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Updates

Michigan ruling expands chance to recoup cleanup, defense costs

LANSING, Mich.—A pro-policyholder trigger-of-coverage decision by the Michigan Supreme Court significantly expands the availability of pollution cleanup and defense cost coverage for comprehensive general liability insurance policyholders.

The court on Jan. 21 unanimously ruled that policyholders can tap all their CGL policies from the time property damage first occurred. The court's adoption of the injury-in-fact trigger reverses two appellate court decisions that only the policy in effect when

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AIG facing rival in bid for insurer

By DOUGLAS McLEOD

MIAMI—Only weeks after announcing plans to take over American Bankers Insurance Group, American International Group Inc. has a fight on its hands.

Cendant Corp., a travel and real estate conglomerate and relative newcomer to the insurance industry, last week launched a cash tender offer for 51% of American Bankers' stock and said it would acquire the balance of the shares later for Cendant stock.

As it announced the $2.7 billion offer, Cendant also sued American Bankers, its board of directors and AIG in federal court in Miami, complaining that American Bankers President Gerald N. Gaston had told Cendant in December the insurer was not for sale.

The suit charges, among other things, that American Bankers and AIG conspired to load their $2.2 billion agreement with restrictions shutting out competing bidders, including one that bars American Bankers from talking to other bidders for 120 days.

American Bankers "suggested we come back in January to discuss it further. Well, we've come back," Cendant Chief Executive Officer Henry R. Silverman said.

AIG responded last week by announcing it will exercise an option—another of the restrictions Cendant complained about—to buy 19.9% of American Bankers' shares in the wake of the unsolicited offer.

AIG also said it "will do everything it can to complete the transaction on a timely basis."

American Bankers, meanwhile, said its board will review the Cendant proposal "in due course" and asked shareholders to wait for the board's response before taking any action.

Cendant's offer, amounting to $58 per share vs. $47 per share offered by AIG, jolted industry observers and raised uncertainty about who will ultimately control American Bankers, a profitable provider of credit-related insurance products.

"If you are American Bankers, how do you stop your shareholders from taking $58 rather than $47?" wondered A. Michael Frinquelli, an insurance analyst with

See **Cendant** *on page 39*

Benefits agenda outlined

By JERRY GEISEL

WASHINGTON—President Clinton continues to pursue a modest benefits agenda.

In his State of the Union address last week and in background papers, the administration laid out benefits proposals it would like to see Congress pass this year.

Several of those proposals, including lowering the eligibility age for Medicare in certain situations and expanding child care tax credits, were outlined last month by the administration.

Other proposals are recycled versions of earlier initiatives: Requiring health care plan administrators to furnish the names of their employees—chiefly older workers—eligible for Medicare, and expanding the Pension Benefit Guaranty Corp.'s missing participant program to cover defined contribution plans are among the proposals that have been previously introduced.

But the administration did offer a variety of new benefit proposals. Those include:

• Requiring employers with 401(k) plans to accelerate vesting of matching contributions. Under the administration proposal, matching contributions in which cliff schedules are used would have to be first and fully vested at the end of three years, while contributions in plans using graded schedules would have to gradually vest until they

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President Clinton's benefit proposals

- Faster vesting for 401(k) plans
- More information for pension plan participants
- Expansion of PBGC missing participant program
- New simplified pension plans for small employers
- Payroll deduction IRAs
- Expand Family and Medical Leave Act to more small employers
- Lower eligibility age for Medicare
- More rights for enrollees in managed care plans
- Child care tax credits for employers and employees

Schools return to self-insurance

California districts find low workers comp rates not lasting

By JOANNE WOJCIK

LOS ANGELES—Several California school districts that took advantage of low workers compensation rates when open rating started in 1995 are returning to self-insurance.

While most of the districts realized significant savings up-front by re-entering the insurance market, many are finding the low rates they paid at first were short-lived.

Still other districts are returning to self-funding to regain control over claims handling.

"I think we're seeing the beginning of the migration back to self-insurance," observed John Wilson, executive director of the Schools Excess Liability Fund, an excess liability pool based in Sacramento. "I'm hearing a lot of discontent."

Part of the reason the savings were short-lived is that school districts were self-funded for so long, there was little or no actuarial information on their workers comp experience available to insurers seeking the business, observers explained.

Since the late 1970s, all but about 5% of the state's 1,020 school districts had been self-insured, mostly through joint powers authorities, he said.

The remainder purchased coverage from the State Compensation Insurance Fund, the competitive state workers compensation fund.

But in July 1995, when legislation was implemented permitting the school districts to purchase commercial workers comp insurance, nearly 60% of them did, estimates Mr. Wilson of SELF.

The primary reason was price: In nearly every case, insurers offered deep discounts compared with the districts' self-insurance costs.

"These are business officials focused on one-year budgets who tend to focus on the short term and not on the long term," Mr. Wilson explained.

The Ventura County Schools Self-Funding Authority is one of many JPAs that realized significant short-term gains by buying commercial workers comp insurance. It will have saved a little more than $1 million by going fully insured between July 1, 1995, and June 30, 1998, estimates

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Spotlight on

Benefits: Health Care Innovations

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Coverage of TV rights limited

By GAVIN SOUTER

NAGANO, Japan—Budgetary constraints mean insurance would cover less than half the $500 million that broadcasters have paid for the television rights of the 1998 Winter Olympic Games.

As for past Games, the organizing committee can afford to purchase only between $150 million and $200 million in TV rights coverage.

However, if the Nagano Games follow the loss-free tradition of recent Olympics, neither the insurers nor the Nagano Olympics Organizing Committee will be troubled by any claims. The estimated 2 billion viewers around the world should, if they choose, be able to watch all the events in their entirety.

Indeed, even after a pipe bomb exploded at the 1996 Summer Games in Atlanta, the Games and the TV coverage continued without any cancellations.

That continued clean record should lead to broader coverage for future Games, said Patrick Vajda, director of sport and events insurance at Paris-based brokerage Gras Savoye S.A. Gras Savoye has placed the TV

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PHOTO: AFP

Insurance coverage is in place for the 1998 Winter Olympic Games, which begin Feb. 7 in Nagano, Japan.

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NEWSPAPER

Updates

Ruling benefits policyholders

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when the damage was discovered, or manifested, is triggered.

Many Michigan policyholders would have lost all pollution coverage with a manifestation trigger. The Supreme Court earlier ruled that the sudden and accidental pollution exclusion, adopted in the early 1970s, bars coverage for gradual pollution damage. For many policyholders, pollution damage occurred gradually, and often the damage was not discovered until the late 1970s at the earliest, noted policyholder attorneys involved in the case.

"The decision breathes new life into insurance policies that basically had been nullified by the Michigan Court of Appeals," said policyholder attorney David Fink of Fink Zausmer P.C. in Detroit, which represented Gelman Sciences Inc. in the case.

Mr. Fink noted that a policyholder's pollution-related defense costs often far exceed its cleanup costs. The Michigan Supreme Court ruling should allow policyholders to recover all of those costs, because they are "a joint and several obligation of each insurer." However, Mr. Fink expects the next coverage battle will be over insurers' attempts to allocate some of those costs to policies with the sudden and accidental pollution exclusion.

Twelve of 13 other state supreme courts that have considered the trigger issue have ruled similarly, policyholder attorneys say.

RRG may pair with insurer

NASHVILLE, Tenn.—Consolidated Catholic Casualty Risk Retention Group, a group captive for Catholic health care systems, is negotiating a possible consolidation with Preferred Physicians Insurance Co.

Vermont-domiciled CCCRRG, with offices in Nashville, Tenn., provides up to $50 million in excess general liability limits to its 11 health care system owners and generated 1996 gross premiums of $9 million. Three of the risk retention group's members also are owners of Omaha, Neb.-based PPIC, which writes primary medical malpractice coverage for physicians affiliated with owners' hospitals and which is licensed in 30 states.

Robert Sinclair, president and chief executive officer of CCCRRG, said the merger talks are being driven by several factors, including a drop in premium at the risk retention group caused by consolidation among its members; the desire of CCCRRG to expand its products beyond the current excess coverages; and PPIC's desire to strengthen its capital base.

CCCRRG reported policyholder surplus of $43.7 million as of last Sept. 30, while PPIC, with $16.2 million in 1996 direct written premiums, reported surplus of $12.8 million as of the same date.

The two have formed a task force to evaluate the possible consolidation. The review is expected to be completed before the insurers' boards meet in early May, Mr. Sinclair said.

OSHA extends CCP deadline

WASHINGTON—The Occupational Safety and Health Administration has extended to Feb. 17 the deadline for employers to sign up for its new Cooperative Compliance Program.

The agency said the extension of the sign-up period from the Jan. 30 deadline stemmed from a variety of concerns. The concerns include the bad weather in the Northeast and a greater degree of interest in the program than OSHA had anticipated.

The program targets more than 12,000 work sites with the highest frequency of workplace accidents and lost workdays. Participating companies must carry out a variety of safety-related activities, including creating a formal health and safety plan, or face the possibility of extensive OSHA inspections.

Four employer groups, questioning whether the program is truly cooperative rather than coercive and whether it was properly implemented, asked a federal judge late last month to review the matter (*BI*, Jan. 26). The groups also asked OSHA to suspend the program until the judge had ruled. As of press time, OSHA had not issued its formal response to that request.

OSHA Administrator Charles Jeffress said in a statement issued last week that the suit "is frivolous; it has no merit and aims only to hinder our ability to protect working men and women from often life-threatening hazards." Mr. Jeffress noted that the "goal of CCP is to use OSHA's limited resources to identify dangerous work sites and work in partnership with management and labor to find and fix hazards."

Ruling protects employee suits

WASHINGTON—Older workers who accept severance packages still can sue their former employers under the Age Discrimination in Employment Act under certain circumstances without returning their severance even if they have signed waivers of all legal claims, the Supreme Court has ruled.

In *Dolores vs. Oubre vs. Entergy Operations Inc.*, the high court ruled 6-to-3 last week that Entergy Operations Inc. could not enforce the waiver because it had not fully complied with the Older Workers Benefit Protection Act of 1990, through which Congress had amended the ADEA.

The case involved a 41-year-old Louisiana woman who was told her job performance was poor and that she would be fired if she did not agree to a severance package in return for agreeing not to sue her employer, New Orleans-based Entergy (*BI*, Sept. 29, 1997).

Ms. Oubre accepted the package and sued nearly a year later, alleging age discrimination. Lower courts held that Ms. Oubre could not sue unless she reimbursed Entergy for the severance pay.

The high court majority disagreed. Writing for that majority, Justice

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Errors & omissions

Because of incorrect information supplied to *Business Insurance*, a Jan. 19 story reported that Bath Iron Works Corp. had no business interruption coverage. The company does carry business interruption insurance.

Arizona ruling deals blow to utilization review

By DAVE LENCKUS

PHOENIX—An Arizona Supreme Court decision heralded as providing landmark protection for managed health care consumers also raises some potential problems for health plan sponsors and participants.

The first-of-its-kind decision threatens the viability of utilization review and, as a result, the stability of health care costs, plan representatives and attorneys say.

Without explanation, the state's high court on Jan. 21 affirmed an

Florida high court strikes managed care ballot initiative . . . . . page 31

appellate court decision allowing the state's Board of Medical Examiners to take action against a managed care plan's medical director.

The board in 1994 determined the medical director of Blue Cross & Blue Shield of Arizona in Phoenix inappropriately denied coverage to a group plan participant after assessing the medical necessity of treatment the patient's physicians prescribed. The appellate court ruled the director, a physician, practiced medicine in denying the coverage. He became subject to the medical

See **Arizona** *on page 31*

Clarifying COBRA eligibility

Supreme Court will rule on those with other coverage

By JERRY GEISEL

WASHINGTON—As a cancer patient who expected high medical bills, James Geissal wanted the best health insurance possible after Moore Medical Corp. dismissed him in 1993.

After termination, Mr. Geissal, who was 62 and worked seven years for Moore, was offered COBRA coverage by Moore and made monthly premium payments.

Mr. Geissal also had coverage as a dependent under a health care plan his wife, Bonnie, received through her job at Trans World Airlines. Mr. Geissal kept the TWA dependent coverage after he lost his job at Moore and became a COBRA beneficiary.

Now, the U.S. Supreme Court has agreed to decide whether individuals who are covered by another employer's health plan at the time of termination are entitled to COBRA coverage through their former employer. This marks the first time the high court has taken up a case involving the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Mr. Geissal "wanted the best treatment regardless of the cost," said Sheldon Weinhaus, a principal with Weinhaus & Dobson in St. Louis. He represented Mr. Geissal, who has since died, and now represents Bonnie Geissal.

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AT&T offers enhanced benefits in effort to reduce workforce

By ROBERT KAZEL

NEW YORK—AT&T Corp. is hoping a generous early retirement benefits package for managers will help in its drive to eliminate between 15,000 and 18,000 positions over the next two years.

For virtually all segments of management in the company's mainstay long-distance operation, the company will offer expanded pension benefits and make it easier to obtain post-employment company-paid life and health insurance.

To some veteran executives, AT&T's offer could include accelerated retirement benefits amounting to hundreds of thousands of dollars in cash. But it is also designed to offer sizable sums to young managers who otherwise might not consider quitting.

New York-based AT&T will eliminate 10,000 to 11,000 management positions over the next two years, said George Fromme, acting human resources vp. He works in the company's Morristown, N.J., office.

This will begin with a voluntary "window" period during which managers may declare their intention to leave. If not enough take

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Premiums down, claims up

Combination in D&O market could hurt insurers: Survey

By MICHAEL PRINCE

Premiums in the directors and officers liability insurance market have fallen to a level not seen since 1985, a survey finds.

D&O premiums have fallen for the third consecutive year, with last year's drop the largest since the insurance crunch of the mid-1980s, and lawsuit frequency is at an all-time high, the Watson Wyatt Worldwide study shows. The premium for a typical D&O policy dropped about 15% in 1997 compared with 1996, while it decreased 8% in 1996 over the prior year, according to the study.

"Prices are now back to the level they were at the beginning or before the crisis" in D&O insurance in 1985, Mark Larsen, a consultant with Watson Wyatt in Chicago and author of the survey, said in an interview.

"They just continue to go down, despite some evidence that they should go the other way," he added.

What might cause premiums to rise is the increase in suits. The 1997 survey shows lawsuits hit an all-time high, rising slightly from 1996. Although Mr. Larsen described the increase as "modest," it continues a decade-long upward trend.

The 1997 survey revealed the same trends that emerged from the 1995 and 1996 surveys: lower premiums and more lawsuits. "In the long term, it could be a problem" for risk managers concerned about the financial health of their D&O insurers, Mr. Larsen said.

The survey is the 20th of its kind that Watson Wyatt has

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- We are glad the Florida Supreme Court—even if only for procedural reasons—disallowed a ballot initiative that could have seriously harmed managed care in the state, this week's editorial says. **PAGE 8**
- Bermuda-based ACE Ltd. is moving to streamline its involvement in Lloyd's of London. **PAGE 31**
- State regulators assert in an NAIC white paper that they have the right to regulate managed care entities that assume risk. **PAGE 36**

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Health Care Innovations

New ideas in health care cost control

HMO extras may burn out under glare of costs

By JOANNE WOJCIK

Health maintenance organizations in the last year have marketed a variety of programs to attract participants, but mounting cost pressures may force the health plans to separate the wheat from the chaff among the new offerings.

"Fifteen years ago, HMOs tried to differentiate themselves by offering preventive care," said Tom Beauregard, a consultant in the Rowayton, Conn., office of benefit consultant Hewitt Associates L.L.C. "Now they are offering direct access, fertility coverage, alternative medicine."

While some of these benefits are inexpensive marketing tools, others could add to health care costs.

"The HMOs are going to have to take a real hard look at which programs save money in the long run and which cost more," said Leslie Schneider, a principal in Buck Consultant Inc.'s Atlanta office.

Higher costs are a concern when shareholders are demanding better financial performance; employers are making it known that HMOs must keep premiums in check; and providers are seeking more compensation from many plans after seeing their incomes erode with the expansion of managed care. Technology also pushes up health care costs.

Already, Aetna U.S. Healthcare announced last month that it is dropping coverage of assisted reproductive techniques from its basic benefits package in response to pressure from Wall Street investors to pare costs and increase profits.

Aetna, which said some people were enrolling just to take advantage of the benefit—which can cost $8,000 per treatment—later backed off. The insurer said it would cover in vitro fertilization, but only for employers who request it and pay an additional premium.

The Aetna decision on fertility coverage has added fuel to the debate over whether health plans can afford to offer such rich benefits.

Some examples of the new HMO coverage offerings:

- Several insurers in Washington State—including Blue Cross of Washington and Alaska, Group Health Cooperative and Kaiser Foundation Plan of the Northwest—are offering coverage for "complementary" and "alternative" health care not usually prescribed by doctors who practice Western medicine.
- Oxford Health Plans in March 1997 unveiled "Oxford On-Call," a 24-hour toll-free emergency triage telephone center staffed by Oxford registered nurses.

The Norwalk, Conn.-based HMO also provides members open access to a network of alternative medicine providers, including chiropractors, acupuncturists, homeopaths, yoga instructors, massage therapists, nutritionists, dietitians and (in Connecticut only) naturopaths.

- Blue Shield of California in September 1997 launched a new program called Lifepath, a network of chiropractic and acupuncture practitioners, massage therapists, stress management seminars and fitness clubs and services available at a discount to HMO members.

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Direct reimbursement makes dentists smile

Proponents say program holds down costs

By MICHAEL PRINCE

The dentists strike back.

In an attempt to offer employers an alternative to dental managed care plans, the American Dental Assn. is aggressively promoting an alternative dental benefit concept called direct reimbursement.

Direct reimbursement essentially is a self-funded fee-for-service program in which an employer directly reimburses employees, who are allowed to see the dentists of their choice.

In part because insurers aren't trying to sell it and brokers largely aren't familiar with it, a relatively small number of employers have implemented the idea.

Proponents say direct reimbursement is a winner for employers, employees and dentists and holds down costs by eliminating the administrative expense of an insured or managed plan.

Critics of the concept charge, however, that without oversight of dental care by a third party, such as an insurer or managed care company, employer costs will rise due to unnecessary or inappropriate treatment.

"This is their attempt to fight managed care," Cathye Smithwick, a consultant with William M. Mercer Inc. in San Jose, Calif., said of the ADA's push for direct reimbursement programs.

A key feature of direct reimbursement is that it is uninsured, yet proponents say the costs of retaining this risk are not excessive for employers.

Costs for dental benefits are very predictable, said Rick Durig, president and chief executive officer of Minnesota Dental Benefits in St. Paul, Minn., a wholly owned for-profit subsidiary of the Minnesota Dental Assn.

"You can predict within pennies the cost for dental care," he said.

Because there is almost no risk

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Savvy employers escort managed care practices into rural communities

By ROBERTO CENICEROS

Large employers with operations in smaller communities are taking the initiative to introduce managed care concepts to their workers and health care providers.

Additionally, a recent federal law allowing private plans to compete with Medicare could spawn doctor networks that would be in a position to contract with employers in rural areas, one consultant says.

Also, like employers in larger areas, some are doing their own contracting.

For example, in Sioux Falls, S.D., benefit executives for John Morrell & Co. examined the area's health care landscape in 1996 and found that the company's young employees were charged more for hospital visits than Medicare patients, who typically require greater treatment intensity.

The pork-processing company also found that Sioux Falls has more than 30 well-paid cardiologists, when eight typically are enough to serve a population of about 110,000 people, said Wayne A. Ure, Morrell's corporate director of benefits and workers compensation in Sioux Falls.

With that information, Morrell contracted directly with two hospitals—one in Sioux Falls and one in Sioux City, Iowa—and doctors to create its own plan, called Morrell Care. Although definitive results are not yet available, preliminary data since implementing the contracts in 1997 suggests the company has cut its costs about 20% through direct contracting, Mr. Ure said.

The plan's success is shown by continued increases in employee interest, with 95% now participating in the plan.

Direct contracting is a good way for employers to lower costs in small communities where managed care has made few inroads, experts say. Sioux Falls has two hospitals and plenty of medical care providers; smaller towns, however, present a tougher yet not insurmountable challenge, experts

See **Rural care** *on page 6*

Utilization management sees the big picture

Emphasis has shifted to ensuring quality care for patients

By JUDY GREENWALD

When Jane Hopper's 9-year-old son, Adam, was diagnosed with bone cancer in 1995, the last thing she wanted or had time for was constant calls to confirm coverage for treatment.

But that turned out to be unnecessary, thanks to the disease management program at Minneapolis-based United HealthCare Corp.'s utilization management operation.

With her case manager, Judy, Ms. Hopper had a friendly contact who was able to smooth the way so the worried mother could focus instead on where she was needed most: helping her son get better, says Ms. Hopper, who works at her family's Hickey & Son Funeral Home in Monticello, Ky.

"She took care of everything for us, and any time we had a question about a billing or a filing, we just called her and she handled it," said Ms. Hopper.

"It's wonderful when you don't have to make phone call after phone call after phone call," said Ms. Hopper. "If I had had to chase each individual bill down on my own, I would never have had time to take care of my son."

Ms. Hopper's son, now 12, has recovered after extensive chemotherapy and surgery but still requires physical therapy and quarterly checkups.

The days are largely over when employees viewed utilization management companies and their prior-approval requirements as an irritation at best and a bar to adequate treatment at worst. That's because of changes driven in part by employer concern as well as by the general backlash against managed care, observers and utilization management officials say.

Today, United HealthCare's approach is in line with an industry trend toward disease management—the management of long-term illnesses such as cancer, diabetes and asthma—and a more sophisticated approach to basic case management, the observers say.

This trend acknowledges that an emphasis on quality ultimately reduces costs, they say.

"The main reason employers implemented utilization management and the whole industry sprung up was the need to control excess utilization, but I think another reason that the industry exists is to make sure that unnecessary, dangerous care is not

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HMOs

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• Health Net, the Woodland Hills, Calif.-based HMO subsidiary of Foundation Health Inc., began offering direct access to acupuncture treatment last year. The move is the next step in a planned expansion of its complementary and alternative medicine coverage, which is still subject to approval by the state Department of Corporations, which regulates HMOs.

While HMOs are aggressively marketing these additional services, employers aren't buying most of them. Most employers have established a core package of benefits they want plans to offer so they can control costs, Mr. Beauregard said.

But ultimately these programs—aimed at attracting individual buyers—could lead to higher costs for everyone, because HMOs still have to recoup the expense of marketing and administering them.

"Because you put in the benefit doesn't mean it's free," said Helen Darling, manager of international compensation and benefits for Stamford, Conn.-based Xerox Corp.

And HMOs can't keep passing on the costs of these benefits to patients and payers without some kind of backlash, experts say. Therefore, some of them will be eliminated.

Buck's Ms. Schneider predicts HMOs will likely eliminate exercise incentives and some diet programs now that new research has put into question the long-term health benefits of weight loss.

"But disease management they're likely to keep," she said, as well as "true wellness and early detection programs," such as breast and cervical cancer screenings.

'There are too many really important things that we need, and if we cover "comfort care". . .there won't be enough money left to pay for them,' says Xerox's Helen Darling.

Many plans will likely focus more on disease management programs, which have proved their effectiveness in clinical studies, agreed Randy Abbott, principal and health care practice leader in the Little Falls, N.J., office of Watson Wyatt Worldwide.

It was Oxford Health Plans, one of the more innovative HMOs, that pioneered the practice of "care teams" in disease management. The care teams consist of physicians, hospitals, therapists, social workers and other health professionals that specialize in treating specific illnesses and do so for a capitated fee (*BI*, March 31, 1997).

Now such approaches have a chance to prove their worth, Mr. Abbott said.

For the most part, enhancing health care quality can reduce costs over the long haul, said Ms. Darling.

For example, while disease management programs may cost more to implement in the short run, in the long run they "keep costs down by preventing the likelihood of reinjury," Ms. Darling said.

But some innovations, especially those lawmakers have mandated, "are increasing costs without managing care better," she said. She cited open access to non-network providers as an example of a benefit likely to increase costs without enhancing quality.

Open access, the one innovation that employers are likely to purchase, can raise premiums 5% to 15%, Mr. Beauregard said. Indeed, some experts believe there will be tighter controls on the use of specialists.

On the other hand, some experts believe alternative medicine coverage will survive any cutbacks.

"People are focusing on Oxford, but they haven't backed away from alternative medicine programs, homeopathic care, acupuncture or even massage therapy," pointed out Thomas Billett, vp at the MEDSTAT Group in Stamford, Conn.

That's because "those programs are not terribly costly to begin with," he said, estimating they may add less than 3% to the overall cost of outpatient services.

In some cases, HMOs "could make an argument those benefits are cost-saving," he said.

For example, part of the reason Health Net decided to offer alternative medicine was based on its experience with chiropractic care, according to a company spokeswoman.

"Studies show that chiropractic care reduces the cost of treating lower back pain," she said. "We used the chiropractic model to show what alternative treatment could achieve."

But Xerox's Ms. Darling is skeptical that HMOs that cover alternative medicine will realize any long-term savings.

"People should be able to budget for some of these expenses themselves," she said.

"There are too many really important things that we need, and if we cover 'comfort care' such as massage therapy, there won't be enough money left to pay for them," Ms. Darling asserted.

Rather than abandoning inexpensive benefits like alternative medicine, "more likely we'll see moves more like Aetna's dropping of fertility benefits" from its basic package, which are significantly more expensive, MEDSTAT's Mr. Billett predicts.

HMOs also will likely put tighter controls on the use of all benefits, most experts believe. "Ultimately, what we will see is more emphasis on control and accountability," Mr. Billett said.

For example, HMOs will likely limit out-of-network benefits or speciality referrals, or the plans will put more financial risk on the providers themselves, he suggested.

"We've reached the end of the era of HMO expansion at the expense of fee-for-service indemnity plans," Mr. Billett observed. Up to now, HMOs "have built market share by taking members away from indemnity plans," he said.

In the future, plans can't afford to compete by offering more benefits, he said.

See **HMOs** *on page 6*



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HMOs

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Instead, "they'll compete on cost, quality and network accessibility," he predicts.

HMOs also are likely to maintain their investments in data collection and interpretation, an effort that began primarily in response to the National Committee for Quality Assurance's HEDIS project, experts say.

This is certainly ironic given that initially many HMOs complained about participating in the data-collection project, observed Ms. Schneider.

"While they complained about participating in HEDIS, they may be able to use it to their advantage," she said.

"The well-managed program needs data to succeed," agreed Mr. Abbott.

For example, the data that shows the long-term cost-effectiveness of performing certain preventive health care measures will help HMOs guide their physicians toward more cost-effective medicine, according to Mr. Abbott.

HMOs also can use this technology to better track the performance of individual physicians, he added.

In the future, "the differentiation will be the ability to invest in the technology and the telecommunications structure needed to improve the quality of health care," Mr. Abbott said.

Eventually, such technology also will enable plans to check on insurance coverage, make referrals, obtain precertifications and even to get paid.

"Ultimately, the entire financial transaction must be conducted electronically," he said.

Widespread use of technology is certain to also lower overhead in the long run, according to Mr. Abbott.

Technology may also serve to separate the winners from the losers in the HMO market share battle, Mr. Abbott said.

"Many of them will not be able to keep up," he said. "The weak will not survive. There will have to be more mergers and acquisitions."

What is happening to HMOs today is merely a continuation of the evolution and consolidation of managed care, some experts theorize.

Some think more consolidation of the managed care market would help keep costs in check, because a pool of fewer HMOs would give them more leverage in negotiating payments with providers.

"Long-term, I think there's still significant (profit) margin in the market," observed Hewitt's Mr. Beauregard.

But he thinks it may take as long as 10 years for the necessary consolidation to take place.

"Meanwhile, we'll see plans charge significant increases, and those plans will lose business," he predicts.

"Most people think HMOs are awash in profits, but there's no extra money there," observed Mark Hyde, CEO and president of Lifeguard, a non-profit HMO in San Jose, Calif.

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Rural care

Continued from page 3

say.

"As an employer, you don't have a lot of negotiating clout with a one-hospital town, because you can't say, 'If I send you all my employees, give me a nice, big discount,' " said Kirby Bosley, a William M. Mercer Inc. consultant in San Diego. "They will say, 'What are you going to do if I don't?' "

What semblance of managed care does exist in the hinterlands generally consists of preferred provider networks.

But just moving to that stage of managed care requires much work.

Companies that specialize in forming preferred provider networks are not always eager to expand into small markets, said Roy Merrill, health care consultant for Watson Wyatt Worldwide in Denver.

Typically in a rural setting, the patients tend to be sicker, and there is a higher rate of indigent care, he explained. Or there may not be enough insured lives to make a network worthwhile for a health care management company.

Employers who use managed care plans for their urban employees often are forced to offer indemnity plans to workers in outlying areas, Mr. Merrill said. But with health care costs expected to rise, large employers increasingly ask about managed care's prospects for those employees in remote facilities, too.

"They're asking for it, but unfortunately, it's generally not available," Mr. Merrill said.

"There is no roaring groundswell toward managed care in rural areas," Mercer's Ms. Bosley agreed.

But there has been some progress, she said. Glendale, Calif.-based Nestle USA Inc. is one of Ms. Bosley's clients that has gained experience with applying managed care in rural locations. Nestle has food processing plants in agricultural communities across the United States, said Michael Pos, manager of hourly benefits for Nestle.

Mr. Pos said Nestle has chosen to work with CCN, a San Diego-based health care management company that administers PPO networks.

Working with a PPO vendor can eventually gain him negotiating leverage in rural areas where competition is lacking, Mr. Pos said. That can come about because a network company can eventually attract other employers in the region, and the participating employers can combine their clout.

The strategy requires a long-term commitment from employers, Mr. Pos advised.

Working closely with human resource departments in remote areas also is important because they know the local landscape, and they have information about employees that is not always reflected in claims experience, such as which providers employees really prefer.

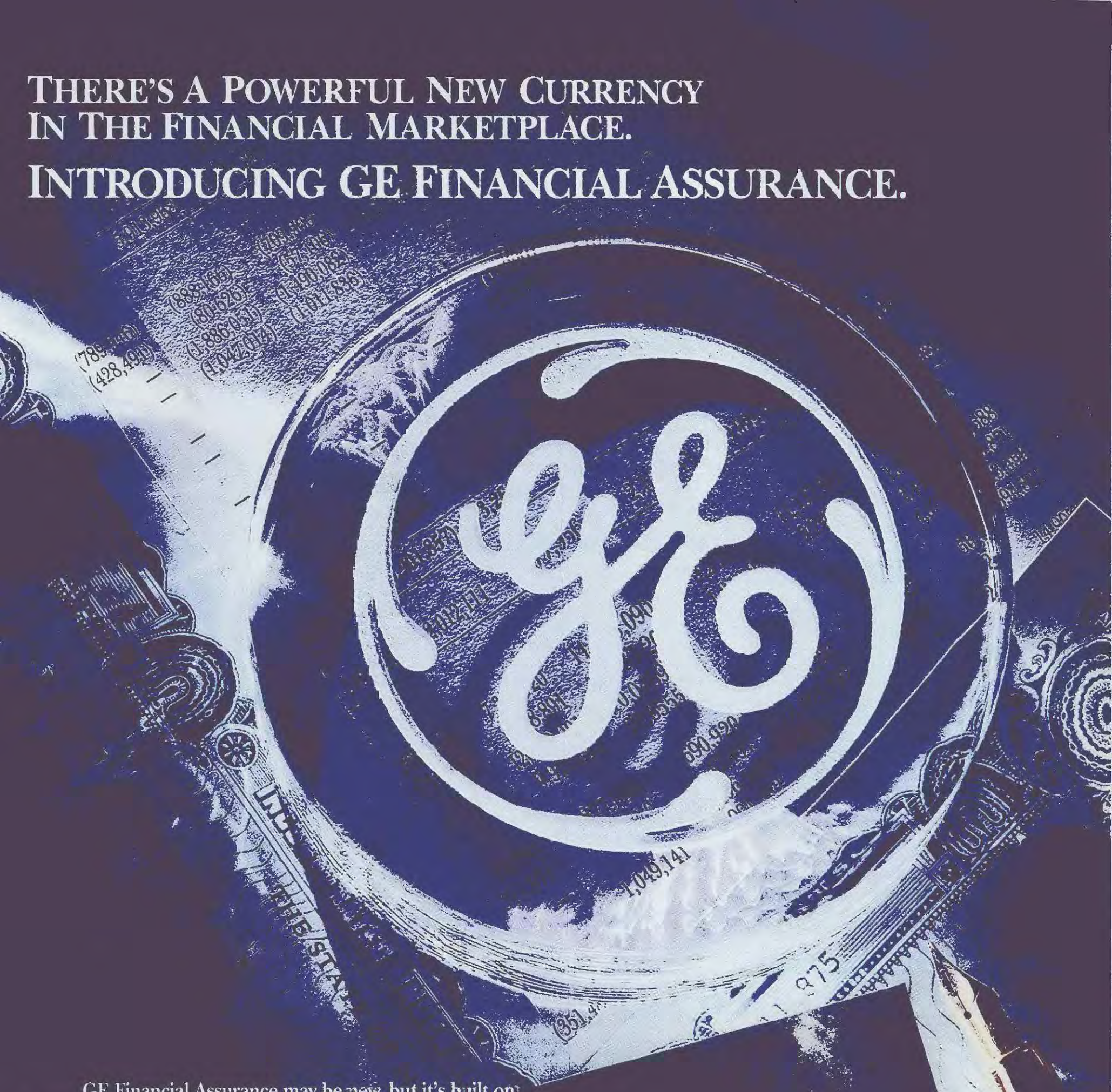
Employee communications and consideration of worker needs becomes more than just a benefits administration cliche, Mr. Pos said. Cooperating employees can help recruit leery doctors into the network by promoting it to them.

But employers need to be flexible while building the network. They

See **Rural care** *on page 12*

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Opinions

Managed care survives scare

WE ARE RELIEVED that the Florida Supreme Court has disallowed a proposed ballot initiative that, if approved by voters, would have amended the Florida Constitution and gutted managed care programs in the state.

Although the state court rejected the initiative for procedural rather than substantive reasons, we applaud the end result all the same.

As we report on page 31 in this issue, the Florida court unanimously ruled that the proposed initiative had not met state requirements that it be limited to a single subject and clearly inform voters of its complete meaning.

The proposed constitutional amendment would have allowed members of managed care plans to choose their physicians. If passed by voters, the proposal would have had an especially broad impact in Florida, because managed care is a key element of the state workers compensation system.

The proposed initiative starkly illustrates the significant threat facing managed care plans across the country.

We think it is significant, however, that the threat in Florida was not led by outraged employees and consumers; rather, it was spearheaded by chiropractors, workers compensation plaintiffs attorneys and some doctors—all of whom stood to gain financially from the change.

Employees, we believe, recognize and accept that managed care is a trade-off: In exchange for restrictions on choice of physician, health care costs are considerably lower than under traditional fee-for-service plans. Indeed, if managed care payers were unable to steer plan participants to selected doctors that have agreed to negotiated or capitated fees, costs would rise significantly for both group health and workers comp plans.

In group health programs, those costs might be passed on to plan participants in terms of, for example, increased premium contributions from employees. Smaller employers might simply opt to stop providing costly health insurance or be discouraged from offering plans to begin with. Under workers comp, higher rates due to rising medical costs could drive some smaller employers out of business.



Having said this, we do not believe managed care plans are above scrutiny. Practices by some managed care plans widely considered abuses by the public, such as putting pressure on providers to discharge women from the hospital a day or less after giving birth, have triggered widespread outrage and legislative remedies.

As we've said, we believe the trade-off inherent in managed care plans—less choice but lower costs—is one that is generally understood by the public. Reckless interference with that trade-off gets us ever closer to days past when complete freedom of choice meant absolutely out-of-control health care costs.

We know the result of spiraling medical costs means health care plans become less affordable, with employers dropping coverage and a reduction in the number of Americans without group coverage.

The forces that would undo managed care would be wise to keep that in mind before employees and consumers suffer the consequences.

Letters

Liquidation of EMLICO belongs in Bermuda

To the editor: We are writing in response to your editorial of Jan 19 ("Grab Chance to Fix Mess"). Even for an industry publication, this editorial is surprisingly one-sided. Your editorial simply parrots the allegations of a few reinsurers whose only interests are delay and avoidance of their obligations to pay under contracts of insurance with EMLICO. Your editorial concludes, wrongly, that EMLICO should be returned to Massachusetts.

The basic facts are straightforward. EMLICO was a mutual insurer that wrote insurance for thousands of policyholders for more than 65 years. General Electric was the largest policyholder of EMLICO. At a time when it faced large claims from GE for environmental and asbestos risks, EMLICO applied to Massachusetts to move to Bermuda.

As part of its application, EMLICO proposed a structure to entirely protect the non-GE policyholders in the event of an insolvency of EMLICO (which if it had occurred in Massachusetts would have threatened the coverage of those policyholders) and entirely protect the Massachusetts Insurers Insolvency Fund from GE's claims, (which if an insolvency had occurred in Massachusetts would have affected all Massachusetts policyholders). The commissioner found it was in the best interests of those policyholders—a conclusion that has never been seriously challenged, and a consideration to which your editorial inexplicably gives no weight.

Now, 2½ years later, the Massachusetts court ruled the commissioner misinterpreted the relevant statute; the court decided that this statute precludes any insurer domiciled in Massachusetts from relocating anywhere outside the United States. The court then stated that while EMLICO remained a Massachusetts insurer, its status as a Bermuda corporation was a question of Bermuda law to be decided by a Bermuda court.

The Massachusetts court decision was not based on any finding of impropriety by EMLICO or the Massachusetts commissioner of insurance. The decision does nothing to change the fact that EMLICO remains a Bermuda corporation in the process of being wound up in Bermuda. Nor does it change the fact that Bermuda has a fair system for the liquidation of insurers—a system under British law that governs scores of Bermuda companies conducting business in America.

From the beginning, your publication has steadfastly avoided the real issue in this controversy. A few of EMLICO's reinsurers have spent tens of millions of dollars to avoid and delay their contractual obligations, obligations unaffected by the location of EMLICO's liquidation. Indeed, every court that has examined the issue, including the Massachusetts court, has found that the reinsurers are debtors of EMLICO whose only interests are contrary to EMLICO's. As to the reinsurers' assertions of harm in connection with EMLICO's redomestication, the Supreme Judicial Court of Massachusetts found that the reinsurers failed to state any "cognizable injury directly related to the commissioner's order" authorizing EMLICO's move to Bermuda.

EMLICO should be wound up as promptly and efficiently as possible. This means Bermuda, where EMLICO exists and which has an undeniably fair system and where more than two years have been spent in precisely this task.

Robert W. Risch
Manager-State Government Relations
General Electric Co.
Boston

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Rural care

Continued from page 6

need to allow workers to receive in-network benefit levels even if they go outside the network during the building process. That gives employees a taste of the benefits. It also prods doctors to join when they see some patients migrate into the network. Eventually employers gain a little more negotiating leverage, Mr. Pos said.

Do not wait until the network is complete and in place before offering its benefits, Mr. Pos said.

"It may never happen," Mr. Pos explained. "You really need to initiate the PPO with the providers you have and be really user-friendly to the employees in the process of building it. That allows the providers and hospital to know you are serious in your desire to build a network.'

Employers with little negotiating clout also can appeal to a hospital or providers' sense of community, Mercer's Ms. Bosley advised. Visit the local hospital and point out that it is in both your interests to improve services and control costs.

Mr. Pos agrees. "You have to be really patient and show them that in the long run for the company to be in business, we need to have competitive pricing for health insurance," he said.

"There has to be a major amount of trust," Mr. Merrill added. Adversarial relations don't work when there is a lack of competition and everyone in the community knows one another, he said.

A shortage of doctors also can hamper the spread of managed care in some regions, several observers said. However, Wal-Mart Stores Inc.—a company that operates retail stores in many smaller communities—has found in some cases that by increasing the number of insured lives in an area, it can attract additional providers to the region, said Dan Filla, Wal-Mart director of network benefits in Rogers, Ark. That is particularly true in locations where Wal-Mart places its distribution centers, because they employ roughly 10 times the number of employees working at a Wal-Mart retail store.

Adversarial relations don't work when there is a lack of competition and everyone in the community knows one another, says Roy Merrill of Watson Wyatt.

Wal-Mart also relies on insurers and companies such as CCN to establish doctor networks, Mr. Filla said. In the past, Wal-Mart contracted directly with hospitals. But now, direct contracting would require a huge benefits staff to negotiate with doctors across the country. So Wal-Mart hires network companies to handle its contracts with providers and hospitals.

However, establishing a new network in rural areas requires more employer involvement than in urban areas. For example, to help a network management company establish a network, Mr. Filla will write letters and call local doctors. If a Wal-Mart store manager has contacts at the area hospital, Mr. Filla may have that manager make an introduction.

"It doesn't seem like we need to in the urban areas, because the doctors are more network-oriented," Mr. Filla said. "The networking idea has been brought to them by other insurance or employer groups."

Rural doctors also may require more education and hand-holding to implement managed care practices, said Sherrill Mauzy, senior account manager for CCN. Some are not even familiar with a discount fee schedule typically used to pay network doctors. In those cases, CCN at first pays them a percentage discount off the fees the doctor normally charges patients.

That makes it easier for the doctors to judge how much of a discount they can afford to give, and it is simple for them to adjust their billing, Ms. Mauzy said. After a relationship between the providers and the payers develops, CCN then can teach the doctors how to administer things such as fee schedules.

Morrell kept it easy for providers when it first started creating its health plan one step at a time, Mr. Ure said.

For example, Morrell began by reaching an agreement with the doctors, paying them based on a discount fee schedule with a long-term goal of moving toward capitation agreements.

In return, Morrell made it easier for the doctors to see their employees. The company's plan eliminates practices such as gatekeeper doctors, precertification and second surgical opinions. Morrell Care also provides a financial incentive and increased benefits for employees who see network doctors.

Morrell studied the area's hospitals—Sioux Falls and Sioux City, Iowa, about 75 miles to the south, each has two hospitals—by looking at Medicare reports and other available information. The company found that 7% a profit margin was common.

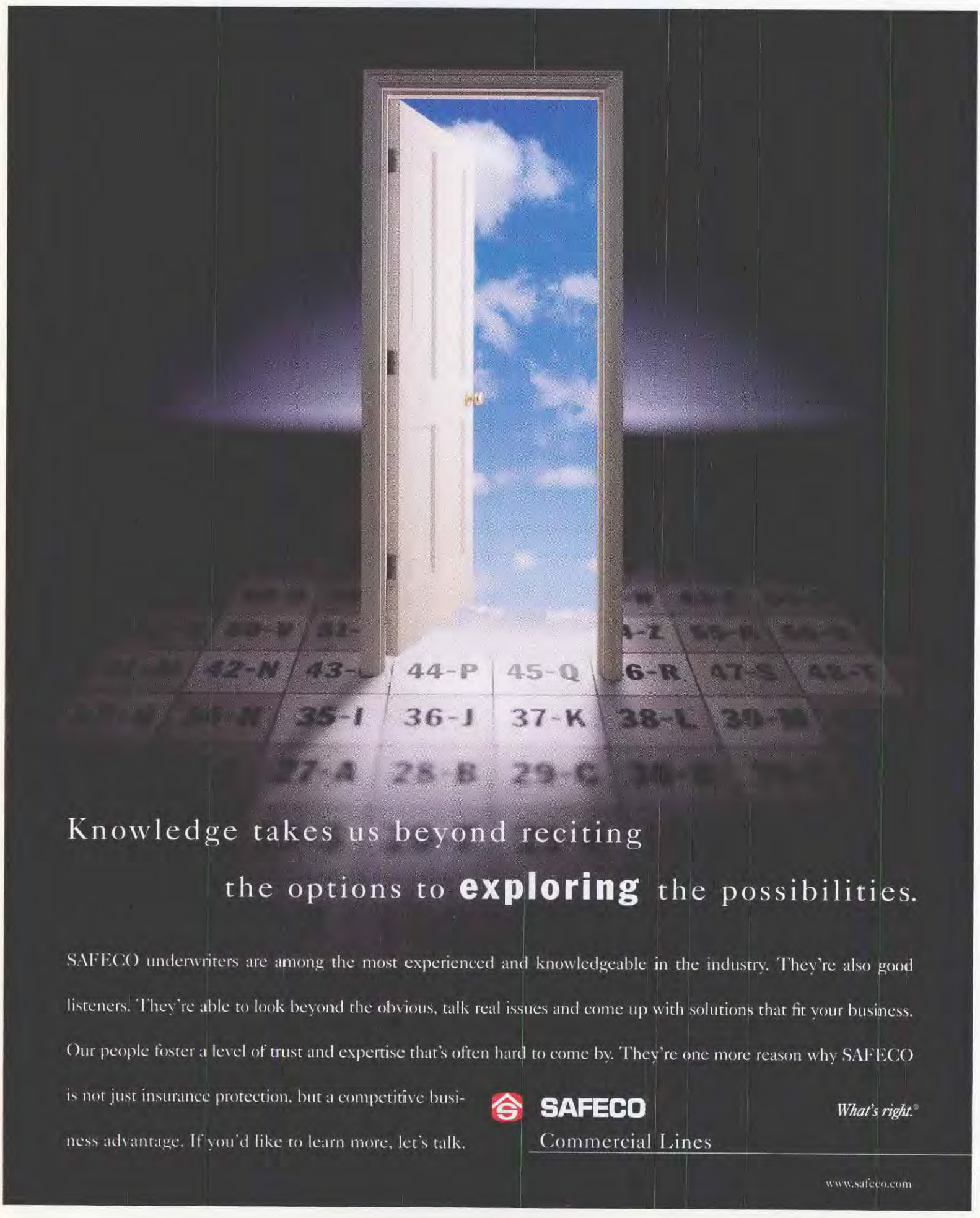
"Everyone of our hospitals, with one exception, was way on the top end of its peer group in terms of income and profitability," Mr. Ure said when speaking in November at The National Managed Health Care Congress in Los Angeles. The information was then used in discussions with area hospitals.

Eventually it was clear which hospitals wanted Morrell's business, Mr. Ure said. Those hospitals offered to base their charges on a Medicare diagnostic related group fee schedule but adjusted it to account for the company's younger and healthier population.

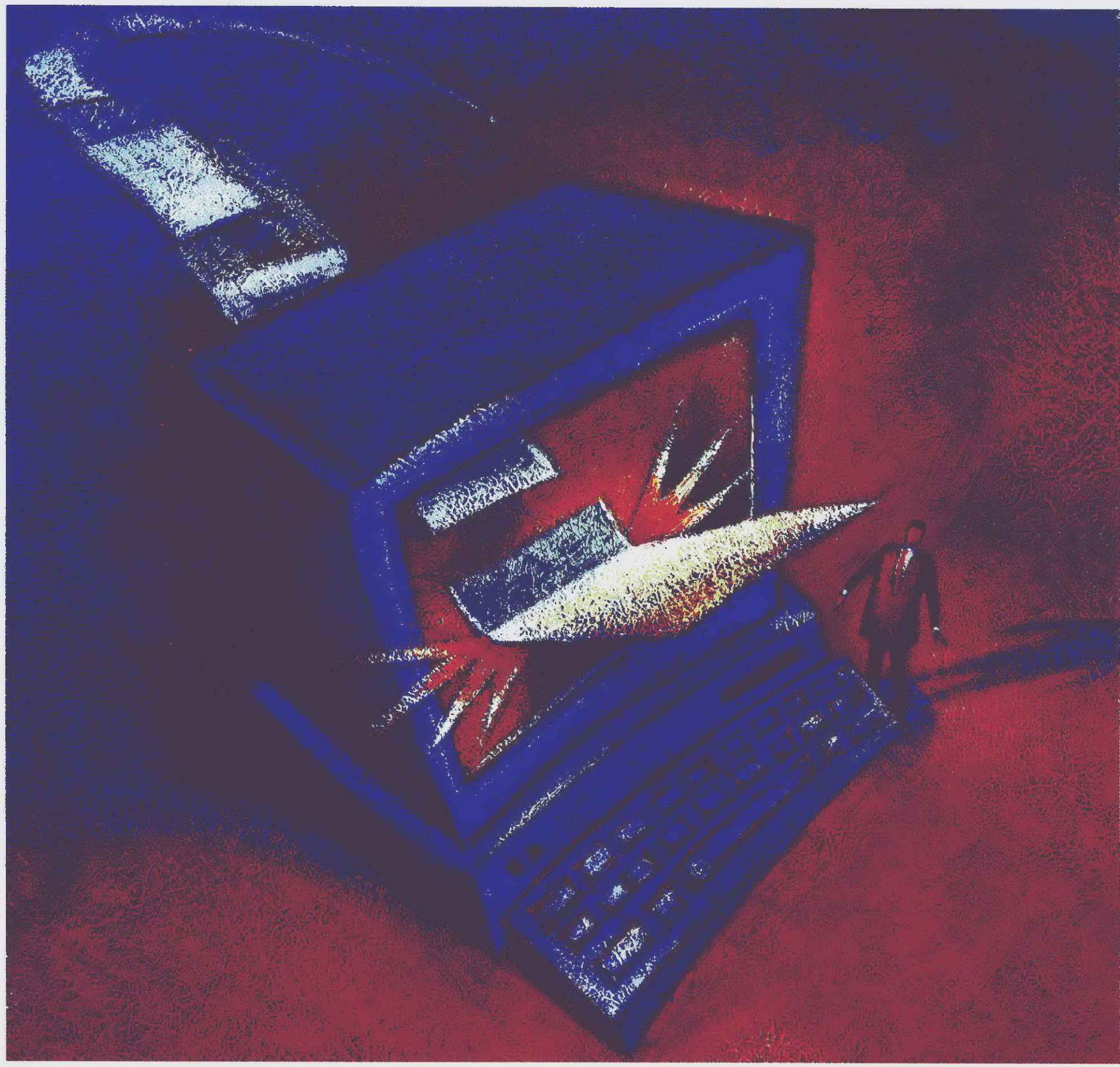
While Morrell created its own network, a new federal law allows Medicare-eligible retirees to choose coverage from preferred provider organizations, high-deductible health insurance plans linked to tax-favored medical savings accounts, indemnity plans offered by commercial insurance companies or provider-sponsored organizations—HMO-like plans established by providers—as well as Medicare itself.

The law could motivate doctors to organize themselves into networks to serve the Medicare patients in rural areas, Mr. Merrill suggested.

Once they organize for Medicare purposes, he said, the next logical step would be for them to use their organizations to serve employers' active populations. BI



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Dental

Continued from page 3

of large catastrophic losses with dental plans, compared with health plans, there is no downside for employers to fund the risk themselves, Mr. Durig said.

"When you take away most of the risk, you take away the need for insurance companies," he explained. Also eliminated, he said, is the need to pay for an insurer to assume the risk.

In direct reimbursement, an employee visits a dentist and submits the receipt to his or her employer for reimbursement. The employer can process the reimbursement or contract with a third-party administrator to process claims.

A typical direct reimbursement program reimburses employees 100% for the first $100 in expenses. Then it covers the next $200 at 80%. Finally, direct reimbursement covers the next $700 at 50%, reaching the annual limit of $1,000 in costs, Mr Durig said.

Under such an arrangement, an employee would be reimbursed $610 for $1,000 in annual dental expenses. Any costs over $1,000 the employee must pay. Employers can tailor their own benefits.

By reducing the role of insurance administrators, the costs for dental benefit administration drop greatly, saving the employer money, proponents claim.

"More dollars go to benefits and less to overhead than any other dental plan," said Roger Schultz, president of Schultz Rosen Inc. in Atlanta. A subsidiary is Direct Reimbursement Benefit Plans Inc., a direct reimbursement TPA. He said his company charges between 4% and 6% in administrative fees for acting as a TPA for self-insured dental plans, depending on the size of the employer.

Direct reimbursement's proponents also tout its simplicity to employers and employees.

"The employees just love this program," Mr. Durig said. "Once you put it in, it's hard to take out."

But perhaps most importantly, direct reimbursement allows participants to visit any dentist and eliminates insurer oversight of dentists, often present in managed dental plans. This aspect is especially attractive to dentists.

'When you take away most of the risk, you take away the need for insurance companies,' says Rick Durig, president and CEO of Minnesota Dental Benefits.

"It's the only benefit where everybody wins," Mr. Schultz said.

To spread the word about direct reimbursement, the ADA has committed $2.5 million a year for the next three years for advertising and promotion of the concept to employers, brokers and benefit consultants, said Tom Killam, a manager with the ADA in Chicago and the person responsible for promoting the idea.

The organization also is working with state dental societies that are conducting their own media campaigns to promote direct reimbursement.

Dentists like the idea because "they want any insurance company involvement out of the equation," said Barry Rosenfeld, a consultant with Apex Management Group Inc., a benefit consultant in Princeton, N.J.

But eliminating insurance company involvement alarms some critics.

Without a third party overseeing the dentists' work, direct reimbursement will lead to higher costs and excessive utilization, critics of the idea charge.

"Any time a system is unmanaged, there is a concern people will gain the system," said Keith Dallas, a principal and consulting actuary with Buck Consultants Inc. in Boston.

A third-party insurer reviewing claims also helps "eliminate unnecessary treatment or inappropriate treatment," adds Mercer's Ms. Smithwick.

She co-authored two articles on direct reimbursement that were funded by Oak Brook, Ill.-based Delta Dental Plans Assn., the country's largest managed dental care company. The articles concluded that managed dental plans controlled costs better than direct reimbursement while providing better care.

Direct reimbursement's proponents dispute that conclusion, saying copayment structures and competition among dentists will keep employers' costs in check.

In addition, proponents note that most people don't like visiting the dentist, which minimizes the risk of excessive utilization.

"Dentists won't price themselves out of the market," Mr. Killam of the ADA said. "If someone is overly expensive, the patient will go someplace else."

Ms. Smithwick counters, however, that patients don't know if they are being overcharged or if a certain dental procedure is necessary.

A third party, such as an insurer, managed care company or utilization management firm, which monitors dentists and collects claim information, is in a better position to judge whether a dentist's treatment is too costly or unnecessary, she said.

"The DR arrangement is based on the unrealistic claim that consumers are well-informed," states the article Ms. Smithwick co-authored.

A spokesman for Delta Dental Plan of California in San Francisco said Ms. Smithwick's article was funded to examine direct reimbursement as possible competition. Based on it, "Delta Dental does not see direct reimbursement as presenting viable competition in the dental benefits marketplace," the spokesman said.

"There is no sign the marketplace is buying this model of delivery," he added.

A lack of employers adopting the direct reimbursement concept is what the ADA campaign is trying to rectify. Although exact figures on the number of people involved in direct reimbursement are not available, the numbers are increasing, according to the ADA.

Mr. Durig said Minnesota Dental Benefits had 10,000 covered lives at the start of this year, and he expects that figure to grow to 55,000 by 1999.

Mr. Schultz said participants with his TPA will expand this year beyond the 75,000 lives it now covers.

Mr. Schultz said the main reason direct reimbursement has been slow to catch on with more employers is that because insurance companies do not profit from it, they don't sell it. Also, most brokers aren't familiar with the concept and can't promote it to their clients.

At least one corporate benefit manager has endorsed the concept.

Peg Noesen, vp of human resources for United Community Bancshares in Eagan, Minn., said the company and its employees have benefited since adopting direct reimbursement in January 1997.

She said the company pays 10% less for dental benefits compared with its former dental PPO.

Employees love it because "they have the choice," she said.

Although Ms. Noesen said she was concerned costs might rise due to unrestricted utilization, that has not occurred.

"The best thing is the money is spent on true dental care, not dispersed on administrative costs," she added.

It's precisely because direct reimbursement has lower administrative costs compared with managed care that makes it less costly, Mr. Schultz said.

Using managed care for dental benefits is "overkill," he said. "It will cost you more to manage it than you will save. It makes no sense."

But Ms. Smithwick of Mercer disagrees.

"That's not been our experience," she said. "Some insurance companies are very good at managing utilization and costs and result in a net savings for their clients," she said.

"The savvy company that monitors performance of an insurance company can get a well-managed care plan and get a better value for employees over direct reimbursement," she added. BI

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Management

Continued from page 3

delivered," said Mary Case, a principal with The Kwasha Lipton Group in Fort Lee, N.J.

But now, many employers are seeing employees' and providers' unhappiness with the focus on phone calls approving treatment and the administrative costs those calls engender. Employers "are stepping back and saying: 'Is this doing what I want it to do? Am I micromanaging too much and overlaying a complex architecture on something that doesn't need it anymore? Where should I focus my efforts?' " Ms. Case said.

As a result, some employers are rethinking the traditional emphasis on dialing an 800 number to get two days of hospitalization approved and "are really wondering whether they want to retain that, whether they should focus more on the places where the opportunity is not only to save the most money but also influence care: the really big cases," said Ms. Case.

This means concentrating not on the routine appendectomy but on cancer and cardiac cases, "where most of the money is being spent and where the ability to influence outcome by careful involvement in case management is the greatest," said Ms. Case.

"I surely hope for that as a general trend," said Dee Kemnitz, vp-employee benefits at the Minneapolis-based Carlson Cos. Inc. and a founding member of the local Buyers Health Care Action Group. Minneapolis-based Health Risk Management Inc. handles her company's utilization management.

"I believe that the former, old-school utilization review system that tended to squeeze off care is not productive long-range and that it's very important to be doing something that actually is helpful to the patient," said Ms. Kemnitz. "In general, we find if you do the right thing for the patient, it minimizes the bill for whomever is paying the bill," she said.

Kathy Fliehler, vp at West Des Moines, Iowa-based ENCOMPASS Health Management Systems, said, "In our mind, under- or overutilization represents inappropriate quality and leads to potential complications and/or additional costs."

"We think that it's our responsibility to educate consumers and providers about care alternatives, about potential outcomes," she said. "We feel it's our responsibility to act as a consumer advocate."

Others are moving in the same direction as well, said Ms. Fliehler. "I think that there's definitely a reduced focus today on utilization management and an increased focus on disease management programs, which are really geared more toward patients taking a more active role in managing their conditions," she said.

The utilization review function "definitely is evolving," said Dr. Dick Justman, United HealthCare's national medical director for strategic business services. "The idea, for example, of doing medical necessity review for isolated events. . .is going to disappear and will be replaced by a management of patients' illness across a continuum," he said.

"Instead of looking at how many days we can shave off a hospitalization, or 'Can I avoid this particular procedure?' what we're looking at is taking a look at the condition in general and how it can be managed in a way the patient outcome is the best."

When looking at the hospitalization of a heart attack patient, for instance, the focus is not on how quickly the patient will get out of the hospital, but on "is the patient getting the care he or she needs?" said Dr. Justman.

Once the patient goes home, the focus is on whether someone is there to make sure the patient gets the medication he or she needs and whether the patient has been enrolled in a smoking cessation program, if that is called for.

The trend toward disease management has been driven by managed care and its focus on outcome measurements, said Tim Beck, a Los Angeles-based principal with Buck Consultants Inc.

Now that managed care companies have been able to gather this data over many years, people can look at information on severity, frequency and occurrence and "truly manage the outcome of particular therapies" for diseases such as diabetes or asthma, "where historically, technology or data really hasn't been available to do effective disease management," said Mr. Beck.

As Philadelphia-based Intracorp has gotten more data and become more advanced in its provider profiling, its focus has shifted from quality of services, such as how long it takes to return a phone call, to quality of care, how it is rendered and getting a good outcome, said Dr. Kristin Crosby, medical director.

For instance, utilization management could mean that a patient with meningitis, who needs four to six weeks of intravenous antibiotics, can be treated at home after spending the first few days in the hospital.

Dollars and effort are put into the more complicated cases, where the return is greatest, and in "making sure the right number of days are approved," said Dr. Crosby. "We really try to automate the routine case," she said.

Disease management means "taking a population of patients with a certain disease—say, asthma—and treating their asthma aggressively on an outpatient and home basis, so they really don't get bad enough to be put in the hospital, and that can be effective, and it's better quality," said Dr. Mark Bloomberg, chief medical officer for Private Healthcare Systems Inc., a Waltham, Mass.-based preferred provider organization and utilization management company.

Along with this, there is "a greater focus toward care being given in the proper location of care, and for the proper lengths of stay rather than getting into discussions as to reviewing the appropriateness of the admission itself per se," Dr. Bloomberg noted.

Employers are a major factor behind the focus on disease management.

"I'd say large employers are driving it, very definitely," said Mr. Beck. "These are issues that are near and dear to the large employer because of the potential to have some significant cost impact to the program."

Each employer must look at its own situation and help develop an appropriate disease management program, "as opposed to taking just a general program and unilaterally trying to apply it to the general population," said Mr. Beck.

ENCOMPASS' Ms. Fliehler said, "Certainly the employers that we work with are often industrial employers with a heavy union influence, and they are very interested in demonstrating to their employees and to their unions that quality is important.

"I think employers are beginning to recognize that they need to have a healthy workforce to have a productive workforce, and quality plays a key role in that," she said. An employer cannot just reduce utilization, she said.

While saving money is nice, "our focus is on getting the best care to the employee, and that's our No. 1 concern," said Melanie Wallace, compensation and benefits manager for Oshkosh B'Gosh Inc., which takes a disease management approach.

Ken Driscoll, health care planning manager for Chicago-based Navistar International Corp., said his company takes a more traditional utilization management approach but is investigating disease management. He noted studies have found that disease management programs impact both the quality and cost of care for individuals. "I think over the long run we will see some cost savings attributable to these programs," said Mr. Driscoll.

Betsy Rychlewski, vp of managed care for Rockford, Ill.-based Pioneer Life Insurance Co., an indemnity insurer that contracts with Louisville, Ky.-based National Health Services Inc. on behalf of its policyholders, said: "The industry continues to change. The precertification case management that we used to know is no longer going to be around."

Ms. Rychlewski said she favors a disease management approach that helps educate consumers instead. "We see the value of it, and even if it does cost us. . .the cost/benefit analysis is still in our favor." Helping people understand a disease could keep it from becoming a chronic condition and require hospitalization, she said.

Tony Pino, president of National Health Services, a utilization management company, said, "We develop our programs in a collaborative effort with our clients, and our clients are very much involved in what we do in terms of setting up a process."

The anti-managed care climate has been an influence as well, say observers. "I think the national managed care climate has made people more aware of different possibilities," though the focus remains on delivering the right care at the right time and in the right setting, said Intracorp's Dr. Crosby.

"I think, first of all, 85% of American workers are now in managed care plans, and managed care implicitly is the management of utilization, either prospectively or retrospectively," said Marlene Travis, Health Risk Management's president and chief operating officer.

"I think the anti-managed care sentiment is driven by consumers who fear that they are being deprived of services that they need, that are medically appropriate, so consequently I think managed care organizations must provide documentation and evidence that they are complying with best practices," said Ms. Travis, whose company has developed and markets a series of such guidelines. BI

Accrediting group changes with industry

Renamed organization has kept focus on delivery of quality care

By JUDY GREENWALD

The American Accreditation HealthCare Commission/URAC, around since 1990, is nimbly keeping up with rapid changes in the utilization review industry, its policy director says.

The organization, which has changed its name from the Utilization Review Accreditation Commission, accredits 177 managed care organizations and issued its third revision of its standards this past June, said Guy D'Andrea.

Throughout its existence, the organization has emphasized the delivery of quality care, Mr. D'Andrea said.

"I think that sentiment was embodied in the founding of URAC in 1990 and in our first set of standards: that the medical decision-making process should first and foremost be about making the right decision, not just saving costs," said Mr. D'Andrea.

The Commission/URAC's standards always have called for having appropriately trained medical personnel involved in the decision-making process, having the process conducted in a timely manner, and ensuring that the patients have appeals rights, said Mr. D'Andrea.

"Our standards, our quality focus and our accreditation programs are for the most part voluntary, so that companies that choose to seek accreditation from us have made a commitment to quality," he noted.

The June revision in the organization's UR standards, Mr. D'Andrea said, included adding standards related to "scripted clinical screening." This is a process, he explained, under which a utilization management organization receives a case and applies a "script" of protocols that determine if a case can be approved automatically, or if it needs to go on for utilization review.

Utilization management organizations have developed programs to expedite this process over the past several years, "and our standards were refined to recognize that," Mr. D'Andrea said.

"Our goal is to keep pace with the rapid evolution of the utilization management industry in particular as utilization management programs become more fully integrated with other aspects of care," said Mr. D'Andrea.

"Accreditation by URAC indicates that an organization has the necessary structures and processes in place to render and administer an effective and meaningful review process that protects patients' interests," Mr. D'Andrea said.

The 177 managed care organizations accredited by the Commission/URAC include most of the large, multistate utilization review organizations, "but not necessarily all of the smaller, local organizations," he said.

Accreditation is granted for two years, with a basic $10,000 fee, said Mr. D'Andrea.

URAC-accredited utilization management organizations praise the URAC.

It "serves a very useful purpose in terms of providing evidence there is a certain standard level of competency in the utilization management functions that are being performed," said Dr. Mark Bloomberg, chief medical officer for Private Healthcare Systems Inc., a Waltham, Mass.-based preferred provider organization and utilization management company.

Accreditation "shows the company is serious in providing high-quality utilization services," he said. It is a "Good Housekeeping Seal of Approval."

Dr. Kristin Crosby, medical director for Philadelphia-based Intracorp, said she frequently sees a political environment where people ask what can be done legislatively to make sure citizens are well taken care of and protected from "'fly-by-night agencies or some of the really egregious instances of abuse we read about in the paper."

Her response, she said, is to tell people to look for accreditation by an umbrella organization such as the Commission/URAC. "I think the voluntary organizations have done a good job of providing that type of oversight," said Dr. Crosby. A Commission/URAC accreditation "gives you a lot of assurance," she said. BI

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Directory of UR/case management providers

A

ADMAR Corp.

1551 N. Tustin Ave., Suite 300,
Santa Ana, Calif. 92705;
714-953-9600; fax: 714-953-6309

Utilization Review/Case Management

1997 revenues

Total gross revenue	$13,539,277
UR revenue	$989,127
Case mgmt. revenue	$55,853

Staff

Total UR/case management employees	15
Professionals	15

Clients

Total	40

Covered lives/reviewed admissions

Acute care inpatient adm. reviewed	2,940

UR/case mgmt. services since: 1978.
Parent: The Principal Financial Group.
Services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings.
Medical services reviewed/managed: Group health, chiropractic, psychiatric/substance abuse, pediatric.
Compensation: $1.30 per employee per month (UR); $200 per case (prenatal); $100 to $150 per hour.
Officers: Richard Toral, chairman/CEO; Virginia Pascual, chief administrative officer; Kraig Boysen, vp-managed care services; Elisabeth Hagel, director-managed care services; Dawna Edwards, operations manager.

Advanced Focus Medical Management

7650 Corporate Center Drive,
Suite 300, Miami, Fla. 33126;
800-732-1255; fax: 305-715-6093

Utilization Review/Case Management

1997 revenues

Total gross revenue	$2,900,000
UR revenue	$1,500,000
Case mgmt. revenue	$300,000
UR/case mgmt. direct to employers	60%
Svcs. to managed care/ins. provicers	2%
Other services	38%

Staff

Total UR/case management employees	29

Clients

Total	346
Corporate/institutional employer clients	345

Covered lives/reviewed admissions

Employee benefit plan lives served	240,000
Acute care inpatient adm. reviewed	12,027

UR/case mgmt. services since: 1990.
Parent: John Alden Financial Cos.
Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination discharge planning, telephone case management, review of lab work, patient education, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.
Occasional services: Onsite case management, free pre-screening, second surgical opinion.
AAHC/URAC accreditation status: Health Utilization Management Standards.
Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.
Branch offices: Miami, Minneapolis.
Compensation: $1.00 to $2.50 per employee per month; $75 to $300 per case; $70 to $150 per hour; percent of savings.
Officers: Jill McGinley, vp.
Contact: Clark Fischer, national sales representative.

Advo Care Inc.

4645 Richmond Road, Suite 103,
Cleveland, Ohio 44128;
216-514-1221; fax: 216-514-1227

Utilization Review/Case Management

1997 revenues

Total gross revenue	$1,800,000
UR revenue	$900,000
Case mgmt. revenue	$900,000

Staff

Total UR/case management employees	28

Clients

Total	3,000

Covered lives/reviewed admissions

Employee benefit plan lives served	30,000
Diverted for outpatient treatment	30%

Continued on page 20



Utilization review/case management provider directory terms

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

To be included companies were required to report their 1997 gross revenues or an acceptable estimate; companies who did not report gross revenues were not included.

Business Insurance defines utilization review as reviewing inpatient and/or outpatient hospital care and services through programs such as preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, case management, retrospective review and second surgical opinions. Case management is defined as providing planning and monitoring throughout the course of high-risk illnesses, including discharge planning, onsite or telephone case review and/or patient referrals.

Listings begin with the company name and address. Financial/statistical information includes: total **1997 gross revenues**, followed by the actual dollar amount of revenues generated by utilization review and/or case management services.

Listed next is the percentage of revenues attributable to three sources: utilization review and/or case management services provided directly to employers; utilization review and/or case management services to insurance companies, managed care providers and TPAs; and other services.

Staff information lists total staff assigned to utilization review and/or case management, including a breakout of total professional staff members and staff members on retainer. Staff numbers are provided in full-time equivalents, except for those on retainer.

Business volume is represented by the number of **utilization review/case management clients; covered lives,** including employee benefit plan and workers compensation lives served; total **acute care hospital admissions reviewed** and the percent of proposed admissions/cases diverted for outpatient care. All figures provided are for 1997.

The text section of each listing includes the **year the company began offering utilization review or case management services** and the parent company, if applicable.

Specific utilization review and case management services the company provides are described under **frequent and occasional services**. Next, the types of **medical services reviewed/cases managed** are provided. American Accreditation HealthCare Commission/URAC status in noted, if applicable.

Branch offices are other locations performing utilization review and/or case management, followed by **compensation**, the method used to bill for services. Names and titles of **principal officers** and a **contact** complete the listings.

This directory is published as an editorial service to our readers. There is no charge for companies to be listed. Information reported is based on each company's response to a *BI* questionnaire. Although every effort is made to publish complete and accurate listings, *BI* is unable to verify all information.



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CorVel

Continued from page 18

UR/case mgmt. services since: 1996.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, review of lab work, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Patient education, retrospective review, second surgical opinion, hospital bill audits.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability.

Compensation: $1.50 to $2.00 per employee per month; $75 to $300 per case; $65 to $250 per hour.

Officers: Karen M. Agnich, Joseph Cannelongo, George Cyphers.

Contact: Karen M. Agnich, 806-659-4025.

** Reflects total employers.*

Alicare Medical Management

730 Broadway,
New York, N.Y. 10003-9511;
212-539-5757; fax: 212-473-1354

Utilization Review/Case Management

1997 revenues

Total gross revenue	$3,906,000
UR revenue	$1,771,000
Case mgmt. revenue	$400,000
UR/case mgmt. direct to employers	40%
Svcs. to managed care/ins. providers	16%
Other services	44%

Staff

Total UR/case management employees	54
Professionals	38
UR/case mgmt. employees on retainer	3

Clients

Total	84

Covered lives/reviewed admissions

Employee benefit plan lives served	200,000
Acute care inpatient adm. reviewed	17,954
Diverted for outpatient treatment	5%

UR/case mgmt. services since: 1990.
Parent: Alico Services Corp.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, retrospective review, second surgical opinion, hospital bill audits, outpatient service precetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, 24 hour nurse helpline, network referra.

Occasional services: Onsite case management, review of lab work.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Salem, N.H.

Compensation: Per employee per month, per case, per hour; pricing varies with services and group size.

Officers: Claire Levitt, president; Annette Duclos-Watson, vp/COO.

Contact: Barbara Bara, sales executive, 212-539-5757

American Health Holding Inc.

921 Eastwind Drive, Suite 104,
Westerville, Ohio 43081;
614-818-3222; fax: 614-818-3223

Utilization Review/Case Management

1997 revenues

Total gross revenue*	$9,000,000
UR/case mgmt. direct to employers	60%
Svcs. to managed care/ins. providers	3%
Other services	37%

Staff

Total UR/case management employees	40
UR/case mgmt. employees on retainer	32

Clients

Total	24

Covered lives/reviewed admissions

Employee benefit plan lives served	500,000
Acute care inpatient adm. reviewed	24,000

UR/case mgmt. services since: 1985.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Onsite case management, review of lab work, free prescreening.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical sAervices reviewed/managed: Group health chiropractic, rehabilitation, psychiatric/substance abuse, pediatric.

Branch offices: Little Rock, Ark.; Indianapolis; Columbus, Ohio; Pittsburgh; Houston.

Officers: Ivan S. Gilbert, chairman; Michael Reidelbach, president; Gene Shumar, vp-sales; Merry P. Korn, vp-marketing; Joan M. Yockel, vp-operations.

Contact: Merry P. Korn, ext. 232; Gene Shumar, ext. 221.

** BI estimates.*

AmeriSys Inc.

402 S. Central Ave.,
Oviedo, Fla. 32765;
800-752-0886; fax: 407-366-0489

Utilization Review/Case Management

1997 revenues

Total gross revenue	$5,500,000
UR revenue	$2,000,000
Case mgmt. revenue	$3,000,000
UR/case mgmt. direct to employers	10%
Svcs. to managed care/ins. providers	80%
Other services	10%

Staff

Total UR/case management employees*	450
Professionals	35
UR/case mgmt. employees on retainer	401

Clients

Total	60
Corporate/institutional employer clients	10

Covered lives/reviewed admissions

Acute care inpatient adm. reviewed	2,500
Diverted for outpatient treatment	22%

UR/case mgmt. services since: 1986.

Services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, review of lab work, patient education, free prescreening, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Carmichael, Calif.; Oviedo, Fla.; Honolulu; Chicago; Metairie, La.; Newton Upper Falls, Mass.; Omaha, Neb.; Albuquerque, N.M.; Las Vegas; Valhalla and Vernon, N.Y.; Columbus, Ohio; Portland, Ore.; Paoli and Verona, Pa.; Garland, Texas; Richmond, Va.; Seattle; Madison, Wis.

Officers: Ron Warble, president; Geoffrey Greenstein, vp-operations; Wayne Leland, vp/CFO; Lynn Lusardi, vp-utilization management; Bryan Chaffee, vp-business devel-

Continued on next page

10 largest general service utilization management firms

Based on total acute care inpatient admissions reviewed in 1997

Company	Acute care inpatient admissions reviewed 1997	Total staff 1997	Physicians 1997	RNs 1997	Physicians on retainer
Private Healthcare Systems	552,372	275	33	149	NA
Intracorp	498,135	3,432	80	897	616
National Health Services Inc.	235,632	237	13	130	83
ENCOMPASS Health Management Systems	183,500	199	3	110	334
IPRO	180,000	200	13	100	600
Cost Care Inc.	145,990	348[1]	36	204	NA
Health Risk Management Inc.	165,000	265	19	238	9
CareAdvantage Health Systems Inc.	160,000	67	12	55	124
CONCENTRA Managed Care Services	130,245	3,510	6	1,350	50
Health International Inc.	68,088	114	5	100	25

1 Includes professionals only NA=Not available

Source: BI survey

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Agent/Broker Topics

Clusters increasingly winning over insurers

By ROBERTO CENICEROS

Agency clusters have gained acceptance among skeptical insurers, which now see them as valuable sources of good business.

But even though insurers are no longer as quick to say no, they do have criteria for doing business with clusters. And a few still prefer to avoid clusters.

In years past, many insurance companies said they would not work with clusters, which are groups of agents pooling their resources to gain access to and clout with insurers.

Insurers still fear a loss of control, because in cluster arrangements they don't always have a direct relationship with the agent placing the business. Also, some insurers say the potential is greater that agents will use a cluster as a dumping ground for their less desirable business. Clusters tend to work together in placing business with a few insurers but still place business individually with other companies.

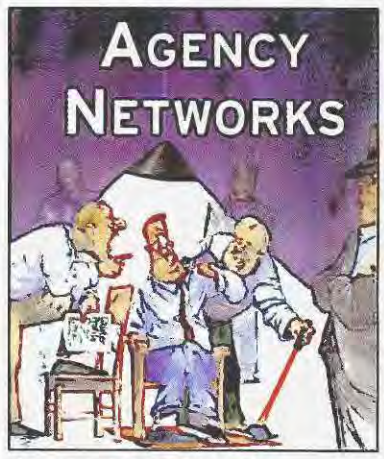
Yet many insurers are rethinking their decision not to do business with cluster arrangements.

"Companies that had been a little bit reluctant are now seeing that this is the way of the future and this is what is happening now," said Greg Pope, owner of Greg Pope Insurance Agency in Attleboro, Mass.

"Companies can either be a part of it or get left aside and not get a piece of it, and they do see it as a growing trend. Rather than not have anything to do with it, they might as well pick and choose the better (cluster groups) now," said Mr. Pope, who also is president of allMass Group Inc., an eight-agency cluster in Massachusetts.

Agents in other regions of the country echo his sentiments.

The days are gone when insurers said flat out that they would not deal with clusters, said John Morey, president of The J. Morey Co. in San Jose, Calif., and president of San Francisco-based Insurance Brokers & Agents of the West. Insurer rejection was more pronounced years ago when the cluster idea was new and insurers were uncertain



the concept would work.

"Now that it is becoming a very commonplace arrangement for agents, companies feel more and more comfortable with it," Mr. Morey said.

Yet some insurers still decline to work with clusters. Cincinnati Insurance Co. is one.

"The problem we have with clustering—and we don't believe it is bad for agencies to be in clusters—but implicit in cooperating with a cluster is you will do business with every single one of the members," said J.F. Scherer, senior vp in sales and marketing for Cincinnati Insurance Co. and several other units of Fairfield, Ohio-based Cincinnati Financial Corp.

A cluster member could turn out to be associated with an agency that Cincinnati Insurance does not find desirable and is in the same community as a competing agency that the insurer prefers to work with, Mr. Scherer said. That could cause tension with the preferred agency if Cincinnati Insurance allows the cluster agency to handle some of the insurer's business.

While some companies still do not work with clusters, many other insurers continue to call the National Assn. of Professional Insurance Agents for information from an extensive study the association conducted on clusters in 1995.

Insurers and agents call to learn more about clusters, said Patricia Borowski, division vp for the Alexandria, Va.-based PIA. Many insurers call after learning they actually have been dealing with clusters without knowing it, or after having said they would not deal with them.

That happens because their field offices have entered into the arrangements, leaving the home office unaware. The home office often finds out after a negative experience, such as having a block of business leave after a fallout among cluster partners, she explained.

"Insurance companies clearly see the potential advantages of clusters to them for an immediate shot of production and the potential for bringing that shot of production in at a lower expense," she said.

"But companies today are still yet not convinced that clusters as a whole can really provide them with long-term benefits. They certainly appreciate that clusters can provide agencies with more benefits long-term than they can for a company," she added.

Although the PIA completed its cluster study a few years ago, the association continues to update it by

See **Clusters** *on page 20D*

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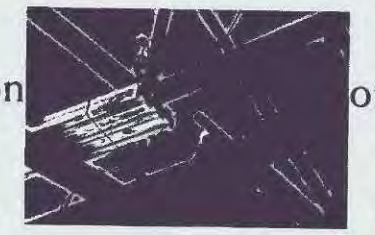
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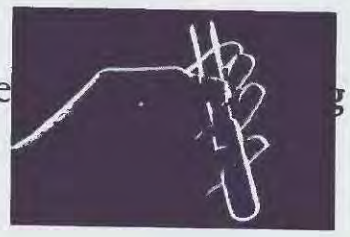
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Clusters

Continued from page 20B

surveying companies that call for information.

After talking to insurers and agents requesting information, Ms. Borowski said that during 1997 more large, multistate commercial lines agencies seemed to be considering clustering arrangements, she said.

Yet that does not necessarily signal a trend. Ms. Borowski said she does not have statistical evidence but a limited number of observations. Additionally, growth in cluster arrangements over the years has tended to ebb and flow. Although the exact number of clusters is unknown, the PIA "very firmly believes that the cluster segment is here to stay," Ms. Borowski said.

Other industry observers also see signs of continued interest.

"More recently we find smaller or rural agents clustering to avoid being terminated," said Neal Montgomery, assistant director of agency compensation for The Travelers Insurance Co. in Hartford, Conn. "We have seen more of it in the last few years even. It seems to be heating up; even within 1997 I have heard of more of these."

For cluster arrangements to work, all parties must understand the business discipline and planning that a quality cluster requires, Ms. Borowski said. It takes more than just a group of agents with successful agencies who hit it off socially and share similar business philosophies.

More importantly, agents must have similar tolerances and expectations for the day-to-day operations of the business. They must understand the discipline each will bring to those operations, she said.

"If that is not in sync, that will destroy the best of plans," Ms. Borowski said. She advises PIA members to be clear on their reasons for joining a cluster and to determine where it will put them in three years.

As for insurers, "every single company has a war story," she said.

So she tries to help them understand that individual bad experiences should not lead to a condemnation of all clusters.

Most, if not all, insurers that work with clusters do not have a written policy on what they require of clusters, several observers said. But many insurers look at a variety of factors.

Gaining operational and processing efficiencies is one chief factor, Mr. Montgomery said. That can come as a result of one or maybe two agents in the group maintaining strong central control.

Some insurers look for the ability to easily terminate relations with individual agencies if their business turns sour, rather than sever ties with the entire group.

Mr. Pope said he keeps insurers happy by applying underwriting standards stricter than insurers require. "A company sees that and they say, 'OK, the business coming through is good quality; it's not high-risk. It's not leftovers,'" he said.

That type of attitude may have helped soften industry attitudes.

Recently, Mike McLaughlin, corporate marketing executive for Royal Insurance in Charlotte, N.C., said he heard of one Royal branch general manager who specifically planned to target cluster business.

"He was going town to town virtually looking for cluster opportunities," Mr. McLaughlin said. BI



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Rules key in running networks

By SALLY ROBERTS

If one bad apple can spoil the whole bunch, what should an agency network do if a member agency begins to smell?

Throw it out, veteran agency network executives say.

"We're absolutely, positively, totally ruthless," said Twig Branch, president of Iroquois Insurance Group, a Charlotte, N.C.-based network of 900 members and nearly $130 million in 1997 combined premium volume. "Once an agency crosses the line, it is out of the organization. It's pretty Draconian."

Executives say being ruthless is a must if an agency network is to survive. This is especially true with arrangements designed to provide more market opportunities for groups of independent agents. These networks thrive on the reputations of their agency members. One member agency that spoils a relationship with an insurer due to an attitude problem, or an agency that has a very high loss ratio, can wreak havoc on the entire organization.

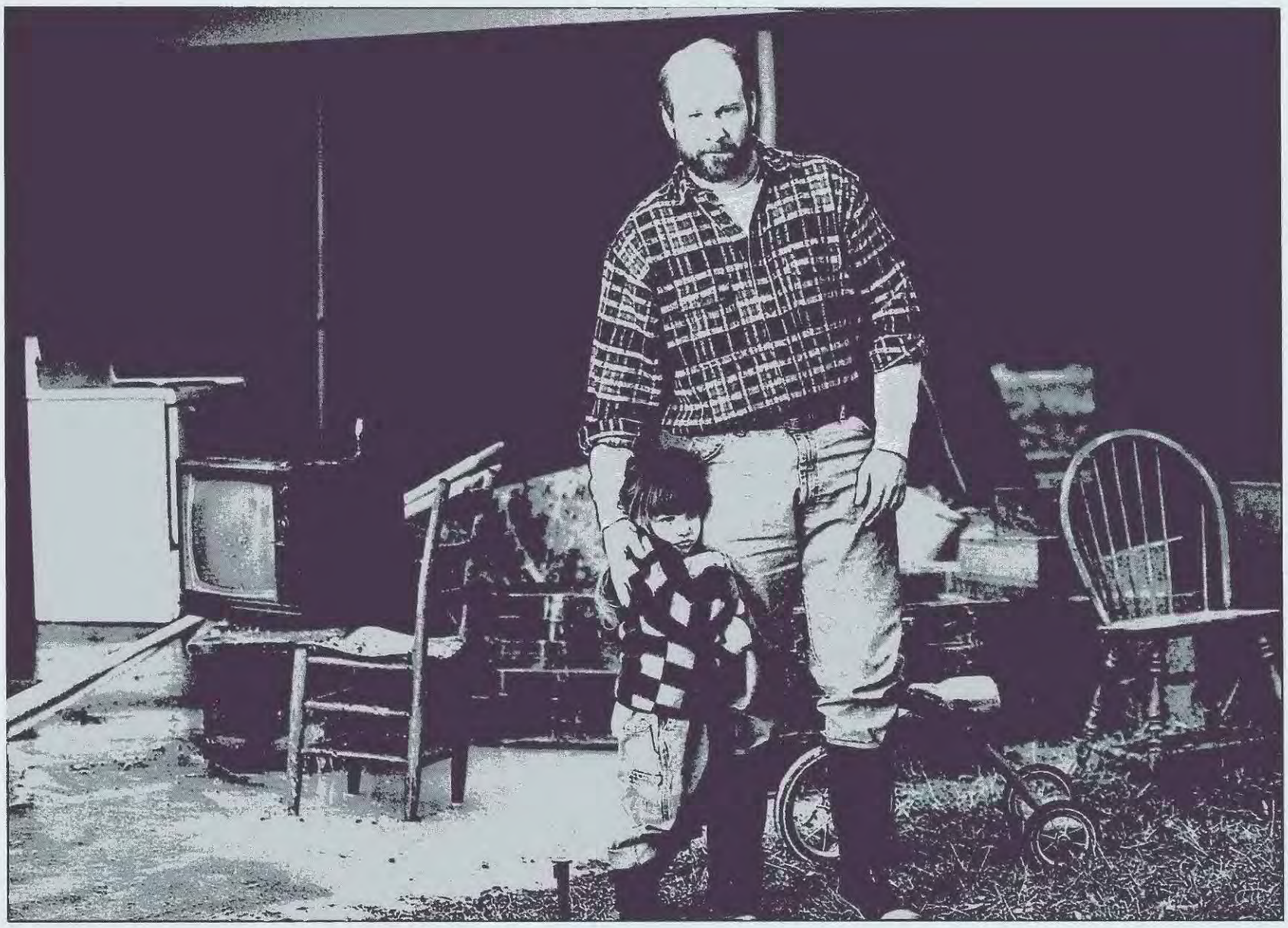
"This is a huge concern for us because one bad apple can spoil the bunch," Mr. Branch said. "The problem you have is that the bad apple is remembered." Not only can it burn up relations with insurers, but it also can drive good apples out of the group.

A network needs "absolute authoritarian control over the process, with clearly defined rules and regulations and very onerous results for any violations of those rules," concurred Timothy J. Cunningham, a principal with Insight Management Group in Chicago.

The best way to avoid having to use the club is not to pick the bad apple in the first place. This is where due diligence comes in.

"You can greatly mitigate the problem from occurring if you do a good job at the qualification level,"

See **Rules** on *page 20F*



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Rules

Continued from page 20D

said Jim Masiello, chairman of the Satellite Insurance Agency Alliance. To become a part of the Keene, N.H.-based distribution network, prospective agencies go through a rigorous screening process that can last several months, Mr. Masiello said.

This process includes obtaining an in-depth profile of the prospective agency's business, financial performance and short- and long-term goals. SIAA also will talk to others in the industry about the agency, look at insurance company experience reports and run credit checks, he explained.

Most of all, though, Mr. Masiello said, he has to like the people at the agency. "I'm a relationship type of person. I've got to like you."

He admits, though, that even the best due diligence doesn't screen out all potential problems.

"What starts out as Utopian can sour," he said. "I have personally had an agent who was a wonderful producer, but he was an absolute mess at running an agency," he said. "He was playing games with premium financing."

"The only way to make sure you have a good person is to have very close scrutiny financially and morally," Mr. Masiello said. "We put a lot of time into quality control."

One of Mr. Masiello's major concerns with member agencies is "E&O-type" problems, he said. This might include an agency not getting applications to insurers on time, binding business without authority, pocketing premium finance money or taking on third-party brokerage business—business that is produced by licensed agents who are not under the control of the agency placing the coverage.

If this happens, SIAA turns to its contracts.

"Our contracts are extremely strong," he said. "They ensure the integrity of the organization. We have the right to rehab a book of business or to tell an agency to not write a certain type of business." Also, if there is cause, the contracts call for termination.

SIAA members, for instance, are contractually forbidden from placing third-party brokerage business. "If we catch them doing so, it is considered good cause in our agreement and results in termination," Mr. Masiello said.

Mr. Branch said that, with 900 members in the Iroquois network, he also deals with "interesting" problems.

"We had two occasions where normal people developed cocaine problems," he said. Marital problems and substance abuse can result in a whole different person. Mr. Branch said the network most often terminates agencies due to arrogant attitudes resulting in their "inability to talk to insurers."

"We have zero tolerance with rules," Mr. Branch said, stressing that agencies are not terminated unless there is just cause. Prospective agencies are put through a "fair amount of examination" prior to becoming a part of the network, and Iroquois is very clear about the rules up front, he said.

Careful screening of prospective members also is important at The Rockwood Corp., a Chicago-based cluster representing 45 independent agencies, said President Norman Westerhold.

The cluster, formed 101 years ago, gives independent agency members access to more markets. As a result, "we rely heavily on profit-sharing money," Mr. Westerhold said. One agency with a bad loss ratio can hurt the entire group's ability to obtain profit sharing or contingent commissions, he said. "Most agencies depend on that for a good source of income."

An agency with a bad loss ratio "hurts us more than it does them," he said. "If it doesn't work out, the agency is free to go and take its book of business with it."

While it's been almost nine years since an agency was terminated from the cluster, Mr. Westerhold said rules and regulations are in place if various problems arise.

A network really is only as strong as its weakest link, summed up Thomas W. Harvey, president and chief executive officer of Assurex International in Columbus, Ohio. Its 69 partners generated an estimated $7.8 billion in 1997 premiums.

If a network or cluster is stuck with a bad apple, "do everyone a favor and replace it with someone who is more energetic," he advises.

Mr. Harvey said because prospective partners buy shares in Assurex and pay hefty dues, he does not face many deadbeat agencies. He admits, though, "We have asked agencies to resign because of failure to grow or failure to not meet one of the requirements" set forth in the network's affiliation agreements.

A membership evaluation committee, made up of Assurex partners, reviews Assurex partners to make sure they are meeting all the requirements in the agreement. "Everyone is subject to a review," he said. BI

Agencies working together in Ohio

By AMANDA MILLIGAN

The distance and diversity among the seven Ohio agencies that make up The Eagle Insurance Group give the network broad resources in serving customers.

The agencies represent different insurers and maintain their own regional contracts, said Bill Somers, treasurer of The Eagle Insurance Group.

Because each agency handles its own marketing, he said the group can't be described as a cluster. When it comes to attracting large, national contracts, however, each member can draw from the expertise and pooled resources of the group to gain access to business a smaller agency otherwise couldn't obtain.

"We're all far enough apart to talk about common problems without worry of someone sniping an account," said Mr. Somers, president of Somers Agency in Elyria, Ohio, and the Eagle Group's treasurer since 1993. "Not only do we have our own resources, but we're able to pick each other's brains. This brings a better service to the customer."

The group is an outgrowth of these informal discussions dating back to the early '80s. About six years ago, as a response to a move-

See **Eagle** *on page 20H*

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Eagle

Continued from page 20F

ment of national insurers withdrawing from small cities and towns, the participating agencies agreed to a formal arrangement.

"We're all seven very independent agents," said Tom Wiseman, president of The Wiseman Agency in Gallipolis, Ohio. But this independence doesn't prohibit the exchange of ideas within the geographically diverse network.

Members of The Eagle Insurance Group are: Consolidated Insurance Agency of Springfield, Ohio; Lance & Co. of Medina, Ohio; Roby, Foster, Miller & Earick of Mansfield, Ohio; Somers Agency; Spencer-Patterson Agency of Findlay, Ohio; Stouffer-Herzog Insurance Agency of Ashtabula, Ohio; and The Wiseman Agency.

The Eagle Insurance Group places commercial property and casualty lines and workers compensation insurance. While the network considered working with regional and national insurers, Mr. Somers said the group is not currently exploring this option.

The agencies write their own life/health and personal lines business and keep those revenues, which are separate from the stated 1996 combined premium volume of $59 million for The Eagle Insurance Group, Mr. Wiseman said.

The operational structure of The Eagle Insurance Group led to what member agents perceive as a win-win situation for agents and insurers. Agents have access to a broader market reaching beyond state borders, and insurers can do business with seven agents through one office. This streamlined system saves insurers money, Mr. Somers said.

The network vied for access to the national insurers because in the past they have been more competitive than regional insurers, Mr. Somers said. Still, for some insurers, the lure of new business opportunities was not enough to persuade them to try The Eagle Insurance Group.

Mr. Wiseman said some insurers, which also have offices in the mostly rural towns where Eagle-affiliated agencies are, were concerned about the power this network could wield. Despite another group of agents operating as a cluster in southern Ohio, Messrs. Somers and Wiseman said the competition they encounter collectively on national accounts is from the larger brokers.

"We face a lot of the same challenges as any other Main Street agency," Mr. Somers said.

One of those challenges is expansion. As with any organization, each member agency has an opinion about which direction the group should go. For this reason, the group plans to hold its membership steady for a few years.

Mr. Wiseman's vision for the network could involve franchising or moving into other non-traditional services, in the same way that banks now are selling insurance. "The truly forward-thinking brokers have to expand products beyond traditional services," he said. Ultimately, he hopes the group will become "a very viable entity on its own."

"Our real goal is to build the perfect type of agency," which would consist of a plan for governing, a solid management team and staff, and key producers, he said.

The group has discussed the possibility of jointly purchasing an agency and increasing the number of national insurers. But much of the future decision-making of The Eagle Insurance Group could come from new players, as Mr. Somers said many of the agents are approaching retirement. The network's longevity depends on "the next generation of owners coming up and becoming more active," he said.

Initially, eight agencies were in The Eagle Insurance Group, and the group met monthly. One member opted out of the network several years ago, Mr. Somers said, and each agency currently owns one-seventh of the corporation.

Because of the distance among them, meeting monthly became too demanding. The group now convenes quarterly over several days—ample time to discuss marketing and specialty programs, niche markets, and to visit with a representative from one national insurer each meeting. Member agents are also pursuing some form of continuing education with the intention of "remaining astute in our business," said Mr. Somers.

Part of "stay(ing) ahead of the learning curve" for four members of The Eagle Insurance Group involves focusing on computer skills and related technology, Mr. Somers said. To ease communications and business transactions, these four agencies are beginning to explore standardization of their systems. One way this may occur is to automate using Internet technology.

"The Internet's here, and we'll have to be proactive in that regard," said Wiseman, who would like to see the network launch its own Web site.

A self-described "Internet neophyte," Mr. Somers and his agency contribute by managing the group's accounting. Some of the collective tasks rotate, but his agency's function is permanent.

To make the group operate successfully, the daily tasks were spread over the seven agencies equally, Mr. Somers said. "Everyone pulled equally on the oars; no one just skimmed the water."

Cooperation is only part of the equation that makes networking a positive endeavor for agents. Agents that want to network can learn from The Eagle Insurance Group's experience, Mr. Somers said. He recommends visiting other potential member agencies to learn how each operates and holding brainstorming sessions to generate ideas that benefit everyone, individually and collectively.

When The Eagle Insurance Group's members meet to brainstorm, "we do leave our egos at the door," said Mr. Wiseman. BI

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Utilization Review/Case Management

1997 revenues

Total gross revenue	$8,000,000
UR revenue	$1,350,000
Case mgmt. revenue	$1,350,000
UR/case mgmt. direct to employers	15%
Svcs. to managed care/ins. providers	15%
Other services	70%

Staff

Total UR/case management employees	15
Professionals	15

Clients

Total	77,454
Corporate/institutional employer clients	351

Covered lives/reviewed admissions

Employee benefit plan lives served	206,545
Workers compensation lives served	16,150
Acute care inpatient adm. reviewed	28,417
Diverted for outpatient treatment	11%

UR/case mgmt. services since: 1984.

Frequent services: Preadmission certification, concurrent hospital treatment review, discharge planning, telephone case management, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Onsite case management, review of lab work, patient education, retrospective review, maternity program.

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, pediatric.

Compensation: $2.00 to $2.25 per employee per month; $150 per hour.

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Utilization Review/Case Management

1997 revenues

Total gross revenue	$4,400,000
UR revenue	$800,000
Case mgmt. revenue	$3,400,000
UR/case mgmt. direct to employers	59%
Svcs. to managed care/ins. providers	36.5%
Other services	4.5%

Staff

Total UR/case management employees	39
Professionals	33
UR/case mgmt. employees on retainer	3

Clients

Total	40
Corporate/institutional employer clients	400

Covered lives/reviewed admissions

Workers compensation lives served	100,000

UR/case mgmt. services since: 1993.

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Utilization Review/Case Management

1997 revenues

Total gross revenue	$1,500,000

Staff

Total UR/case management employees	12
UR/case mgmt. employees on retainer	600

Clients

Total	60

Covered lives/reviewed admissions

Employee benefit plan lives served	500,000

UR/case mgmt. services since: 1986.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, review of lab work, patient education, retrospective review, second psychiatric opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Free pre-screening.

Medical services reviewed/managed: Psychiatric/substance abuse.

Branch offices: Asheville, N.C.

Compensation: Per employee per month.

Officers: Dr. Leo Bradman, chairman/CEO; Dr. Ernest Cohen, medical director; Denise Scott, administrator.

Contact: Dr. Leo Bradman.

C

CCN*

5251 Viewridge Court, San Diego, Calif. 92123; 800-247-2898; fax: 619-278-8621

Utilization Review/Case Management

1997 revenues

Total gross revenue	$164,114,000
UR revenue	$1,462,000
Case mgmt. revenue	$21,743,000
UR/case mgmt. direct to employers	1%
Svcs. to managed care/ins. providers	13%
Other services	86%

Staff

Total UR/case management employees	498
Professionals	270
UR/case mgmt. employees on retainer	288

Clients

Total	4,824
Corporate/institutional employer clients	3,329

Covered lives/reviewed admissions

Employee benefit plan lives served	4,800,000
Workers compensation lives served	25,800,000
Acute care inpatient adm. reviewed	38,100
Diverted for outpatient treatment**	2%

UR/case mgmt. services since: 1977.

Parent: Columbia/HCA Healthcare Corp.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Patient education, second surgical opinion, hospital bill audits.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, dental (California only), chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Long Beach and San Diego, Calif.; Tampa, Fla.; Farmington Hills, Mich.; Salt Lake City; 25 onsite case management offices nationwide.

Compensation: $1.25 to $2.00 per employee per month; $96 to $110 per hour.

Officers: Richard Mastaler, CEO; Michael Bell, president/COO; Blaine Faulkner, senior vp/CFO; Mark Heinemeyer, senior vp/chief sales and marketing officer; Bob Marchetti, vp-product development/management.

Contact: Mark Heinemeyer.

** CCN now includes the OneSource Health Networks, which consist of Premier Medical Network, The Health Advantage Network, PPO Alliance and MedNet. ** Estimate.*

CNR Health Inc.

2514 S. 102nd St., Milwaukee, Wis. 53227; 800-654-5160 or 414-327-5197; fax: 414-327-0886

Utilization Review/Case Management

1997 revenues

Total gross revenue	$18,788,000
UR revenue	$4,927,000

Continued on next page

A few words about what UNICARE's growth means for U.

Undeniable strength.

UNICARE is a part of WellPoint Health Networks Inc., a Fortune 500 company. The WellPoint organization, with over 6.1 million members, has a 60-year tradition of leading the industry in innovative healthcare solutions. And, by combining the strengths of John Hancock's® group health and related life business and MassMutual's® Group Life & Health division into one organization, UNICARE can provide even greater resources, product and service choices as well as flexibility to serve both regional and multi-state businesses.

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1-800-277-9300

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Continued from previous page

Case mgmt. revenue $272,000
UR/case mgmt. direct to employers 20%
Svcs. to managed care/ins. providers 8%
Other services 72%

Staff

Total UR/case management employees 37
Professionals 37

Clients

Total 89
Corporate/institutional employer clients 74

Covered lives/reviewed admissions

Employee benefit plan lives served 825,000
Acute care inpatient adm. reviewed 7,946
Diverted for outpatient treatment 1.4%

UR/case mgmt. services since: 1985.

Parent: United Wisconsin Services Inc.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services referrals to alternative settings.

Occasional services: Onsite case management, review of lab work, hospital bill audits, written reports.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, psychiatric/substance abuse, pediatric, prenatal.

Branch offices: Houston, Milwaukee.

Compensation: $1.25 to $3.20 per employee per month; $45 to $85 per hour.

Officers: Ralph Cavaiani, president; Dianne Kiehl, executive vp; Jack Melton, vp-behavioral health clinical services; Louise Murphy, vp-Southern region.

Contact: Elizabeth Ferris, 800-654-5160 (Northern region); Shirley Cortez, 800-554-6171 (Southern region).

Cannon Cochran Management Services Inc. dba MSI compSolutions

2 E. Main St., Towne Centre Building, Danville, Ill. 61832;
217-446-1089; fax: 217-443-0927

Utilization Review/Case Management

1997 revenues

Total gross revenue $25,345,000
UR revenue $450,000
Case mgmt. revenue $19,000
UR/case mgmt. direct to employers 1.8%
Svcs. to managed care/ins. providers 0.1%
Other services 98.1%

Staff

Professional UR/case mgmt. employees 8.5
UR/case mgmt. employees on retainer 10

Clients

Total 950

Covered lives/reviewed admissions

Employee benefit plan lives served 15,500
Workers compensation lives served 120,000

UR/case mgmt. services since: 1995.

Frequent services: Concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings.

Occasional services: Preadmission certification, onsite and telephone case management, review of lab work, patient education, free pre-screening, retrospective review, hospital bill audits, written reports.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, catastrophic loss.

Branch offices: Danville and Oak Brook, Ill.; Des Moines, Iowa; North Kansas City and St. Louis, Mo.

Officers: Robert L. Cowgill, chairman/CEO; Gary J. Schirmer, vice chairman; Stephen W. Ferguson, president/COO; G. Bryan Thomas, executive vp/chief marketing officer; Steven F. Luebbert, executive vp.

Contact: Annie Mariage, 800-252-5059 ext. 200.

CAPP CARE Inc.

2 Trans Am Plaza, Suite 400,
Oakbrook Terrace, Ill. 60181;
800-772-2844; fax: 630-705-1414

Utilization Review/Case Management

1997 revenues

Total gross revenue $23,000,000
UR revenue $8,500,000
Case mgmt. revenue $2,000,000

Staff

Professional UR/case mgmt. employees 61
UR/case mgmt. employees on retainer 7

Clients

Corporate/institutional employer clients 7,000

Covered lives/reviewed admissions

Employee benefit plan lives served 3,400,000
Acute care inpatient adm. reviewed 61,000
Diverted for outpatient treatment 17%

UR/case mgmt. services since: 1982.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, written reports, preadmission authorization review, prior authorization of outpatient surgeries.

Occasional services: Onsite case management, second surgical opinion, referrals to alternative settings, prior authorization of outpatient diagnostic procedures, maternity options management.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, pediatric.

Branch offices: Newport Beach, Calif.

Compensation: $1.50 per employee per month (utilization management); $115 per hour (case management).

Officers: Dr. Ed Zalta, chairman; Michael Henry, president/CEO; Nouri Zalta, COO; Joseph P. Radigan, chief marketing officer; Gregory L. Hamblin, CFO.

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CareAdvantage Health Systems Inc.

485-C Route 1 S.,
Iselin, N.J. 08830-3037;
732-602-7030; fax: 732-602-7027

Utilization Review/Case Management

1997 revenues

Total gross revenue $14,000,000
UR/case mgmt. direct to employers 3%
Svcs. to managed care/ins. providers 97%

Staff

Total UR/case management employees 67
UR/case mgmt. employees on retainer 124

Clients

Total 5

Covered lives/reviewed admissions

Employee benefit plan lives served 2,200,000
Acute care inpatient adm. reviewed 160,000
Diverted for outpatient treatment 7%

UR/case mgmt. services since: 1994.

Parent: CareAdvantage Inc.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, retrospective review, second surgical opinion, referrals to alternative settings, written reports.

Occasional services: Review of lab work, patient education, hospital bill audits, outpatient service predetermination.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, rehabilitation, pediatric.

Branch offices: Portland, Maine; Iselin, N.J.; Buffalo, N.Y.; Providence, R.I.; Montpelier, Vt.

Officers: Thomas Riley, CEO; Dr. Richard Freeman, executive vp; Stephan Deutsch, national medical director; Mary Ellen O'Donnell, vp-business development; Pegeen O'Driscoll, vp-strategic products.

Contact: Ellen Freedman, vp-care management, 732-602-8089.

Catastrophic & Rehabilitation Management Inc.

2735 Clyde Park Ave. S.W.,
Grand Rapids, Mich. 49509;
616-531-4040; fax: 616-531-4070

Case Management

1997 revenues

Total gross revenue $260,000
Case mgmt. revenue $260,000
Case mgmt. direct to employers 20%
Svcs. to managed care/ins. providers 80%

Staff

Case management employees 2

Clients

Total 10

Covered lives/reviewed admissions

Acute care inpatient adm. reviewed ..... NA
Diverted for outpatient treatment 80%

Case mgmt. services since: 1991.

Frequent services: Concurrent hospital treatment review, discharge planning, onsite case management, patient education, retrospective review, second surgical opinion, referrals to alternative settings, written reports.

Occasional services: Length of stay determination, hospital bill audits.

Continued on next page

Continued from previous page

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, workers comp/disability.
Compensation: $75 to $140 per hour.
Officers: Charlotte Stein.

ComPsych Behavioral Health

NBC Tower, 24th Floor,
Chicago, Ill. 60611;
312-595-4004; fax: 312-595-4029

Utilization Review/Case Management

1997 revenues*
Total gross revenue $50,000,000
UR revenue $9,000,000
Case mgmt. revenue $7,000,000
UR/case mgmt. direct to employers 21%
Svcs. to managed care/ins. providers 11%
Other services 68%
Staff
Total UR/case management employees 14
Clients
Total 64
Corporate/institutional employer clients 57
Covered lives/reviewed admissions
Employee benefit plan lives served 2,100,000
Acute care inpatient adm. reviewed 8,990
Diverted for outpatient treatment 92%

UR/case mgmt. services since: 1984.
Services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, free pre-screening, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings.
Medical services reviewed/managed: Psychiatric/substance abuse.
Branch offices: Chicago.
Compensation: $1.50 to $4 per employee per month; $250 to $700 per case.
Officers: Dr. Richard Chaifetz, CEO; David Levine, senior vp; Dr. Ewa Antonowicz; Anita Madison, vp-training.
Contact: Mike Garfield, 312-595-4006.
**Estimate.*

CONCENTRA Managed Care Services

312 Union Wharf,
Boston, Mass. 02129;
617-367-2163; fax: 617-367-8519

Utilization Review/Case Management

1997 revenues
Total gross revenue $248,000,000
UR revenue $109,000,000
Case mgmt. revenue $139,000,000
UR/case mgmt. direct to employers 11%
Svcs. to managed care/ins. providers 88%
Other services 1%
Staff
Total UR/case management employees 3,510
Professionals 1,356
UR/case mgmt. employees on retainer 50
Clients
Total 1,912
Covered lives/reviewed admissions
Acute care inpatient adm. reviewed 130,245

UR/case mgmt. services since: 1978.
Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, referrals to alternative settings, written reports.
Occasional services: Review of lab work, patient education, free pre-screening, outpatient psychiatric and substance abuse services.
AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.
Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability.
Branch offices: 205 locations.
Officers: Donald J. Larson, president/CEO; Joseph F. Pesce, executive vp-finance/CFO; John A. McCarthy Jr., president-CONCENTRA Managed Care Services; Ken Loffredo, senior vp-mar-keting/sales; Anne E. Kirby, vp-mar-keting/product development.
Contact: Anne E. Kirby.

CorVel Corp.

2010 Main St., Suite
1020, Irvine, Calif. 92614;
714-851-1473; fax: 714-851-1469

Utilization Review/Case Management

1997 revenues
Total gross revenue $136,000,000
UR revenue $11,000,000
Case mgmt. revenue $75,000,000
UR/case mgmt. direct to employers 18%
Svcs. to managed care/ins. providers 44%
Other services 38%
Staff
Total UR/case management employees 1,146
Professionals 960
UR/case mgmt. employees on retainer 190
Clients
Total 495
Corporate/institutional employer clients 72
Covered lives/reviewed admissions
Employee benefit plan lives served 25,116
Workers compensation lives served 6,100,000
Acute care inpatient adm. reviewed* 40,000
Diverted for outpatient treatment 5%

UR/case mgmt. services since: 1975.
Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, referrals to alternative settings, written reports, concurrent outpatient utilization review.
Occasional services: Outpatient psychiatric and substance abuse services.
AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.
Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, physical therapy, prescription drug, physical medicine, first and third party liability claims.
Branch offices: 220 locations nationwide.
Compensation: $1.25 to $1.40 per employee per month; $110 to $150 per case; $70 to $75 per hour.
Officers: Gordon Clemons, president; Daniel Davis, vp-business development; Lou Silverman, vp-operations; Richard Schweppe, CFO; Don McFarlane, vp-information technology.
Contact: Daniel Davis, 215-953-5060.
** Includes outpatient UR.*

Cost Care Inc.

660 Newport Center Drive, Suite
600, Newport Beach, Calif. 92660;
714-729-4500; fax: 714-729-4668

Utilization Review/Case Management

1997 revenues
Total gross revenue $46,000,000
UR revenue $28,000,000
Case mgmt. revenue $17,000,000
UR/case mgmt. direct to employers 50%
Svcs. to managed care/ins. providers 46.3%
Other services 3.7%
Staff
Professionals 348
Clients
Total 696
Corporate/institutional employer clients 353
Covered lives/reviewed admissions
Employee benefit plan lives served 2,656,656
Acute care inpatient adm. reviewed 145,990

UR/case mgmt. services since: 1981.
Parent: WellPoint Health Networks Inc.
Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, review of lab work, patient education, free pre-screening, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, disease state management, demand management.
Occasional services: Onsite case management, written reports.
AAHC/URAC accreditation status: Health Utilization Management Standards.
Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.
Branch offices: Orange County, Calif.; Atlanta; Chicago; Boston; Jackson, Miss.
Compensation: Per employee per month, per case, per hour.
Officers: Ryan Trimble, senior vp-managed care services; Randy Schwartz, vp-operations; Dr. Rocky Crocker, vp-care management services; John Webster, vp-management information systems; Cedric D'Abrera, director-finance.
Contact: Scott Schilling, national sales director, 800-762-4528.

Crawford & Co.

5620 Glenridge Drive,
Atlanta, Ga. 30342;
404-256-0830; fax: 404-847-4028

Utilization Review/Case Management

1997 revenues
Total gross revenue $692,000,000
UR revenue $20,000,000
Case mgmt. revenue $83,000,000
UR/case mgmt. direct to employers 7%
Svcs. to managed care/ins. providers 8%
Other services 85%
Staff
Total UR/case management employees 288
Professionals 288
Clients
Total 1,500
Corporate/institutional employer clients 1,021
Covered lives/reviewed admissions
Employee benefit plan lives served 290,919
Workers compensation lives served 11,825
Acute care inpatient adm. reviewed 15,580
Diverted for outpatient treatment 2%

UR/case mgmt. services since: 1984.
Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.
Occasional services: Review of lab work, patient education.
AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.
Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.
Branch offices: Culver City, Calif.; Orlando, Fla.; Atlanta and Savannah, Ga.; Cleveland.
Compensation: $1.10 to $1.50 per employee per month; $95 to $110 per case; $52 to $72 per hour.
Officers: Dennis Smith, chairman/CEO; Archie Meyers, president-claims management services; Don Chapman, executive vp-finance; Jim Bryant, executive vp; Judd Osten, senior vp.
Contact: Patti Nyberg.

D

Direct Medical Management Inc.

4301 Darrow Road,
Stow, Ohio 44224;
330-686-7030; fax: 330-686-7015

Utilization Review/Case Management

1997 revenues
Total gross revenue $275,000
UR revenue $275,000
UR/case mgmt. direct to employers 100%
Staff
Total UR/case management employees 2
Clients
Total 92
Covered lives/reviewed admissions
Employee benefit plan lives served 35,000
Acute care inpatient adm. reviewed 1,800
Diverted for outpatient treatment 3%

UR/case mgmt. services since: 1983.
Parent: The Chandler Group of Cos.
Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, review of lab work, retrospective review, referrals to alternative settings, written reports.
Occasional services: Onsite and telephone case management, second surgical opinion, outpatient service predetermination.
AAHC/URAC accreditation status: Health Utilization Management Standards.
Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, pediatric.
Officers: Arthur W. Chandler, chairman; Joseph Colosi, senior vp-managed care; Burton Margolis, CFO; James K. Piper, president.

E

E-V Benefits Management Inc.

1900 E. Dublin-Granville Road,
Columbus, Ohio 43229-3515;
614-895-4001; fax: 614-895-4995

Utilization Review/Case Management

1997 revenues
Total gross revenue $2,137,775
UR revenue/case mgmt. revenue $210,663
UR/case mgmt. direct to employers 10%
Other services 90%
Staff
Total UR/case management employees 3
Professionals 2
UR/case mgmt. employees on retainer 1
Clients
Total 26
Corporate/institutional employer clients 26
Covered lives/reviewed admissions
Employee benefit plan lives served 26,205
Acute care inpatient adm. reviewed 1,800

UR/case mgmt. services since: 1993.
Services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.
Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, pediatric, short-term disability.
Branch offices: Columbus, Ohio.
Compensation: $1.00 to $2.50 per employee per month; $85 to $100 per hour.
Officers: Jim Eggert, chairman; Gary Van Arsdale, president; Greg Nickell, vp.
Contact: Francine Crider, director-medical administration.

Ellis & Associates Inc.

745 McClintock Drive, Suite 305,
Burr Ridge, Ill. 60521;
630-887-4747; fax: 630-887-4077

Case Management

1997 revenues
Total gross revenue $3,400,000
Case mgmt. revenue $2,900,000
UR/case mgmt. direct to employers 15%
Svcs. to managed care/ins. providers 70%
Other services 15%
Staff
Total UR/case management employees 30
Clients
Total 160
Corporate/institutional employer clients 37

UR/case mgmt. services since: 1979.
Services: Discharge planning, onsite and telephone case management, free pre-screening, retrospective review, second surgical opinion, hospital bill audits, written reports.
Medical services reviewed/managed: Group health, chiropractic, psychiatric/substance abuse, workers comp/disability.
Branch offices: Chicago and Peoria, Ill.; Indianapolis; St. Louis; Milwaukee.
Compensation: $1.25 to $3.50 per employee per month; $72 to $85 per hour.
Officers: Cindy R. Ellis, president.

Employee Benefit Management Services Inc. dba CARELINK

2075 Overland Ave., P.O. Box
21367, Billings, Mont. 59104-1367;
406-245-3575; fax: 406-652-5380

Utilization Review/Case Management

1997 revenues
Total gross revenue $4,766,000
UR revenue $302,000
Case mgmt. revenue $170,000
UR/case mgmt. direct to employers 10%
Other services 90%
Staff
Total UR/case management employees 6
UR/case mgmt. employees on retainer 1
Clients
Total 107
Corporate/institutional employer clients 8
Covered lives/reviewed admissions
Employee benefit plan lives served 51,000
Acute care inpatient adm. reviewed 2,281
Diverted for outpatient treatment 1%

UR/case mgmt. services since: 1989.
Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, referrals to alternative settings, written reports.
Occasional services: Onsite case management, review of lab work, patient education, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services.
Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, pediatric.
Compensation: $1.50 to $2.60 per employee per month; $300 per case; $75 to $100 per hour.
Contact: Frederick H. Larson, president.

ENCOMPASS Health Management Systems

6000 Westown Parkway, Suite
350E, West Des Moines, Iowa
50266-7771; 515-223-2857;
fax: 515-222-2407

Utilization Review/Case Management

1997 revenues
Total gross revenue $26,565,000
UR revenue $10,500,000
Case mgmt. revenue $6,500,000
UR/case mgmt. direct to employers 55%
Svcs. to managed care/ins. providers 9%
Other services 36%
Staff
Total UR/case management employees 199
Professionals 133
UR/case mgmt. employees on retainer 334
Clients
Total 186
Corporate/institutional employer clients 177
Covered lives/reviewed admissions
Employee benefit plan lives served 4,000,000
Workers compensation lives served 2,250,000
Acute care inpatient adm. reviewed 183,500
Diverted for outpatient treatment 12%

UR/case mgmt. services since: 1975.
Parent: Iowa Foundation for Medical Care.
Frequent services: Preadmission certification, concurrent hospital treatment review, discharge planning, telephone case management, patient education, free pre-screening, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, high-risk pregnancy review.
Occasional services: Length of stay determination, review of lab work.
AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.
Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, home health, skilled nursing facilities.
Branch offices: Minneapolis.
Compensation: $1.65 to $2.45 per employee per month; varies per case; $85 to $150 per hour.
Officers: Kathy R. Fliehler, vp; Michael Larson, national sales director; Elodie Opstad, director-marketing/business development; Sheri Ivey, director-utilization management; Jeffrey D. Stahl, medical director.
Contact: Kathy R. Fliehler.

F

FARA Healthcare Management

2360 Fifth Ave.,
Mandeville, La. 70471;
504-624-8383; fax: 504-624-8489

Utilization Review/Case Management

1997 revenues
Total gross revenue $13,000,000
UR revenue $800,000
Case mgmt. revenue $1,200,000
UR/case mgmt. direct to employers 7%
Svcs. to managed care/ins. providers 3%
Other services 90%
Staff
Total UR/case management employees 12
Professionals 12
UR/case mgmt. employees on retainer 1
Clients
Total 250
Covered lives/reviewed admissions
Employee benefit plan lives served 6,000
Workers compensation lives served 95,000
Acute care inpatient adm. reviewed 196
Diverted for outpatient treatment 1%

UR/case mgmt. services since: 1992.
Parent: F.A. Richard & Associates Inc.
Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, second surgical opinion, hospital bill audits, outpatient service predetermination, written reports.
Occasional services: Review of lab work, patient education, retrospective review, outpatient psychiatric and substance abuse services, referrals to alternative settings.
Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability.
Branch offices: Mobile, Ala.; Boca Raton, Fla.; Atlanta; Baton Rouge, Lafayette, Metairie, New Orleans and Shreveport, La.; Beaumont, Corpus Christi, Dallas and Houston, Texas; Norfolk, Va.
Compensation: $1.50 to $3.00 per employee per month; $98 to $105 per case; $69 to $85 per hour.
Officers: Francis A. Richard, CEO; Todd Richard, president; Reed A. Bell, executive vp.
Contact: Reed A. Bell.

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G

GENEX Services Inc.

440 E. Swedesford Road,
Suite 3050, Wayne, Pa. 19087;
610-964-5100; fax: 610-964-1919

Utilization Review/Case Management

1997 revenues

Total gross revenue	$90,000,000
UR/case mgmt. direct to employers	8%
Svcs. to managed care/ins. providers	72%
Other services	20%

Staff

Total UR/case management employees	800
Professionals	650

Clients

Total	850
Corporate/institutional employer clients	575

Covered lives/reviewed admissions

Employee benefit plan lives served	17,000
Workers compensation lives served	100,000
Acute care inpatient adm. reviewed	10,000
Diverted for outpatient treatment	4%

Parent: Provident Cos.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, patient education, outpatient service predetermination, referrals to alternative settings, written reports, disability management.

Occasional services: Review of lab work, free pre-screening, retrospective review, second surgical opinion, hospital bill audits, outpatient psychiatric and substance abuse services.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: 120 offices nationwide.

Officers: Peter C. Madeja, president; Edward J. McBurnie, senior vp-sales/marketing; Delphia B. Frisch, senior vp-operations; Daniel P. Lubas, senior vp-information systems; Richard A. Baron, CFO.

Contact: Betsy Robinson, vp-product management/development.

Green Spring Health Services Inc.

5565 Sterrett Place, Suite 500,
Columbia, Md. 21044;
800-458-2740; fax: 410-740-8573

Utilization Review/Case Management

1997 revenues

Total gross revenue	$366,000,000
UR revenue	$56,000,000
Case mgmt. revenue	$300,000,000
UR/case mgmt. direct to employers	7.4%
Svcs. to managed care/ins. providers	89.9%
Other services	2.7%

Staff

Total UR/case management employees	384
Professionals	199
UR/case mgmt. employees on retainer	185

Clients

Total	99
Corporate/institutional employer clients	34

Covered lives/reviewed admissions

Employee benefit plan lives served	16,722,000
Acute care inpatient adm. reviewed	63,000

UR/case mgmt. services since: 1989.

Parent: Magellan Health Services Inc.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings.

Occasional services: Onsite case management, review of lab work, patient education, free pre-screening, written reports.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Psychiatric/substance abuse.

Branch offices: San Diego; Atlanta; Chicago; Portland, Maine; Columbia, Md.; Lansing, Mich.; Parsippany, N.J.; Cincinnati; Portland, Ore.; Philadelphia; Providence, R.I.; Chattanooga and Nashville, Tenn.; Richmond, Va.; Tacoma, Wash.

Officers: Dr. Henry T. Harbin, president/CEO; Clarissa C. Marques, executive vp/chief clinical officer; Steven J. Scheidt, executive vp/chief marketing officer; John J. Wider, executive vp/COO; Dr. Jonathan D. Book, senior vp/chief medical officer.

Contact: Steven J. Scheidt, 410-964-1003.

H

HCH Administration*

P.O. Box 1986,
Peoria, Ill. 61656-1986;
309-673-7330; fax: 309-673-7369

Utilization Review/Case Management

1997 revenues

UR/case mgmt. revenue	$700,000
UR/case mgmt. direct to employers	10%
Svcs. to managed care/ins. providers	10%
Other services	80%

Staff

Total UR/case management employees	6
Professionals	6
UR/case mgmt. employees on retainer	2

Clients

Total	80

Covered lives/reviewed admissions

Employee benefit plan lives served	33,131
Acute care inpatient adm. reviewed	4,500
Diverted for outpatient treatment	10%

UR/case mgmt. services since: 1986.

Parent: Health Care Horizons.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings.

Occasional services: Review of lab work, retrospective review, second surgical opinion, written reports.

Medical services reviewed/managed: Group health, dental, rehabilitation, psychiatric/substance abuse, pediatric.

Compensation: $1.25 to $2.25 per employee per month; $100 per hour (large case management).

Officers: Philip C. Walker II, chairman; James D. Stevenson, president; Gloria J. Towles, vp-finance; Patti Thornton, director-operations; Linda Walker, director-utilization management.

** Formerly Keppie & Co. Inc.*

HCX Inc.

600 New Hampshire Ave. N.W.,
Suite 1250, Washington, D.C.
20037; 202-625-3200;
fax: 202-298-6188

Utilization Review/Case Management

1997 revenues

Total gross revenue	$10,000,000
UR revenue	$9,800,000
Case mgmt. revenue	$200,000
UR/case mgmt. direct to employers	32%
Svcs. to managed care/ins. providers	68%

Staff

Total UR/case management employees	71
Professionals	21
UR/case mgmt. employees on retainer	141

Clients

Total	212
Corporate/institutional employer clients	72

Covered lives/reviewed admissions

Acute care inpatient adm. reviewed	30,264
Diverted for outpatient treatment	5%

UR/case mgmt. services since: 1962

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, free pre-screening, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination.

Occasional services: Telephone case management, review of lab work, patient education, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability.

Branch offices: Phoenix; Naperville, Ill.

Compensation: $0.95 to $1.50 per employee per month; $125 to $175 per case; percentage of savings.

Officers: Donald E. Hernley, president; Sharon F. O'Shea, COO; Daniel J. Ianni, CFO; Karen E. McCray, vp-operations; Barbara Beck Dickson, vp-general counsel.

Contact: David Henderson, director-marketing.

HHS Inc.

5363 44th St. S.E.,
Grand Rapids, Mich. 49512;
616-956-9440; fax: 616-956-6843

Utilization Review/Case Management

1997 revenues

Total gross revenue	$5,203,035
UR revenue	$2,834,732
UR/case mgmt. direct to employers	43%
Svcs. to managed care/ins. providers	11%
Other services	46%

Staff

Total UR/case management emplcyees	21.8
UR/case mgmt. employees on retainer	84

Clients

Total	350

Covered lives/reviewed admissions

Employee benefit plan lives served	197,446
Acute care inpatient adm. reviewed	18,000
Diverted for outpatient treatment	1%

UR/case mgmt. services since: 1984.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings.

Occasional services: Onsite case management, review of lab work, written reports.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Compensation: $0.45 to $1.90 per employee per month; $375 per case; $80 per hour.

Officers: Denise Zoeterman, president/CEO; Richard Hodsdon Jr., customer relations director; Moni Evans, director-heath management; Bill Jones, director-finance; Tim Hart, information systems manager; Nancy Bolthouse, human resources/facility manager.

Contact: Customer relations department.

Health Benefits Management Inc./The Precertification Center

P.O. Box 898125,
Camp Hill, Pa. 17089-8125;
717-232-0946; fax: 717-232-1713

Utilization Review

1997 revenues

Total gross revenue	$4,000,000
UR revenue	$3,880,000
UR/case mgmt. direct to employers	99%
Other services	1%

Staff

Total UR/case management employees	42
Professionals	33

Clients

Total	989
Corporate/institutional employer clients	987

Covered lives/reviewed admissions

Employee benefit plan lives served	642,868
Workers compensation lives served	40,000
Acute care inpatient adm. reviewed	42,821
Diverted for outpatient treatment	5%

UR/case mgmt. services since: 1984.

Parent: Pennsylvania Blue Shield/Capital Blue Cross.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services.

Occasional services: Retrospective review, referrals to alternative settings.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, hospice, skilled nursing, FMLA certification, home health care, private-duty nursing.

Compensation: $0.95 to $2.40 per employee per month; $85 to $135 per case.

Officers: Jerry E. Boyer, president; Elizabeth A. Galitski, vp-operations; Yvonne M. Fry, manager-precertification programs; Peggy Belfonti, manager-disability programs.

Health Care Evaluation Inc.

6702 N. Inglewood Ave., Suite G,
Stockton, Calif. 95207;
800-333-3018 or 209-951-6711;
fax: 209-951-2731

Utilization Review/Case Management

1997 revenues

Total gross revenue	$2,029,953
UR revenue	$1,573,221
Case mgmt. revenue	$456,732
UR/case mgmt. direct to employers	88%
Svcs. to managed care/ins. providers	11%
Other services	1%

Staff

Total UR/case management employees	26
Professionals	26
UR/case mgmt. employees on retainer	230

Clients

Total	55
Corporate/institutional employer clients	52

Covered lives/reviewed admissions

Employee benefit plan lives served	357,015
Workers compensation lives served	23,238
Acute care inpatient adm. reviewed	14,426
Diverted for outpatient treatment	18%

UR/case mgmt. services since: 1968.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, nursing facility reviews, claims audits.

Occasional services: Onsite case management, review of lab work, patient education, free pre-screening, written reports.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Sacramento and San Francisco, Calif.

Compensation: $1.00 to $2.50 per employee per month; $45 to $100 per case; $60 to $125 per hour.

Officers: Jeff Roby, president/CEO/chairman; Trevor Logette, secretary; Tom Spoon, CFO; Peggy Hoover, vp-review operations; Dick Bukar, vp-marketing/sales.

Contact: Dick Bukar, 714-281-7846.

Health International Inc.

14770 N. 78th Way,
Scottsdale, Ariz. 85260;
800-333-3760; fax: 602-948-2523

Utilization Review/Case Management

1997 revenues

Total gross revenue	$12,058,846
UR/case mgmt. direct to employers	100%

Staff

Total UR/case management employees	114
Professionals	106
UR/case mgmt. employees on retainer	25

Clients

Total	115
Corporate/institutional employer clients	115

Covered lives/reviewed admissions

Employee benefit plan lives served	482,004
Workers compensation lives served	85,000
Acute care inpatient adm. reviewed	68,088
Diverted for outpatient treatment	50%

UR/case mgmt. services since: 1987.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, review of lab work, patient education, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, high-risk maternity screening and case management, disease management, short/long term disability case management, workers compensation case management.

Occasional services: Onsite case management, retrospective review, second surgical opinion.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Compensation: Capitated fees.

Officers: Dr. Donald K. Kelly, chairman/CEO; Dr. Kenneth R. Roepke, vp/chief medical officer; Suzanne D. Kelly, vice chairman/co-CEO; Michael C. Peerboom, president/COO; Ronald L. Eggleston, vp-medical administration.

Contact: Donald K. Kelly, ext. 4351.

Health Risk Management Inc.

8000 W. 78th St.,
Minnneapolis, Minn. 55439;
612-829-3500; fax: 612-946-7694

Utilization Review/Case Management

1997 revenues

Total gross revenue	$62,000,000
UR revenue	$20,276,000
Case mgmt. revenue	$5,522,000
UR/case mgmt. direct to employers	34%
Svcs. to managed care/ins. providers	7%
Other services	59%

Staff

Total UR/case management employees	265
Professionals	265
UR/case mgmt. employees on retainer	9

Clients

Total	111
Corporate/institutional employer clients	80

Covered lives/reviewed admissions

Employee benefit plan lives served	1,170,369
Workers compensation lives served	55,331
Acute care inpatient adm. reviewed	165,000
Diverted for outpatient treatment	2%

UR/case mgmt. services since: 1984.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings.

Occasional services: Onsite case management.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Minneapolis, Milwaukee.

Officers: Dr. Gary McIlroy, CEO; Marlene Travis, president/COO; Thomas P. Clark, senior vp/CEO; Adele Kimpell, executive vp-operations.

Contact: Kate McGuire-Ilstrup, marketing associate or Victoria Haulcy, director-marketing.

Health Services Advisory Group Inc.

301 E. Bethany Home Road,
Suite 157-B, Phoenix, Ariz. 85012;
602-264-6382; fax: 602-241-0757

Utilization Review/Case Management

1997 revenues

Total gross revenue	$5,384,197
UR revenue	$1,000,000
UR/case mgmt. direct to employers	3%
Svcs. to managed care/ins. providers	15%
Other services	82%

Staff

Total UR/case management employees	11
Professionals	10

Clients

Total	14
Corporate/institutional employer clients	6

Covered lives/reviewed admissions

Employee benefit plan lives served	10,500
Acute care inpatient adm. reviewed	4,400

UR/case mgmt. services since: 1982.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, patient education, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Review of lab work, retrospective review, hospital bill audits.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, pediatric, podiatric, home health, prescription drug, skilled nursing facilities, durable medical equipment.

Branch offices: Phoenix.

Compensation: $0.80 to $2.15 per employee per month; $98 per case; $35 to $200 per hour; sliding scale.

Officers: Dr. Lawrence J. Shapiro, president/CEO; Dr. Herbert S. Rigberg, vp-medical affairs; Mary Ellen Dalton, vp-private division; Joellen Tenison, vp-administration; Debra L. Nixon, director-corporate development.

Contact: Debra L. Nixon.

Hines & Associates

115 E. Highland Ave.,
Elgin, Ill. 60120; 847-741-1291;
fax: 847-741-1391

Utilization Review/Case Management

1997 revenues

Total gross revenue	$5,600,000
UR revenue	$1,774,000
Case mgmt. revenue	$3,827,000
UR/case mgmt. direct to employers	4%
Svcs. to managed care/ins. providers	96%

Staff

Total UR/case management employees	115
Professionals	80
UR/case mgmt. employees on retainer	97

Clients

Total	372
Corporate/institutional employer clients	14

Covered lives/reviewed admissions

Employee benefit plan lives served	255,220

UR/case mgmt. services since: 1987.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge plan-

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ning, onsite and telephone case management, review of lab work, patient education, free pre-screening, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, peer review, PPO channeling.

Occasional services: Hospital bill audits.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: San Diego; Denver; Tallahassee, Fla.; Bloomington, Champaign, Rockford and Western Springs, Ill.; Des Moines and Dubuque, Iowa; New Orleans; Bay City, Mich.; Omaha, Neb.; Cleveland; Charleston, S.C.; Greenville, Tenn.; Dallas; Arlington and Portsmouth, Va.; Appleton and Brookfield, Wis.

Compensation: $1.05 to $1.65 per employee per month; $100 to $2,500 per case; $88 to $98 per hour.

Officers: Judith Hines, president; Eileen Zurblis, executive vp; Mary Hasterok, vp; Lynn Britbach, vp; Grace Richard, director-marketing.

Contact: Grace Richard, 800-735-1200.

I

Integra Group

4660 Duke Drive,
Mason, Ohio 45040;
513-459-1010; fax: 513-459-8835

Utilization Review/Case Management

1997 revenues

Total gross revenue	$8,000,000
UR/case mgmt. direct to employers	25%
Svcs. to managed care/ins. providers	5%
Other services	70%

Staff

Total UR/case management employees	15
Professionals	12

Clients

Total	41
Corporate/institutional employer clients	74

Covered lives/reviewed admissions

Employee benefit plan lives served	25,222
Acute care inpatient adm. reviewed	2,800
Diverted for outpatient treatment	3%

UR/case mgmt. services since: 1988.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Onsite case management, review of lab work, patient education, retrospective review, second surgical opinion, hospital bill audits.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Compensation: $1.85 to $2.50 per employee per month; $95 per hour.

Officers: Mary J. Hanley, president; William D. Stief, CEO; Vincent J. Homan, executive vp; Kathleen J. Lutz, COO; Thomas E. Brackmann, chief information officer.

Contact: Christina L. Meyer.

Intracorp

1601 Chestnut St., 2 Liberty Place, (TL11G), Philadelphia,
Pa. 19192-2116; 215-761-7100;
fax: 215-761-7458

Utilization Review/Case Management

1997 revenues

Total gross revenue	$346,600,000
UR revenue	$81,100,000
Case mgmt. revenue	$49,200,000
UR/case mgmt. direct to employers	14.2%
Svcs. to managed care/ins. providers	23.5%
Other services	62.3%

Staff

Total UR/case management employees	3,432
Professionals	1,165
UR/case mgmt. employees on retainer	816

Clients

Total	1,026
Corporate/institutional employer clients	630

Covered lives/reviewed admissions

Employee benefit plan lives served	20,000,000
Workers compensation lives served	4,000,000
Acute care inpatient adm. reviewed	532,135
Diverted for outpatient treatment	5.6%

UR/case mgmt. services since: 1984.

Parent: CIGNA Corp.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, review of lab work, patient education, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, 24 hour health care information and decision report, disease management, high risk maternity, integrated disability management, dependent care assessments.

Occasional services: Hospital bill audits.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, auto liability, safety and prevention services, work/life management services.

Branch offices: Anaheim, Calif.; Norcross, Ga.; Itasca, Ill.; Pittsburgh and Plymouth Meeting, Pa.; Chattanooga, Tenn.; Dallas; 57 offices throughout the U.S., Canada, Puerto Rico and the Virgin Islands.

Compensation: Per employee per month; per case; percentage of savings for some auditing/fee management services.

Officers: Dennis Mouras, president/CEO; Maddy Bowling, senior vp-property/casualty managed care; John Weymer, senior vp-group health managed care; Ken Ross, senior vp-life management services; Daniel Moore, CFO/vp-finance; Dr. Joel Levin, chief medical officer/vp-medical management.

Contact: Betty J. Nelson, director-corporate communications/public relations, 215-761-7146.

IPRO

1979 Marcus Ave.,
Lake Success, N.Y. 11042;
516-326-7767; fax: 516-328-2310

Utilization Review/Case Management

1997 revenues

Total gross revenue	$30,000,000
UR/case mgmt. direct to employers	25%
Svcs. to managed care/ins. providers	25%
Other services	50%

Staff

Total UR/case management employees	200
UR/case mgmt. employees on retainer	600

Clients

Total	35
Corporate/institutional employer clients	5

Covered lives/reviewed admissions

Acute care inpatient adm. reviewed	180,000

UR/case mgmt. services since: 1984.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, telephone case management, retrospective review, second surgical opinion, hospital bill audits, written reports.

Occasional services: Discharge planning, onsite case management, outpatient service predetermination, referrals to alternative settings.

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Albany, N.Y.; Burlington, Vt.

Compensation: $1.55 to $2.55 per employee per month; $125 to $300 per case; $100 to $175 per hour.

Officers: Dr. Thomas J. Sheehy Jr., president; Theodore O. Will, executive vp; Harry Feder, senior vp; Dr. Raphael P. Nenner, vp-medical affairs.

Contact: Robin J. Husney, senior director-communications/corporate development.

J

Jordan Services Inc.

900 Merchants Concourse,
Suite 112, Westbury, N.Y. 11590;
516-683-0100; fax: 516-683-0259

Utilization Review/Case Management

1997 revenues

Total gross revenue	$7,088,889
UR revenue	$1,520,000
Case mgmt. revenue	$4,860,000
UR/case mgmt. direct to employers	15%
Svcs. to managed care/ins. providers	75%
Other services	10%

Staff

Total UR/case management employees	82
Professionals	60

Clients

Total	715
Corporate/institutional employer clients	155

Covered lives/reviewed admissions

Employee benefit plan lives served	11,600
Workers compensation lives served	45,000
Acute care inpatient adm. reviewed	9,200
Diverted for outpatient treatment	35%

UR/case mgmt. services since: 1974.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, patient education, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, referrals to alternative settings, written reports.

Occasional services: Review of patient lab work, outpatient psychiatric and substance abuse services.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Iselin, N.J.

Compensation: $1.38 to $4.40 per employee per month; $86 to $165 per hour.

Officers: Morris Ehrenreich, president; Sandra Horowitz, CFO; Phyllis Snow, director-marketing; Joan Jennings, director-professional services.

Contact: Phyllis Snow.

L

Laurel Rehabilitation Services Inc.

67 S. Black Horse Pike,
Blackwood, N.J. 08012;
609-346-9748; fax: 609-232-8430

Utilization Review/Case Management

1997 revenues

Total gross revenue	$1,027,041
UR revenue	$373,810
Case mgmt. revenue	$601,869
UR/case mgmt. direct to employers	10%
Svcs. to managed care/ins. providers	85%
Other services	5%

Staff

Total UR/case management employees	16
Professionals	14
UR/case mgmt. employees on retainer	70

Clients

Total	22
Corporate/institutional employer clients	2

Covered lives/reviewed admissions

Employee benefit plan lives served	12
Workers compensation lives served	24
Acute care inpatient adm. reviewed	18
Diverted for outpatient treatment	3%

UR/case mgmt. services since: 1988.

Frequent services: Discharge planning, onsite and telephone case management, patient education, retrospective review, hospital bill audits, written reports.

Occasional services: Preadmission certification, concurrent hospital treatment review, length of stay determination, free prescreening, second surgical opinion, outpatient service predetermination, referrals to alternative settings.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Compensation: $60 to $75 per hour; $375 to $600 per review.

Officers: Patricia Deffler, president; John Deffler, vp.

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READER REPLY SERVICE

PRODUCTS & SERVICES LISTING

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All questions must be answered to process inquiries.

PLEASE CHECK ONE ITEM FOR EACH CATEGORY:

1. My organization is best described as:
A ❑ Mfg/Svcs B ❑ Association C ❑ Union D ❑ Government E ❑ Educational Inst F ❑ Ins Agent G ❑ Ins Broker H ❑ Ins/Reins Co I ❑ Consultant J ❑ Actry/Attorney K ❑ Adj/Apprs L ❑ TPA M ❑ Health care Inst N ❑ Other_____

2. Number of employees:
1 ❑ 150 or less 2 ❑ 151 - 499 3 ❑ 500 - 999 4 ❑ 1,000 - 4,999 5 ❑ 5,000 or more 6 ❑ Unknown

3. My title is best defined as:
A ❑ Administrative Mgt B ❑ Financial Mgt C ❑ Risk Mgt D ❑ Benefits Mgt E ❑ Loss Prevention Mgt F ❑ Other_____

4. My purchasing involvement for the requested products is to:
1 ❑ recommend only 2 ❑ specify 3 ❑ approve

5. Do you now receive a personally addressed copy of *Business Insurance*?
A ❑ Yes B ❑ No, so please send subscription info

Circle the numbers below that correspond to the companies listed on our Advertiser Index for the **February 2, 1998** issue. Cards with more than 20 items circled will not be processed. This card expires **March 30, 1998**.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
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31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
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Please print clearly

Name_____

Title_____

Company_____

Address_____

City_____State_____Zip_____

Phone ( )_____

Continued from previous page

Managed Care USA Services Inc.

4401 Barclay Downs Drive,
Charlotte, N.C. 28209;
704-945-2706; fax: 704-945-2634

Case Management

1997 revenues
- Total gross revenue $3,800,000
- Case mgmt. direct to employers 10%
- Svcs. to managed care/ins. providers 80%
- Other services 10%

Staff
- Total case management employees 40

Clients
- Corporate/institutional employer clients 10

Covered lives/reviewed admissions
- Employee benefit plan lives served 20,000
- Workers compensation lives served 108,280

Case mgmt. services since: 1995.

Parent: Managed Care USA Inc.

Frequent services: Preadmission certification, telephone case management, outpatient service predetermination.

Occasional services: Concurrent hospital treatment review, length of stay determination, discharge planning, onsite case management, review of lab work, patient education, retrospective review, second surgical opinion, hospital bill audits, referrals to alternative settings, written reports.

Medical services reviewed/managed: Group health, rehabilitation, workers comp/disability.

Branch offices: Atlanta; Chattanooga, Knoxville and Nashville, Tenn.

Officers: Steven M. Mariano, president/CEO; Robert W. Granow, CFO/treasurer; John C. Scarborough, president-OccuCare Partners; David H. Dunn, president-Managed Care USA Health Plans Inc.

MedCost L.L.C.

1399 Ashleybrook Lane,
Suite 100, P.O. Box 25347,
Winston-Salem, N.C. 27114-5347;
336-760-3090; fax: 336-760-1503

Utilization Review/Case Management

1997 revenues
- Total gross revenue $10,000,000
- UR/case mgmt. services 33%
- Other services 67%

Staff
- Total UR/case management employees 30

Clients
- Total 79
- Corporate/institutional employer clients 34

Covered lives/reviewed admissions
- Employee benefit plan lives served 414,500
- Acute care inpatient adm. reviewed 19,811
  - Diverted for outpatient treatment 2%

UR/case mgmt. services since: 1984.

Parent: North Carolina Baptist Hospital/Carolina Healthcare System.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, free pre-screening, retrospective review, second surgical opinion, referrals to alternative settings, written reports, prenatal program, personal health management program, outpatient surgical/diagnostic review.

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

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, pediatric.

Officers: Otto Mueller, president; Kathryn Showalter, vp-business development; Joel Groce, vp-administration; Judith Beauchamp, director-utilization management; William B. Lorentz Jr., medical director.

Contact: Elaine Davis, marketing assistant, 336-760-3090 ext. 340.

Medicus Resource Management

50 Commerce Court,
Wyomissing, Pa. 19610;
800-647-2500; fax: 610-371-0310

Utilization Review/Case Management

1997 revenues
- Total gross revenue $500,000
- UR revenue $500,000
- UR/case mgmt. direct to employers 60%
- Svcs. to managed care/ins. providers 40%

Staff
- Total UR/case management employees 11
  - Professionals 7

Clients
- Total 50

Covered lives/reviewed admissions
- Employee benefit plan lives served 70,000
- Workers compensation lives served 830
- Acute care inpatient adm. revewed 3,302

UR/case mgmt. services since: 1989.

Parent: Berkshire Health Plan.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, second surgical opinion, outpatient service predetermination, referrals to alternative settings, written reports, gatekeeper, referral management.

Occasional services: Onsite case management, review of lab work, patient education, second surgical opinion.

Med-Valu Inc.

485 Metro Place S., Suite 200,
Dublin, Ohio 43017; 614-764-2282;
fax: 614-766-0004

Utilization Review/Case Management

1997 revenues
- UR revenue $6,300,000
- Case mgmt. revenue $700,000
- UR/case mgmt. direct to employers 0.5%
- Svcs. to managed care/ins. providers 89.5%
- Other services 10%

Staff
- Total UR/case management employees 81
  - Professionals 81
- UR/case mgmt. employees on retainer 153

Clients
- Total 31
- Corporate/institutional employer clients 7

Covered lives/reviewed admissions
- Employee benefit plan lives served 3,500,000

UR/case mgmt. services since: 1987.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, free pre-screening, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, gatekeeper, referral management.

Occasional services: Onsite case management, retrospective review, hospital bill audits, outpatient psychiatric and substance abuse services.

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Compensation: $5.25 to $8.00 per employee per month (includes network access); $2.00 to $3.50 per employee per month (UR only).

Officers: Edward Wargo, president; Dr. Robert Brigham, chairman Dr. David Starbuck, medical director; Lawrence Cobaugh, CFO.

Contact: Misty L. Wintsch, director-provider/customer relations.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, physical therapy, occupational therapy,.

Compensation: Per employee per month; per case; per hour.

Officers: Michael Linde, president/CEO; Mary Ellen O'Grady, vp; Frank Anzelmo, vp.

Contact: Mary Ellen O'Grady.

Dr. Donald P. Milione

330 E. 79th St., Suite 1-C,
New York, N.Y. 10021;
212-988-6900; fax: 212-988-8904

Utilization Review

1997 revenues
- Total gross revenue $100,000
- UR revenue $25,000
- UR direct to employers* 10%
- Svcs. to managed care/ins. providers* 10%
- Other services* 80%

Staff
- Total UR employees 4
  - Professionals 4

Clients
- Total 30
- Corporate/institutional employer clients 15

UR services since: 1996.

Frequent services: Telephone case management, review of lab work, patient education, referrals to alternative settings, written reports, independent physical examinations.

Occasional services: Onsite case management.

Medical services reviewed/managed: Chiropractic, workers comp/disability.

Branch offices: Brooklyn and New York, New York.

Compensation: $300 to $500 per case; $150 per hour.

Officers: Dr. Donald P. Milione, C.G. Sammis, Christine Mauro, Nancy Ruiz.

Contact: Dr. Donald P. Milione.

** Estimate.*

NHA Review Services Inc.

770 S. Post Oak Lane, Suite 445,
Houston, Texas 77056;
800-759-3118; fax: 713-888-1986

Utilization Review/Case Management

1997 revenues
- Total gross revenue $279,972
- UR revenue $267,172
- Case mgmt. revenue $12,800
- UR/case mgmt. direct to employers 5%
- Svcs. to managed care/ins. providers 95%

Staff
- Total UR/case management employees 6

Clients
- Total 42
- Corporate/institutional employer clients 9

Covered lives/reviewed admissions
- Employee benefit plan lives served 22,149
- Workers compensation lives served 3,275
- Acute care inpatient adm. reviewed 1,078
  - Diverted for outpatient treatment 20%

UR/case mgmt. services since: 1988.

Parent: National Healthcare Alliance Inc.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, second surgical opinion, outpatient service predetermination, referrals to alternative settings, written reports.

Occasional services: Onsite case management, review of lab work, patient education, retrospective review, hospital bill audits, outpatient psychiatric and substance abuse services.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Compensation: $1.25 to $1.50 per employee per month.

Officers: Robert Woolfolk, CEO; Melvin Thorne, president; Dr. John Baird, medical director; Beverly Knacht, director-UR.

Contact: Melvin Thorne, 713-888-1902.

National Health Services Inc.

9200 Shelbyville Rd., Suite 700,
Louisville, Ky. 40222; 800-762-7360;
fax: 502-339-8057

Utilization Review/Case Management

1997 revenues
- Total gross revenue $19,800,000
- UR revenue $12,800,000
- Case mgmt. revenue $6,240,000
- UR/case mgmt. direct to employers 17%
- Svcs. to managed care/ins. providers 80%
- Other services 3%

Staff
- Total UR/case management employees 237
  - Professionals 142
- UR/case mgmt. employees on retainer 83

Clients
- Total 50
- Corporate/institutional employer clients 4

Covered lives/reviewed admissions
- Employee benefit plan lives served 2,744,281
- Acute care inpatient adm. reviewed 235,632
  - Diverted for outpatient treatment 4%

UR/case mgmt. services since: 1984.

Parent: United Payors & United Providers.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, free pre-screening, retrospective review, outpatient service predetermination, referrals to alternative settings, written reports, claims audit review, high risk maternity screening, maternity review, nursing home review, long-term care facility case mix review, ancillary therapy review, home and community based waivers, durable medical equipment review, disease management, demand management, specialty referral review.

Occasional services: Onsite case management, review of lab work, second surgical opinion, hospital bill audits, outpatient psychiatric and substance abuse services.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Compensation: $1.10 to $2.50 per employee per month; $40 to $175 per case; $80 to $150 per hour.

Officers: Anthony Pino, CEO; Frank Whyte, CFO; Richard Dankworth, executive vp; Barbara Freeman, executive vp/chief medical officer; Christie Sturzebecher, senior vp.

Contact: Lisa Dohoney, 800-762-7360 ext. 594.

National Utilization Management Corp.

7301 N. 16th St., Suite 201,
Phoenix, Ariz. 85020;
602-371-3860; fax: 602-371-3885

Utilization Review/Case Management

1997 revenues
- Total gross revenue $2,000,000
- UR revenue $1,400,000
- Case mgmt. revenue $600,000
- UR/case mgmt. direct to employers 8%
- Svcs. to managed care/ins. providers 92%

Staff
- Total UR/case management employees 35
  - Professionals 34
- UR/case mgmt. employees on retainer 60

Clients
- Total 120

Covered lives/reviewed admissions
- Employee benefit plan lives served 450,000
- Workers compensation lives served 70,000
- Acute care inpatient adm. reviewed 11,000
  - Diverted for outpatient treatment 20%

UR/case mgmt. services since: 1990.

Parent: USA Managed Care Organization Inc.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, high-risk maternity program, disease management.

Occasional services: Onsite case management, review of lab work, second surgical opinion, hospital bill audits.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Austin, Texas.

Compensation: Varies by client size and requirements.

Officers: George Bogle, chairman/CEO; Constance Lambert, president; W. Joseph Martin, CFO; Wendy Sara, secretary; Dr. James Gerace, medical director.

Contact: Constance Lambert, 800-354-2464.

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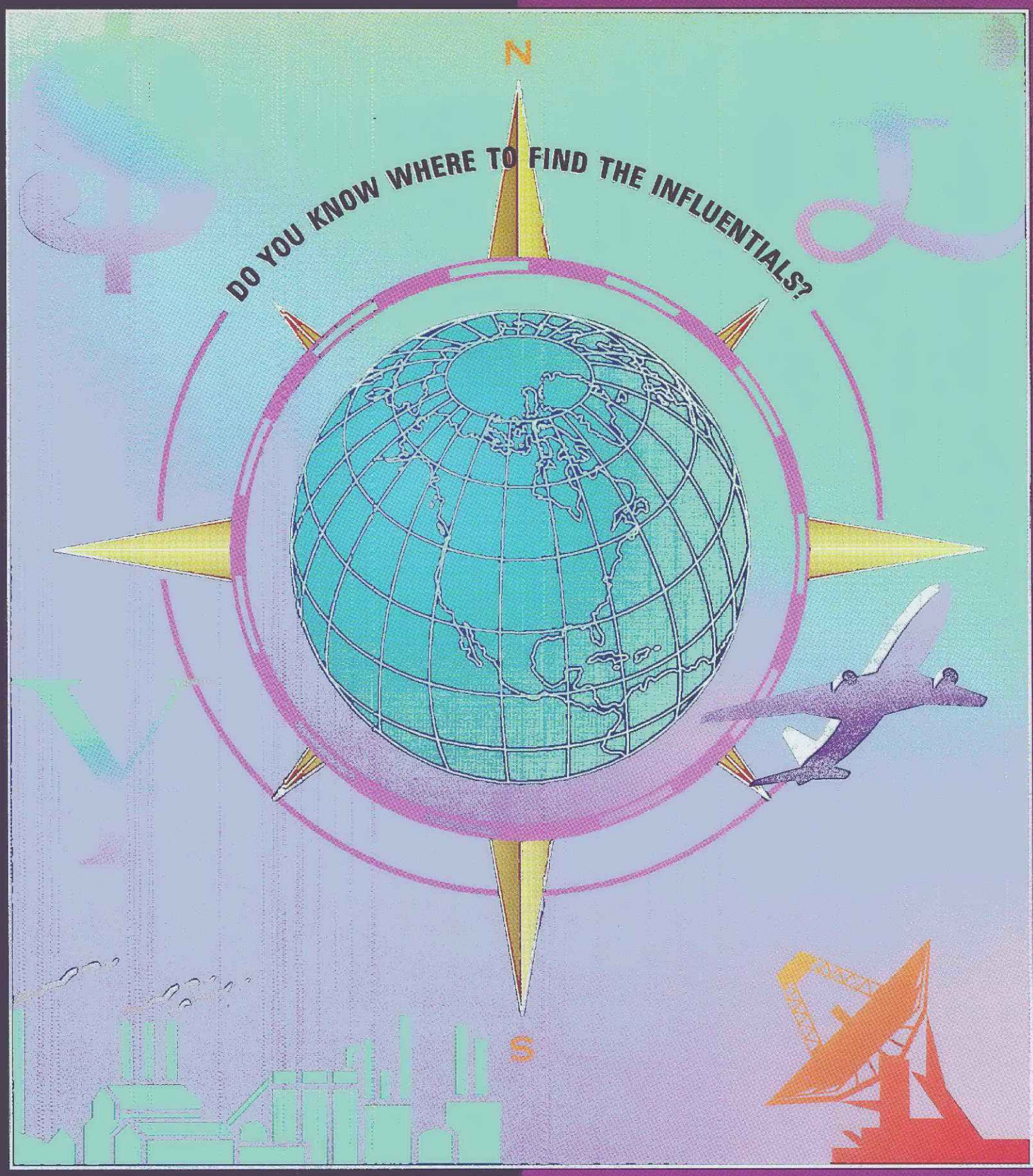
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Los Angeles, California 90017
Contact: Viviane Krief
Tel: 213 833 0288
Fax: 213 833 0277
E-mail: VKrief@ECom.Net
IFIS

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1997/98 DIRECTORY OF BUYERS 1997/98

When you want to reach corporate influentials who matter most in purchasing commercial insurance, risk management, employee benefits and related products and services, you'll want to reach for the most comprehensive reference tools from the publishers of *Business Insurance*.

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Business Insurance
www.businessinsurance.com

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Nationwide Case Management Services

P.O. Box 16361,
Irvine, Calif. 92713;
714-753-2757; fax: 714-496-3667

Utilization Review/Case Management

1997 revenues

UR revenue	$180,000
Case mgmt. revenue	$20,000
UR/case mgmt. direct to employers	20%
Svcs. to managed care/ins. providers	75%
Other services	5%

Staff

Total UR/case management employees	1

Clients

Corporate/institutional employer clients	2

Covered lives/reviewed admissions

Employee benefit plan lives served	20
Workers compensation lives served	220
Acute care inpatient adm. reviewed	40
Diverted for outpatient treatment	40%

UR/case mgmt. services since: 1993.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, free pre-screening, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Review of lab work, patient education.

AAHC/URAC accreditation status: Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, workers comp/disability.

Branch offices: Irvine and Torrance, Calif.

Officers: Sally Swenson, Mark Fernandez.

O

Ohio Health Choice

1621 Euclid Ave., Suite 1400,
Cleveland, Ohio 44115;
800-554-0027 or 216-436-4000;
fax: 216-621-3178

Utilization Review/Case Management

1997 revenues

Total gross revenue	$5,684,814
UR revenue	$1,034,406
Case mgmt. revenue	$9,384

Staff

Total UR/case management employees	12

Clients

Total	70,000

Covered lives/reviewed admissions

Employee benefit plan lives served	580,000
Acute care inpatient adm. reviewed	8,310

UR/case mgmt. services since: 1983.

Parent: Columbia/HCA Healthcare Corp. and Sisters of Charity of St. Augustine.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, review of lab work, patient education, second surgical opinion, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Retrospective review, outpatient service predetermination.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, pharmacy.

Branch offices: Cleveland.

Compensation: $2.10 to $5.05 per employee per month; per hour (case management).

Officers: C. Michael Rutherford, executive vp/COO; Joan M. Mason, director-operations; Elizabeth Jamieson, director-networks; Debra Mulanax, controller.

Contact: Linda Farley, marketing coordinator.

OPTIONS

700 River Ave.,
Pittsburgh, Pa. 15212;
412-323-8500; fax: 412-323-8502

Utilization Review/Case Management

1997 revenues

UR revenue	$8,000,000
Case mgmt. revenue	$7,000,000
UR/case mgmt. direct to employers	20%
Svcs. to managed care/ins. providers	45%
Other services	35%

Staff

Total UR/case management employees	150
Professionals	75
UR/case mgmt. employees on retainer	1,000

Clients

Total	250

Covered lives/reviewed admissions

Workers compensation lives served	300,000
Acute care inpatient adm. reviewed	NA
Diverted for outpatient treatment	20%

UR/case mgmt. services since: 1981.

Parent: McCabe & Scarlata Inc.

Services: Preadmission certification, concurrent hospital treatment review, discharge planning, onsite and telephone case management, review of lab work, free pre-screening, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, referrals to alternative settings, written reports.

Medical services reviewed/managed: Chiropractic, rehabilitation, workers comp/disability.

Branch offices: Atlanta; Chicago; Charlotte, N.C.; Summit, N.J.; Philadelphia; Dallas; Houston; Charleston, W.Va.

Compensation: $50 to $300 per case; $45 to $75 per hour; percent of savings.

Officers: Joseph M. McCabe, chairman; Antonia L. Scarlata, CEO; Michael M. Lindberg, president; Steve Mazefsky, vp-sales; Bob Watters, vp-sales.

Contact: Steve Mazefsky, ext. 117.

A ranking of utilization management firms appears on page 20.

P

PHA Review

1350 Old Bayshore Highway,
Suite 570, Burlingame, Calif. 94010;
650-375-5800; fax: 650-375-5820

Utilization Review/Case Management

1997 revenues

UR revenue	$700,000
Case mgmt. revenue	$300,000
UR/case mgmt. direct to employers	60%
Svcs. to managed care/ins. providers	20%
Other services	20%

Staff

Total UR/case management employees	14
Professionals	7
UR/case mgmt. employees on retainer	10

Clients

Total	30

Covered lives/reviewed admissions

Employee benefit plan lives served	300,000
Workers compensation lives served	10,000
Acute care inpatient adm. reviewed	14,600
Diverted for outpatient treatment	10%

UR/case mgmt. services since: 1986.

Parent: Pacific Health Alliance.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, patient education, retrospective review, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Review of lab work, free pre-screening, second surgical opinion.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Fresno, Calif.

Compensation: $1.75 to $3.50 per employee per month; per case; $85 to $125 per hour.

Officers: L.W. Cappel, CEO; R. Yates, CFO; Robert Mackler, executive vp; M. Shields, director-utilization management; B. Thombeery, director; A. Werking, director.

Contact: Lawrence Cappel.

PHM Diagnostics*

20700 Ventura Blvd. Suite 100,
Woodland Hills, Calif. 91364;
818-615-0250; 818-615-0270

Utilization Review/Case Management

1997 revenues

Total gross revenue	$17,000,000
UR/case mgmt. revenue	$510,000
UR/case mgmt. direct to employers	2%
Svcs. to managed care/ins. providers	2%
Other services	96%

Staff

Total UR/case management employees	7
Professionals	6
UR/case mgmt. employees on retainer	1

UR/case mgmt. services since: 1989.

Parent: Preferred Health Management Inc.

Occasional services: Telephone case management, retrospective review, outpatient service predetermination, written reports, prospective and concurrent review.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, workers comp/disability.

Branch offices: Woodland Hills, Calif.

Officers: Louis Spidalette, CEO; Jeff Trigilio, COO; Brian Schuman, vp-finance; John Mitchell, vp-sales.

Contact: 800-659-0200.

** Formerly Future Diagnostics.*

PRNA Services

12000 Ford Road, Suite 240,
Dallas, Texas 75234; 972-247-0592

Utilization Review/Case Management

1997 revenues

Total gross revenue	$4,000,000

Staff

Total UR/case management employees	36
UR/case mgmt. employees on retainer	32

UR/case mgmt. services since: 1986.

Frequent services: Preadmission certification, length of stay determination, onsite and telephone case management, review of lab work, retrospective review, hospital audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, written reports.

Occasional services: Concurrent hospital treatment review, patient education, second surgical opinion, referrals to alternative settings.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability.

Compensation: Per case, per hour.

Officers: Colin Herlitz, president; Bruce Wood, CFO; Liz Minch, executive vp; Marc Semmelmann, vp-sales.

Parman & Associates Inc.

2211 Lake Club Drive, Suite 105,
Columbus, Ohio 43232-3155;
614-575-9400; fax: 614-575-9399

Utilization Review/Case Management

1997 revenues

UR revenue	$1,000,000
Case mgmt. revenue	$1,400,000
UR/case mgmt. direct to employers	50%
Svcs. to managed care/ins. providers	40%
Other services	10%

Staff

Total UR/case management employees	147
Professionals	25
UR/case mgmt. employees on retainer	122

Clients

Total	100

Covered lives/reviewed admissions

Workers compensation lives served	100,000
Acute care inpatient adm. reviewed	1,000
Diverted for outpatient treatment	20%

UR/case mgmt. services since: 1992.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, retrospective review, hospital bill audits, outpatient service predetermination, written reports.

Occasional services: Patient education, second surgical opinion, referrals to alternative settings.

Medical services reviewed/managed: Dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability.

Branch offices: Cincinnati, Cleveland and Toledo, Ohio.

Compensation: $75 per hour.

Officers: Jamie Parman, president; Karl Shuster, director-operations; Christine Moranda, director-case management; Mary Shaeffer, director-administration.

Preferred Mental Health Management Inc.

401 E. Douglas, Third Floor,
Wichita, Kan. 67202; 800-264-7439
or 316-262-0444; fax: 316-262-0003

Utilization Review/Case Management

1997 revenues

Total gross revenue	$2,800,000
UR/case mgmt. revenue	$2,650,000

Staff

Total UR/case management employees	10
Professionals	5
UR/case mgmt. employees on retainer	1

Clients

Total	45
Corporate/institutional employer clients	44

Covered lives/reviewed admissions

Employee benefit plan lives served	600,000
Acute care inpatient adm. reviewed	1,886
Diverted for outpatient treatment	12%

UR/case mgmt. services since: 1986.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, retrospective review, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, written reports.

Occasional services: Review of lab work, patient education, referrals to alternative settings.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Psychiatric/substance abuse.

Branch offices: Wichita, Kan.

Compensation: $1.25 to $3.00 per employee per month (ASO); capitated: $3.75 to $6.00 per employee per month.

Officers: Les Ruthven, president/CEO; Courney Ruthven, executive vp/CFO; Joan Laing, clinical director; Calvin Olmstead, medical director; Tim Hicks, director-sales/marketing.

Preferred Utilization Management Inc.

P.O. Box 190, Clayton, Calif. 94517;
510-672-2366; fax: 510-672-6657

Utilization Review

1997 revenues

Total gross revenue	$300,000
UR direct to employers	30%
Svcs. to managed care/ins. providers	70%

Staff

Total UR employees	3.5
UR employees on retainer	5

Clients

Total	11

Covered lives/reviewed admissions

Employee benefit plan lives served	2,500,000

UR services since: 1982.

Services: Telephone case management, retrospective review, outpatient service predetermination, referrals to alternative settings, written reports, treatment preauthorization, concurrent review.

Medical services reviewed/managed: Chiropractic, physical therapy.

Compensation: $0.07 to $0.65 per employee per month; $45 to $250 per case (large-volume UR); $275 to $500 per hour.

Officers: Dr. Ronald S. Cataldo, president/medical director.

Contact: Ron Cataldo or Ron Cataldo Jr.

Private Healthcare Systems

1100 Winter St.,
Waltham, Mass. 02154;
617-895-7500; fax: 617-895-6848

Utilization Review/Case Management

1997 revenues

Total gross revenue	$109,860,894
UR revenue	$45,678,612
Case mgmt. revenue	$3,611,037
UR/case mgmt. direct to employers	2%
Svcs. to managed care/ins. providers	43%
Other services	55%

Staff

Total UR/case management employees	275
Professionals	182

Clients

Total	37
Corporate/institutional employer clients	3

Covered lives/reviewed admissions

Acute care inpatient adm. reviewed	552,372
Diverted for outpatient treatment	5.5%

UR/case mgmt. services since: 1985.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, telephone case management, review of lab work, patient education, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, high-risk maternity screening, medical necessity review.

Occasional services: Discharge planning, onsite case management, retrospective review.

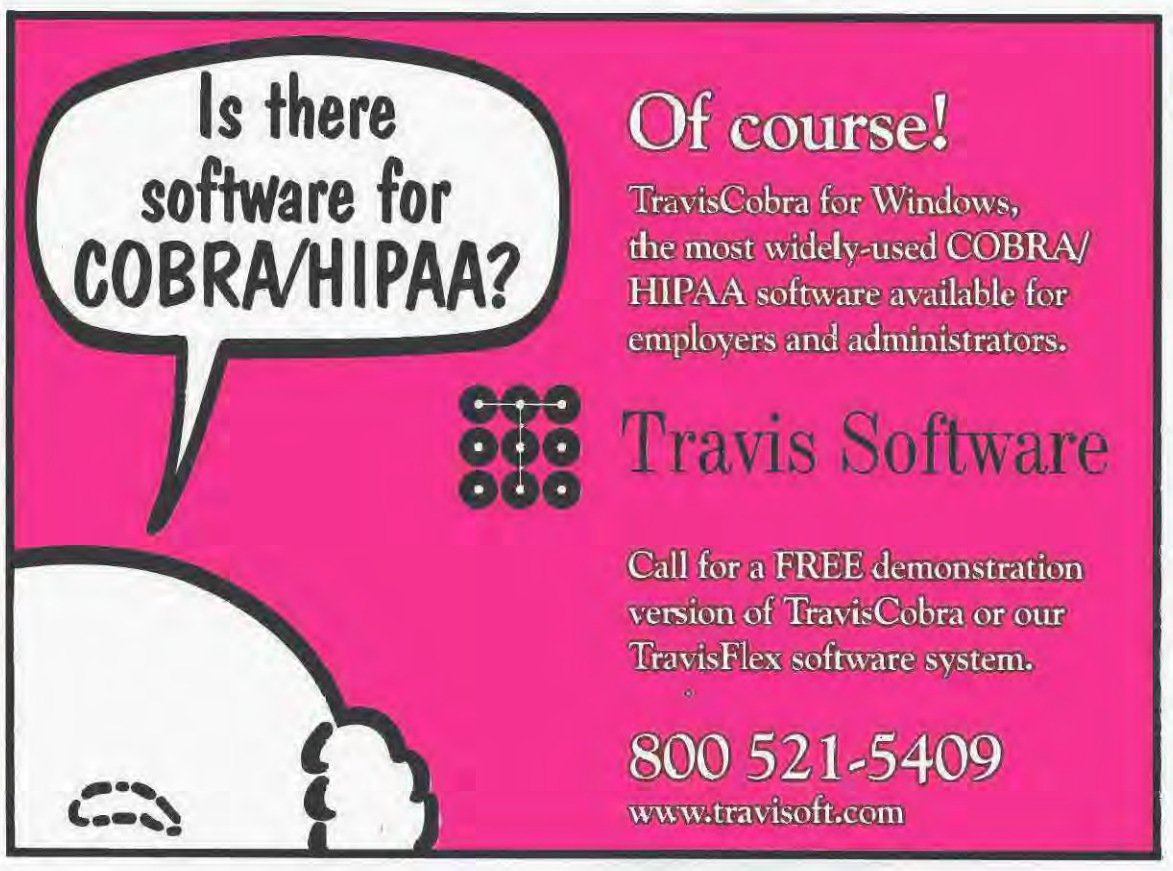
Medical services reviewed/managed: Group health; chiropractic; rehabilitation; psychiatric/substance abuse; pediatric; home health infusion therapy; physical, occupational and speech therapy.

Branch offices: Irvine, Calif.; Chicago.

Compensation: Per employee per month, per case, per hour.

Officers: Richard Belloff, president/CEO; Dr. Mark Bloomberg, chief medical officer; James Herrington, chief marketing officer; Ed Sandrick, chief network/operations officer; Phil Lockwood, chief human resources officer; Richard Kwei, chief information officer;

Continued on next page



Continued from previous page

Jason Dunn, vp/general counsel.

Contact: Sue Thomson, director-national sales/marketing.

Private Healthcare Systems is owned by 14 stockholders and affiliates.

PRO-West, A Professional Review Organization

10700 Meridian Ave. N., Suite 100,
Seattle, Wash. 98133-9075;
206-364-9700; fax: 206-368-2419

Utilization Review/Case Management

1997 revenues

Total gross revenue	$11,626,470
UR revenue	$5,749,100
Case mgmt. revenue	$873,000
UR/case mgmt. direct to employers	10%
Svcs. to managed care/ins. providers	47%
Other services	43%

Staff

Total UR/case management employees	242
Professionals	50

Clients

Total	60
Corporate/institutional employer clients	20

Covered lives/reviewed admissions

Employee benefit plan lives served	4,000,000
Workers compensation lives served	10,000
Acute care inpatient adm. reviewed	44,690
Diverted for outpatient treatment	1%

UR/case mgmt. services since: 1974.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, patient education, referrals to alternative settings, written reports, prenatal care coordination, prenotification review, DRG validation, technology assessment, special studies.

Occasional services: Retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services.

AAHC/URAC accreditation status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, alternative medicine.

Branch offices: Anchorage, Alaska; Boise, Idaho; Cheyenne, Wyo.

Compensation: Per employee per month, per case, per hour, per review.

Officers: John W. Daise, CEO; Dr. Joseph T. Palermo, chairman; Robert Bowman, secretary/treasurer; Dr. William McKee, vice chairman; Dr. Jonathan Sugarman, director-health care evaluation/quality improvement.

Contact: Michael B. Garrett, executive director-client relations/utilization and case management.

Professional Case Management Consultants Inc.

P.O. Box 940338,
Maitland, Fla. 32794-0338;
800-647-6347; fax: 407-647-1395

Utilization Review/Case Management

1997 revenues

UR revenue	$125,000
Case mgmt. revenue	$685,000
UR/case mgmt. direct to employers	30%
Svcs. to managed care/ins. providers	60%
Other services	10%

Staff

Total UR/case management employees	36
Professionals	1
UR/case mgmt. employees on retainer	35

Clients

Total	53
Corporate/institutional employer clients	9

UR/case mgmt. services since: 1993.

Frequent services: Discharge planning, onsite and telephone case management, review of lab work, patient education, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, certified life care planning, chronic disease management, vocational case management, provider negotiation, high-risk maternity, liability reviews.

Occasional services: Preadmission certification, concurrent hospital treatment review, length of stay determination, free prescreening, hospital bill audits, independent medical exam, research, peer review.

AAHC/URAC accreditation status: Workers Compensation Utilization Management Standards.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, drug therapy, long term care, occupational therapy, physical therapy, home health.

Compensation: $65 to $125 per hour, flat fee.

Officers: Belinda Brice, president.

Quality Managed Care Inc.

7245 W. 95th St., Suite 200,
Overland Park, Kan. 66212;
913-642-7997; fax: 913-642-4201

Utilization Review/Case Management

1997 revenues

UR revenue	$500,000
Case mgmt. revenue	$2,500,000
UR/case mgmt. direct to employers	8%
Svcs. to managed care/ins. providers	72%
Other services	20%

Staff

Total UR/case management employees	40
Professionals	35
UR/case mgmt. employees on retainer	36

Clients

Total	140
Corporate/institutional employer clients	40

Covered lives/reviewed admissions

Employee benefit plan lives served	400,119
Workers compensation lives served	25,000
Acute care inpatient adm. reviewed	3,300
Diverted for outpatient treatment	20%

UR/case mgmt. services since: 1989.

Parent: The Olsten Corp.

Frequent services: Preadmission certification, concurrent hospital treatment review, discharge planning, onsite and telephone case management, patient education, free pre-screening, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Occasional services: Length of stay determination, hospital bill audits.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, durable medical equipment, Ob/Gyn, skilled care, home health.

Branch offices: Phoenix: Aurora and Denver, Colo.; West Palm Beach, Fla.; Chicago; Overland Park and Wichita, Kan.; Minneapolis; Philadelphia.

Compensation: Per employee per month, per case, per hour.

Officers: Noreen E. Whalen, vp/general manager.

The directory begins on page 18. An explanation of terms used in the directory is on page 19.

RNS HealthCare Consultants Inc.

1010 Hurley Way, Suite 525,
Sacramento, Calif. 95825;
916-929-6506; fax: 916-929-6013

Case Management

1997 revenues

Total gross revenue	$650,000
Case mgmt. revenue	$600,000
Case mgmt. direct to employers	15%
Svcs. to managed care/ins. providers	75%
Other services	10%

Staff

Total case management employees	5
Professionals	5
Case mgmt. employees on retainer	4

Covered lives/reviewed admissions

Workers compensation lives served	498

Case mgmt. services since: 1989.

Frequent services: Concurrent hospital treatment review, discharge planning, onsite and telephone case management, review of lab work, patient education, retrospective review, second surgical opinion, referrals to alternative settings, written reports, life care planning, legal consultation.

Occasional services: Length of stay determination, free pre-screening, hospital bill audits, outpatient psychiatric and substance abuse services.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, workers comp/disability.

Compensation: $2.65 to $5.35 per employee per month; $195 to $5,000 per case; $65 to $150 per hour.

Contact: Cynthia E. Whitaker, president/CEO.

Resolve Rehabilitation Consulting Co.

10451 Mill Run Circle, Suite 225,
Owings Mills, Md. 21117;
800-929-2291; fax: 410-363-4074

Case Management

1997 revenues

Total gross revenue	$3,200,000

Continued on next page

Carvill

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Continued from previous page

Case mgmt. revenue $3,200,000
Case mgmt. direct to employers 30%
Svcs. to managed care/ins. providers 70%

Staff

Total case management employees 50
Professionals 30
Case mgmt. employees on retainer 3

Clients

Total 67
Corporate/institutional employer clients 23

Covered lives/reviewed admissions

Workers compensation lives served 750
Acute care inpatient adm. reviewed 3,919

Case mgmt. services since: 1983.

Frequent services: Onsite and telephone case management, patient education, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports, disease management.

Occasional services: Discharge planning.

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, vocational case management.

Branch offices: Washington; Baltimore; Asheville, Charlotte, Fayetteville, Raleigh, Durham and Winston-Salem, N.C.; Chattanooga, Memphis and Nashville, Tenn.; Fairfax, Norfolk, Richmond and Roanoke, Va.

Compensation: Per employee per month; $60 to $81.50 per hour.

Officers: Nancy Chadwick, president; Jim Chadwick, CFO.

Contact: Eric Prager, sales manager or Jim Chadwick, 410-363-1174.

S

Sagamore Health Network Inc.

11555 N. Meridian St.,
Suite 400, Carmel, Ind. 46032;
317-573-2900; fax: 317-573-2946

Utilization Review/Case Management

1997 revenues

Total gross revenue $25,408,365
UR revenue $1,500,404
UR/case mgmt. direct to employers 0.1%
Svcs. to managed care/ins. providers 5.8%
Other services 94.1%

Staff

Total UR/case management employees 18
Professionals 17
UR/case mgmt. employees on retainer 12

Covered lives/reviewed admissions

Employee benefit plan lives served 700,045
Workers compensation lives served 8,000
Acute care inpatient adm. reviewed 20,829

UR/case mgmt. services since: 1994.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite case management, retrospective review.

Occasional services: Telephone case management, patient education, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Branch offices: Carmel, Ind.

Compensation: $2.00 per employee per month; $100 per hour for case management; $0.60 per employee per month for prenatal program.

Officers: Greg Yust, president/CEO; John Johnson, CFO; Sharon Paulus, vp/general counsel; Malinda Hinkle, vp-marketing; Julie Beckner, chief information officer.

Contact: Heather Buzzingham, 317-580-2297.

Sentinel Management Services Inc.

1871 Santa Barbara Drive,
Lancaster, Pa. 17601;
800-432-8877 or 717-581-1245;
fax: 717-581-8841

Utilization Review/Case Management

1997 revenues

Total gross revenue $500,000
UR revenue $300,000
Case mgmt. revenue $200,000

Staff

Total UR/case management employees 6
Professionals 5
UR/case mgmt. employees on retainer 1

Clients

Total 130
Corporate/institutional employer clients 125

Covered lives/reviewed admissions

Employee benefit plan lives served 18,000
Acute care inpatient adm. reviewed 1,096
Diverted for outpatient treatment 2%

UR/case mgmt. services since: 1988.

Services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, pediatric.

Compensation: $1.75 to $1.85 per employee per month; $60 per hour; $150 to $600 per case (peer reviews).

Officers: Susan C. Rossi, president; Robert Hettrick, vp; Anne Reinsmith, treasurer; Sara Amman, secretary.

Southwest Medical Management Associates

5815 Callaghan,
San Antonio, Texas 78228;
210-681-6055; fax: 210-522-9287

Utilization Review

1997 revenues

Total gross revenue $650,000
UR revenue $162,500
UR direct to employers 5%
Svcs. to managed care/ins. providers 10%
Other services 85%

Staff

Total UR employees 7
Professionals 7
UR employees on retainer 50

Clients

Total 58
Corporate/institutional employer clients 50

Covered lives/reviewed admissions

Workers compensation lives served 95,500
Acute care inpatient adm. reviewed 120
Diverted for outpatient treatment 85%

Case mgmt. services since: 1982.

Parent: Barron Risk Management Services Inc.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, telephone case management, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, referrals to alternative settings.

Occasional services: Discharge planning, review of lab work, patient education, free pre-screening, outpatient psychiatric and substance abuse services, written reports.

Medical services reviewed/managed: Dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability.

Branch offices: Austin, Dallas, Harlingen, Houston and San Antonio, Texas.

Compensation: $65 to $75 per hour.

Officers: Miguel A. Vasquez, medical director; Sally A. Lopez, director-operations.

Contact: Sally A. Lopez.

Spectrum Review Services Inc.

3845 FM 1960 W., Suite 110,
Houston, Texas 77068;
800-258-5055 or 281-444-2194;
fax: 281-444-2482

Utilization Review/Case Management

1997 revenues

Total gross revenue $1.100,000
UR revenue $440,000
Case mgmt. revenue $660,000
UR/case mgmt. direct to employers 80%
Svcs. to managed care/ins. providers 20%

Staff

Total UR/case management employees 10
Professionals 10
UR/case mgmt. employees on retainer 150

Clients

Total 184

Covered lives/reviewed admissions

Employee benefit plan lives served 500,000
Acute care inpatient adm. reviewed 16,000
Diverted for outpatient treatment 5%

UR/case mgmt. services since: 1991.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, patient education, free pre-screening, second surgical opinion, outpatient service predetermination, referrals to alternative settings, written reports, high-risk pregnancy screening.

Occasional services: Onsite case management, review of patient lab work, retrospective review.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric.

Compensation: $1.25 to $1.50 per employee per month; $100 per hour (medical case management), $150 per hour (physician review).

Officers: Frank J. Berrier Jr., president/CEO; Ernest C. Munshower, COO; Ruby Jones, director-utilization management; Terri Bissonette, director-case management.

Contact: Frank J. Berrier Jr.

U

United HealthCare-Care Management Centers

9900 Bren Road E.,
Minnetonka, Minn. 55343;
800-662-1264; fax: 612-797-4229

Utilization Review/Case Management

1997 revenues

Total gross revenue $62,000,000

Staff

Total UR/case management employees 825
Professionals 695
UR/case mgmt. employees on retainer 195

Clients

Total 10,000

Covered lives/reviewed admissions

Employee benefit plan lives served 5,500,000
Workers compensation lives served 3,800,000
Acute care inpatient adm. reviewed 48,000
Diverted for outpatient treatment 2.6%

UR/case mgmt. services since: 1974.

Parent: United HealthCare Corp.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, free prescreening, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings.

Occasional services: Onsite case management, patient education, second surgical opinion, hospital bill audits, written reports.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability, pediatric, home health, transplants.

Branch offices: Brea and Sacramento, Calif.; Glastonbury, Conn.; Tampa, Fla.; Westmont, Ill.; Westborough, Mass.; Golden Valley, Minn.; Dayton, Ohio; Oklahoma City.

Compensation: Per employee per month, per case.

Officers: Dr. William W. McGuire, chairman/president/CEO; David P. Koppe, CFO; Bernard F. McDonagh, investor relations; Jeannine M. Rivet, vp-operations; Elizabeth Malkerson, corporate communications.

Contact: Carol Schneewies, 612-797-4898.

United Review Services

67 Walnut Ave.,
Suite 405, Clark, N.J. 07066;
732-815-0330; fax: 732-382-2035

Utilization Review/Case Management

1997 revenues

Total gross revenue $4,600,000
UR revenue $100,000
Case mgmt. revenue $500,000
UR/case mgmt. direct to employers 4%
Svcs. to managed care/ins. providers 11%
Other services 85%

Staff

Total UR/case management employees 15
Professionals 12
UR/case mgmt. employees on retainer 5

Clients

Total 55
Corporate/institutional employer clients 25

Covered lives/reviewed admissions

Employee benefit plan lives served 100,000
Workers compensation lives served 20,000
Acute care inpatient adm. reviewed 1,492
Diverted for outpatient treatment 3%

UR/case mgmt. services since: 1988.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite case management, review of lab work, patient education, hospital bill audits, outpatient service predetermination, referrals to alternative settings, written reports.

Occasional services: Telephone case management, retrospective review, second surgical opinion.

Medical services reviewed/managed: Group health, chiropractic, rehabilitation, workers comp/disability, pediatric, long-term care.

Compensation: $1.25 to $1.60 per employee per month (utilization review); $90 to $100 per hour (case management).

Officers: Terry Wallace, president; Dorothy Maxemow, vp; Marie Wallace, corporate secretary.

Contact: Marie Wallace, ext. 106.

V

Value Behavioral Health Inc.

3110 Fairview Park Drive S.,
Falls Church, Va. 22042;
703-205-7000; fax: 703-876-5644

Utilization Review/Case Management

1997 revenues

Total gross revenue $213,700,000
UR revenue $4,700,000
Case mgmt. revenue $188,500,000
UR/case mgmt. direct to employers 55%
Svcs. to managed care/ins. providers 33%
Other services 12%

Staff

Total UR/case management employees 453

Clients

Total 1,017
Corporate/institutional employer clients 989

Covered lives/reviewed admissions

Employee benefit plan lives served 22,500,000
Acute care inpatient adm. reviewed 86,274

UR/case mgmt. services since: 1983.

Parent: Value Health Inc.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, onsite and telephone case management, retrospective review, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Medical services reviewed/managed: Psychiatric/substance abuse.

Branch offices: Long Beach, Calif.; Skokie, Ill.; Boston; Southfield, Mich.; Albuquerque, N.M.; Raleigh, N.C.; New York and Troy, N.Y.; Irving, Texas; Falls Church, Va.

Compensation: Per employee per month, per case.

Officers: Charlton Tooke, CEO; Edith Jardine, COO-public sector; Tina Blasi, COO-commercial programs; Scott Yturria, CFO; Catherine Gross, chief information officer; Dr. Ian Shaffer, chief medical officer.

Contact: Judith A. Barber, assistant vp-marketing.

W

Wellmark Administrators Inc.*

500 Walnut, Suite 300,
Des Moines, Iowa 50309;
515-243-3210; fax: 515-282-0719

Utilization Review/Case Management

1997 revenues

Total gross revenue $11,230,000
UR/case mgmt. revenue $1,900,000
UR/case mgmt. direct to employers 15%
Svcs. to managed care/ins. providers 2%
Other services 83%

Staff

Total UR/case management employees 73
UR/case mgmt. employees on retainer 121

Clients

Total 79

Covered lives/reviewed admissions

Employee benefit plan lives served 123,000
Acute care inpatient adm. reviewed 7,500
Diverted for outpatient treatment 10%

UR/case mgmt. services since: 1985.

Parent: Wellmark Inc.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, review of lab work, patient education.

Occasional services: Onsite case management, retrospective review, second surgical opinion, hospital bill audits, outpatient service predetermination, written reports, prenatal screening.

AAHC/URAC accreditation status: Health Utilization Management Standards.

Medical services reviewed/managed: Group health, rehabilitation, psychiatric/substance abuse, pediatric.

Branch offices: Sioux City, Iowa.

Compensation: Per employee per month, per case, per hour.

Officers: Paula Ryan, president; Sally Wood, COO; Carla Bates, financial services.

Contact: Sandra McNeal, 515-246-4874.

** Formerly Benefit Administrators of America.*

Z

Zenith Administrators Inc.

201 Queen Anne Ave. N.,
Suite 100, Seattle, Wash. 98109;
206-282-4100; fax: 206-285-1701

Utilization Review/Case Management

1997 revenues

Total gross revenue $49,800,000
UR revenue $500,000
Case mgmt. revenue $700,000
UR/case mgmt. direct to employers 2%
Other services 98%

Staff

Total UR/case management employees 13

Clients

Total 22

Covered lives/reviewed admissions

Employee benefit plan lives served 180,700
Acute care inpatient adm. reviewed 11,751
Diverted for outpatient treatment 5%

Parent: ULLICO.

Frequent services: Preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, telephone case management, retrospective review, hospital bill audits, outpatient service predetermination, referrals to alternative settings.

Occasional services: Onsite case management, review of lab work, patient education, second surgical opinion, outpatient psychiatric and substance abuse services, written reports.

Medical services reviewed/managed: Group health, dental, chiropractic, rehabilitation, psychiatric/substance abuse, pediatric.

Branch offices: San Francisco, Denver, Indianapolis, Seattle.

Compensation: Per employee per month, per case.

Officers: Robert A. Georgine, chairman/CEO/director; James W. Luce, president/director; Lester H. Null Sr., secretary/treasurer/director; Jerome P. Pollock, executive vp/director; Joseph A. Carabillo, vp/counsel/assistant secretary/director.

Zurich Services Corp. Managed Care Service Center

1400 American Lane,
Schaumburg, Ill. 60196;
800-972-1111; fax: 847-706-2608

Utilization Review/Case Management

1997 revenues

UR revenue $1,000,000
Case mgmt. revenue $3,000,000
UR/case mgmt. direct to employers 10%
Svcs. to managed care/ins. providers 35%
Other services 55%

Staff

Total UR/case management employees 55
Professionals 51

Clients

Total 1,200

Covered lives/reviewed admissions

Acute care inpatient adm. reviewed 5,022
Diverted for outpatient treatment 15%

UR/case mgmt. services since: 1995.

Parent: Zurich-American Insurance Group.

Services: Preadmission certification, concurrent hospital treatment review, length of stay determination, onsite and telephone case management, patient education, retrospective review, hospital bill audits, outpatient service predetermination, outpatient psychiatric and substance abuse services, referrals to alternative settings, written reports.

Medical services reviewed/managed: Dental, chiropractic, rehabilitation, psychiatric/substance abuse, workers comp/disability.

Branch offices: Colorado Springs, Colo.; Schaumburg, Ill.; 17 claims offices.

Compensation: $85 per case (pre-cert.); $72 per hour; $170 per case (physician review).

Officers: Jim Lynam, president-Zurich Services Corp.; David Geske, financial director; Duane Perkins, general manager; Tina Preisig, marketing manager; Mary Brown, medical management manager. BI

Arizona

Continued from page 2

board's jurisdiction when he substituted his medical judgment for the judgments of the patient's doctors, the court ruled.

Consumer advocates applauded the decision.

Health plans' medical directors "have to take the bitter with the sweet," said Bob Hunter, director of insurance for the Consumer Federation of America in Washington. "They save money overriding doctors. They have to take responsibility for killing or injuring people."

"Medical directors representing insurance companies are going to have to think twice about denying something the primary care physician or surgeon thinks is necessary," said Arizona State Senator Ann Day, R-Tucson. Sen. Day is chairwoman of the Senate Health Committee.

The "extremely important" decision complements the state's new law that requires health plans to submit coverage disputes to external review boards. Ten other states have enacted similar laws, and the Patient Access to Responsible Care Act legislation in Congress may call for a similar process, according to the Blue Cross & Blue Shield Assn. in Washington.

Assistant Arizona Attorney General Nancy J. Beck, who represented the Board of Medical Examiners, said the decision allows the board to put the public "on notice" about a particular physician. "It serves the public well."

An official with a federation of state medical boards praised the ruling as a "landmark decision" that protects the public's interests and helps maintain public confidence in the medical profession.

While the decision does not bind courts outside of Arizona, it gives medical boards nationwide "greater comfort" in disciplining medical directors of health plans, said Dr. James R. Winn, executive vp of the Federation of State Medical Boards of the United States Inc. in Euless, Texas.

Before the decision, there was no effective process "to hold those doctors accountable for those decisions," Dr. Winn said.

The level of accountability that consumer advocates want health plans to shoulder, though, ultimately could cost plan sponsors and patients dearly, warn health plan representatives and attorneys specializing in benefits law.

If the Arizona high court's decision is widely adopted, managed care's cost containment bedrock of precertification and utilization review could be shattered, health plans contend.

The Health Insurance Assn. of America in Washington is "concerned about the effect on the ability of health plans to do utilization review," a spokesman said.

A spokesman for the American Assn. of Health Plans in Washington deferred to the joint amicus brief the AAHP and the HIAA filed.

In the brief, the groups asserted, among other things, that if the medical board "is permitted to interfere in the precertification process by pressuring medical directors into approving unnecessary treatments or discouraging qualified physicians from taking jobs as medical directors, then insurance companies will simply stop precertifying medical procedures, and patients and medical providers will never know until after they have incurred an expense or provided a service whether it will be covered under the patient's medical benefit plan. The ultimate result will be higher health care costs and less availability of medical services."

The additional liability imposed on health plans also would spark more costly litigation, further driving up health care costs, predicted employer attorney Nancy G. Ross, a partner with McDermott, Will & Emery in Chicago.

Ms. Ross also predicted that health plan medical directors in other states would challenge any authority medical boards try to assert over them as a violation of the Employee Retirement Income Security Act of 1974. ERISA pre-empts state laws relating to benefits. "It's a backdoor approach by states to regulate these plans, which they have been trying to do for some time."

The Arizona appellate and supreme courts did not consider the ERISA issue because it was not raised at the trial court level.

The Blues plan did not raise the ERISA issue because the courts likely would have decided that a state's medical board statute, on which the board relied to assert authority over the health plan's medical director, is not pre-empted by ERISA, said Lyn McKay, assistant general counsel for the Arizona Blues plan.

Ms. McKay compared the statute to the right of patients to sue for medical malpractice free from ERISA intervention.

Ms. Ross called that analysis conservative, because the case involved an ERISA-regulated plan.

The case was sparked in 1992 when a surgeon in an Arizona Blues preferred provider plan sought precertification to remove the gall bladder of a woman enrolled in a group health care plan. After reviewing the woman's file but without seeing the patient, the plan's medical director, Dr. John F. Murphy, refused to precertify the surgery.

Dr. Murphy offered to submit the dispute to a third-party specialist for review at the plan's expense, but the surgeon and the patient rejected the offer. Instead, the surgeon removed the gall bladder, which pathology reports showed was abnormal. The plan later agreed to cover the surgery.

The surgeon complained about Dr. Murphy's "unprofessional conduct" to the state's medical board. The board in July 1994 issued Dr. Murphy a "letter of concern" over his inappropriate medical decision. The advisory letter, which is the weakest action the board can take without dismissing a complaint, is not a disciplinary measure.

Dr. Murphy and the plan sued, arguing the board had no authority over him because he did not make a medical decision. The plaintiffs also argued that Dr. Murphy's insurance benefits decision is independent from and is no substitute for the treatment decisions the patient and surgeon should make regardless of the patient's health benefits.

The appellate court's July 1997 ruling partially affirmed and partially overturned a lower court's 1995 decision.

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John F. Murphy, M.D., and Blue Cross & Blue Shield of Arizona vs. The Board of Medical Examiners of the State of Arizona and Mark F. Speicher, Arizona Supreme Court; No. CV-97-0381-PR.

COBRA

Continued from page 2

The two health plans each had $1 million lifetime limits, Mr. Weinhaus said.

Mr. Geissal paid COBRA premiums for six months. But in January 1994, Moore's health care plan administrator told Mr. Geissal he was ineligible for COBRA benefits because he already was covered under TWA's group policy.

The high court may end confusion on 'one of the great unanswered questions about COBRA,' says Mary Case.

Mr. Geissal's COBRA premium payments were returned, and the plan administrator returned medical bills that providers treating his cancer had submitted.

Mr. Geissal sued Moore, charging that the cancellation of coverage violated COBRA.

Last year, though, the 8th U.S. Circuit Court of Appeals ruled in favor of Moore Medical Corp. It said that because Mr. Geissal was insured by the TWA plan, he did not experience a significant gap in coverage at the time he lost his job and thus was not eligible for COBRA.

"This was a well-reasoned decision," said Bradley Washburn, a partner with Bearden, Matteren, Breckenridge, Washburn, Gidlow & Kazanas, which represents Moore Medical Corp.

In ruling against Mr. Geissal, the appeals court noted that courts have badly split in their interpretations of what COBRA does and does not allow in cases like Mr. Geissal's.

The appeals court described the deepening rift as troublesome given the "importance of guaranteeing equivalent protection to all" participants in group health care plans. It suggested clarification from Congress or the Supreme Court to end the rift.

That clarification could come soon. In agreeing to review the 8th Circuit decision, the high court may end confusion on a provision that has been "one of the great unanswered questions about COBRA," said Mary Case, a principal with The Kwasha Lipton Group in Fort Lee, N.J.

The federal COBRA statute requires employers to offer COBRA coverage in a variety of situations, most typically when employees quit or are let go, or for dependents who lose group health care coverage due to the employee's death or the dependent's divorce or separation from the plan member.

However, the federal law gives employers the right to terminate COBRA benefits when a beneficiary becomes covered under another employer's health plan. That typically occurs when a beneficiary accepts a new job and enrolls in the new employer's health care plan.

But what has bedeviled employers and resulted in conflicting court decisions are situations—like the one in the Geissal case—where an employee already has health care coverage through a spouse at the time the employee had an event that normally would make him or her eligible for COBRA.

A 1995 decision by the 7th U.S. Circuit Court of Appeals held that an employer can terminate COBRA only if a beneficiary obtains other health insurance after he or she elects COBRA.

"The statute clearly provides that the employee's right to continuation coverage terminates only when he or she first becomes, after the election date, covered by any group plan," the appeals court said.

But in a 1991 decision, the 11th U.S. Circuit Court of Appeals came to a different conclusion. It said that in enacting COBRA, Congress was concerned about protecting employees from gaps in coverage such as when they lost their jobs and eligibility to stay in their employer's health care plan.

If a terminated employee had other group coverage, such as through a spouse, at the time his employment ceased, the employee would be ineligible for COBRA because there was no gap in coverage, the 11th Circuit ruled.

Given how awkwardly the COBRA statute is drafted regarding when an employer can terminate COBRA, it is not surprising that courts have interpreted the statute differently, said Henry Saveth, an attorney with William M. Mercer Inc. in Washington.

"This is an area where plan administrators would welcome some clarification," he added. BI

Managed care initiative stricken

Florida court bars plan to allow unrestricted provider choice

By MICHAEL BRADFORD

TALLAHASSEE, Fla.—Managed care proponents are cheering a court ruling that keeps a proposed state constitutional amendment off the 1998 ballot.

Proponents said the amendment would have destroyed managed care in Florida. The state Supreme Court unanimously ruled last month that the proposed amendment did not meet state requirements that it be limited to a single subject and clearly inform voters of its complete meaning. The ruling means the amendment won't appear on the 1998 ballot.

The ruling for now ends the drive by Floridians for Health Care Choice to allow members of managed care plans to choose their physicians. Such an option, if passed by voters, would have been a big blow to managed care in the state, opponents of the proposal say.

The FHCC coalition of chiropractors, workers compensation plaintiffs attorneys and others has argued that plan members should have the right to select their health care providers.

Opponents of the proposed amendment have argued that allowing unrestricted provider choice would mean volume discounts would not be possible because too many providers would be splitting up the patient population.

"In my opinion, (the proposal) would have eliminated managed care in Florida," said Steve Liner, Tallahassee, Fla.-based southern manager for the Alliance of American Insurers. "And that's an amazing prospect."

In a state where managed care is mandatory in the workers compensation system, allowing managed care plan members to choose their own providers would have led to increased costs, insurers said.

"Without question, the proposed constitutional amendment would have sunk a vibrant, low-cost workers comp market," Dick Dorsey, the American Insurance Assn.'s vp-southeast region, said in a statement released after the decision.

A spokesman for the Florida Chamber of Commerce called the proposed ballot initiative "another attempt by special interests to circumvent the contractual arrangements employers have with their employees" to provide health care.

If the amendment had passed the court's muster and been approved by voters, it would have been a setback for businesses, affecting the way they could offer employee benefits, the spokesman added.

Chamber members believe managed care is an effective way to offer health care to workers and "any kind of effort to circumvent that would have detrimental effects on business," he said.

The coalition had not decided as of last week whether to try to get the amendment on the ballot in 2000. Such an effort would mean starting over with a newly drafted proposal and collecting enough signatures required for a Supreme Court review of the initiative's language.

"We'll go back to our folks and see what they want to do," said Barney Bishop, chairman of the coalition and president of Windsor Group, a Tallahassee-based consulting firm for businesses that deal with government agencies.

INSURANCE AGENT/BROKER SERVICES

REQUEST FOR PROPOSALS

The New York City Economic Development Corporation (EDC) is issuing a Request for Proposals (RFP) for insurance agent/broker services to review and evaluate EDC's insurance program, to ensure the most effective combination of coverages, limits and deductibles, and to competitively market and place the various coverages. EDC is a not-for-profit corporation which performs a variety of economic development and property management functions on behalf of the City of New York, including managing approximately 50 city-owned properties with transportation, commercial, industrial and waterfront dependent uses.

Only those firms that have significant current experience in successfully marketing and placing various coverages for public entities should respond to this RFP. The respondent must demonstrate that it meets all of the following criteria: 1) five (5) years of experience in successfully marketing and placing various coverages for public entities; 2) current active placement of insurance for a minimum of three public entities with a combined total of $2 million in premium; 3) total premium volume in excess of $100 million; and 4) maintenance of a New York City office with a minimum of twenty-five (25) professional employees.

Detailed guidelines and submission requirements are outlined in the RFP, which is available from EDC. All requests should be directed to Cheryl A. Elmore at (212) 312-3969. Proposals must be submitted to EDC, 110 William Street, 6th Fl., New York, N.Y. 10038, by 3:00 p.m., Monday, March 2, 1998.

City of New York
Rudolph W. Giuliani, Mayor

New York City Economic Development Corporation
John S. Chalsty, Chairman
Charles Millard, President

D&O

Continued from page 2

issued. For the 1997 survey, 1,046 for-profit corporations responded. They ranged in size from companies with less than $30 million in annual revenues to those with revenue exceeding $5 billion.

According to the survey, in 1997 the Watson Wyatt D&O Premium Index dropped 15% compared with 1996. The index measures the cost of a typical policy for a typical company, similar to the way economists generate the Consumer Price Index.

This decline reflects the broad softening of D&O rates for respondents. Forty-nine percent of respondents reported a drop in their D&O premiums, while some 29% indicated an increase, the survey states. But even for those companies reporting an increase, their policies provided more coverage than in the past.

"Most purchasers also obtained a better D&O insurance product this year, as both buyers and insurers continued to pay special attention to coverage wording," the survey notes.

Some businesses, however, did not enjoy the lower rates. "The D&O insurance marketplace was anything but soft in 1997 for a minority of corporations, such as high-technology companies, IPOs or firms exhibiting even some degree of financial distress," the survey points out.

A major reason for the lower D&O premiums is an abundance of capacity. Mr. Larsen said he is unaware of any new insurers entering the field, but the current insurers have increased their capacity for the 12th consecutive year. Available policy limits from all D&O insurers rose in 1997 to an all-time high of $1.35 billion, compared with $1.16 billion in 1996 and $895 million in 1995.

"Much of the increase in capacity is due to individual carriers raising their allowable limits. Indeed, for the second consecutive year, more than a dozen D&O carriers increased their limits capacity," the survey states.

"It's basically a supply-and-demand issue" that pushed down premiums, said Mr. Larsen.

The leading insurers in the field have not changed, the survey notes. Both Chubb Corp. of Warren, N.J., and American International Group Inc. of New York dominate the market, together writing more than half of all D&O policies.

"In terms of premium alone, AIG continues to lead, with a 33% share. By policy count, Chubb leads among our participants this year, with a 28% share," the survey states.

Also reaching an all-time high, the survey states, is the number of D&O claims. The survey uses two methods to track claims: susceptibility and frequency.

Susceptibility measures the percentage of respondents that have reported a D&O claim in the nine years of 1988 through 1996. This figure rose to 31% in 1997, from a previous record of 30% in 1996.

Claim frequency, which measures the number of claims filed per company, also rose to a record high of the nine-year period of 0.87 claims per respondent last year.

'Claim frequency is on the rise again, especially for middle-market and larger firms,' the survey shows.

"The 1997 survey results confirm that claim frequency is on the rise again, especially for middle-market and larger firms, after seeming to level off two years ago," the survey states.

The size of a policyholder continues to be an indicator of susceptibility to lawsuits. For example, the survey indicates 12% of companies with assets of less than $100 million faced a suit, while 63% of those with assets exceeding $10 billion faced suits.

Corporate activities also influence lawsuits. "Companies active in mergers, acquisitions or divestitures are about twice as likely to have at least one D&O claim and will probably have, on average, three to four times as many D&O lawsuits in total as their counterparts—those companies that have not experienced such reorganizations," the survey reports.

Although the percentage dropped, shareholder suits continue to account for the largest share of claims against directors and officers. Their percentage dropped to 41% last year from 47% in 1996. Employee suits, by contrast, continue to make up a larger share. The survey shows these accounted for 29% of all actions in 1997, up from a previous high of 25% in 1996.

The costs of resolving lawsuits has dropped, the survey states. Of the claims in the nine years ending with 1996 that have closed with a payment, the average payment was $4.2 million, down about 20% from survey results the year before.

This drop, the survey explains, largely stems one respondent settling many small actions against it. Just looking at shareholder suits, the settlement amount increased to $7.51 million, a slight increase from 1996. The majority of suits, however, closed without any payment.

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A copy of the 1997 Watson Wyatt Worldwide D&O Liability Survey Report can be obtained for $375 by calling Mary Maze at 312-704-2719.

Fees in tobacco deals under fire

AUSTIN, Texas—The $15.3 billion settlement Texas and the tobacco industry reached last month is stirring controversy because it includes a provision that pays the state's private lawyers more than $2.2 billion.

In Florida, which settled with tobacco companies last year, private attorneys for the state have been ordered into arbitration with tobacco makers to determine their fees.

U.S. District Judge David Folsom in Texarkana, Texas, on Jan. 16 approved the settlement and attorneys fees in Texas' suit against tobacco makers to recover the costs of treating smoking-related illnesses and other amounts.

Although the Texas attorney general's office has emphasized that the attorneys' payments will not come from the settlement amount, the size of the payments has sparked debate.

A spokeswoman for Gov. George Bush said in a statement that the governor thinks the fees are "clearly excessive and outrageous."

John Cornyn, who resigned last fall as a Texas Supreme Court justice to run for attorney general, filed a writ with the state's high court seeking to block payment of the fees by Attorney General Dan Morales.

A spokesman for Mr. Morales called the move by Mr. Cornyn "amateurish" and an attempt to garner name recognition in his campaign for office. The spokesman pointed out that the fees—which are separate from the settlement money—are being paid by tobacco companies, not the state.

"The governor has known for two years that the fees would be 15% of what we won," the spokesman added. "I guess he didn't expect us to win that much."

Meanwhile, Florida attorneys are headed to arbitration with tobacco makers to determine their compensation for negotiating an $11 billion deal last August.

A provision in the Florida settlement calling for arbitration over fees replaces the original 25% contingency fee contract they had signed. The 25% fee would have earned them $2.8 billion from the settlement proceeds.

Palm Beach County (Fla.) Circuit Court Judge Harold Cohen, who approved the settlement, ordered the arbitration in keeping with terms of the settlement provision. In his order, he wrote that while attorneys did an extraordinary job, a fee of $2.8 billion "simply shocks the conscience of the court."

Under terms of the settlement, the attorneys' fees will be paid by the tobacco industry apart from the $11 billion.

—By Michael Bradford

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INTERNATIONAL

Global Briefs

London-based broker **Willis Corroon Group P.L.C.** has completed the acquisition of almost one-third of the shares of newly formed Jaspers Wuppesahl Industrie Assekuranz at a cost of 40 million deutsche marks ($22.4 million). Willis Corroon held a 20% share in C. Wuppesahl & Co. Assekuranzmakler before the German broker merged with competitor Jaspers Industrie Assekuranz GmbH & Co. KG last September to form the third-largest broker in Germany. Although still subject to German regulatory approval, Willis' deal to increase its holding to 30% of the Jaspers Wuppesahl stock is effective from the beginning of the year. In addition, Willis has agreed with other shareholders to increase its stake to 44.6% by the end of this year, at a cost of 29.2 million deutsche marks ($16.3 million), and if it is not the majority shareholder by the beginning of 2012, it can increase its holding to 51%. . . .Insurance consultant **Risk & Insurance Research Group Ltd.** of London has acquired Guinness Mahon Insurance & Risk Managers Ltd. Set up in 1982, London-based Guinness Mahon Insurance & Risk Managers is the consulting arm of Guinness Mahon Holdings P.L.C., though it provides independent insurance and risk management consulting services to more than 150 clients. Guinness Mahon will retain one-quarter of the combined business. . . .Wolfgang Droste has been appointed regional manager, Asia-Pacific, for the General Re Corp. and Cologne Re group. Mr. Droste now coordinates all the group's reinsurance business from Southeast Asia and Australia, except for Japanese and Korean business, and is based in Hong Kong. He previously was manager of life/health reinsurance in the region. . . .The U.K.'s first **solvent scheme of arrangement** has gotten the green light by a meeting of creditors of reinsurer HIR (UK) Ltd. More than 90% of creditors in value last month voted in favor of the scheme, designed to provide policyholders and shareholders a solvent exit from the business. . . .Insurance consultant and service provider **Hampden P.L.C.** of Great Hampden, Buckinghamshire, has announced it will be taking over Farrant Insurance Services Ltd., Farrant Group Ltd. and Farrant Legal Services Ltd., a group of insurance consultants. The London-based Farrant companies will be combined with Montrose Underwriting Services Ltd. under Farrant Chairman Martin Gray, who will be appointed chairman of the resulting new division of Hampden. . . .Tom Corfield has been appointed underwriter-designate for syndicate 190, managed by **Liberty Syndicate Management Ltd.** Mr. Corfield, who recently joined 190 from syndicate 582 managed by Cassidy Davis Syndicate Management Ltd., where he was property underwriter, will take over as underwriter from Bob Edwards when Mr. Edwards retires in the spring. . . .The Assn. of British Insurers has issued a **draft statement of recommended practice** for insurance accounting, including new proposals for standardizing accounting practices for investment returns so that they are included in profit and loss accounts. . . .London law firm Eversheds has grown its **insurance practice** with the recruitment of three insurance litigators, Peter Driscoll, Simon Brooks and Roly Smith. In addition, Nick Bugler has been brought into the non-litigation insurance practice from the Corporation of Lloyd's. . . .**Lloyd's debt recovery program** has received a boost from a High Court decision last month that Lloyd's records and evidence constitute conclusive evidence of names' debts to Equitas Ltd., the reinsurer of Lloyd's pre-1993 liabilities. This decision has opened the door to further litigation, as Lloyd's will now seek monetary judgments against more than 600 names who did not accept Lloyd's reconstruction and renewal program. About £130 million ($213.8 million) will be sought in the judgments, to take place later this month.

ACE aims to cut its costs at Lloyd's

Insurer plans to combine agencies, restructure capital for syndicates

By SARAH GODDARD

LONDON—ACE Ltd. over the next two years plans to streamline its participation in Lloyd's of London by merging its managing agencies and creating a more flexible capital structure for its syndicates, the Bermuda-based insurer announced last week.

ACE, which entered Lloyd's in 1996, is one of market's largest investors. Its managing agencies—ACE London Underwriting Ltd., ACE London Aviation Ltd. and Methuen Underwriting Ltd.—manage a total capacity this year of £692 million ($1.16 billion), representing about 6.8% of the market's capacity of £10.13 billion ($17.01 billion).

Nearly half of the £692 million under management—£304.46 million ($511.2 million)—comes from ACE Ltd. through two units of subsidiary ACE UK Ltd. ACE's corporate capital infusion of more than £300 million is the largest investment in Lloyd's this year from a single insurance source and more than double ACE's 1997 investment.

ACE last week said it plans to consolidate its managing agencies in a two-year strategy aimed to cut costs and streamline operations. The insurer earlier announced it will transfer the Methuen syndicates—47, 48, 375, 483 and 484—by the end of this year into a greatly expanded ACE London Underwriting. ACE London Underwriting now manages syndicates 122 and 219.

In addition, ACE plans to merge the management of syndicates 925 and 960 into ACE London Underwriting next year. Both 48 and 960 are leading aviation syndicates at Lloyd's, and Peter Williams is underwriter for both; ACE has decided to merge the two syndicates beginning in 1999. The other two managing agencies, ACE London Aviation and Methuen, likely will be merged into ACE London Underwriting.

This is an extension of consolidation ACE undertook last year, merging syndicate 204 into 219, 322 into 47, and 998 into 960 for the 1998 year of account.

But the biggest proposed change is to support all the ACE syndicates with a single capital

See **ACE** *on page 35*

Capacity crowd for '98 account

Market unveils investor statistics

By SARAH GODDARD

LONDON—LIMIT P.L.C. is the first institutional investor to control more Lloyd's of London capacity than any other market entity, 1998 capacity data shows.

U.S. and Bermuda-based insurers also are becoming a greater force in the market, and many investors are strengthening their position by combining the capacity under their control into fewer syndicates.

LLOYD'S

Figures on the breakdown of market capacity were obtained by *Business Insurance* last week from Lloyd's Corporate Membership Unit and Lloyd's press office. Lloyd's still will be finalizing some of the figures this week.

Institutional and insurance industry investors together are supplying 56% of the market's £10.13 billion ($17.01 billion) capacity for 1998, with another 5% coming from names who have converted to limited liability status.

Of the 41 new corporate investors joining the market this year, though, just 11 represent new investments in Lloyd's. The balance are conversion vehicles, which allow unlimited liability names to trade on a limited liability basis. So, even though the number of new corporate investors is the largest since they were admitted in 1994, the capacity they represent is in reality small.

Even the 11 new corporate investors are not exactly massive. Between them, they account for £153.41 million ($257.6 million)—a long distance from LIMIT, which this year is providing £677.34 million ($1.14 billion) spread among many syndicates.

But two of the new investors—Samsung Underwriting Ltd. and Hyundai UK Underwriters Ltd.—represent a new source of Lloyd's capital, as both have South Korean parents. And Commercial Union Corporate Member Ltd. is the first foray into Lloyd's by

See **Lloyd's** *on page 35*

Ruling may hurt conditional fees

By CAROLYN ALDRED

LONDON—Some U.K. attorneys fear the use of conditional fees in England and Wales would be stymied if an appeals court rules that a winning defendant could seek to recover legal costs from the plaintiff's attorneys.

A ruling on this issue was due last week in a class-action case brought against U.K. tobacco companies, but the Court of Appeal postponed its decision.

The judges have been asked to decide whether Imperial Tobacco Ltd. and Gallaher Ltd. may seek to recover their legal costs from claimants' lawyers if the tobacco companies successfully defend the claims. Under the U.K. legal system, the losing party in civil litigation is liable for the winner's legal costs.

If the court rules in favor of the tobacco companies on this issue, the plaintiffs lawyers could be exposed to millions of pounds in legal fees if they lose. That exposure could lead the plaintiffs' lawyers to abandon the litigation, brought on behalf of more than 40 lung cancer victims.

A ruling making attorneys liable for legal fees also could threaten the whole future of "no win, no fee" agreements, whereby lawyers agree to be paid by their clients only if they win the case, lawyers claim.

This in turn could thwart the U.K. government's plans to limit the types of cases eligible for legal aid, the government-subsidized program to fund legal expenses for low-wage litigants.

No win, no fee agreements, known as conditional fee arrangements, are the U.K. legal system's version of contingency fees. Legislation allowing the use of conditional fees in England and Wales only became effective in 1995.

Although the use of conditional fees is restricted mainly to personal injury litigation, the government last October announced plans to extend the use of conditional fee arrangements to all civil litigation, apart from family cases, beginning in April (*BI*, Oct. 27, 1997). At the same time, the government announced plans to scrap legal aid funding for plaintiffs seeking monetary damages.

Unlike the U.S. contingency fee system, in which the plaintiff's lawyer is paid a percentage of any damages awarded but gets nothing if the suit fails, the U.K. conditional fee arrangement provides that if they are successful, the lawyers' normal fees may be increased by a preset percentage in exchange for taking the risk of getting nothing if the plaintiff loses.

The U.K. legal system also provides that a losing litigant pays for all the winner's legal costs in most

See **Fees** *on page 35*

Lloyd's chief outlines challenges

By GAVIN SOUTER

NEW YORK—Insurance industry consolidation and the prospect of capital markets-based insurance products present the newly vibrant Lloyd's of London with an "unprecedented challenge," its new chairman says.

That challenge will include competing with huge insurance and banking conglomerates and trying to retain business that capital markets experts are bound to target, Chairman Max Taylor said.

To survive in the new environment, Lloyd's must continue to embrace radical changes rather than simply improve its present systems, Mr. Taylor said.

"To achieve the kind of quantum leap necessary, we must fundamentally reinvent our current business model," he said late last month at a luncheon meeting in New York sponsored by the APIW and the CPCU Society. It was Mr. Taylor's first public speech in the United States since becoming chairman at the beginning of this year.



Mr. Taylor

To address the changes in the insurance business, Lloyd's will concentrate on several key areas, Mr. Taylor said.

First, Lloyd's will seek to extend its distribution network and to widen access to the market, he said. Only registered Lloyd's brokers are permitted to place business with Lloyd's syndicates.

"Working with our brokers, we have set up study groups to examine ways of expanding and streamlining our existing distribution chain, where possible, and removing unnecessary barriers to the Lloyd's market. We are also seeking to gain licenses for more direct business," Mr. Taylor said.

Second, Lloyd's will concentrate on its underwriting strengths, but at the same time it has initiated a study to consider the implications of alternative risk transfer mechanisms and capital markets techniques for Lloyd's, he said.

Third, Lloyd's will improve its claims handling, processing and payments and policy issuance by improving its systems and networks, Mr. Taylor said.

Fourth, Lloyd's will work with regulators to ensure the market provides security to policyholders and an opportunity for investors to make high returns, he said.

Finally, Lloyd's will encourage market participants to improve their professional standards, such as the Chartered Property Casualty Underwriter designation, Mr. Taylor said.

"To that end, we are working with CPCU so that, where appropriate, our qualifications will be recognized and accepted in the U.S. and vice versa. In the meantime, we are encouraging market participants to earn CPCU qualifications," he said.

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ACE

Continued from page 33

base starting Jan. 1, 2000.

That arrangement would replace the rigid allocation of certain amounts of capacity to each syndicate and give the syndicates more flexibility on underwriting opportunities, explained Bill Loschert, chairman of ACE UK Ltd. The single capital base also would help with buying reinsurance and streamline syndicate accounting processes, he added.

This year, ACE is supplying 44% of the capacity on its syndicates, while corporate capital—whether ACE or other corporate investors—represents 65% of the total backing the syndicates.

Mr. Loschert, also vice chairman of ACE Ltd., sees the balance shifting by the time the proposed capital base model is in place. He hopes that by 2000, 75% of the ACE syndicates' capacity will come from the parent, with the balance from "spread vehicle" corporate investors, or investment vehicles quoted on the stock market that back a number of Lloyd's syndicates.

Although he did not reject the idea of traditional unlimited liability capital supporting ACE syndicates at that time, he does not foresee them having much involvement.

"If structurally we can accommodate them, we will. Otherwise we will encourage them to move to other forms," such as Scottish Limited Partnerships, a type of investment vehicle enabling names to transfer their membership status to limited liability.

"We will be very involved with the auctions" this year, said Mr. Loschert, though "at the right price," and in bilateral deals, using any suitable opportunity to increase ownership of ACE-controlled capacity.

Having the capacity coming from a single base will give the different syndicates more flexibility, said Mr. Loschert. The syndicates may continue at different boxes within Lloyd's, with different syndicate numbers and their own business plans, he said. In that way, underwriters will continue to have "pride of ownership," and "we want to keep the entrepreneurial base of the syndicates," he added.

One of the reasons for not implementing the full plan until 2000 is that it gives ACE time to work out the right strategy for the market and structure for the business, Mr. Loschert said.

A spokeswoman for ACE Ltd. in Bermuda said ACE's entry into Lloyd's had been a "significant strategic" investment as part of the insurer's aims to diversify globally and in products. The proposed structure will be more streamlined and efficient, she said, and aims to meet the needs of ACE's customers.

Mr. Loschert characterized the expansion as long-term planning. The aim is to take all the ACE syndicates to lead positions within particular areas of business, he said. Already through the aviation syndicates 48, 925 and 960, it is the biggest aviation writer at Lloyd's, and Mr. Loschert wants to replicate that success in other specialties, particularly marine business.

Mr. Loschert said ACE may acquire new underwriters with experience in classes that it currently does not write and may take over other syndicates. BI

Fees

Continued from page 33

cases. The Law Society of England & Wales offers an insurance policy for plaintiffs that will pay the legal costs of a policyholder's opponent if a personal injury case is lost. Other insurers are developing similar policies.

The insurance is not compulsory, though, and insurance is not available for all cases; litigants in the tobacco case were unable to obtain insurance to cover the risk of having to pay the defendants' costs.

Because it is unlikely the plaintiffs in the tobacco case could afford to pay the defendants' costs, which could top £10 million ($16.5 million), the tobacco companies argued that the conditional fee arrangements make the plaintiffs' attorneys liable under the doctrine of "maintenance," an ancient tort that implies lawyers are funding clients' litigation, according to a spokesman from the Law Society.

As a result, the tobacco companies claim they should be able to recover costs from the lawyers should the companies win the case.

In a private hearing last year, Judge Popplewell ruled that he would not prevent the tobacco companies from trying to recover the costs from the plaintiffs' lawyers.

If that ruling is upheld by the Court of Appeals, and if the tobacco companies eventually win a ruling that the lawyers are liable for the costs, lawyers could find themselves liable for opponents' costs in future conditional fee cases, the Law Society spokesman explained.

Lawyers are "very nervous and worried about this case," said the Law Society's spokesman. If the ruling is not overturned, "then there will be a huge obstacle placed on the future of conditional fees."

This ruling "is massively important and has major implications," said the spokesman. The ruling has become a "big public policy issue," particularly in light of the government's plans to extend conditional fees and cut legal aid, he noted.

Regardless of how the Court of Appeals rules, the issue likely will go to the House of Lords eventually, the spokesman said. If the ruling is not overturned, the Law Society will press the government to introduce legislation that would overturn the court's decision, he added.

"We as a profession are terribly worried about what the Court of Appeal is going to say," said Ian Walker, a partner of London law firm Russell Jones & Walker.

If successful defendants are able to pursue plaintiffs lawyers for legal costs under a conditional fee arrangement, the lawyers could end up bearing the costs even if insurance is in place, predicted Mr. Walker, because the policies cover plaintiffs, not their attorneys.

However, Mr. Walker agreed with the Law Society spokesman that the government will be forced to introduce legislation to overturn the ruling if it is upheld by the Court of Appeal or House of Lords.

"The government's plans to widen conditional fees and cut back legal aid will go out of the window" unless the current law is changed, he said.

Anne Ware, a defense attorney and a partner with London law firm Davies Arnold Cooper, also predicted the government "will try and find a way around (the ruling) or put legislation in place" if it is not overturned.

However, Ms. Ware said she does not believe the current ruling will mean the "end of conditional fees."

For 99% of cases taken on a conditional fee basis, the insurance will pay the winning defendant's costs, she noted. Plaintiffs lawyers would be sued personally only if the plaintiff did not have insurance for the case, she said. BI

Implants blamed in baby's illness

By CAROLYN ALDRED

NORFOLK, England—In one of the first cases of its kind, U.K. attorneys are considering suing silicone breast implant makers on behalf of a baby alleged to have become ill from breast-feeding.

Although the case was granted government-funded legal aid, it is not yet known whether a lawsuit will be filed. If the case goes to court, U.S. and U.K. lawyers are expected to follow the suit closely.

Lawyers representing the plaintiff, an 18-month-old baby, declined to be identified and would not comment on the case.

A spokeswoman for the National Silicone Implant Information Clearinghouse had not heard of any litigation in the United States involving breast-fed babies suing silicone implant manufacturers. Plaintiffs lawyers contacted by *Business Insurance* also were not aware of any such cases.

A spokesman from Dow Corning Corp., which proposed a multibillion-dollar global settlement of breast implant litigation last year (*BI*, Sept. 1, 1997), said no such cases have been filed against Dow Corning. Although a few may have been filed against other manufacturers, none had come to trial, he said.

In the U.K. case, the baby's mother, Mary Bowler of North Walsham, Norfolk, claims a leaking silicone breast implant may have been responsible for the illnesses, which have included allergies and digestive problems.

In a news release issued by the Legal Aid Board after widespread publicity of the case, the board emphasized that the legal aid granted so far is "in a very limited form and does not at this stage cover the issue of proceedings."

"The limited legal aid which has been granted will allow the (baby's lawyers) to obtain an expert's opinion. Once this has been obtained, a decision will be made as to whether the case merits further funding," said the board, adding that "this case is at a very early investigative stage."

Legal aid is available to citizens in England and Wales unable to afford legal costs. In addition to an applicant's financial status, the Legal Aid Board looks at the "legal merits of the claim to establish if there are reasonable prospects of success and whether it is reasonable in all the circumstances to grant legal aid," the board explained.

The board added it will "consider if the benefits to be gained from going ahead with the action justify the costs involved. Once legal aid has been granted, the case will be monitored by the board to ensure it continues to meet the criteria."

Immediately after the Legal Aid Board's announcement, the British Assn. of Aesthetic Plastic Surgeons denied silicone was harmful.

"Silicone is not poisonous," the association said in a statement, adding that "silicone has long been widely used in infant care with complete safety," such as in rubber nipples on feeding bottles and some medications.

"Many scientific tests have all shown that silicone implants do not cause leakage into mother's milk," the BAAPS said.

According to the association, "there is no evidence whatsoever to support the view that breast-feeding should be avoided by women with breast implants, and mothers should be given every reassurance that the advantages of breast-feeding strongly outweigh any improbable and non-quantifiable risk attributed to silicone gel breast implants."

Russell Levy, a partner with plaintiffs law firm Leigh, Day & Co. in London, also did not know of any cases in which a baby is suing due to alleged silicone poisoning. Leigh, Day is representing 450 British women with breast implants participating in Dow Corning's global settlement.

However, "the concern that breast-fed children may be affected is not new," he said, predicting more cases.

Lloyd's

Continued from page 33

a U.K. composite insurer, with the Commercial Union P.L.C. venture providing Lloyd's with £28.4 million ($47.7 million) in dedicated capacity. The smaller conversion vehicles range in size from £320,000 to £78.46 million ($537,312 to $131.7 million) The total investment by the new conversion vehicles this year reaches £553.7 million ($929.7 million)—substantially less than the £1.76 billion drop ($2.96 billion) in unlimited liability capacity from 1997 to 1998.

This implies that many of the estimated 3,124 names who resigned from traditional underwriting at the end of 1997 have decided to leave rather than convert their underwriting status. In fact, that number may be greater than it appears, because £473 million ($794.2 million) of the conversion capital has been supplied by converting names, the balance being added by the vehicles' sponsors.

Lloyd's is expecting to calculate final membership numbers for the 1998 year of account this week but estimates 6,835 unlimited liability names will be trading this year, providing £4.06 billion capacity ($6.82 billion). That means just 40% of the market's 1998 capacity of £10.18 billion comes from its traditional capital source.

Bermuda-based insurer ACE Ltd. is set to dominate the Lloyd's market this year, supplying £304.46 million ($511.2 million) in capacity to its nine syndicates, and through those syndicates controlling £692 million ($1.16 billion). That figure represents 7% of the total capacity backing Lloyd's business this year (see story, page 33).

But ACE is not alone among Bermuda companies in having a controlling interest in a substantial amount of Lloyd's capacity. Mid Ocean Reinsurance Co. Ltd., through its ownership of agencies Brockbank Personal Lines Ltd. and Brockbank Syndicate Management Ltd., controls £551.6 million ($926.2 million), and in addition supplies almost £210 million ($352.6 million) in capacity to the Brockbank syndicates. That gives the Bermuda-based insurer a 38% share of the syndicates' business, and means that the two Bermuda companies between them control more than 12% of Lloyd's capacity for 1998.

In all, Bermuda-based investors are investing £1.05 billion ($1.76 billion) in underwriting at Lloyd's this year.

Chicago-based Aon Group Inc. also has substantial interests in Lloyd's managing agencies, though these are in partnership with other investors from the U.S. insurance industry. In partnership with organizations such as TIG Reinsurance Co., Aon has control over £528.9 million ($888.1 million) in a market where it is one of the largest introducers of business. TIG Re separately has a £25 million ($42 million) investment in its corporate syndicate 1218.

Another substantial U.S.-based Lloyd's investor is State Farm Fire & Casualty Co., which with Fund American owns 40% of Murray Lawrence Corporate Ltd. and Murray Lawrence & Partners Ltd. State Farm and its partners also supply the agencies with £116 million ($194.8 million) capacity. In a move it had been planning for some time, Murray Lawrence grouped its syndicates together for the start of this year and now operates the largest in the market, syndicate 2001, underwriting against capacity of £528.9 million ($888.1 million).

Hiscox Syndicates Ltd. made a similar move for its 1998 business, merging syndicates 52 and 625 into syndicate 33, which is writing against £360.2 million capacity ($604.8 million) for the year.

However, Hiscox has set up its ownership in a different way, with the agency owned by holding company Hiscox P.L.C.—in part one-third owned by the Trident Partnership from Bermuda. In addition, a corporate investor member of the Hiscox Group has a £75.2 million ($126.3 million) investment in the syndicate.

In total, the U.S. insurance industry is supplying Lloyd's with £1.07 billion ($1.8 billion) in capacity.

But the largest overall controller of Lloyd's capacity is spread vehicle LIMIT P.L.C. LIMIT wholly owns Bankside Syndicates Ltd. and has a majority shareholding in Janson Green Ltd. Through them, LIMIT controls £744.8 million ($1.25 billion)—more than 7% of Lloyd's 1998 capacity. In addition, it is an investor in Standfast Ltd. which has a 47% shareholding in AE Grant (Underwriting Agencies) Ltd., managing £60.1 million ($100.9 million) in capacity this year. LIMIT's £677.34 investment in Lloyd's, derived from U.K. institutional investors, is up slightly from its 1997 investment of £648 million ($1.10 billion).

Non-insurance industry investment is £3.34 billion ($5.6 billion) this year, up 16.7% from 1997 and representing 33% of the total capacity of Lloyd's.

Some investors have dropped their capacity this year, particularly some of the corporate spread vehicles. New London Capital P.L.C. has lowered its provision of capacity 9.2% to £121.94 million ($204.7 million), as has another spread corporate investor, Masthead Insurance Underwriting P.L.C., which reduced its involvement by 27.4 % to £54.13 million. Tarquin Underwriters Ltd. also dropped 5.9% to £188.32 million, and Angerstein Underwriting Trust P.L.C. lowered its capacity 4.5% to £188.21 million.

Of the dedicated corporate capital vehicles, Liberty Corporate Capital Ltd., dedicated to the two Liberty Syndicate Management Ltd. syndicates, has reduced its capacity 45.9% to £100 million ($167.9 million). CNA Corporate Capital Ltd. has lowered its capacity 29.8% to £33.67 million ($56.5 million). But F&G UK Underwriters Ltd., part of USF&G Corp., hiked its dedicated capacity to £52.54 million ($88.2 million), up 130%. BI

Benefits

Continued from page 1

were fully vested after six years.

• Giving pension plan participants more timely information about their benefits. Participants in defined benefit plans would have to be given statements every three years detailing the value of benefits payable at retirement, while defined contribution plan participants would have to be given annual benefit statements.

• Giving small employers tax credits to offset some of the cost of establishing defined benefit or defined contribution plans. During the year in which a plan is established, the tax credit would be 50% of up to the first $2,000 in administrative and retirement education expenses. In both the second and third years, the credit would be 50% of up to $1,000 of such expenses.

The package also calls for a new defined benefit plan option for employers with less than 100 employees. The so-called SMART plan, short for Secure Money Annuity or Retirement Trust, would be exempt from most non-discrimination rules. Few details were provided about the plans.

In addition, President Clinton called in general terms for a health care consumer "bill of rights" and an expansion of the 1993 Family and Medical Leave Act so that employers with as few as 25 employees would have to offer employees up to 12 weeks of job-protected unpaid leave in a variety of family situations, such as the birth of a child or an employee's own illness. The 1993 law now only applies to employers with at least 50 workers.

For an administration that once wanted to revolutionize the nation's health care system in one fell swoop, this is a decidedly modest benefits agenda.

"They have learned—the hard way—that on social policy issues not to try to do everything at once," said Stuart Brahs, vp-federal government relations in the Washington office of The Principal Financial Group.

Indeed, some of the proposed pension requirements are less than what employers now voluntarily do.

For example, employers with defined benefit plans, especially larger firms, typically provide employees annual statements with the accrued value of their benefits; the administration proposal only would require such statements every three years.

In defined contribution plans, quarterly benefit statements are common, while many employers offer a toll-free number for employees to find out the latest account balance of their defined contribution plan. The administration is calling for annual statements.

"I have never seen a situation where employees in a defined contribution plan got statements any less frequently than once a year," said Fred Rumack, vp of taxes at Buck Consultants Inc. in New York.

"Employers are way ahead of what the administration is proposing," said Dick Prey, a senior vp at The Principal Financial Group in Des Moines, Iowa.

Similarly, most employers already exceed the three-year cliff and six-year graded vesting schedule proposed by the administration for 401(k) plans, noted Pam Scott, a principal at The Kwasha Lipton Group in Fort Lee, N.J.

Employers would welcome other administration proposals, especially one that would allow employers terminating defined contribution plans to turn over to the PBGC the burden of finding participants that employers cannot locate.

"Employers would be eager to do this," Ms. Scott said. A similar missing participant program now exists for defined benefit plans and has been used by about 600 employers.

Other proposals are vastly scaled back from earlier initiatives. For example, back in 1993, the administration backed a proposal designed to reduce the likelihood that Medicare paid bills for employees for which employers were responsible. The proposal would have required employers to file reports with the government listing all employees and dependents in their health care plans. That proposal later was repealed amid protests from employers that the government was seeking information beyond what was necessary to stop improper Medicare payments.

By contrast, the latest proposal only requires plan administrators to inform the government of any participants in their health care plans who are eligible for Medicare. Those would chiefly be employees staying on the job after 65, a very small percentage of a typical employer's workforce.

Still, some proposals are not without controversy. The small business community is concerned about the administration seeking to expand the FMLA to employers with as few as 25 employees.

"We don't like it when the government says these are the kind of benefits you have to offer," according to Leslie Aubin Pryor, senior director of government relations with the National Assn. of Wholesaler-Distributors in Washington.

Under an earlier administration proposal, employees age 62 through 64 could enroll in Medicare by paying a monthly $300 premium.

At age 65, that premium would cease, but retirees would pay a monthly surcharge of approximately $15 to $50 a month depending on the age of the retiree when he or she enrolled in Medicare.

Under other parts of the proposal, employees as young as age 55 who lose their jobs and exhaust their COBRA coverage also could enroll in Medicare by paying monthly premiums of $400.

In addition, employers that terminate health care plans for retirees age 55 and older would be required to extend COBRA coverage until the retiree reached age 65.

A separate administration proposal, with strong bipartisan support, would give employers providing child care services to employees annual tax credits of $150,000 or 25% of qualified costs, whichever is less. In addition, tax credits for employees with child care expenses would be increased (*BI*, Jan. 12). BI

Court passes on Microsoft

Appellate ruling that free-lancers were employees stands

WASHINGTON—The U.S. Supreme Court last week refused to review an appellate ruling that Microsoft Corp. improperly excluded workers wrongly classified as independent contractors from its 401(k) and stock purchase plans.

The class-action suit originally was filed by eight plaintiffs who worked for Microsoft in the United States between 1987 and 1990 as free-lancers in the company's international division. The free-lancers all had signed contracts that said in part that they were self-employed and responsible to pay all their own insurance and benefits.

However in 1989 and 1990, the Internal Revenue Service concluded the workers were not independent contractors but employees for withholding and Social Security tax purposes.

After learning of the IRS decision, the workers sought various employee benefits, including participation in the company's 401(k) and stock-purchase plan.

In July, the full 9th U.S. Circuit Court of Appeals upheld an earlier decision of a three-judge panel of the circuit and said that because Microsoft now has agreed the workers were not independent contractors, its reasons for rejecting their participation in these plans are invalid (*BI*, July 28, 1997).

A Microsoft spokesman said the company was disappointed by the court's unwillingness to hear the case.

"We feel we have a very strong case and that the appeals court did not consider the relevant Washington state contract law," said the spokesman, who estimated about 800 people are involved.

He said the case will now be returned to federal district court, which will determine who is eligible under the ruling and the appropriate remedy. No current temporary workers or independent contractors will be affected, he said.

Dennis Coleman, a principal with The Kwasha Lipton Group in Fort Lee, N.J., said the outcome of the case could have a chilling effect on employee stock purchase plans sponsored by employers with non-employee workers who potentially could be reclassified as employees.

—By Judy Greenwald

State oversight OK for risk-taking MCOs: Report

By MEG FLETCHER

KANSAS CITY, Mo.—State insurance regulators assert in a new white paper that they have the authority to regulate any managed care entity that assumes health care cost risks.

To determine if such "insurance risk" exists, the National Assn. of Insurance Commissioners urges states to focus on the functions the entities serve rather than looking at what they are called, how they are structured, who owns them or whom they serve.

However, state regulators also must ensure that any regulatory framework used to respond to the rapidly evolving marketplace "should foster a level playing field among risk-bearing entities which engage in similar insurance arrangements, as opposed to a regulatory framework that favors the development or maintenance of any particular organizational form assuming insurance risk," the NAIC white paper says.

Doctors and employers generally support regulators' efforts to protect consumers but also want to avoid excessive state regulation and keep markets competitive, representatives say.

For example, the American Medical Assn. will continue trying to minimize state oversight for provider-sponsored organizations, said Dr. Ted Lewers, a nephrologist in Easton, Md., and the AMA's secretary/treasurer.

Doctors and hospitals that promoted the PSO concept before Congress last year ultimately lost their major goal of federal licensure (*BI*, March 31, 1997). However, the final version of the Balanced Budget Amendment allows PSOs to seek federal waivers from state regulations if states impose discriminatory rules or don't respond promptly.

Also, self-insured employers want to ensure they preserve their ERISA exemption from state health insurance regulations. The federal Employee Retirement Income Security Act of 1974 exempts qualified self-insured employers from state health insurance regulations.

The NAIC adopted the white paper, "The Regulation of Health Risk-Bearing Entities," at its December meeting, after more than two years of work.

The 64-page white paper points out that states vary widely in regulating managed care entities, though every state has enacted a health maintenance organization statute or regulation.

The issues in the white paper will take on new relevance in coming weeks.

Everyone is waiting for the current PSO working group's proposals for federal solvency and consumer protection rules for PSOs operating under a Medicare-related program, said Kansas Insurance Commissioner Kathleen Sebelius, who chairs the NAIC's Accident and Health Insurance Committee.

Options for solvency standards may include a minimum $1.5 million capitalization requirement, found in many states' HMO requirements. They may also include a discounted version of that standard, such as reflecting doctors' non-cash assets, or use of the new risk-based capital standards for health organizations that the NAIC adopted late last year.

NAIC

"The AMA supports the NAIC's desire for protection of consumers but requests that state insurance regulators preserve flexibility for unique or innovative organizations—like PSOs—in the delivery of care," Dr. Lewers said. Specifically, the AMA wants regulators to adopt lower capitalization requirements for PSOs, he said.

It is important to remember that "PSOs will bring needed competition into the marketplace, based not only on cost but the quality of care rendered," he said.

In fact, the NAIC's white paper does recognize that risk-bearing entities do have different qualities, and that it may be appropriate to subject them to different levels of regulation, said Bob Atlas, a consultant with The Lewin Group, a Fairfax, Va.-based, a health care consulting firm.

Meanwhile, employers and other groups generally are reacting favorably to the NAIC's white paper.

"What we want to do is find the best way to balance the cost savings of good, voluntary managed care with good quality of care for the benefit recipient," said Anne Allen, assistant director-government affairs for the New York-based Risk & Insurance Management Society Inc. The organization also wants to avoid adding an extra layer of regulation.

Catherine Kunkle, acting president of the National Business Coalition in Washington, added, "It's reasonable that there be a level playing field if the entities bear risk."

The Health Insurance Assn. of America also supports the NAIC's recommendation of equal treatment for similar entities.

The 38-member Buyers Health Care Action Group in Minneapolis took special care to avoid arrangements that would make providers risk-bearing, said Steve Wetzell, executive director of policy and public affairs for the employer coalition in Minneapolis.

The coalition took a very "proactive" approach to get approval for its complex provider compensation system from state regulators, he said. That approach was due, in part, to the fact that the State of Minnesota is a member of the coalition, he said.

However, "we always caution regulators from getting too ambitious about what kinds of standards they set in regulating the market," Mr. Wetzell said. "One of the things we are convinced of is as the state has tried to protect consumers by putting in more and more requirements in the managed care market, it has essentially eliminated the ability for any new competitors to enter the state-regulated managed care market."

Eliminating new competitors can keep costs unnecessarily high and hurt consumers in the long run, he said.

•

A copy of the white paper costs $25 and is available by calling the NAIC's Publications Department at 816-374-7259.

Commentary

Managing riot risk is a winning idea

Why is it that some fans take such delight in rioting after their team wins a championship, souring the sweet taste of victory for everyone else and causing municipal risk managers grief?

The latest example of such poor sportsmanship of course occurred in Denver last week after the Broncos finally secured their long-sought Super Bowl championship.

I can understand the fans' enthusiasm for celebrating after this fantastic win in the most exciting Super Bowl game I can remember. It had been a long time coming. And as a long-suffering Buffalo Bills fan, I was truly delighted for the Broncos and their fans that the Broncos broke what we American Football Conference fans considered a spell against our teams.

But when celebration in the streets turns to violence and property damage, it tarnishes the trophy.

And in Denver, some are questioning if the police overreacted in their approach to crowd control.

A good risk management plan can prevent this sort of outrageous behavior and can prevent the police from being second-guessed after the fact.



Kathryn J. McIntyre

Chicago has taken one approach that works, adopted after fans rampaged down North Michigan Avenue after the Bulls' 1992 National Basketball Assn. championship.

Since then, Chicago fans have been put on notice by the mayor's office preceding a final championship game that the police will be out in extra force and that any mob actions, rioting or looting will be stopped immediately. Certain streets have been blocked off after a Bulls victory to prevent fans from forming a mob.

In addition, the Chicago Bulls do their part to try to prevent chaos after a win. Commercials featuring team members and the coach have urged fans to behave themselves when celebrating.

As a result, the Chicago papers after a Bulls victory are filled with stories about the win, not street riots.

No one can prove if it is the fear of being arrested or the persuasive powers of the Bulls that quells riots in Chicago after Bulls victories. I'm inclined to think it is a combination of the two and offer Chicago's approach to other municipal risk managers facing the prospect of a championship in their city.

Some may think that a public warning that extra police will be on the street and any violations of the law will be dealt with swiftly and seriously is too Draconian an approach. I don't. The would-be fans who begin trashing cars and busting windows after a victory by a hometown team are mostly hoodlums at heart just looking for an excuse to misbehave. It seems to me that a strong warning of arrest is the only language these types understand.

As for the basically law-abiding citizen who can get caught up in the frenzy of a celebration, the pre-victory reminders from the players and coach will ring in their ears as they begin their parties.

Of course, the police must be trained in what actions are appropriate to keep the peace and what actions can be deemed police brutality. A police force that quells a disturbance only to leave the city facing charges of police brutality is not an effective police force.

The disturbances that follow major league team victories also raise a broader issue: how municipalities respond to civil rights demonstrations that turn into rioting.

Every municipality, not just those with professional sports teams, faces the risk of civil rights riots. Municipal risk managers need to be sure their police forces have a comprehensive plan to deal with mob action that protects the public and private property. And they must be sure their officers are properly trained in dealing with mob actions so that their efforts do not expose the city to lawsuits charging excessive use of force.

Publisher and Editorial Director Kathryn J. McIntyre and Editor Paul D. Winston write columns on alternate weeks.

Schools

Continued from page 1

Paul Wilhelmsen, executive director.

UNICARE underwrote the coverage, which Keenan & Associates of Torrance administered. The insurer did not return phone calls by deadline.

"It was a good experience for us. We jumped into the market at a good time, and we jumped back out when things started to change," he said.

"Our renewal quote was up 5% from the previous years, and we were starting to see perceptions of conflict of interest" in claims handling, particularly on those claims that spanned over the insured and self-insured years, he explained.

'Looking at it on a decade-long basis, it's always more cost-effective to self-insure,' says Terry Norwood. 'However, this was an unusual cycle in this class of business in California.'

The Inland Empire Schools Insurance Authority in San Bernardino also is reviewing its options after seeing its savings shrink, according to Terry Norwood, executive director.

"We were a $9 million pool, but we paid only $6.2 million for coverage the first year," he said. But the premium grew to $6.7 million in 1996-97 and $8.1 million in 1997-98.

"We're almost back to $9 million. So now we're going to review the alternatives and cost them out," he said.

The district is insured by UNICARE and purchases third-party administration services from Keenan.

San Joaquin Delta College in Stockton decided to self-insure when the joint powers authority to which it belonged opted to fully insure its workers comp exposures for the third consecutive year.

In July 1995, the JPA purchased workers comp coverage from a unit of American International Group Inc., paying $4.2 million for its 300,000 employees. But after just one year, AIG declined to renew the coverage.

"We had controls in place and we thought we had a wonderful year, but AIG said we had a terrible year and dropped us," said Toni Cardinale, risk manager for San Joaquin Delta College.

An AIG spokesman said the insurer's policy is not to discuss its policyholders.

The next year, the JPA paid $5.3 million to Fireman's Fund Insurance Cos. for workers comp coverage, she said. A Fireman's Fund spokesman said it insures eight school districts, one of which was picked up from a competitor, which the insurer declined to name.

Meanwhile, the college conducted a feasibility study and found it would save 30% on its workers comp coverage if it self-insured.

"The controls were the overriding trigger for the decision," Ms. Cardinale explained. "Many times, even if the district wanted to accept an injury, the decision-making was taken away."

At other times, the insurer opted to pay claims the district would have contested, she added.

While Ms. Cardinale disagreed with the JPA's decision to go fully insured, she understood their reasoning.

"I think that people are always looking for a better way to do business. When they saw there would be more money in their pocket, they thought it would be favorable for the district," she reasoned.

"But those of us who've been around a while remember the last time the market shifted and how hard it was to get back control," she said.

Indeed, many of the school districts that opted to take advantage of relatively low-priced workers comp insurance in the commercial market were short-sighted, agreed Joe Myers, executive director of the Redwood Empire Schools Insurance Group in Santa Rosa. The group has been self-insured since 1979 and self-administered since 1990.

"If their rates were high because they didn't have strong claims management, it was a good move," he said. "But for those seeking short-term gains, it was short-sighted."

Many districts "went into it blindly thinking they'd save a lot of money," Mr. Myers continued. "But soon they found they no longer had control over claims management, and they lost the intimacy that had existed between the employer and the employee."

In some cases, the districts even found they had less extensive coverage through their insurers, he pointed out.

For example, many JPAs paid workers comp claims filed by volunteers who were not school district employees, but the insurers did not cover anyone who was not on the payroll.

The insurers also declined to pay defense costs involved in defending employment practices liability cases, many of which are brought in connection with workers comp claims, Mr. Myers added.

"There were a lot of things to lose," he said. "I've been preaching this up and down the state for a long time."

"Looking at it on a decade-long basis, it's always more cost-effective to self-insure," concurred Mr. Norwood of the Inland Empire Schools Insurance Authority. "However, this was an unusual cycle in this class of business in California."

Insurance broker John Keenan, chief executive officer of Keenan & Associates, agreed.

"At the time, we told our clients we didn't know how long it would last, but why not take advantage of it when you can?" Mr. Keenan recounted. BI

AT&T

Continued from page 2

this option, the company is pledging to institute an involuntary program that will yield the same results.

"We will selectively ask people to leave," Mr. Fromme said.

In addition, the company expects 5,000 to 7,000 non-management workers to leave the company through attrition and downsizing initiatives that already have been announced.

The benefits that will be offered to early retirees include:

- A 20% increase in pension benefits in addition to a previous increase last August for managers.
- Alternatively, depending on the manager's choice, the company's cash balance plan can be increased by 5% of 1997 eligible pay for each whole year of service as of Dec. 31, 1997. The limit is 100% of 1997 eligible pay.

For example, an employee with 10 years of service with an annual salary of $60,000 would receive a bonus of $30,000, which would be added to whatever already is in his or her cash balance account.

- Payment of either type of pension may be taken in cash as a lump-sum—minus tax penalties—or rolled over into an individual retirement account, a 401(k) plan or other tax-deferred account.

Those forced out through the involuntary program are eligible for a maximum of 42 weeks' base pay, the exact amount being dependent on salary, age, length of service and willingness to sign a waiver of the right to sue AT&T, Mr. Fromme said.

The window of opportunity to elect to participate in the buyout will vary from unit to unit at AT&T.

The company also told managers there will be a "limited time liberalization" of eligibility for various retirement benefits, such as medical, dental and life insurance.

Previously, AT&T would pay for post-retirement benefits of workers whose combined age and service equaled 75 or more. Under the early retirement program, that number will decline to 65—a change an AT&T spokesman said would provide benefits to "thousands upon thousands" of additional managers.

The window of opportunity to elect to participate in the buyout will vary from unit to unit at AT&T, and some buyout offers will begin as early as this spring, the spokesman said. Other offers will continue into 1999. Mr. Fromme said the offer would be temporary and that "when the window shuts down, the window will no longer be there."

Practically all managers will be eligible, except those in high-growth areas of the corporation, such as cellular communications and telecommunications outsourcing and consulting, Mr. Fromme said.

Company support for departing managers will include seminars, a telephone hot line, written information, transition workshops, and personalized career guidance.

In 1996, the company said it would lay off 30,000 managerial employees and made a buyout offer that included up to a year of health care coverage. Ultimately, 10,000 lost their jobs, and thousands more were transferred to new posts within the company, the AT&T spokesman said.

The buyout offer then proved to be widely unpopular, but the AT&T spokesman said this time the company is hearing "mostly positive" employee reaction. BI

Olympics

Continued from page 1

rights coverage for the Olympic Games since the 1992 Summer Games in Barcelona.

Although the opening ceremony for the Nagano Games takes place Feb. 7, most of the TV rights insurance coverage period has elapsed, as it was placed three years ago, long before the nearly 2,500 skiers, skaters, hockey players and other athletes gathered in Japan. The TV rights coverage continues until the end of the closing ceremonies.

Television rights coverage for the Olympics has been a vital but largely untroubled exposure for the organizing committees of recent Olympic Games.

The coverage for this year's Games protects the Nagano Olympics Organizing Committee if it has to make full or partial refunds to broadcasters, who have paid a combined $500 million for TV rights.

For example, if bad weather causes the cancellation of any event, the insurance would cover the NOOC for the money it would have to reimburse the broadcasters up to the limit of the policy.

While bad weather in the past has delayed events, no events have had to be canceled in recent years.

U.S. network CBS Inc. paid $375 million for TV rights, by far the largest portion of the $500 million paid. Much of the remainder was paid by the European Broadcasting Union, which paid $72 million, and the balance was paid by broadcasters in Canada, Korea, Australia, New Zealand and South America.

The insurance coverage is led by Tokio Marine & Fire Insurance Co. in Tokyo and reinsured in the worldwide reinsurance market, Mr. Vajda said.

Tokio Marine & Fire is a sponsor of the Games and also leads the coverage for the Games' property and liability program.

Mr. Vajda said the policy limit for the TV rights coverage was between the $150 million purchased for 1994 Winter Games in Lillehammer, Norway, and the $200 million purchased for the 1996 Summer Games in Atlanta.

Consequently, if a disaster, such as a terrorist attack, caused the complete cancellation of the Games, there would be a significant uninsured loss.

However, in recent years the TV rights cancellation programs have not been affected, he said.

The closest call came during the 1996 Games after a bomb exploded at Centennial Park in downtown Atlanta, causing two deaths and injuring more than 100 other people (*BI*, Aug. 5, 1996).

While the explosion did not damage any of the main sporting venues, there was speculation immediately after the incident that the Games might be canceled out of respect for the dead and injured.

But the International Olympic Committee decided no events should be canceled. "The IOC considered what to do, and they quickly made the decision to continue the Games," said David L. Mair, risk manager at the U.S. Olympic Committee in Colorado Springs, Colo.

"The explosion looked like it was the beginning of a claim, but it turned out not to be, as the International Olympic Committee decided that the show must go on," Mr. Vajda said.

Terrorist attack is covered under the TV rights program for Nagano. Cancellations due to earthquake also would be covered, but Nagano is not in an active earthquake zone.

War, however, is excluded under the program. Also excluded is cancellation of all or part of the Games by the NOOC or the IOC for any reason other than the safety of the spectators.

If the good loss record of the Olympics is maintained at Nagano, coverage obtained for future Olympics should be broader, Mr. Vajda said.

"Maybe in the future we'll be able to include other revenues, like ticketing and sponsorship," he said.

The coverage for the Games since Barcelona has largely remained the same, because coverage must be placed before a complete loss record is known, Mr. Vajda said.

For example, the coverage for Nagano was placed prior to the Atlanta Games.

"It is very difficult to change the minds of underwriters, but we have created a climate of confidence over the long term with our good results," he said. BI

Athletes get free health cover

Injured or sick athletes on U.S. Olympic teams between now and the year 2004 will have free health insurance coverage under an agreement announced last month by the Chicago-based Blue Cross & Blue Shield Assn. and its affiliate plans.

In addition, one such plan, Denver-based BC/BS of Colorado, will continue to underwrite health insurance for U.S. Olympic Committee staff and their families, up to and including the Summer Games in Athens, Greece, in 2004.

Other Olympic Games where athletes' health insurance will be covered by Blues plans include Nagano, Japan, this month; Sydney, Australia, in summer 2000; and Salt Lake City in winter 2002.

Three hundred American athletes are expected to participate in the games in Nagano. Coverage is intended to be a secondary policy supplemental to any primary insurance an athlete might have, but it will be the primary insurance if the athlete has no other coverage. Coverage will be limited to $1 million and carries no deductible.

BC/BS of Utah will furnish health insurance for Olympic organizing staff in Salt Lake City.

About 500 U.S. staff are covered by the Colorado Blues primary insurance plan, a BC/BS of Colorado spokesman said. U.S. Olympic Committee headquarters is in Colorado Springs, Colo. The staff's insurance, which is paid by the committee, has a limit of $1.5 million and deductibles of $100 per individual or $300 per family, except if a physician from a preferred provider network in the Colorado Springs area is selected. In that case, there is no deductible.

The national BC/BS association, together with its 55 local Blues plans, will pay for the health insurance of U.S. athletes, as it has for the past decade. Injured or ill athletes and staff this year will use Japan's Nagano Red Cross Hospital, which has been made part of the Blue Cross network.

The insurance will be written by BC/BS of Colorado.

—By Robert Kazel

Merrill Lynch may appeal ruling

Federal judge says gender discrimination case can proceed

BOSTON—Merrill Lynch & Co. is considering whether to appeal a federal judge's ruling last week allowing a former financial consultant to bring her gender discrimination case to court.

In a Jan. 26 ruling, Judge Nancy Gertner of the U.S. District Court for Massachusetts said Merrill Lynch could not force Susan Rosenberg—a former Merrill Lynch financial consultant—to take her gender discrimination case to a New York Stock Exchange arbitration panel because the board's arbitration system is unfair. The judge said that Congress never intended to prevent plaintiffs from taking sex and race discrimination claims to court, and that she was disturbed by the fact the NYSE chairman recommends and appoints the pools from which individual arbitrators are chosen.

Marc Redlich, an attorney with his own firm in Boston who represented Ms. Rosenberg, said the ruling "vindicates the rights of discriminated plaintiffs in the securities industry who now have the right to proceed to court for a jury trial by their peers rather than being forced involuntarily to industry-dominated arbitration."

Merrill Lynch had no further comment on the suit.

The National Assn. of Securities Dealers Inc. requires all registered brokers to bring statutory employment disputes to arbitration. Some critics have charged that mandatory arbitration is unfair, and some of the largest securities firms have faced suits alleging widespread gender discrimination in their firms. The Securities and Exchange Commission is considering an NASD proposal that would eliminate the NASD's mandatory arbitration rule, leaving the decision to impose arbitration to the individual securities firms.

In a separate but related matter, attempts to settle a gender discrimination suit brought by eight former and current Merrill Lynch female brokers reached an impasse last week in Chicago. The suit, originally filed in 1996, alleged that Merrill Lynch systematically denied women chances at employment and advancement and retaliated against those who complained.

Sources familiar with the settlement said the sides could not agree on legal fees. Attorneys for both sides will meet again at a hearing Feb. 25. If a settlement is not reached, attorneys for the plaintiffs plan to refile the suit, confirmed a spokeswoman for Leng Stowell Friedman & Vernon, the Chicago-based firm representing the women.

Regardless of a settlement, Merrill Lynch intends to proceed with its plans to revamp its mandatory arbitration system.

"We are committed to a new dispute resolution policy that provides all employees with a full range of options to resolve all employment disputes," a Merrill Lynch spokesman said. He declined to elaborate, but sources familiar with the issue said the firm's policy—expected to be adopted by this spring—would allow employees to take complaints to court.

—By Sally Roberts

Updates

Ruling protects employee suits

Continued from page 2

Anthony Kennedy wrote: "An employee 'may not waive' an ADEA claim unless the employer complies with the statute. Courts cannot with ease presume ratification of that which Congress forbids."

The release Ms. Oubre signed did not comply with several OWBPA requirements, including giving Ms. Oubre the required amount of time to consider the offer. Justice Kennedy wrote that because Entergy's release did not meet OWBPA requirements, it could not be used to block Ms. Oubre's ADEA suit. Simply keeping the severance money did not "amount to a valid release of her ADEA claims," he wrote. To accept Entergy's argument "might tempt employers to risk non-compliance with OWBPA's waiver provisions," and the court "ought not to open the door to an evasion of the statute by this device," wrote the justice.

Fertility settlement proposed

CHICAGO—The Chicago City Council is expected to approve a proposal to provide about $1.5 million to city employees who were denied insurance coverage for artificial insemination and other fertility procedures.

Under the proposed settlement, employees in the city's self-insured preferred provider organization who were denied coverage for fertility treatments would be entitled to reimbursement of between 50% to 90% of their costs.

The proposed settlement stems from an earlier federal court ruling that reproduction and procreation are major life activities protected by the Americans with Disabilities Act. Nationwide, courts are split on this issue, a plaintiff's attorney said.

The city's denial of coverage had been challenged by a female police officer, who paid about $12,000 to undergo infertility treatment.

In anticipation of the settlement, the city PPO began providing fertility treatment coverage since early January. The proposed settlement does not affect city employees in health maintenance organizations, which are required under a 1991 state law to provide coverage for infertility treatment.

"This will put some pressure on employers to add infertility coverage to their plans, if they do not already have it," said Howard Parker, human resource information manager for the Illinois Chamber of Commerce in Chicago. That will increase costs and may cause them to drop coverage, he added.

Bank offers commercial cover

CHICAGO—A Chicago bank is expanding its offering of commercial property/casualty coverages to small businesses in the Midwest through partnerships with two major insurers.

First Chicago NBD is entering into alliances that will allow its 180,000 small-business customers to buy commercial insurance written by Hartford Insurance Group and CNA Insurance Cos.

The insurers will write property/casualty coverages at various limits for bank customers. Coverages will be sold through a direct-mail campaign and the bank's brokerage subsidiaries in Illinois, Michigan and Indiana.

Businesses comfortable with designing their own programs will purchase coverages from Hartford. The bank expects customers with annual sales of less than $1 million—about 90% of its small-business clients—to choose that option.

Larger companies that need more assistance with insurance decisions will buy from CNA.

Briefly noted

No replacement has been named to succeed **Paul Brown** as director-government and legal affairs for the Risk & Insurance Management Society Inc. Mr. Brown resigned to take a position in the for-profit sector. . . . **American International Group Inc.** is buying the 76% it does not already own of SELIC Holdings Ltd., the holding company for Starr Excess Liability Insurance Co. Ltd. in Bermuda. AIG and other investors set up Starr in 1993 to write excess liability and directors and officers liability business in Bermuda. . . . The AFL-CIO last week said it wants Congress to pass legislation that would require employers with 50 or more employees to pay at least 75% of **family health care premiums** as well as to offer a pension plan. . . . Credit Suisse First Boston Corp. will pay $800,000 to **settle Securities and Exchange Commission charges** that the investment bank negligently omitted and misrepresented facts in the offering statement for a $110 million Orange County, Calif., bond issue in 1994. Under the settlement, First Boston neither admitted to nor denied the allegations, and an SEC administrative order citing the firm for certain securities rule violations makes no allegations of reckless or fraudulent conduct by the bank or its employees. . . . The Florida Senate has drafted a bill that could significantly alter the state's **tort system**. The bill would, among other things, limit the vicarious liability of vehicle owners, eliminate joint and several liability in cases involving damages less than $25,000 and call for punitive damage awards to be split between claimants and the state (*BI*, Jan. 19). The Florida House is drafting similar legislation. . . . Nashville, Tenn.-based Columbia/HCA Healthcare Corp. has agreed to sell its **Value Behavioral Health** subsidiary to FHC Health Systems of Norfolk, Va., for $230 million. Columbia/HCA still is trying to sell two other subsidiaries of Value Health Inc. it purchased last year: ValueRx, a prescription benefit management service, and Value Health Services, a disease management company. . . . A Washington-based consumer group—the Fair Care Foundation—and several policyholders of **Blue Cross & Blue Shield of the National Capital Area** have filed separate suits against the plan's officers and trustees and District of Columbia insurance regulators in an attempt to block the plan's merger with Blue Cross & Blue Shield of Maryland (*BI*, Jan. 5). . . . **Frontier Insurance Group Inc.** of Rock Hill, N.Y., has appointed Harry Rhulen as president and acting chief executive officer, replacing his father, Walter Rhulen, who is in declining health. The younger Mr. Rhulen previously served as chief operating officer and an executive vp of the specialty insurer.

Cendant

Continued from page 1

Renaissance Fund Advisers in New York.

AIG, several analysts said, will likely fight to preserve its deal for the insurer but will probably not try to top Cendant's offering price in a bidding war.

"It is not like AIG to pay more than what they consider the economic value to be," said Vandana Sharma, associate director with Standard & Poor's Corp. in New York.

Mr. Frinquelli also pointed out that AIG stands to collect a $66 million "breakup fee" from American Bankers under the agreement if its shareholders opt for a competing bid.

"It's classic AIG. Even if they lose, they win," he said.

Analysts said last week's unsolicited offer came "out of left field" from Cendant, a consumer services giant formed in December from the merger of Stamford, Conn.-based CUC International Inc. and Parsippany, N.J.-based HFS Inc.

The combined companies' businesses comprise travel services, control of the Avis car rental and Ramada, Days Inn and Howard Johnson hotel brands; real estate services, in which they franchise Century 21, Coldwell Banker and ERA realty offices; and membership services providing access to travel, auto and other services worldwide.

Taken together, the merged operations of Cendant produced more than $4.5 billion in revenue and $600 million in net earnings for their 1996 fiscal years, the company says.

Cendant has been on an aggressive acquisition campaign: In December, before the CUC/HFS merger was completed, HFS announced it would pay $219 million to acquire Providian Auto and Home Insurance Co. from AEGON N.V. Last month, Cendant also completed a $480 million takeover of Jackson Hewitt Inc., a national tax preparation service.

These deals pale beside the $2.7 billion cash and stock offer for American Bankers announced last Tuesday. After the announcement, Cendant on Wednesday began a $58 a share cash tender offer for 51% of American Bankers' stock. After the tender offer is completed, Cendant says it will merge with American Bankers and buy its remaining shares for Cendant stock worth $58 per American Bankers share.

'It is not like AIG to pay more than what they consider the economic value to be,' says Vandana Sharma of Standard & Poor's Corp. in New York.

The offer comes with several conditions, though, including that AIG's "lockup option" to buy 19.9% of American Bankers either be terminated or ruled invalid by a court.

Cendant last week filed suit in U.S. District Court in Miami against American Bankers, Mr. Gaston and 13 other members of the insurer's board, and AIG.

According to the complaint, Cendant Executive Vp John H. Fullmer contacted Mr. Gaston in December to discuss a possible acquisition and was told American Bankers was not on the block.

Later that month, American Bankers announced its deal with AIG. That deal, Cendant charges, amounts to a breach of fiduciary duty by American Bankers' board because the deal virtually precludes competing offers like Cendant's.

Among other things, the suit says the AIG deal:

- Includes a "no-shop" provision barring American Bankers from considering competing offers for 120 days, rendering the AIG takeover a fait accompli.
- Allows AIG to buy 19.9% of the insurer's stock if a competing bid is launched, an option intended only to thwart competitors.

While the stock purchase requires state regulatory approval, observers say they doubt regulators ultimately would have grounds to block the deal.

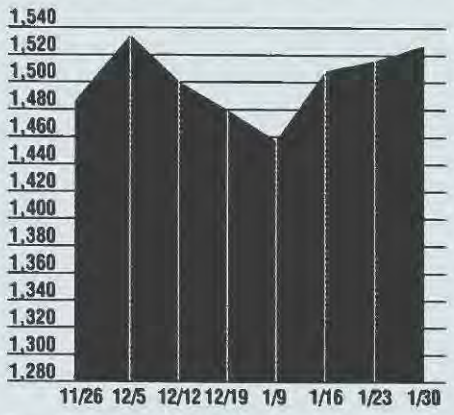
- Requires American Bankers to pay AIG the $66 million breakup fee if shareholders reject the deal.
- Exempts AIG from an American Bankers shareholder rights plan—also known as a "poison pill"—that could be used to thwart any other bidder.

"All of these measures are designed to prevent American Bankers shareholders from obtaining the best available transaction. . .and are intended to deliver control of American Bankers to AIG cheaply in breach of the fiduciary duties owed by the company's directors to its shareholders," Cendant charges.

The suit seeks an order enjoining the AIG takeover and declaring the takeover agreement unlawful.

On Friday, Cendant filed preliminary proxy material with the Securities and Exchange Commission to solicit American Bankers shareholders to vote against the AIG bid. BI

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc. (nordby.com) Boulder, Colo.

PCS catastrophe options

As of Jan. 30

Call spread	Price bid/ask
National Annual 1998	
40/60	10.0/12.0
60/80	7.0/8.3
80/100	5.0/6.0
Eastern September 1998	
20/40	3.5/5.5
40/60	3.0/3.5
Southeastern September 1998	
40/60	2.2/3.0
Northeastern September 1998	
100/150	.8/1.4
California Annual 1998	
40/60	1.3/2.3
150C	1.7/3.0
Western Annual 1998	
40/60	1.5/2.5
80/100	—/1.8
150C	2.2/3.0
Florida September 1998	
40/60	1.4/2.4

Total volume: 553 Total open interest: 18,192

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high—low
Commi Union	989	14.8	35.8	3.7	995—630
Genl Accident	1165	7.9	35.4	3.7	1212—772
Gdn Royal Exch	395	5.6	12.2	3.1	395—257
Legal & Gen	647	16.5	11.6	2.3	658—377
Royal & Sun	687	23.9	19.7	3.5	710—429
Brokers					
Lmbrt Fenchurch	105	7.6	8.4	9.8	138—101
Lloyd Thmpson	178	15.1	10.8	7.4	206—151
Sedgwick Grp	144	10.8	7.4	5.6	171—115
Willis Corroon	138	15.3	6.6	6.2	165—116

Note: Prices are Jan. 30 closings; other numbers from Jan. 29.

Source: *Nordby International Inc.*(nordby.com) Boulder, Colo.

Sinnott named CEO at J&H/M&M

By GAVIN SOUTER

NEW YORK—John T. Sinnott has been named chief executive officer of J&H Marsh & McLennan Inc. as part of a series of changes at the brokerage.

Mr. Sinnott previously was CEO and president of the former Marsh & McLennan Inc. prior to its purchase of Johnson & Higgins last year, but after the purchase he was named one of three vice chairmen.

The other vice chairmen also will take on other responsibilities.

Richard H. Blum will be responsible for the brokerage's overall relationship with insurers and the development of its capital markets-based insurance products. Mr. Blum is a former chairman and CEO of Guy Carpenter & Co., J&H Marsh & McLennan's reinsurance unit.

Norman Barham, who was president of J&H prior to the merger, will be responsible for professional development at J&H Marsh & McLennan.

Mr. Barham is also president of J&H Marsh & McLennan (Global), which is one of three new divisions, which now envelope the operating units of the combined brokerage.

Robert J. Newhouse III is president of J&H Marsh & McLennan (Americas), and Brandon W. Sweitzer is president of Guy Carpenter, the reinsurance division.

A.J.C. Smith, chairman of parent company Marsh & McLennan Cos. Inc., remains chairman of J&H Marsh & McLennan also.

The changes mark the culmination of organizational and management changes at the brokerage since the purchase of J&H, a spokeswoman said.

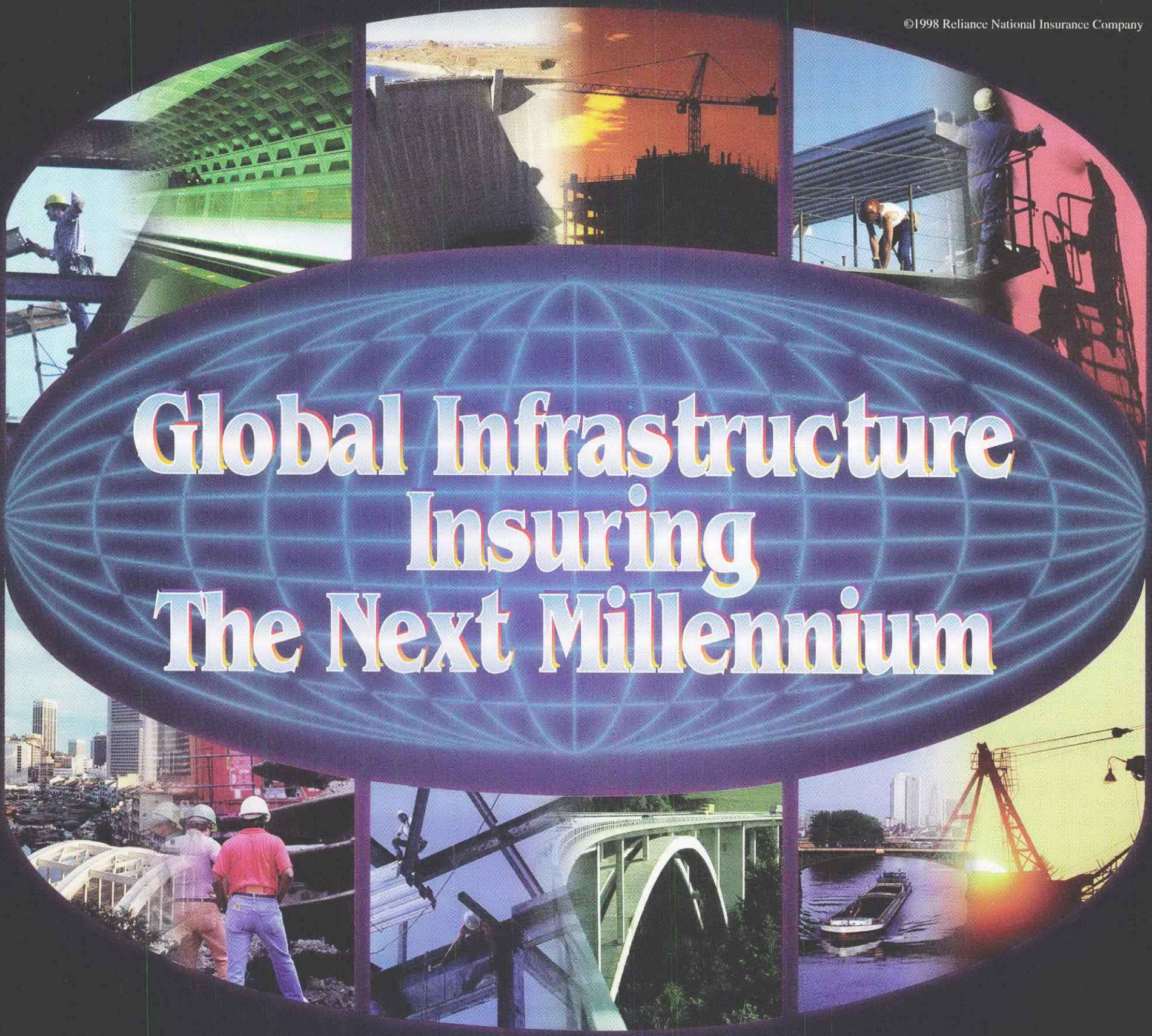
BI Industry Stock Report JAN. 26, 1998 THROUGH JAN. 30, 1998

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
BROKERS							
Aon Corp.	NYS	55.81	1.36	-4.80	58.88	40.25	1015
E.W. Blanch Holdings Inc.	NYS	33.81	-1.99	-1.81	36.00	21.25	140
Gallagher Arthur J. & Co.	NYS	37.00	0.68	7.44	38.25	30.00	287
Hilb, Rogal & Hamilton	NYS	17.63	-2.42	-8.74	19.63	12.50	19
Kaye Group Inc.	NDQ	6.50	-1.89	-1.89	9.00	4.38	2
Marsh & McLennan	NYS	73.88	2.07	-0.92	80.00	52.13	1698
Poe & Brown	NDQ	47.31	7.68	6.02	48.56	25.50	40
Sedgwick Group PLC	NYS	12.00	4.35	-2.54	13.25	9.38	35
Willis Corroon Corp.	NYS	11.31	2.84	-8.12	13.50	9.75	190
BROKERS	AVERAGE		1.42	-1.32			
INSURERS/REINSURERS							
ACE Ltd.	NYS	93.06	0.07	-3.56	101.06	56.63	1169
Acceptance Insurance Cos.	NYS	23.63	-1.31	-2.33	28.63	17.75	185
AEGON N.V.	NYS	94.75	0.13	5.72	97.69	61.13	100
Aetna Life & Casualty	NYS	73.50	-0.51	4.16	118.13	66.31	2237
AFLAC Inc.	NYS	54.44	11.38	6.48	57.88	37.50	1995
Allied Group Inc.	NYS	27.50	5.77	-3.93	35.75	20.69	223
Allstate Corp.	NYS	88.50	1.65	-2.21	94.38	58.63	4778
AMBAC Indemnity Corp.	NYS	47.56	4.53	3.40	48.13	31.00	1173
American Bankers Ins.	NDQ	55.25	20.11	20.27	56.38	24.38	7947
American Financial Group	NYS	37.69	-3.21	-6.51	49.25	32.38	323
American General	NYS	56.38	-0.22	4.28	57.00	36.50	2748
American Heritage Life Ins.	NYS	37.19	0.68	3.30	40.50	23.50	48
American Indemnity/Fin'l	NDQ	12.50	-3.38	-9.91	15.50	11.25	8
American International	NYS	110.31	3.46	1.44	112.56	75.13	6526
Argonaut Group	NDQ	36.00	8.27	6.27	38.13	26.75	1179
AXA-UAP Group	NYS	41.19	5.61	5.61	42.00	29.25	598
Baldwin & Lyons Inc.	NDQ	22.81	11.28	-5.44	28.75	17.38	3
Berkley W.R. Corp.	NDQ	41.13	-0.30	-6.27	46.38	31.19	598
Berkshire Hathaway Inc.	NYS	50300.00	1.62	9.35	50500.00	30000.00	1
Capital RE Corporation	NYS	59.56	-0.73	-4.03	62.88	38.75	126
Capitol Transamerica Corp.	NAS	21.75	1.16	2.05	28.13	19.25	28
CapMac Holdings Ltd.	NYS	30.75	2.71	-11.51	35.75	22.50	406
Centris Group Inc.	NYS	22.00	0.28	-1.40	24.00	17.88	60
Chartwell Re	NYS	33.88	-0.91	0.37	36.25	24.50	31
Chubb Corp.	NYS	75.94	-2.17	0.41	79.13	51.13	2115
CIGNA Corp.	NYS	169.56	-2.83	-1.63	200.75	136.94	1162
CNA Financial Corp.	NYS	133.63	1.71	4.60	135.94	96.38	121
CNA Surety	NYS	15.88	2.83	2.83	16.50	12.88	315
EMC Insurance Group Inc.	NDQ	13.38	-0.93	0.94	15.00	10.75	21
ESG Re Limited	NDQ	24.50	1.03	4.26	25.00	20.88	594
Enhance Financial Services	NYS	55.63	3.73	-6.51	62.13	34.25	356
Everest Reinsurance	NYS	37.88	2.71	-8.18	43.00	26.50	907
Executive Risk Inc.	NYS	71.25	-2.40	2.06	74.19	37.00	288
EXEL Ltd.	NYS	61.00	1.88	-3.75	65.19	39.00	468
Fremont General Corp.	NYS	50.94	1.88	-6.96	55.50	26.38	278
Frontier Insurance Group	NYS	23.88	3.80	4.37	39.25	18.88	1320
Gainsco Inc.	NYS	8.00	-2.29	-5.88	10.19	7.94	170
General RE Corp.	NYS	208.13	0.12	-1.83	221.25	151.13	801
Gryphon Holdings	NDQ	15.63	0.00	-6.72	17.75	13.88	42
Harleysville Group	NDQ	25.38	11.54	5.73	27.50	14.50	152
Hartford Steam Boiler	NYS	59.13	2.83	7.13	59.50	44.00	444
HCC Insurance Holdings	NYS	18.63	13.31	-12.35	32.69	15.63	4310
ING Groep N.V.	NYS	45.63	-1.08	7.83	53.00	38.88	494
IPC Holdings Ltd.	NDQ	29.88	-2.85	-7.18	32.88	22.38	202
Hartford Financial Services	NYS	90.00	0.00	-3.81	94.56	68.13	2387
LaSalle Re Holdings Ltd.	NYS	33.88	1.50	-4.24	36.13	26.50	136
Life Re Corp.	NYS	61.50	3.14	-5.66	65.38	37.38	97
Lincoln National	NYS	76.13	0.74	-2.56	78.88	49.00	617
MAIC Holdings Inc.	NYS	26.00	0.73	-2.93	29.13	14.44	58
Markel Corp.	NYS	162.69	3.62	4.20	164.00	96.00	17
MBIA Insurance Group	NYS	64.75	1.17	-3.09	68.44	45.44	1411
Meadowbrook Insur. Group	NYS	28.94	1.09	11.03	29.50	21.25	43
Mid Ocean Ltd.	NYS	54.38	-1.81	0.23	66.75	44.13	383
MMI Cos. Inc.	NYS	24.44	-2.25	-2.74	31.13	20.75	74
Mutual Risk Mgmt. Ltd.	NYS	29.81	4.15	-0.42	30.50	16.75	287
NAC Re Corp.	NYS	50.00	-1.11	2.43	52.88	35.00	157
Navigators Group	NDQ	17.50	-4.11	-6.82	22.50	15.75	8
Nobel Insurance Ltd.	NDQ	13.25	0.95	0.95	15.38	11.88	27
NYMagic Inc.	NYS	27.50	-2.22	-0.23	29.81	18.13	8
Ohio Casualty Corp.	NDQ	45.31	3.28	1.54	51.00	34.50	189
Old Republic Int'l	NYS	39.19	1.95	5.38	40.19	24.63	1066
Orion Capital Corp.	NYS	44.56	-0.83	-4.04	51.00	30.75	217
Partner Re Ltd.	NYS	46.50	0.95	0.27	47.88	30.75	441
Penn-America Group Inc.	NDQ	19.75	-1.25	-3.66	21.75	10.88	46
Philadelphia Cons. Holding	NDQ	19.00	-7.32	7.04	23.25	12.75	80
PXRE Corp.	NYS	33.88	6.90	2.07	35.25	24.75	58
Reliance Group Holdings	NYS	14.00	-0.44	-0.88	15.13	9.00	1001
Reliastar Financial Corp.	NYS	41.50	-0.60	0.76	42.38	27.00	877
RenaissanceRe Holdings Ltd.	NYS	41.75	2.14	-5.38	50.00	33.50	212
Risk Capital Holdings	NDQ	22.25	-1.25	0.00	24.00	16.00	54
RLI Corp.	NYS	49.56	3.93	-0.50	50.38	30.50	109
St. Paul Companies	NYS	87.03	-0.96	6.05	88.13	60.88	3266
SCOR	NYS	51.00	3.95	6.81	52.13	35.25	50
SAFECO Corp.	NDQ	49.94	2.70	2.44	55.38	37.50	2590
SCPIE Holdings Inc.	NYS	28.50	3.40	-1.51	32.13	19.13	NA
Selbels Bruce Group	NDQ	7.13	0.00	-5.00	9.50	5.88	108
Selective Ins. Group	NDQ	26.00	4.79	-3.70	28.63	19.00	206
Tera Nova Insurance Co. Ltd.	NYS	25.25	2.54	-3.81	30.00	18.00	95
TIG Holdings	NYS	26.81	-20.41	-19.21	38.00	26.38	1969
Tokio Marine & Fire	NDQ	55.50	-4.31	-3.90	66.00	41.25	80
Torchmark Corp.	NYS	41.75	0.30	-1.04	44.25	25.50	1431
Transatlantic Holdings	NYS	71.56	-0.35	0.09	76.56	51.75	95
Travelers Property	NYS	41.75	-4.84	-5.11	46.06	31.38	1226
Travelers Corp.	NYS	49.63	3.52	-7.89	57.38	30.88	14750
Trenwick Group Inc.	NDQ	34.75	0.72	-7.64	39.63	31.88	52
Unico American Corp.	NDQ	12.00	-2.04	-2.04	14.13	9.63	24
United Fire & Casualty	NDQ	42.75	1.79	-3.39	47.00	30.00	14
Unitrin	NDQ	62.38	1.94	-3.48	68.50	48.50	418
UNUM Corp.	NYS	48.63	-0.77	-10.57	54.63	33.63	1890
USF&G Corp.	NYS	23.88	-1.04	8.22	25.50	15.63	10045
Vesta Insurance Co.	NYS	56.50	-9.42	-4.84	64.75	32.75	632
Zenith National Ins.	NYS	25.06	-1.23	-2.67	28.75	24.50	19
INSURERS/REINSURERS	AVERAGE			1.06	-0.80		
HEALTH MAINTENANCE ORGANIZATIONS							
Humana Inc.	NYS	20.06	2.88	-3.31	25.31	17.63	2212
Oxford Health Plans	NDQ	17.50	19.15	12.45	89.00	13.75	10645
Pacificare Health Sys.	NDQ	56.13	-2.81	11.69	85.63	46.75	212
Safeguard Health Enter.	NDQ	8.25	-2.94	-38.89	17.13	8.13	17
Sierra Health Services	NYS	32.44	-1.70	-3.53	41.63	23.75	108
United Healthcare Corp.	NYS	51.25	8.32	3.14	60.13	42.44	4197
Wellpoint Health Networks	NYS	49.00	-0.13	15.98	61.13	32.50	810
HMOs	AVERAGE			3.25	-0.35		
ALL COMPANIES	AVERAGE			1.91	-0.82		

Top advancing issues: American Bankers Ins., Oxford Health Plans, HCC Insurance Holdings. Leading decliners: TIG Holdings, Vesta Insurance Co., Philadelphia Cons. Holding. Most active issue: Travelers Corp. The *BI* Index rose 0.8%; the Dow Jones 30 Industrials gained 2.7%; the S&P 500 increased 2.4% and the NYSE Composite gained 2.0%. Average P/E: Brokers, 18.1; Insurers/reinsurers, 40.4; HMOs, 20.8.

Source: *Nordby International Inc.* (nordby.com), Boulder, Colo.

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