 1985. The remaining \$45 million will be paid by Union Carbide India Ltd., which operated the pesticide plant and was 50.9% owned by Union Carbide.

The settlement will resolve all civil and criminal litigation between the government and Union Carbide, including homicide charges against Warren Anderson, the company's chairman at the time of the accident.

How the money will be distributed among more than 500,000 claimants—or how it may be put to other uses—is still to be determined.

Processing of the claims is expected to take some time, however.

Although the settlement has been criticized as inadequate by groups representing Bhopal victims, it was a "fair deal" for both sides, noted Bruce A. Finzen, a lawyer with Robins, Kaplan, Miller & Ciresi, a Minneapolis law firm that represented the Indian government.

The settlement caps more than four

years of litigation that followed the worst industrial accident in history.

In the year after the gas leak, roughly 150 lawsuits were filed against Union Carbide in U.S. courts in 14 states on behalf of more than 200,000 individual claimants.

The Indian Parliament passed legislation in April 1986 making the Indian government the sole representative for all victims of the disaster, and a month later a federal judge in New York ruled that the government's lawsuit against Union Carbide should be transferred to an Indian court.

More than two years of litigation and settlement talks in India ensued. Union Carbide had offered to settle the claims for \$300 million and agreed to ask its board of directors to increase the offer to \$350 million under certain circumstances.

This offer was rejected by the Indian government, which originally sought \$3 billion in damages and later offered to settle for \$630 million.

The settlement came last week while Union Carbide was appealing a lower court order that it pay \$190 million in interim compensation before the case went to trial.

Union Carbide is expected to pay the majority of the settlement from its own earnings.

In announcing the agreement, the company said it will take a retroactive charge of up to 50 cents per share, or about \$68.8 million, against 1988 earnings.

Union Carbide previously charged \$185 million against 1985 earnings and \$85 million against 1987 earn-

ings, most of which related to Bhopal claims and expenses, a Carbide spokesman said.

Meanwhile, the company's liability insurers will be called on to pay less than half the settlement, and part of this amount may end up coming from a state guaranty fund on behalf of three insurers that became insolvent after the Bhopal disaster.

For the 1984 policy year, Union Carbide had a \$500,000 primary liability policy and a \$2 million lead excess policy written by American Motorists Insurance Co., a Kemper Group unit.

The American Motorists excess policy, however, contained a \$2 million deductible, making it a fronting policy for a self-insured retention.

Above the \$2.5 million in underlying coverage was an eight-layer umbrella liability insurance program with limits of \$200 million (BI, Dec. 24-31, 1984; Dec. 10, 1984).

However, \$32.5 million of the \$200 million in coverage was written by now-insolvent insurers. Union Carbide is now suing the Connecticut Insurance Guaranty Assn. to recover the limits of excess policies written by Transit Casualty Co., ordered liquidated in 1985; Midland Insurance Co., ordered liquidated in 1986; and Integrity Insurance Co., ordered liquidated in 1987 (BI, Feb. 13).

Union Carbide already has collected the limits of the American Motorists policies, and Royal Indemnity Co. spokesman said Royal has paid Union Carbide the \$5 million limit of its first-layer umbrella policy.

However, several umbrella insurers writing in layers above Royal's have not been formally notified of the settlement or asked to tender their limits. While these insurers expect the request shortly, some have been less than pleased with what they perceive as high-handed treatment by

Union Carbide during defense and settlement of the Bhopal litigation.

Leonard Sheft, a lawyer with the New York firm of Sheft & Sweeney, representing five excess insurers, said they had not been formally notified by Union Carbide of the settlement.

"Whatever we know, we've read in the paper, which has been fairly typical of our relations with Carbide in this case," said Mr. Sheft, noting that communications between the chemical company and its insurers "have not been the best."

"The carriers really have not been included at all in what's going on," said a spokesman for one excess insurer who requested anonymity. "Insurers are really angry that they were excluded."

Union Carbide was "being very presumptuous" during Bhopal defense and settlement proceedings, said the claims representative of an excess insurer who requested anonymity. "They were dictating to the insurance companies what was going on."

However, this source also faulted some of the excess insurers for preferring to "pout and sit in the corner" rather than insist on a more active role in defense and settlement talks.

Sources familiar with the investigation of Bhopal claims say the insurers initially estimated compensatory damages from the disaster at between \$45 million and \$60 million, based on payouts from other catastrophes in India.

However, publicity surrounding the accident and pressures on the Indian government and Union Carbide made a larger settlement inevitable, sources say.

In retrospect, it would be difficult to value the death and injury claims at \$60 million given the fact that the Indian government expended

\$70 million in relief efforts alone, one source said.

Despite complaints about Union Carbide's stance in the litigation, though, officials and representatives of several insurers agreed that coverage disputes are unlikely.

"One should not attack the reasonableness of a settlement where Carbide pays more than its insurers," Mr. Sheft said.

Union Carbide's liability insurance program excess of the \$5 million first-layer Royal policy was structured as follows:

- A second layer of \$18.5 million with Transit Casualty participating for \$10 million, London markets for \$4.5 million and National Casualty Co. of Southfield, Mich., for \$4 million.

The London market portion comprises a 32.65% participation through the Policy Signing and Accounting Centre, a policy issuing organization for non-Lloyds of London non-marine underwriters, and a 67.35% participation by other London market insurers.

National Casualty, a unit of Nationwide Corp., participated through an affiliate, Scottsdale Insurance Co. of Scottsdale, Ariz.

- A third layer of \$20 million excess of \$23.5 million, with International Surplus Lines Insurance Co., a Crum & Forster Inc. unit, participating for \$5 million; Integrity for \$5 million; and London markets for \$10 million.

The London market portion consisted of a 13% participation by Lloyd's underwriters, a 49% participation by PSAC and a 38% participation by other London insurers under two policies.

- A fourth layer of \$29.5 million excess of \$43.5 million, with ISLIC participating for \$10 million, Midland for \$6.5 million and London markets for \$13 million.

The London market portion included a 31.2% participation by Lloyd's underwriters, a 42.5% participation through PSAC and a 26.3% participation by other London insurers under two policies.

- A fifth layer of \$27 million excess of \$73 million. Participants on this layer are Gibraltar Casualty Co., a unit of Prudential Reinsurance Co., for \$10 million; American International Underwriters, an American International Group Inc. unit, for \$7 million; Royal again for \$5 million; and Midland again for \$5 million.

- A sixth layer of \$50 million excess of \$100 million. Granite State Insurance Co., another AIG unit, wrote a \$10 million portion of this layer, while AIU wrote an additional \$7 million in limits. Other participants were Gibraltar for \$9.625 million; London markets for \$8.375 million; Transit Casualty for \$5 million; American Centennial Insurance Co., a unit of First Delaware Holdings Inc., for \$5 million; and New England Reinsurance Corp., a Hartford Insurance Group unit, for \$5 million.

The London market portion consisted of a 29.85% participation by Lloyd's underwriters, 28.36% through PSAC and 41.79% by other London insurers under two policies.

- A seventh layer of \$25 million excess of \$150 million, written largely by three Hartford units: New England Re participated for \$5 million, Twin City Fire Insurance Co. for \$5 million and First State Insurance Co. for \$10 million. The fourth participant on this layer, Republic Insurance Co., a Winterthur Swiss Insurance Co. unit, wrote a \$5 million limit.

- An eighth layer of \$25 million excess of \$175 million. National Union Fire Insurance Co. of Pittsburgh, Pa., an AIG unit, wrote a \$5 million portion of this layer, while Granite State participated for \$2 million and AIU for an additional \$1 million. Other participants were Allianz Underwriters Insurance Co. of Los Angeles for \$8 million; Insurance Co. of North America, a CIGNA Corp. unit, for \$5 million; Republic for \$3 million; and Integrity for \$1 million.

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Program forecasts loss, claims trends

The Fisher Associates, a unit of Surplus Risk Services of Torrance, Calif., is marketing a computer software program designed to help self-insurers forecast future loss and claims trends for general liability, workers compensation and property exposures.

The program, the FORErisk Risk Management Information System, operates from a menu system and allows self-insurers, among other things, to:

- Provide dollar totals by year of all outstanding claims and chart their future potential impact. The projections can also include user-provided inflation projections and investment returns.

- Establish hindsight studies, which review the accuracy of past reserve behavior compared with actual claims payment to show the adequacy of past reserving practices.

- Run time series analyses including multiplicative trend analyses, which provide claims projections based on past behavior of claims, payments and reserves; seasonally adjusted trend analysis, which provides similar reports with seasonal trend analysis; linear regression studies, which provide graphic reports of the relationship of one variable, like paid claims, with another variable, like monthly sales.

System file update capabilities allow users to tailor claim files to their own specifications; enter variables like inflation rates and investment returns; and design custom graphic displays.

FORErisk will generate for users a 50% savings over the cost of outside actuarial consulting and accounting advice, according to Frederick J. Fisher, president of The Fisher Associates and Surplus Risk Services.

"Our software is the only affordable, user-friendly software that will allow municipalities to meet 1990 Government Accounting Standard Board requirements, which require that loss reserve and IBNR estimations appear on public entity balance sheets and be adequately budgeted," Mr. Fisher claims (BI, Nov. 30, 1987).

The software for self-insurers requires an IBM personal computer or compatible with 640 kilobytes of random access memory.

Each of the FORErisk modules—property, general liability and workers compensation—costs \$2,950. Discounts are available for the purchase of more than one module.

An insurance company version of FORErisk will be released this summer.

This product will allow insurance companies to track claims data against number of policies sold. This allows the insurer to track frequency and severity factors to predict future loss ratio trends.

For more information, contact The Fisher Associates, 3465 Torrance Blvd., Suite N, Torrance, Calif. 90503; 213-540-8803.

HMO evaluation

DEMOTTECH Inc. offers employers an evaluation of the financial condition of health maintenance organizations.

"Employers talk about being scared of the HMO option because of the issue of financial stability," said Joseph L. Petrelli, president of DEMOTTECH, a Columbus, Ohio-based consulting firm that specializes in analyzing the financial stability of HMOs.

Using financial information from HMOs' annual statements filed with state regulators, DEMOTTECH assigns each HMO a rating based

Products & services

on its assessment of the HMO's ability to maintain financial stability throughout the coming year.

The firm also publishes an "HMO Rating Guide" listing financial information and its ratings of all licensed HMOs in the states of Ohio, Michigan, West Virginia and Kentucky.

Mr. Petrelli, who is an actuary, worked as a consultant to the Ohio Department of Insurance from 1983 to 1986.

DEMOTTECH developed its "Financial Stability Analysis Model" computer program in 1985 by analyzing hundreds of financial statements from both financially stable

and unstable HMOs.

To perform the computer analysis on a given HMO, DEMOTTECH uses the HMO's annual statements for the current year, plus the statements of the two previous years.

In the analysis, the following financial criteria are assigned a weighted value: total current assets; working capital; total liabilities; total property and equipment; net income; retained earnings; total assets; total current liabilities; net worth; total revenue; comparison of actual vs. budgeted revenues and expenses; receivables; and total expenses.

The HMO then is assigned a fi-

ancial stability rating.

DEMOTTECH ratings are as follows:

- "A," meaning above average financial stability is expected over the next calendar year.

- "B," meaning average financial stability is expected over the next calendar year.

- "C," meaning that some financial stability is expected over the next calendar year.

- "I-Y," meaning that the HMO is ineligible for a rating because DEMOTTECH requires a minimum of three complete calendar years of business to assign a rating.

- "I-N," meaning the HMO is ineligible for a rating because DEMOTTECH requires an HMO to have a positive statutory insurance accounting net worth to assign a rat-

ing.

In its "HMO Rating Guide," DEMOTTECH includes an HMO's financial statement as filed with state insurance departments and information on the HMO's officers and directors.

The firm also provides HMOs with an opportunity to include in the guide their own written discussions of their financial conditions.

DEMOTTECH currently has no plans to expand its rating guide to cover HMOs in other states, but will offer analysis on individual HMOs.

The available state guides sell for \$199 per copy. For a copy of a rating guide or for more information, contact DEMOTTECH Inc., 2941 Donnylane Blvd., Columbus, Ohio 43235; 614-761-8602.



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Companies adjusting health benefits: GAO

By DEBORAH SHALOWITZ

WASHINGTON—Most companies surveyed by a federal agency say they have the right to modify or terminate health care benefits for active workers and retirees, and many company officials say they are considering changing their retiree health care plans in the future.

In a survey of 29 companies with retiree health plans in the Chicago area, the U.S. General Accounting Office found that specific language in the plans of 27 of the 29 companies reserves the companies' right to modify or terminate the plans.

Furthermore, officials of 21 of the companies said they are considering changing their retiree health care plans in light of new

Washington

accounting standards for retiree health care liabilities released by the Financial Accounting Standards Board (see story, page 1).

Changes to retiree health care plans that the 21 officials say they are considering include:

- Varying health benefits based on the length of employment.
- Placing a varying dollar cap on annual medical payments based on length of employment.
- Allowing workers to choose from among a variety of pension and welfare benefits.
- Setting up individual medical fund accounts to help active workers purchase health insurance when they retire.

All of the 29 companies surveyed by the GAO changed their health care plans—affecting both active workers and retirees—between 1984 and 1988, the report says. The changes primarily involved adding cost-containment measures such as utilization review or raising the amount plan participants pay for coverage and medical services.

The 29 companies had a total of approximately 321,000 active workers and 137,000 retirees, with the number of workers per firm ranging from 186 to 50,000 and the number of retirees per firm ranging from 12 to 39,000.

Copies of the report, "Employee Benefits: Company Actions to

Limit Retiree Health Costs," are available by writing the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, Md. 20877; 202-275-6241. The first five copies are free. Additional copies are \$2 each. Orders must be prepaid with cash, check or money order made out to the Superintendent of Documents.

Education benefits

Employer-provided educational assistance benefits would be taxable to workers under a bill introduced in the Senate late last month.

The bill, S. 260, introduced by Sen. Daniel Moynihan, D-N.Y., would extend and make permanent a section of the Internal Revenue Code that allows employees to re-

ceive on a tax-free basis up to \$5,250 annually in employer-provided educational benefits such as tuition reimbursement and outside training.

Section 127 of the IRC had expired Dec. 31, 1987, but Congress extended it retroactively from Dec. 31, 1987, to Dec. 31, 1988, in the waning days of last year's session (BI, Oct. 31, 1988).

Sen. Moynihan's bill, which has nine co-sponsors, permanently would extend the exemption.

Also, S. 260 would allow graduate-level courses to be included in the tax-free benefits. Congress' extension of the bill last year did not include these courses.

"Section 127 is not some extravagant fringe benefit for highly paid executives," Sen. Moynihan said.

"Employees earning less than \$30,000 (annually) participate at a much greater rate than those above that income and participation rates decline as salary levels increase," he explained. "Moreover, employees making less than \$15,000 participate at almost twice the rate of those who earn over \$50,000."

Rep. Frank Guarini, D-N.J., plans to introduce companion legislation in the House in the next few weeks, according to a staffer.

New Section 89 bill

Support for legislation to delay or repeal Section 89 non-discrimination rules for welfare plans is growing on Capitol Hill.

More than 100 congressmen have joined in co-sponsoring a bill to repeal Section 89 introduced last month by Rep. John J. LaFalce, D-N.Y.

"The growing momentum behind this repeal effort demonstrates the increasing concern in the Congress about the adverse impact of Section 89," Rep. LaFalce said.

However, none of the co-sponsors of the bill, H.R. 634, serves on the House Ways and Means Committee, which controls the fate of this legislation.

Texaco fined

White Plains, N.Y.-based Texaco Inc. will pay a fine of \$750,000 for failing to conduct safety tests during oil drilling operations at an offshore platform on the California coast.

A U.S. District Court in Los Angeles approved the fine last month as part of a plea bargaining arrangement. The platform drilling supervisor also was fined \$5,000 and placed on probation for three years.

Injury reporting

Employers with 11 or more employees in certain industries must post during February a summary of the total number of job-related injuries and illnesses that occurred during 1988, reminds the Occupational Safety and Health Administration.

Since 1972, employers have been required to post the last page or right-hand portion of OSHA Form 200, "Log and Summary of Occupational Injuries and Illnesses." The form is to be displayed wherever notices to employees are usually posted. The form includes information on the type of injury or illness sustained, the extent of the injury or illness and the outcome.

Copies of OSHA Form 200 can be obtained by sending a self-addressed label to the closest OSHA field office or the OSHA Publications Office, Department of Labor Building, 200 Constitution Ave., N.W., Room N-3101, Washington, D.C., 20210; 202-523-9667. ■

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Stop-loss cover

Continued from page 2

Freddy Hamilton, director of Carritt & Partners, another leading stop-loss insurance broker. Last year, Carritt placed stop-loss insurance on a one-year basis for 5,000 members, Mr. Hamilton said.

Mr. Hamilton and Paul Fletcher, another Carritt director, explained that Lloyd's members had been expecting a "bumper" profit for 1986, which closed Dec. 31, 1988, under Lloyd's three-year accounting system.

But, because of currency exchange rate fluctuations, increasing long-latent disease claims and new tax laws reducing profits, "1986 will be disappointing to many names," Mr. Fletcher predicted.

"The member is going to think, 'If 1986 was a bumper year and this is all I got, and I have the October windstorm in 1987 and Piper Alpha in 1988, what's the point in being a member?'" Mr. Fletcher said, referring to Lloyd's share of the expected 3 billion pounds (\$5.31 billion) of losses from the hurricane-force winds that swept through Southeast England in October 1987 and the \$1.4 billion loss of the Piper Alpha oil platform in the North Sea last July.

Traditionally, a Lloyd's member buys stop-loss insurance to cover net underwriting losses, or losses that remain after the profits and losses of all the syndicates of which he is a member are aggregated. Normally, the member must pay his own net underwriting losses up to the equivalent of 10% to 15% of his annual premium income limit—known as the excess point—before stop-loss insurance responds.

Until this year, members could purchase a three-year policy with up to 1 million pounds (\$1.8 million) of limits with excess points of 10% to 15% through Holman Wade, said Mr. Wade.

However, a member typically bought only "a couple of hundred thousand pounds" of coverage for a premium of between 1,500 pounds and 2,000 pounds (\$2,655 and \$3,540), he said.

In recent years, the coverage has always been led in the Lloyd's market through facilities set up by Lloyd's brokers.

Not all of Lloyd's 31,000 members—who theoretically should be able to afford to pay their losses out of their personal reserves and fortunes—purchase stop-loss coverage. Many Lloyd's underwriters do not buy stop-loss insurance, for example, to show confidence in their underwriting abilities.

However, many Lloyd's members who do not buy the coverage call brokers to see whether the insurance is available, Mr. Wade said. "Even if people don't buy it, they like to know it's available. If it isn't available, they wonder why."

By the end of last year, however, few members could buy stop-loss coverage.

Two syndicates that specialized in writing stop-loss insurance and led some of the smaller line slips in the market stopped underwriting because of devastating losses.

Non-marine syndicates 134 and 184, underwritten by C.N. Mackinnon and managed by Mackinnon Hayter & Co. Ltd., reported 5 million pounds (\$7.25 million at year-end 1985 exchange rates) in losses for the years 1983, 1984 and 1985, according to Lloyd's League Tables for 1985, published by Chatset Ltd. last September.

The syndicates also were forced to keep their 1983 and 1984 accounts open because members for whom the syndicate wrote stop-loss coverage belonged to other syndicates whose accounts had been left open.

At the same time Mackinnon's stop-loss insurance syndicates stopped writing, Lloyd's marine

'The member is going to think, "If 1986 was a bumper year and this is all I got, and I have the October windstorm in 1987 and Piper Alpha in 1988, what's the point in being a member?" ' says Mr. Fletcher of Carritt & Partners.

underwriter Stuart Thompson decided that marine syndicates 80 and 843, managed by R.A.F. Macmillan & Co. Ltd., would pull out of the stop-loss insurance market from 1989. The syndicates had written the coverage under underwriter John Macmillan, who retired last year.

About 5.5 million pounds (\$9.7 million) of capacity was removed from the stop-loss insurance market when the four syndicates pulled out, according to Digest of Lloyd's News for members.

Other underwriters also decided to either pull out of the market or

reduce capacity.

The underwriters blame the situation on "the appalling experience" produced by stop-loss underwriting, summed up Seascope's Mr. Godfrey. The underwriters were hit particularly hard by the losses on syndicates that have been left open such as syndicates managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. and C.J.W. (Underwriting Agencies) Ltd.

Stop-loss insurance underwriters also may have been scared off by the Piper Alpha North Sea oil platform loss, which may trigger many members' stop-

loss policies, Mr. Godfrey said.

However, Mr. Wade believes underwriters pulled out because "like errors and omissions underwriters or professional indemnity underwriters, people get it into their heads that they don't want to write it."

While the stop-loss underwriters "sustained losses, they were not huge. Underwriters on our slip made a profit," Mr. Wade said.

The stop-loss insurance capacity crunch has forced brokers to search for new capacity to complete their facilities. Most have not yet completed the task.

For example, Holman Wade has had to replace syndicates underwritten by Mr. Macmillan, who led the broker's facility, and Mr. Mackinnon. Together, the two underwriters accounted for 18% to 19% of the slip's capacity.

The slip is now led by Lloyd's underwriter Eric Pieri and is more than 90% placed, Mr. Wade said.

Mr. Wade hopes the slip will be

completed within a week or so. But, "there could be a 10% coinsurance" requirement for the members if the broker cannot complete the slip, he said.

The slip should have been completed by the beginning of January, but the underwriters wanted to reduce the policy term to one from three years and to exclude coverage for members of syndicates that leave their accounts open, Mr. Wade said, adding that Holman Wade refused those conditions.

Carritt also is about a month behind in offering coverage "because of the state of the market," Mr. Fletcher said.

Carritt sent letters dated Feb. 17 to its clients offering coverage on a 10% coinsurance basis. "We haven't completed our coverage, but time is pressing on," Mr. Fletcher said in an interview.

Carritt still hopes to complete the line slip so members will not have to coinsure.

Continued on next page

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Stop-loss cover

Continued from previous page

Carritt's coverage, which will be offered only to renewals, will offer 100,000 pounds (\$177,000) in limits, the same as last year, and will be led by Lloyd's underwriter Derek Walker with an excess point of between 10% and 15%.

Also, Carritt can offer coverage of up to 250,000 pounds (\$442,500) excess of 100,000 pounds, the same as last year, said Mr. Fletcher.

However, the coverage will cost at least twice as much: Premiums have jumped to between 3,000 and pounds 7,000 pounds (\$5,310 and \$12,390) this year from 1,500 pounds to 2,500 pounds (\$2,655 and \$4,425) last year.

Lloyd's members' agents say Seascope is the only broker that has completed its line slip for traditional stop-loss coverage.

But Mr. Godfrey pointed out that the broker lost more than half of its market and has had to restructure the facility.

The policy, which so far is only being offered to previous policyholders, is for one year only with a 100,000 pound limit and an excess point of 10%.

Last year, the members could have purchased as much as 250,000 pounds of coverage on the slip, Mr. Godfrey said.

Premiums also have skyrocketed to between 2,500 pounds and 6,000 pounds (\$4,425 and \$10,620) for 100,000 pounds in

capacity from 1,800 pounds (\$3,186) for up to 250,000 pounds in limits last year, he said.

And, earlier this month Lloyd's broker Robert Fraser Insurance Brokers Ltd. launched a controversial personal stop-loss "insurance" policy.

The five-year policy has limits equal to 10% of a member's first-year allocated premium income, with a 5% excess point.

Thus, if a members' premium income capacity is 250,000 pounds, the policy would

The five-year Zurich International Ltd. policy 'is an interesting development, but it means that a person must take a long view of his membership at Lloyd's,' said the ALM spokesman, adding that the policy will not cover Lloyd's members for heavy losses.

pay a maximum of 25,000 pounds after the member paid the first 12,500 pounds in losses.

Premiums, set at an annual rate of 2% of annual premium income, are paid over the term of the policy.

If there are no claims after the five-year period, the member can recover up to 90% of the premium he has paid, and is taxed on his return premium. Or, the member can roll over the premium to pay for a subsequent five-years policy, be charged an extra nomi-

nal premium for the next five years of coverage, and continue to earn a tax deduction on the rolled-over premium.

The policy is written by Zurich International Ltd., a Bermuda subsidiary of Zurich Insurance Co. of Zurich, Switzerland.

Zurich is ceding a portion of the risk to Centre Reinsurance Holdings Ltd. in Bermuda, which is not retroceding any portion of its risk, said Centre Re Chief Executive Officer Steven M. Gluckstern.

losses prior to 1985. However, some agents personally benefitted from the investment income generated by the policy premiums paid to offshore companies. Rollovers have since lost favor at Lloyd's.

The five-year Zurich policy "is an interesting development, but it means that a person must take a long view of his membership at Lloyd's," said the ALM spokesman, adding that the policy will not cover members for heavy losses.

But Robert Fraser and Centre Re defend the coverage.

The policy, which has been approved by Lloyd's and the Inland Revenue, will cover 90% of the losses a member incurs, said Garth Bearman, chairman of Robert Fraser.

And, if members want to buy more coverage, the broker has completed two facilities that attach above the Zurich policy or can be purchased separately. The first facility, led by Lloyd's underwriter Vic Broad, offers 100,000 pounds of coverage excess of the Zurich policy. The second layer, led by Lloyd's underwriter David West, provides 150,000 pounds excess of Mr. Broad's coverage.

Robert Fraser hopes at least 3,000 members will buy the coverage. "A lot of triennial policies are ending this year. Can they get the cover they want or will they resign (from Lloyd's)?" asks Mr. Bearman.

"This concerns the 12th floor" of Lloyd's, the site of the Lloyd's chairman's office, he said. "Our policy will relieve this fear." ■

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Business Insurance Circulation Breakdown* Commercial Consumers

Administrative:	
CEO's Presidents and Owners	2,621
Vice-Presidents, General Managers and Other Administrative Personnel	3,657
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,993
Secretaries, Treasurers, controllers and other Financial Personnel	4,454
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	10,994
Sub-total	24,719
Associations:	
Government, Unions and Educational Institutions	477
Commercial Consumers	979
Sub-total	26,175
Insurance Agents and Brokers	10,557
Insurance Companies	7,380
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators	3,843
Others Allied to the Field	2,991
TOTAL	50,946
* Source: Business/Occupational breakdown of qualified circulation, May 30, 1988 issue, as submitted to BPA for June 1988 BPA Publisher's Statement.	

OIL announces 'preliminary' 50% rate hike

By ROGER SCOTTON

HAMILTON, Bermuda—Bermuda-based Oil Insurance Ltd., a petroleum industry group captive, says a "preliminary" 50% rate increase is not solely attributable to large claims in 1988.

"To say that we are increasing our 1989 rates by 50% because of last year is misleading. Our rate adjustments are based on a five-year claims period, rather than on a single 12-month period, said Ronald Massey, OIL's senior vp.

OIL losses in 1988 included the Jan. 2 Ashland Oil fuel spill into the Monongahela River near Pittsburgh and the July 6 explosion of the Piper Alpha oil rig in the North Sea (BI, July 11, 1988; Jan. 11, 1988).

"The losses last year will have an impact, but the rate increase is a rolling five-year figure which reflects debits and credits arising from our loss experience. It is unlikely that anyone is going to have to pay the full 50% increase, which is really an estimated preliminary figure that will be adjusted as losses mature," Mr. Massey said.

OIL—which writes all-risk property insurance, loss-control insurance and third-party pollution liability insurance for its member companies—offers primary limits of up to \$150 million per occurrence depending on the assets of the company, and offers an additional \$150 million in excess limits for all three types of coverage.

Mr. Massey said that OIL's last rate increase was in 1986, followed by rate reductions in 1987 and 1988. This followed OIL's "premium development procedure," which pushes rates up after a year of large losses and reduces them after good years, he added.

OIL's net premiums written and earned fell to \$66.1 million for the year-ended Dec. 31, 1987. According to the company's 1987 report, premium volume for 1988 was expected to be nearly the same and substantial profits were unlikely. In 1987, the last year for which complete financial results are available, OIL posted a net loss of \$19.3 million. This compared with net income of \$319.6 million on net premiums written of \$293.7 million in 1986.

Meanwhile, New York-based Mobil Corp. and Champlin Refining & Chemicals of Irving, Texas, joined OIL on Jan. 1, Mr. Massey said. He said both companies were participating in the captive's primary and excess coverage programs.

Forty-seven corporations were members of

Bermuda briefs

OIL as of Jan. 1, one fewer than a year earlier.

Unrelated business

Captive insurers taking on long-term unrelated business should be required to show regulators that their loss reserving practices have passed certain actuarial tests, a Bermuda-based risk management consultant says.

Malcolm Butterfield, joint managing director of Betterley Risk Consultants (Bermuda) Ltd., also urged the Bermuda government to consider issuing captive companies operating licenses that reflect the underlying nature of a licensee's insurance business.

Under Bermuda's present rules, only those insurers writing professional and product liability insurance are required to have their loss reserves certified by a casualty actuary, said Mr. Butterfield, who was an inspector with the government's main insurance regulatory body, the Registrar of Companies, before joining Betterley.

"However, this area is not a problem for (all) captives" Mr. Butterfield said. "Our problems pertain mainly to captives writing long-term, third-party business."

Mr. Butterfield also urged regulators to review the island's insurance licensing requirements, which he described as "another concern of the 1990s."

"Bermuda needs to examine this area," he said. "A captive writing only related business should get one type of license and if a captive writes third-party business" then it should get a different license.

Mr. Butterfield said that although the Registrar of Companies is doing "a commendable job" in coping with Bermuda's approximately 1,300-strong captive community, it "may have a resources problem in tackling companies that fail to meet statutory financial filing deadlines."

The Betterley managing director called for the employment of more professional staff in the registrar's department, additions that he said would not only help cope with a heavy workload but also "add more credence and authority" to the regulator's role.

He also recommended that the Bermuda government hire a public relations specialist to market the island as an offshore domicile

for captive insurers.

Marketing was also the theme of an address at the seminar by Betterley's U.S.-based president, Richard Betterley.

Mr. Betterley predicted increased competition between captive domiciles and, in turn, more pressure on Bermuda to communicate its biggest assets: quality and expertise.

These, he said, should be marketed heavily, both by the Bermuda government and by the industry to a "new wave" of captive owners—a group of "less sophisticated organizations who do not understand the offshore advantage and tend to equate Bermuda with the Bahamas."

Mentor claims deadline

Mentor Insurance Ltd. liquidators Charles Kempe and Michael Arnold have set a filing deadline of May 31 for creditors who want their insurance claims considered for payment from Mentor's first interim cash distribution.

The liquidators expect to make the payout before the end of 1992.

A letter sent to creditors last month announcing the deadline also included reinsurance claims forms and a copy of an order from Bermuda's Supreme Court detailing the terms of the claims filing procedure.

New claims or existing claims "lodged on or after June 1, 1989," will not be allowed to participate in the first dividend, according to the court order. Later claims are expected to be considered for a future dividend.

"Claimants who are also reinsurers of Mentor should comply with the above filing deadline for amounts owed by Mentor."

The Bermuda Supreme Court order and the filing deadline were set after only 837 of Mentor's 2,700 creditors responded to earlier requests and submitted claims worth about \$561 million, the liquidators said.

Creditors were warned in September at Mentor's most recent creditors' meeting that unless "sufficient creditors" came forward with their claims that "a method of compulsion would be introduced" (BI, Sept. 26, 1988; Sept. 19, 1988).

Mentor issued a statement saying, "The joint liquidators expect that all or the vast majority of creditors will comply with the

filing deadline, which should enable them to progress Mentor's liquidation faster than any other of a similar size and complexity."

According to the statement, Mentor's liabilities are estimated at \$700 million, of which 90% were contingent at the time of the company's compulsory winding up on June 21, 1985.

The liquidators point out that Mentor's portfolio includes U.S. property/casualty business, from which claims normally would not mature for more than 20 years.

Ferry damages

A Bermuda-based insurer has agreed to pay more than \$4 million for the removal of a ferry that ran aground on a coral reef off Puerto Rico in 1985.

Standard Steamship Owners Protection & Indemnity Assn. (Bermuda) Ltd., a P&I club managed by Charles Taylor & Co., had written coverage for the ferry and its operator.

A spokesman for Charles Taylor said the agreement was reached after the U.S. Department of Justice filed a civil complaint last fall in San Juan, Puerto Rico, against the ferry owner, its operator and the insurer.

The bulk of the award will cover removal of the wreckage and cleanup of the coral reef, which is regarded as an important part of the habitat of the endangered Hawksbill sea turtle.

The 3,568-ton, Panamanian-registered A. Regina ran aground Feb. 15, 1985. The Justice Department lawsuit charged that the vessel killed live coral and polluted the surrounding waters with fuel oil and debris.

"Hawksbills, more than any other turtle species, depend heavily on healthy coral reef habitat for shelter and food throughout their life cycle. Much of the hope for survival and recovery of this species depends on the maintenance of suitable and undisturbed nesting beaches and related foraging habitat," according to the suit.

The Justice Department accused the ferry owners of negligence and alleged they had violated the Endangered Species Act and the Rivers and Harbors Act because the ferry was obstructing navigation and causing pollution.

The bulk of the award will cover the cost of cleanup, which already has begun. The Charles Taylor spokesman said at least \$641,000 will be paid to the Commonwealth of Puerto Rico for damages to its natural resources and future cleanup costs. ■

Raymark fails again in attempt to certify class-action lawsuit

ATLANTA—Asbestos producer Raymark Industries Inc. has failed in a second attempt to consolidate all of the bodily injury claims it faces into a class-action lawsuit.

U.S. District Judge Robert L. Vining Jr. late last month denied Raymark's second try at getting a class-action lawsuit certified.

Attorneys for Raymark say they will seek to appeal the decision. Interestingly, Judge Vining last June approved Raymark's first attempt at consolidation (BI, June 20, 1988). However, his order was overturned by the 11th U.S. Circuit Court of Appeals in July (BI, July 25, 1988).

In its second attempt to consolidate all claims pending against it, Raymark tried to meet some of the objections raised by the 11th Circuit.

While calling Raymark's second effort "commendable," Judge Vining ruled that he could not certify a mandatory plaintiff class.

The judge said that the court would be violating the constitutional rights of some plaintiffs outside the court's jurisdiction by forcing them to be included in the class.

And, the judge said that because a class-action lawsuit would necessarily enjoin thousands of state court actions now pending against Raymark, it would violate the federal Anti-Injunction Act.

Despite his ruling, Judge Vining appeared sympathetic to Raymark's position, stating: "The court is of the firm belief that the process of having each individual litigate his or her claim against Raymark in all the thousands of cases pending against Raymark is ineffective and inefficient and results in substantial funds being expended for attorney's fees that could more properly be used to compensate asbestos victims.

"Furthermore, the current method of handling asbestos litigation does nothing to ensure that those persons whose injuries have not yet manifested will be able to receive compensation for their injuries, since the funds to pay them may by that time be depleted," Judge Vining said.

—By Stacy Adler

Jury rules bank can't recover bad investment from Crawford

By STACY ADLER

WORCESTER, Mass.—A Massachusetts bank is seeking to overturn a recent jury verdict that Crawford & Co. is not primarily to blame for the loss of tens of millions of dollars the bank invested in a now-insolvent Florida property/casualty insurer.

Attorneys for Consumer's Savings Bank of Worcester, Mass., last week filed post-trial motions seeking to have the jury's verdict overturned by the judge.

Consumer's sued Atlanta-based Crawford for \$15 million—which could be trebled to \$45 million under a state statute—it lost in the 1983 purchase of Kent Insurance Co. of Hialeah, Fla.

Consumer's said it relied on misleading reports from Crawford that Kent was financially sound when, in fact, the insurer was grossly underreserved.

Prior to its December 1983 purchase of Kent, Consumer's hired Crawford as a consultant to review the claims files and claims handling capacity of the insurer.

After conducting a two-day cursory review of Kent's claims files, Crawford produced a report for Consumer's stating that Kent was underreserved by \$1.12 million, when in fact, the insurer was underreserved by more than \$12 million.

Kent, a property/casualty insurer that wrote mostly workers compensation business, was liquidated in 1985.

Consumer's said it relied on the Crawford report when it purchased Kent, and that it further relied on Crawford's report when it subsequently pumped more than \$15 million into Kent in a failed attempt to keep it afloat.

Consumer's sued Crawford for negligent misrepresentation, breach of contract, negligence, gross negligence and fraud.

The bank also sued Crawford for unfair business

practices under the Massachusetts Unfair Trade or Deceptive Practices statute, which enabled the bank to treble its claim.

During the two-week trial, Crawford argued that it did not have the expertise nor did it agree to certify the aggregate loss reserves of Kent.

Consumer's, on the other hand, told the jurors that Crawford had agreed to perform a more extensive review of Kent, which was to include certification of loss reserves.

The bank said Crawford's failure to perform a more detailed review misled the bank's directors and officers into thinking Kent was financially sound when it was grossly underreserved.

After deliberating for 11 hours over three days, the jury on Feb. 3 found that Crawford & Co. was only 20% responsible for Consumer's losses associated with the purchase of Kent, while it said Consumer's was 80% responsible for conducting its own investigation of the financial soundness of the insurer prior to purchasing it.

Under Massachusetts law, when a party's own negligence exceeds 50%, it cannot recover a judgment.

In a separate ruling, Judge Robert W. Mulkern denied Consumer's allegations that Crawford was guilty of unfair business practices.

The judge said Consumer's was a large, sophisticated corporation and that it "had access to sources of information which could fully investigate the stability of the insurance company. It elected not to do so."

After Kent was liquidated in 1985, Consumer's also filed suit against the former executives of Kent and New York-based Touche Ross & Co., Kent's accountants.

The lawsuit against the former executives of Kent is still pending.

Consumer's settled its lawsuit against Touche Ross in 1987 for an undisclosed sum. ■

Final FASB draft ready for review

By DEBORAH SHALOWITZ

NORWALK, Conn.—After 10 years of deliberation, the Financial Accounting Standards Board is detailing in a final exposure draft its proposed accounting standard requiring employers to recognize retiree health care liabilities and the cost of those liabilities on their financial statements.

Under the exposure draft FASB issued last week, employers would have to switch to accrual from cash accounting for post-retirement welfare benefits such as retiree health care, life insurance, tuition and dependent care assistance.

FASB believes employees earn these benefits in exchange for service rendered as another form of deferred compensation, thus, the

Under the exposure draft FASB issued last week, employers would have to switch to accrual from cash accounting for post-retirement welfare benefits such as retiree health care, life insurance, tuition and dependent care assistance.

accrual for future benefits should be made during an employee's working career, not after retirement.

Employers would have to accrue as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the date the employee is first eligible for retirement health care benefits.

Employers would have to begin recognizing liabilities for retiree health care on their income statements beginning in fiscal years after Dec. 15, 1991 (BI, Oct. 17, 1988).

Employers now report as an expense item on their income statements only their pay-as-you-go costs for retiree health care benefits, such as the premium for a

health insurance policy or claims costs if a company self-funds its retiree health care plan.

Also under the proposal, employers would be required to amortize on a straight-line basis their accumulated retiree health care liabilities as of the standard's effective date over the average remaining service period of employees expected to receive the benefit or over 15 years.

The amortized transition obligation cannot be less than the annual expense for retiree health care costs as they were accounted for on a cash basis.

An employer's total retiree health care transition obligation must be recognized as a footnote to the income statement beginning in fiscal years after Dec. 15, 1991.

Employers also would have to disclose in a footnote to their income statements the health care inflation rate used to calculate retiree health care liabilities.

The effect of a 1% increase or decrease in the health care inflation rate also must be outlined in the footnote.

Employers with retiree health care plans that cover non-U.S. workers and non-public companies that do not have any retiree health care plans that cover more than 100 participants would not have to comply with the standard until fiscal years beginning Dec. 15, 1993.

Another provision of the proposed standard would require all employers to begin recognizing on their balance sheets a minimum liability for retiree health care beginning in fiscal years after Dec. 15, 1996.

This minimum liability must include at least the present value of retirement health care liabilities for current workers who are eligible to retire as well as the liabilities for current retirees.

For example, if the unfunded obligation for eligibles and retirees is \$125,000 but the accrued liability to be reported on the balance sheet is only \$100,000, an additional liability of \$25,000 would be recorded with an offsetting charge to an intangible asset.

FASB will conduct two sets of public hearings on the proposed standard.

The first hearing will be held at 8 a.m. Oct. 10-12 at the Grand Hyatt Hotel in New York.

The second FASB hearing will be held at 8 a.m. Nov. 2-3 at the J.W. Marriott Hotel in Washington, D.C.

An individual or organization wishing to speak at one of the public hearings should notify FASB by June 30 and must submit by Aug. 7 a position paper, an outline of a proposed presentation or a comment letter addressing the proposal.

Speakers at the hearing will be allotted 10 minutes for presentations and will be questioned following the presentations by the FASB board and staff.

Written comments on the proposal—which will be given the same consideration as oral testimony—must be received by Aug. 14.

All submissions should be addressed to the Financial Accounting Standards Board, Director of Research and Technical Activities, File Reference 078,401 Merritt 7, P.O. Box 5116, Norwalk, Conn. 06856-5116; 203-847-0700.

One copy of the exposure draft, "Proposed Statement of Financial Accounting Standards: Employers' Accounting for Postretirement Benefits Other Than Pensions," is available free from FASB until Aug. 14 by writing to the FASB Order Department at the same address.

Prices for multiple orders and copies of the exposure draft ordered after Aug. 14 are available from the order department.

Since 1973, FASB has been the designated private sector organization to establish standards governing the preparation of financial accounting and reporting.

Final standards are officially recognized as authoritative by the federal Securities and Exchange Commission and the American Institute of Certified Public Accountants.

The board has seven members, each of whom is appointed for a five-year term by the Financial Accounting Foundation, which is composed of independent trustees.

RISK MANAGEMENT SERVICES

publishing: March 13

Spotlight Report

Risk Management Services

On March 13 Business Insurance editors will take an in-depth look at market conditions affecting risk management services. With potential rate hikes in the property/casualty market at stake, editors will report on the types of special risk management projects that companies are currently using as well as projects which should be considered.

In this highly competitive marketplace, risk management consultants are becoming increasingly important to business operations. To keep readers up-to-date, BI will rank the top independent risk management consultants and profile major risk management consulting units of brokers and insurers.

Directory

Risk Management Consultants

Included in this spotlight report is BI's Directory of Risk Management Consultants — serving as the information center for 155,346* Business Insurance readers. Our annual listing provides important information on approximately 300 consultants and types of services they offer.

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Business Insurance

Plan changes

Continued from page 1

company to change retiree health care plans that should have been changed years ago," said John Hickey, a partner at benefit consultant Kwasha Lipton in Fort Lee, N.J. "We are about to see tremendous changes in retiree health care plans," said Rich Ostuw, a vp in the Cleveland office of TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc.

Employers gradually will eliminate plans with that open-ended commitment to provide a fixed level of contributions—regardless of medical inflation or a retiree's age or length of service before retirement.

Replacing those plans will be new programs with features similar to pension plans. For example:

- New retiree health care plans will base benefits or employer contributions on length of service.

"There will be proportionally larger benefits or contributions for retirees with longer lengths of stay," said TPF&C's Mr. Ostuw.

"We've been looking at a number of approaches to managing the liability," such as linking how much a retiree pays for coverage to length of service, added Kevin Flatley, vp-employee benefits at American Express Co. in New York.

- Employers will actuarially reduce health benefits for those retiring before normal retirement age.

"Companies will recognize that the cost of providing an early retirement health care benefit could be multiples of the cost of a pension benefit," said Dallas Salisbury, president of the Employee Benefit Research Institute.

- Employers will limit their contributions to retiree health benefits to a fixed amount similar to a defined contribution pension plan approach.

"I'd call it a 'defined dollar' approach," said Richard Raskin, a consultant with The Wyatt Co. in New York. "If contributions are fixed, the employer is better protected from medical care inflation. The risk of inflation is shared with employees."

One example of this defined contribution or defined dollar approach would involve a company making fixed annual contributions to an employee's "account."

Then, when the employee retired, the balance would be used to purchase coverage for the retiree.

"Under this approach, the employer's liability is the sum of the account balance. You don't have to predict medical care inflation," said Lance Tane, chairman of Wyatt's group/flex practice in New York.

"You can predict with greater precision the retiree health care cost," suggested Linda Havlin, a consultant with Hewitt Associates in Lincolnshire, Ill.

Joseph Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., said Allied-Signal is considering the defined dollar approach, as well as increased use of managed care, to reduce the company's retiree health care obligations.

"We want to try to fix our cost at some level so we can better control liabilities in light of FASB," Mr. Duva said.

Some companies, in fact, may choose the ultimate solution to their FASB problem: Eliminate their retiree health care plans.

"Some employers may say they don't need a retiree health care plan, especially since Medicare has been recently expanded" to cover more acute care catastrophic expenses, said Kwasha Lipton's Mr. Hickey.

However, elimination of retiree health care plans likely will be an exception rather than the rule, benefit experts say.

"Companies want to provide benefits. But they want to be able to better control the cost of that benefit," said Rob Davidson, a principal in the St. Louis office of William M. Mercer Meidinger Hansen Inc.

While the proposed FASB rules will not take effect until 1992 at the earliest, giving employers time to

Rules no problem for some

Some companies do not face any problems complying with the proposed Financial Accounting Standards Board rules because they do not offer retiree health care benefits.

For example, while Washington-based Marriott Corp. extends its group health care program for active workers to retirees who are not yet eligible for Medicare, the retirees must pay the full cost of the coverage.

In addition, Marriott workers who retire after they are eligible for Medicare can receive a Medigap policy available through a local Blue Cross/Blue Shield plan. While retirees don't have to show proof of insurability under this program, they still must pay the full premium for the Medigap policy.

"Years ago, we determined that our ability to afford to provide retiree health care coverage was not as great as other companies," said Robert Dankmyer, Marriott's vp-employee benefits.

carefully consider retiree plan changes, some companies—in anticipation of the rules and in recognition of soaring health care costs—have already overhauled their programs.

For example, Chicago-based Quaker Oats Co. in January established a new health care program for future retirees that, among other things, links the company's contributions for coverage with length of service (BI, Aug. 22, 1988).

While the proposed FASB rules—and their impact on the company's profits and balance sheet—were a factor in Quaker's move to a new plan, the need to control rising medical care costs was just as important.

"The problem is not just FASB," said Robert Penzkover, Quaker's director of employee benefits. "The problem is the state of health care in this country. People may be living longer, but they aren't necessarily any healthier."

In recent years, Quaker's post-employment medical care costs have increased by an annual average of 18% per retiree, rising to \$1,208 per retiree in 1987 from \$381 in 1980.

Other companies also report big increases in retiree health care costs.

Inland Steel Co.'s retiree health care costs climbed 55.6% to \$23.5 million in 1987 from \$15.1 million in 1985, according to filings by the Chicago-based company with the Securities and Exchange Commission.

Retiree health care costs will continue to soar because of both medical inflation and the growing number of employees reaching retirement age.

For example, 15.7% of the U.S. population will be 65 or older in the year 2020, compared with only 11% in 1980, according to a 1987 report of the Social Security Administration's Board of Trustees.

Indeed, while employers and consultants may argue with technical aspects of the FASB proposals, there is growing acceptance of the philosophy underlying FASB's proposals: "Pay-as-you-go" accounting is not a true measure of a company's expense and liability for retiree health care.

"Personally, I don't think anyone disagrees with FASB's general approach. The disagreement is over time... The time in which employers will have to get their houses in order," said Mr. Duva.

Estimates of employers' unfunded retiree health care liabilities have ranged from \$100 billion to as much as \$1 trillion.

Some say there is a silver lining in the proposed FASB rules: They will force top corporate executives to pay attention to their retiree health care obligations now rather than wait until their companies are imperiled by huge liabilities in the future.

"FASB will force companies to make decisions sooner rather than later. Companies can plan changes rather than be faced with a threatened bankruptcy down the road or having to eliminate a plan to survive," said EBRI's Mr. Salisbury.

And, some experts believe that an additional upside to the FASB proposal is that it will lead to more rational retiree health care plan design.

For example, many experts say at a time of growing labor shortages, it makes little sense to induce workers to retire early by promising full medical coverage as early as age 55.

Because of the huge cost and big

liabilities of early retirement health care coverage—retirees are not eligible for Medicare until age 65—cutbacks in early retirement health care coverage are viewed as most likely.

"There is a stark realization of how expensive early retirement health care benefits are," said Steven Ferruggia, director of group actuarial practice at Buck Consultants Inc. in Secaucus, N.J.

For example, a recent survey by Foster Higgins found that annual health care plan costs for retirees under age 65 totaled \$2,397 per retiree, or 42.7% greater than average plan costs of \$1,372 per retiree over age 65 and, thus, eligible for Medicare benefits (BI, Feb. 13).

Virtually any approach that employers take to reducing post-employment retiree health care liabilities will mean new costs to be absorbed by their retirees. Thus, these moves will be resisted by employees and retirees, experts warn.

For that reason, companies are likely to grandfather or exempt current retirees or those near retirement from any major plan changes.

"Younger, active employees will be better able to prepare for future changes," said Mr. Ferruggia.

Until recently, the fear of adverse court rulings may have inhibited companies from making any major cutbacks in their retiree health care programs.

But after several adverse federal district court rulings in the early 1980s, federal appellate courts have ruled that employers can alter their retiree health care programs if they reserved such a right in plan documents (BI, Jan. 2).

Employers say the proposed FASB rules would be more palatable if companies would at least have the right to take tax deductions for contributions to pay for future retiree health care benefits.

But, Washington observers say the odds of that happening anytime soon are poor.

"In an era of scarce federal resources, with so many other priorities competing for those resources, Congress is unlikely to give any substantial new tax incentives for prefunding in the next few years," said Frank McArde, a consultant with Hewitt in Washington, D.C.

"The FASB proposals will restimulate the debate on retiree health care, but I doubt Congress will act to approve any tax incentives for prefunding," added Stuart J. Brahs, vp-federal government relations in the Washington, D.C., office of The Principal Financial Group.

In fact, the only way Congress may consider tax incentives for retiree health care funding would be by curbing or eliminating the tax favored status of another employee benefit, such as flexible spending accounts, some say.

Still, at least some members of Congress are interested in encouraging prefunding of retiree health care liabilities.

"From a public policy standpoint, the FASB draft is useful because it focuses attention on the need to begin funding these promises when they are made," said Rep. Rod Chandler, R-Wash., who plans to introduce legislation soon to give employers tax breaks for prefunding retiree health care benefits. ■

Update

Proposition 103 hearing set

Continued from page 2

The court has 90 days to announce a decision after the hearings.

Meanwhile, the state Senate has passed S.B. 103, which would impose penalties on insurers that arbitrarily cancel or refuse to renew private passenger auto insurance policies in the state. The bill is awaiting a committee assignment in the state Assembly.

Penalties under the bill would equal half the premiums charged in the preceding year on canceled policies. Insurers also could be required to refund higher premiums paid by former policyholders who obtained coverage elsewhere.

Also, A.B. 121, which would require insurers to freeze premiums at Nov. 8, 1988, levels until the state Supreme Court rules on the constitutionality of Proposition 103's rollback provision, has moved to the Assembly floor.

Right-to-know rule enforcement

WASHINGTON—The Occupational Safety and Health Administration will begin enforcing all provisions of the federal hazard communication standard for all industries next month.

The federal worker right-to-know rule has been the subject of numerous court and administrative actions—including several temporary stays—since it was expanded in August 1987 to cover all industries (BI, Sept. 5, 1988; July 18, 1988).

Many of the challenges to the rule were brought by the construction industry, and OSHA has not enforced the rule for construction firms. The U.S. Supreme Court is considering hearing a case challenging a U.S. appellate court ruling that the construction industry must comply with the standard (BI, Jan. 30).

However, the agency announced last week that "all provisions of the rule are now in effect in all segments of industry."

Compliance with the rule will be checked beginning March 17 during scheduled inspections of construction firms.

Searle to appeal award

ST. PAUL, Minn.—G.D. Searle & Co. will appeal an \$8.7 million jury award to a Minnesota woman who claimed she was injured by the company's Copper-7 intrauterine device.

A federal judge refused to grant a retrial in the case, but the judge did delete a jury finding that Searle had been negligent in testing the product.

In the case, a Minnesota woman claimed that use of the CU-7 rendered her sterile (BI, Sept. 19, 1988).

Searle had asked U.S. District Court Judge Robert Renner to call for a retrial in the case because of alleged juror misconduct (BI, Nov. 28, 1988). While the judge did not condone the conduct of the jurors, he ruled that Searle received a fair trial.

However, Judge Renner did delete the jury's finding that Searle had been negligent in testing the product. But, he did not diminish the jury award.

A Searle spokeswoman said the judge's deletion leaves only one jury finding against Searle: misrepresentation of the product to doctors through labeling and advertising.

The spokeswoman refused to speculate how the deletion might affect the appeal, which will be made to the 8th U.S. Circuit Court of Appeals in St. Louis. But, she said that "it sends a signal in terms of future cases" and would "narrow" the basis for future suits.

The spokeswoman also said that since the September ruling, Searle has won nearly 30 CU-7 cases while losing none.

\$43 million E&O settlement

LONDON—Errors and omissions liability underwriters for accounting firm Arthur Young & Co. last week agreed to pay 24.3 million pounds (\$42.9 million) to Johnson Matthey P.L.C. in an out-of-court settlement of claims stemming from the collapse of Johnson Matthey Bankers Ltd.

The payment is in addition to a 25 million pound (\$44.3 million) settlement with the Bank of England by Arthur Young's underwriters last fall.

Johnson Matthey and the Bank of England sued New York-based Arthur Young for professional negligence in its work as auditor of JMB prior to the bank's collapse and rescue by the Bank of England in October 1984. The latest settlement ends all litigation against Arthur Young relating to Johnson Matthey Bankers, said Peter Edwards, managing partner of Arthur Young's U.K. operation.

Arthur Young's E&O coverage was placed by Minet Professional Indemnity Ltd., a subsidiary of London-based Minet Holdings P.L.C., mainly in the London and U.S. markets.

Johnson Matthey remains embroiled in litigation with nearly 200 insurers and reinsurers in the U.S. and London markets that are refusing to pay at least 20 million pounds (\$35.4 million) in claims filed by Johnson Matthey and its former banking subsidiary (BI, May 16, 1988).

Briefly noted

David Saul, the top civil servant in Bermuda's Ministry of Finance from 1976-81, will oversee international companies operating on the island as the new finance minister. Mr. Saul replaces Clarence James, who lost his seat in Bermuda's Parliament in the Feb. 9 elections... A London High Court last week ruled R.H.M. Outhwaite (Underwriting Agencies) Ltd. cannot appeal a November arbitration decision that Outhwaite syndicate 317/661 could not void an unlimited runoff reinsurance policy it wrote for another Lloyd's syndicate (BI, Nov. 28, 1988)... The Texas State Board of Insurance is unable to locate the assets of National County Mutual Fire Insurance Co. President Robert H. Walker, who has been missing since December. The board is seeking the assets to help repay the state guaranty fund, which will pay claims against the insurer. A State Board lawsuit charges Mr. Walker with mishandling funds of the insurer, which is insolvent by \$54 million (BI, Nov. 7, 1988).

FASB impact

Continued from page 1
reduce reported profits and net worth," said Daniel Coulson, accounting director for Ford Motor Co. in Dearborn, Mich.

The proposed accounting standard "will change the earnings of many companies by 10% or more," predicted Jeff Petertil, a principal in the Chicago office of William M. Mercer Meidinger Hansen Inc.

Under the exposure draft of the

FASB standard, employers would have to switch to accrual from cash accounting for post-retirement welfare benefits—including retiree health care plans, life insurance, tuition and dependent care assistance—in fiscal years beginning after Dec. 15, 1991 (see story, page 86).

Employers would have to accrue as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the date the employee is first eligible for retirement health

care benefits.

Also under the proposal, companies would be required to identify their retiree health care liabilities as a footnote to their balance sheets by the 1992 fiscal year. Companies then must gradually amortize this liability on the balance sheet, which could take as long as 15 years. However, by fiscal 1997 companies must show a minimum health care liability on their balance sheets for all existing retirees and for all active employees eligible for retirement.

Some experts say the impact of the proposed FASB standard on corporate earnings will be less severe for companies with a high ratio of retirees to active workers than for companies with relatively few retirees compared with active employees.

Companies with a "more mature employee and retiree population" could be forced to report retiree health care expenditures in the first year of compliance with the standard that are five, six or seven times greater than the company's current pay-as-you-go expense, said Joseph Rosmann, a partner in the Chicago office of Coopers & Lybrand.

That estimate is based on preliminary findings of a survey conducted by Coopers & Lybrand on the effect of the FASB proposal on some 25 companies.

Mr. Rosmann noted that "mature" companies would include many of the old Rust Belt manufacturing firms and any company with a retiree-to-active worker ratio of 1-to-1 or even 2-to-1.

However, "younger" companies, such as those with a retiree-to-active-worker ratio of 1-to-5, 1-to-6 or more, could be forced to report in the first year of compliance retiree health care expenditures that are 20 to 30 times greater than their current pay-as-you-go costs, he said.

The total liability for retiree health care promises for a young company could be 30 to 50 times the firm's current pay-as-you-go retiree health care costs, he added.

However, Mercer's Mr. Petertil pointed out that the current amount a young company spends on retiree health care is so low that multiplying its current expense by a large number may not necessarily yield a large dollar amount.

"Older, more mature companies are not going to see nearly as dramatic an impact" from the proposal as younger companies, said Lonnie Arnett, vp and controller of Bethlehem Steel Corp. of Bethlehem, Pa.

For example, the effect of the rule on Bethlehem Steel "is going to be a very minor multiple, if any," Mr. Arnett said, referring to a comparison of the steelmaker's current pay-as-you-go retiree health care expenses to the expense recognition under the proposed FASB standard.

Bethlehem Steel has a retiree-to-active-worker ratio of approximately 2-to-1.

E.I. du Pont de Nemours & Co.'s recognized expense for retiree welfare benefit obligations will be two to four times the company's current \$175 million annual cost for retiree health care and life insurance, according to A. Herbert Nehrling Jr.,

assistant treasurer.

The Wilmington, Del.-based chemical manufacturer has a retiree-to-active-worker ratio of approximately 1-to-2.

Some companies already know the precise impact of the FASB standard because they have already begun accounting for post-retirement welfare benefits according to the standard.

For instance, Dallas-based LTV Corp. in November posted a one-time charge against income of \$2.26 billion for its total accumulated obligation for retiree medical and life insurance benefits through 1987 for current retirees, active workers eligible to retire and the past service of active employees (BI, Nov. 28, 1988).

LTV has almost twice as many retirees as active employees.

The company last November also posted an additional \$98.2 million charge for its accumulated obligation for retiree medical and life insurance benefits for the first nine months of 1988 for current retirees, active workers eligible to retire and the past service of active employees.

Earlier this month, LTV posted a \$33.8 million charge for its accumulated obligation for retiree medical and life insurance benefits for the last quarter of 1988.

"Because LTV is in Chapter 11, we believe it is appropriate for the company to record all its liabilities, including the liability for these post-employment benefits, so that they may be appropriately dealt with in the reorganization process," said LTV Chairman and Chief Executive Officer Raymond A. Hay in a statement.

The company plans to continue to post a charge each quarter representing the accumulated service obligation for retiree medical and life insurance benefits, according to a spokesman.

In addition to a company's retiree-to-active-worker ratio, another demographic factor that will determine how severely a company is affected by the FASB standard is the nature of the company's business.

Generally, labor-intensive companies, like large manufacturers, "will be hit hardest by these rules," said Richard Raskin, a consulting actuary in the New York office of The Wyatt Co.

The more revenue generated per employee, the less the company will be affected by the standard, noted Rich Ostuw, a vp in the Cleveland office of TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc.

However, companies in some labor-intensive industries, like fast-food franchising and retailing, will not be hit hard by the standard because employee turnover is so high, he added.

Conversely, capital-intensive companies will be affected less by the FASB standard, Mr. Ostuw said, since fewer employees mean reduced liabilities.

Of course, the proposed standard will hurt companies with generous retiree health care plans more than those firms with limited retiree health care benefits.

For example, industries like retailing and fast food franchising will not

be severely affected by the standard because they tend to offer only very limited retiree health care plans, Mr. Raskin said.

Another factor that will influence how a company's financial statement is affected by the FASB standard is the financial assumptions a company uses to calculate its retiree health care obligation.

A particularly important assumption companies will make when calculating their total retiree health care obligation is what the projected medical inflation rate will be, stated Ford's Mr. Coulson.

"That's an area where we think there'll be a fair amount of debate" during the comment period on FASB's exposure draft, he said.

"This assumption is very powerful in the measurement process" and "it's very subjective," stated Diana Scott, FASB project manager.

Experts also noted that the proposed accounting standard poses other financial threats to companies, like jeopardizing loan agreements.

Mr. Nehrling pointed out that some loan covenants require a company to maintain certain ratios of debt to equity. Putting retiree health care liabilities on a corporation's balance sheet will cause debt to rise—in many cases significantly—throwing that ratio out of balance, he explained.

The standard "will, without question, have an effect on some companies in that regard," he stated.

While there have been fears that stock prices may drop as a result of the hit to earnings caused by the standard, several experts said financial analysts already may be factoring the effects of the proposed standard into their analysis of a company's financial health.

The proposed standard will not have a significant effect on stock prices, predicted du Pont's Mr. Nehrling. Securities analysts already are familiar with the issue, so "it's possible that the market has already discounted this," he said.

Some securities analysts have "gradually been discounting the value of stocks," said Mercer's Mr. Petertil.

Also, companies will release information gradually on how the proposed accounting change will affect their financial statements, so the prospect of a dramatic stock market slide is dim, predicted Mr. Petertil.

"The people that run these firms know that the stock market hates surprises," he noted.

And stock dividends are unlikely to be affected by the FASB proposal because a company's cash flow will not change as a result of the accounting standard, experts said. While the FASB proposal will force companies to report a greater annual expense for retiree health care benefits, the amount actually paid in benefits will not be affected by the change to accrual accounting.

There "shouldn't be much effect on dividend payouts," which are determined by cash flow, Mr. Petertil said.

"Actual cash payments are unaffected," pointed out Ford's Mr. Coulson. "In an economic sense, nothing has really occurred. Fundamentally nothing is changing."

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FASB's effect on profits illustrated

The proposed accounting standard for post-retirement welfare benefits would cut one hypothetical company's profits by almost 25%.

In an example outlined by Rich Ostuw, a vp in the Cleveland office of TPF&C, a division of Towers, Perrin, Forster & Crosby Inc., assume a company has 8,000 active employees and 2,000 retirees. Current annual pay-as-you-go retiree health care costs are \$1,500 per retiree, so the company's current annual retiree health care expenditures total \$3 million.

The total accumulated unfunded liability for retiree health care obligations for current retirees and for the past service obligation of active workers—known as the transition obligation—is \$120 million.

This fictitious company has \$1 billion in annual revenues and \$900 million in expenses, bringing pretax income to \$100 million and aftertax income to \$66 million.

Under the Financial Accounting Standards Board's pro-

posed accounting standard, the company would have to record a \$6 million annual retiree health care liability for current retirees and \$17 million annual liability for the accumulated service obligation of active workers.

Thus, total recognized annual expenses for retiree health care would be \$23 million, or a \$20 million increase over the company's current "pay-as-you-go" costs. This additional \$20 million liability is charged as an expense in the first year of the new accounting rules.

Thus, under FASB's proposed accounting standard, the company will record expenses of \$920 million instead of \$900 million, lowering pretax profits to \$80 million instead of \$100 million under the current accounting rules.

Aftertax profits, under the FASB proposal, would drop 24% to \$50 million from the current \$66 million.

"For companies that have (typical retiree health care plans), these numbers are probably typical," stated Mr. Ostuw.

Aerojet appeal

Continued from page 1

At the outset, Presiding Justice Harry Low indicated, at least in part, what the court's agenda will be by asking Aerojet attorney Moses Lasky pointed questions.

For instance, Justice Low asked Mr. Lasky for his definition of the word "damages" contained in Aerojet's general liability policies.

Like most CGL policies, the Aerojet policies stipulate they will "pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages."

"Damages are equal to detriment," Mr. Lasky responded, adding that Judge Bible erred in ruling that the term "damages" does not include government-imposed cleanup costs.

Aerojet's cost for a cleanup—regardless of whether Aerojet performs the cleanup itself or the government cleans up the site and sues Aerojet to recover the costs—is insurable, said Mr. Lasky of Lasky, Haas, Cohler & Munter in San Francisco.

Under either scenario Aerojet has "the same out-of-pocket costs," Mr. Lasky explained.

However, insurers contend that the term "damages" means only legal damages imposed by a court of law. Costs incurred by a policyholder because of a government order to clean a polluted site are equitable in nature and, therefore, not insurable, they say.

"The whole purpose of the 'damages' wording is to limit the coverage to traditional tort damages," Richard L. Seabolt, who represents Lloyd's of London syndicates and other London market insurers known as Cheshire & Cos., told the judges.

"The (legal) rules require us to give meaning to each and every word of the policy," said Mr. Seabolt, who is with Hancock, Rother & Bunshoft in San Francisco.

"The word 'damages' is there so that ordinary business expenses are not shoved off onto insurers," Mr. Seabolt said.

Any other interpretation of damages would "read the word right out of the policy," he said.

Mr. Seabolt further argued that a new California Insurance Code statute, which took effect Jan. 1, reinforces the insurers' contention that government-mandated cleanup costs are not insurable.

The new law says: "No policy of insurance shall provide, or be construed to provide any coverage or indemnity for the payment of any fine, penalty or restitution in a civil or criminal action or proceeding..." (BI, Nov. 7, 1988).

Mr. Seabolt told the judges that "every federal case has held that (government-mandated cleanup costs) are a form of restitution. And, state law says restitution is not covered."

But California Deputy Attorney General Timothy Patterson, who addressed the panel as a friend of the court on behalf of Aerojet, said the insurance statute "has no application in the hazardous substance field."

"The intent of the legislation is to deal with consumer protection statutes," Mr. Patterson explained in a previous interview. "It was never discussed in the Legislature with respect to hazardous wastes or hazardous substances."

Associate Justice Zerne Haning pointed out that none of the insurance policies define the term "damages."

Judge Haning also expressed displeasure with the trial court decision, remarking that Judge Bible "painted with a very broad brush."

However, attorneys said after the hearing that the judge's remarks probably are not an indication of his view of the case.

In addition, Judge Haning pointed out that "most of the appellate courts that have ruled on this have ruled against" the insurers. "At the very least it seems (insurers) have a duty to defend," he said.

A majority of lower courts and state appellate courts that have ruled on the issue have held that CGL policies do cover the costs of government-mandated hazardous waste cleanups.

However, the only two federal appellate courts to rule on the issue—the 8th U.S. Circuit Court of Appeals and the 4th U.S. Circuit Court of Appeals—have held that these costs are not insurable (BI, March 7, 1988; July 27, 1987).

The U.S. Supreme Court refused to review both federal appellate decisions (BI, Oct. 10, 1988).

Justice Low later asked Mr. Lasky whether insurers have a broader duty to defend than to indemnify Aerojet.

"Of course, the duty to defend is greater," replied Mr. Lasky. "However, the order below does not make that distinction."

Associate Justice Donald King did not ask the parties any questions nor make any comments during the proceedings.

No matter who wins the appeal in the Aerojet case, it is virtually certain that the loser will appeal to the California Supreme Court.

But the state's high court has been denying unusually large numbers of civil appeals for months to concentrate on eliminating the

backlog of death penalty cases.

As a result, the opinion of the 1st District Court of Appeal could become the definitive ruling in California on coverage for government-mandated cleanups.

The court will not hear any further arguments from the parties. The court will render its decision in the case in the next three months.

Judge Bible's earlier ruling would bar Aerojet from recovering tens of millions of dollars from its 55 general liability insurers from 1956 to 1984 to pay for an estimated \$100 million of hazardous waste cleanup.

Aerojet is seeking coverage for the costs of cleaning up groundwater near Sacramento, Calif. Trichloroethylene, or TCE—used by Aerojet as a solvent to clean rocket parts—leached into the groundwater under Aerojet's 8,000-acre facility, and environmental officials suspect the solvent subsequently leached into the American River.

As a result, both the state of California and the federal government have sued Aerojet and its subsidiary, Cordova Corp., for the costs of cleaning up the contaminated area.

The federal government's suit was filed under the Comprehensive Environmental Response, Compensation & Liability Act, better known as the Superfund Act.

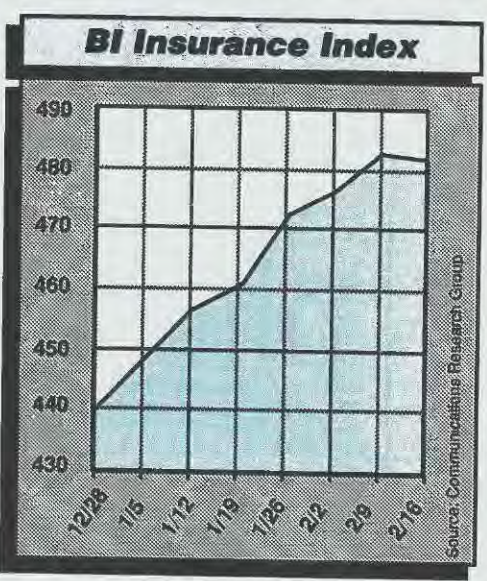
California sued for violation of the state's Regional Water Board regulations.

Aerojet contends that the costs it has incurred under these two lawsuits should be covered by Aerojet's general liability insurers.

From 1956 to 1960, Aerojet had occurrence-base third-party liability coverage with annual limits ranging from \$4 million to \$10 million. From 1960 to 1970, policy limits ranged from \$10 million to \$50 million. In later years, the limits were increased to in excess of \$100 million.

While various primary insurers were on the risk during the 28 years, underwriters at Lloyd's of London and other London market insurers led the primary coverage for 14 years from 1956 to 1970. In addition, the London market wrote excess coverage for Aerojet in later years.

Other insurers that wrote significant limits for Aerojet include AIU Insurance Co. of New York and other American International Group Inc. units; Argonaut Insurance Co. of Menlo Park, Calif.; CNA Insurance Cos. of Chicago; Fidelity & Casualty Co. of New York in Concord, N.H.; Insurance Co. of North America in Philadelphia, a CIGNA Corp. unit; Transport Indemnity Co. of Los Angeles; and U.S. Fire Insurance Co. in Morristown, N.J., a subsidiary of Crum & Forster Inc.



Insurance industry stocks slipped last week, as the **Business Insurance Index** dropped 0.5 points to 482.7 on Feb. 16, from 483.2 on Feb. 9. Advancing issues were led by HMO America Inc., up 10.6%; SCOR U.S. Corp., up 9.5%; and The Home Group Inc., up 7.5%. Declining issues were led by Western Health Plans Inc., down 8.7%; Chandler Insurance Co., down 8.3%; and Forum Re (Bermuda), down 8%. The issue showing the most activity during the period was: Sears, Roebuck & Co. (Allstate) 3.3 million shares traded. The BI Index fell 0.1% for the period; The Standard & Poor's 500 fell 0.6%; and the New York Stock Exchange Composite lost 0.4%.

British Issues

Feb. 16 Companies	Price	P/E	Div. %	Yield %	1 Week High-Low
Comm Union	384	12.4	25.3	6.6	387-383
Genl Accident	983	9.7	58.0	5.9	988-978
Gdn Royal Exch	212	11.4	13.1	6.2	213-210
Royal	424	13.9	30.0	7.1	427-424
Sun Alliance	1098	8.4	54.7	5.0	1111-1098

Brokers	Price	P/E	Div. %	Yield %	1 Week High-Low
Bradstock	229	12.9	9.0	3.9	229-229
CE Heath	472	15.0	34.5	7.3	475-472
Hogg Robinson	157	14.5	8.0	5.1	157-156
Lloyd Thompson	207	16.3	8.0	3.9	207-203
PWS Holdings	118	16.9	5.2	4.4	128-118
Sedgwick Grp	259	21.4	16.0	6.2	264-259
Steel Brt Jones	232	20.7	13.3	5.7	232-229
Willis Faber	244	16.6	15.3	6.3	245-244

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

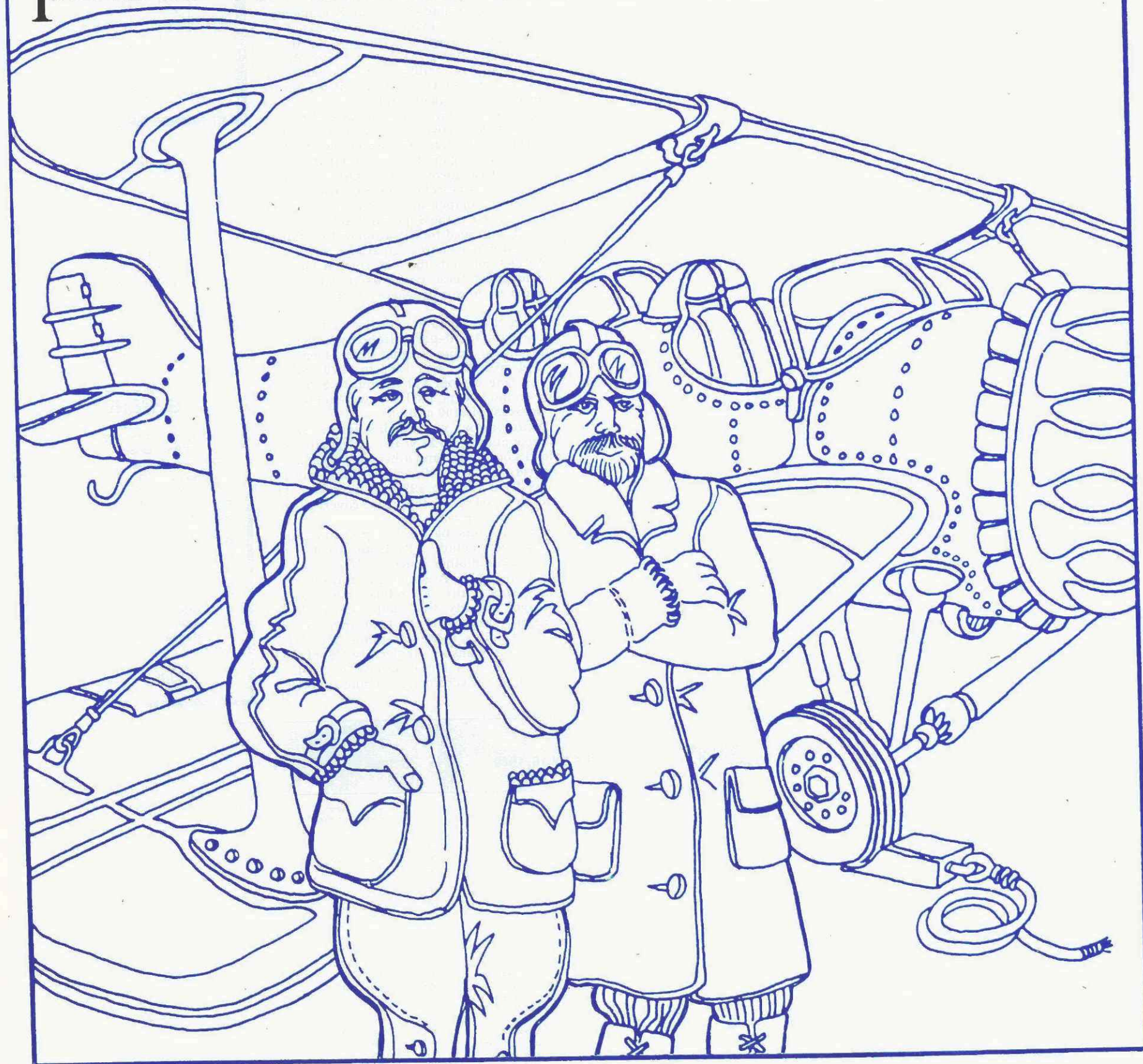
BI Industry Stock Report

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Alexander & Alexander Svcs	23.50	0.5	0.0	28.13	17.75	278	1.00	4.3	15.1	3.71	6.33	Berkley W.R. Corp.	32.25	-0.8	9.3	33.25	23.50	81	0.36	1.1	7.0	17.63	1.83	Aetna Life & Cas Co.	50.50	0.5	6.9	52.50	39.50	954	2.76	5.5	8.6	53.56	0.94	FHP International Corp.	17.25	-2.2	42.2	18.38	6.00	386	0.00	0.0	9.4	3.54	4.87	Corrander & Black Corp.	33.00	0.8	6.0	34.75	28.00	116	1.08	3.3	5.0	12.40	2.66	HMO America Inc.	1.25	10.6	33.0	2.75	0.81	31	0.00	0.0	-2.0	1.12	1.12	Gallagher Arthur J. & Co.	18.13	0.7	8.2	19.13	13.88	57	0.48	2.6	12.9	5.46	3.32	Mexicare Health Plans	0.69	0.0	-8.0	4.25	0.50	639	0.00	0.0	0.0	0.00	N/A	Hall Frank B. & Co.	2.88	0.0	0.0	5.50	2.50	54	0.00	0.0	-1.6	0.00	N/A	Pacificare Health Systems	16.50	3.1	34.7	16.75	5.75	53	0.00	0.0	13.2	6.35	2.60	Hilb, Rogal & Hamilton	15.00	0.0	-1.6	15.75	9.75	16	0.00	0.0	-1.6	0.00	N/A	Safeguard Health Ent.	5.06	-3.6	-8.0	0.00	0.00	0	0.00	0.0	10.1	2.75	1.84	Marsh & McLennan Cos. Inc.	59.38	2.8	5.6	59.63	45.25	308	2.50	4.2	14.5	6.74	8.81	Sierra Health Services	2.25	0.0	38.0	3.00	1.25	49	0.00	0.0	17.3	1.59	1.42	Poe & Assoc. Inc.	8.25	0.0	0.0	9.25	6.75	1	0.40	4.8	9.3	0.27	30.56	United Health Services	6.00	4.3	33.3	6.13	3.50	602	0.00	0.0	-2.3	2.59	2.32	Brokers AVERAGE	0.7	2.6	Berkshire Hathaway Inc. DEL	4850.00	-2.0	38.9	-5050.00	2755.00	38	0.00	0.0	19.5	2492.68	1.95	U.S. Healthcare	7.63	0.0	31.3	7.63	0.0	31	0.00	0.0	-4.2	2.89	2.64	ITT (Hartford Group)	53.75	-0.7	7.2	55.75	43.25	1774	1.48	2.8	9.4	52.23	1.03	Western Health Plans Inc.	0.63	-8.7	-8.7	3.38	0.50	13	0.00	0.0	-0.3	0.82	0.77	Sears Roebuck & Co. (Allstate)	42.38	0.3	3.7	46.13	32.25	3320	2.00	4.7	17.7	34.74	1.22	HMOs AVERAGE	0.4	21.2	ALL COMPANIES AVERAGE	-0.1	8.2	2.6	0.2

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