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UPDATES

Utilities' woes may generate financial guarantee claims

Financial guarantee insurers and reinsurers face potential losses of millions of dollars in the wake of financial problems for two California utilities.

But insurers and rating agency analysts say they do not anticipate potential losses stemming from the difficulties of Pacific Gas & Electric Co. and of Southern California Edison to create devastating losses for the financial guarantee companies. And any losses that do occur are not

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Washington expands CGL cover

Liability for others' pollution is insured: Court

By DAVE LENCKUS

OLYMPIA, Wash.—Comprehensive general liability insurance policyholders nationwide likely will cite a Washington Supreme Court decision to expand pollution cleanup coverage to policyholders that must clean sites contaminated solely by third parties during the policyholders' coverage periods.

Policyholder and insurer attorneys say they believe that the case, which drew amicus briefs from insurance industry groups, marks the first time a state supreme court has ruled on that pollution coverage issue.

The 5-4 decision on Dec. 21, 2000, aids policyholders seeking coverage under pre-1986 general liability policies that contained sudden and accidental pollution exclusions. Many courts, including Washington's high court, have ruled that exclusion does not bar policyholders from recovering pollution cleanup coverage even in cases of gradual pollution, as long as the policyholder neither expected nor intended to pollute.

Under federal and state environmental laws, many of those policyholders seeking coverage face the full or the major cost of cleaning up waste sites, because most of the other companies that dumped waste there have gone out of business.

Attorneys involved in the case decided by Washington's high court said their clients would not allow them to comment on the ruling.

Other attorneys, though, disagreed over the ruling's significance and potential impact on future pollution coverage litigation nationwide.

"I think it was a very strong victory for policyholders and continues the trend in Washington toward reading a policy as broadly as it was intended to apply to a broad range of pollution damages," said policyholder attorney Paul J. Lawrence, a partner with Preston Gates Ellis L.L.P. in Seattle.

Mr. Lawrence, who persuaded the court in a previous case to limit the sudden and accidental pollution exclusion's applicability, predicted that the court's most recent decision would influence other courts. Courts in other juris-

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New guidance for compliance with COBRA

By JERRY GEISEL

WASHINGTON—Nearly 15 years after Congress passed the landmark COBRA health care statute, the Internal Revenue Service is nearly finished issuing regulations that will help employers comply with the law.

Enacted in 1986, COBRA—short for Consolidated Omnibus Budget Reconciliation Act—requires employers to extend, in certain situations, coverage under their group health care plans to former employees and employees' widowed, divorced or separated spouses.

For example, if an employee quits or is terminated, the employee can continue his or her prior coverage for 18 months. If a dependent, such as a spouse, loses coverage due to the death of an employee or a divorce, the dependent can continue coverage for 36 months. Employers can

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IRS offers other benefit guidance...page 24

Lawyers watching airline case

Court expands wiretap law

By JUDY GREENWALD

SAN FRANCISCO—A federal appeals court ruling that an employer violated the federal wiretap law by allegedly gaining unauthorized access to an employee's personal Web site will have much broader implications beyond the employee privacy issues in this particular case, attorneys predict.

In particular, they say, the decision offers companies and individuals added legal protection for unauthorized access of proprietary data on their Web sites.

The Jan. 8 decision by the 9th U.S. Circuit Court of Appeals in *Robert C. Konop vs. Hawaiian Airlines Inc.* is the first to hold that password-protected Web sites are covered by the federal wiretap law. The unanimous opinion by the three-judge panel is expected to be influential in similar cases before federal courts nationwide.

Because it may conflict with another appellate court decision, however, many attorneys expect this issue ultimately will be determined by the U.S. Supreme Court. Hawaiian Airlines has not decided whether to appeal the decision. Congress also may consider legislation addressing issues raised by the case.

While the telecommunications aspects of the case are likely to receive the most attention, employment attorneys say the case also highlights the importance of employers exercising care in respecting employees' privacy.

According to the decision, Mr. Konop, a Hawaiian Airlines pilot, operated a Web site on which he was critical of both the airline and the Airline Pilots Assn. union. He controlled access to the site by requiring visitors to log in with a user name

See **Wiretap** *on page 25*

Long-awaited study adds fuel to debate on ergonomics rule

By MARK A. HOFMANN

WASHINGTON—Both sides in the ongoing debate over a federal ergonomics standard claim that the results of a long-awaited National Academy of Sciences' study of musculoskeletal disorders and the workplace bolster their respective positions.

The congressionally funded study, which was released last week, holds that certain MSDs can be attributed to jobs and workplace conditions and that well-designed intervention can help reduce MSDs. But the study also concluded that programs must be tailored to individual workplaces to be effective, and that they must be evaluated over time. In addition, the NAS report called for further research on the issue.

The report did not pass judgment on the Occupational Safety and Health Administration's ergonomics standard, which was issued in November amid a storm of opposition from employers and other groups The standard took effect last week, although most employers have until Oct. 15 to comply with the rule. Congress had wanted OSHA to delay issuing its ergonomics rule until the NAS had finished its research, but OSHA published its final rule in the Nov. 14, 2000, Federal Register, more than two months before the 19-member NAS panel released its report.

The rule drew a flurry of petitions seeking federal judicial review of the measure on a variety of grounds.

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Benefits: Improving quality
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UPDATES

Utilities' woes may hit insurers

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expected to threaten the primary insurers' AAA ratings, analysts say.

As California businesses and residents continue to face rolling blackouts and the utilities hover on the edge of bankruptcy, analysts note that if the utilities do default on bond payments, the insurers' obligation would be to pay principal and interest as they come due, rather than a lump sum. Furthermore, because a significant percentage of the bonds these companies insured were secured by mortgages, insurers can expect to recover at least part of any payments they must make.

The most heavily exposed company—and the only one to announce an expected claim to date—is Armonk, N.Y.-based MBIA Inc. MBIA, the largest financial guarantee insurer, announced Wednesday it expects claims of about $660,000 as a result of Southern California Edison's missed debt interest payments on two bond issues that were due Jan. 15.

As of Dec. 31, MBIA had direct net par exposure of about $445 million to SoCal Edison and $590 million to PG&E.

Other financial guarantee insurers with exposures include:

- Bermuda-based ACE Ltd., which said its ACE Financial Services Inc. subsidiary has about $140 million in aggregate exposure from the two utilities. This includes $14 million in bond reinsurance and $125 million in senior unsecured exposure through credit default swaps. ACE said, however, that any loss would be substantially less and that any financial statement impact for ACE would be mitigated by existing reserves.
- New York-based AMBAC Financial Group, which has $75.1 million in insured net par exposure to SoCal Edison and $72.6 million to PG&E.
- New York-based Enhance Financial Services Group Inc., which has a $28.8 million exposure through its reinsurance and insurance operations.
- New York-based Financial Security Assurance Inc., which has a total net exposure of $19 million.
- New York-based Financial Guaranty Insurance Co., which has a $15 million exposure.
- Bermuda-based RAM Reinsurance Co., which has about a $10 million exposure.

Plan expense rules clarified

WASHINGTON—Long-awaited guidance released last week by the U.S. Department of Labor spells out the benefit plan expenses that employers must bear and those the plans themselves could pay.

The guidance overturns a position taken by the department's Kansas City, Mo., office. That office held that, in many situations, expenses had to be apportioned between employers and plans. The Kansas City office, in auditing pension plans, maintained that, because employers derive benefits from plans—such as tax deductions for contributions—they should pick up part of certain expenses for administration and communications.

Benefit experts, however, argued that such apportionment of expenses was not workable, and they sought the new guidance.

In a question-and-answer format, the department sets forth who should pay for certain expenses: the employer or the benefit plan.

For example, the employer must pay for activities that relate to the formation of a benefit plan, such as plan-design studies. In addition, certain statements required by the Financial Accounting Standards Board are considered employer expenses.

On the other hand, expenses incurred to amend a plan to comply with changes in tax law and those for routine non-discrimination testing are "reasonable" expenses that can be paid by the plan.

Costs related to the communication of plan benefits, such as preparing and distributing individual benefit statements and benefit booklets, also could be paid by plans. Employers, however, would have to bear a portion of booklet expenses that relate to "non-plan" matters, such as company picnics or fitness centers.

Blanch exec to head new reinsurer

DALLAS—E.W. Blanch Holdings Inc. Vice Chairman Kaj Ahlmann will resign from the reinsurance broker in March to head a new runoff reinsurer that Blanch may have a role in managing and that will be looking to raise at least $750 million in a private placement.

The reinsurer, dubbed Markitas, is being formed to assume books of business from other insurers or reinsurers that want to shed the liabilities for various reasons, such as impending mergers, Mr. Ahlmann said.

J.P. Morgan & Co. is developing the private offering for Markitas. The final amount of the offering is still being discussed but is pegged at a minimum of $750 million, said Mr. Ahlmann. The reinsurer's domicile also remains under discussion, though Bermuda is being reviewed, he said.

While Blanch would not be a significant investor in Markitas, it might become a shareholder of Markitas' management company, and it could also act as a broker on business reinsured by Markitas, Mr. Ahlmann said.

Ted Blanch Jr., the broker's chairman, noted that Blanch has been in-

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Errors & omissions

- Due to an editing error, the directory listing for Professional Case Management Consultants Inc. on page 18 of this issue contains an incorrect fax number. The correct fax number is 407-647-1395.
- A Jan. 15 story misstated the defendant in a policyholder suit. Kmart Corp. last year sued Lexington Insurance Co.—not FM Global—seeking reimbursement of Y2K remediation costs. In addition, ITT Industries Inc.'s suit against FM Global in Indiana was dismissed, while a mirror suit in New York continues. The reverse was reported in the article. Also, contrary to information provided to *BI*, Stanford University's renewal included a premium increase and no additional risk management services, according to Jeffrey Seilbach, director of risk management at the university.
- A listing in the Jan. 8 issue's 2001 Event Guide provided incorrect dates for the Vermont Captive Insurance Assn. annual conference. The VCIA's 2001 annual conference will be held Aug. 7-10 in Burlington, Vt. For more information, contact Diane Leach at 802-658-8242.

Privacy tops HIAA state list

By MARK A. HOFMANN

WASHINGTON—Of the various health insurance-related issues that state legislatures will confront this year, privacy appears to be the most pervasive, according to the Health Insurance Assn. of America.

Although medical records privacy has been an ongoing legislative issue, the enactment last year of Gramm-Leach-Bliley, the financial services modernization act, which also addresses privacy, will lead to activity in "nearly every state," according to HIAA, which last week released its annual legislative forecast.

States that currently lack medical records privacy laws are "looking at new models from the National Assn. of Insurance Commissioners and the National Conference of Insurance Legislators to bring their states into compliance," HIAA says in its forecast.

Gramm-Leach-Bliley—which broke down Depression-era barriers that kept banks, insurers and securities firms out of each other's business—requires all states to implement consumer protections for personal financial information. Although the act doesn't include health information under its privacy strictures, it defines insurers as "financial institutions." HIAA notes in its forecast that most states likely will tackle the privacy issue by midyear in an effort to comply with the Gramm-Leach-Bliley requirements.

Other privacy issues that states may address this year include compliance with privacy standards recently promulgated by the Department of Health and Human Services, as well as matters involving the Internet and e-commerce, according to HIAA.

While privacy tops the list of health insurance-related issues likely to appear before state legislatures this year, it is far from the only significant matter. Two other big issues that states likely will address include expanding access to prescription drugs and tightening "prompt payment" rules, which require insurers to speed up the reimbursement of health care

See **HIAA** *on page 24*

USDA turns to AICPCU/IAA for employee training

Roots of risk management

By RODD ZOLKOS

WASHINGTON—Facing the dual challenges of a changing mission and high levels of personnel turnover, a federal agency is embarking on an organizationwide risk management training program.

To provide that training, the Risk Management Agency of the U.S. Department of Agriculture turned to the entity that has provided risk management and insurance education to so many individuals in the private sector: the American Institute for Chartered Property Casualty Underwriters/Insurance Institutes of America.

"What's really exciting to us is we've never had a real government customer," said Connie Luthardt, director of the Institutes' Northeast region who worked with John Zirschky, the USDA agency's associate administrator, in crafting the program. "To the best of my knowledge, we have never had a large government contract like this."

The USDA Risk Management Agency administers and oversees all programs authorized under the Federal Crop Insurance Corp.

"We used to be primarily a direct writer of insurance, writing insurance directly to farmers as a federally chartered corporation," Mr. Zirschky said. But since the early 1980s, the corporation has moved more toward reinsuring privately sold crop insurance.

The agency has a workforce of about 540 people and 17 field offices across the country. With annual premiums of about $2.5 billion, "we are right now about the fourth-largest domestic reinsurer," Mr. Zirschky said.

"As we've migrated from being direct writers to reinsurers we have two issues going on," he said.

One is addressing the different skills needed by the agency's staff as a reinsurer than as a direct writer.

See **USDA** *on page 21*

Riskclick aids online collaboration

By JOANNE WOJCIK

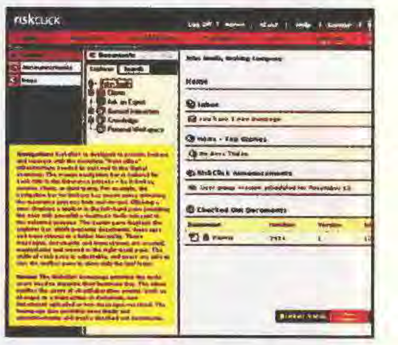
NEW YORK—A London- and New York-based high-tech start-up company formed by former executives of Marsh Inc. and Booz-Allen & Hamilton Inc. is launching an online product that its founders hope will become the insurance industry standard for transacting business via the Internet.

Riskclick Inc.'s e-business infrastructure product will enable brokers, insurers and risk managers to form virtual teams that can work together anywhere, anytime, and share information in real time, said Howard Green, Riskclick's director of marketing. Mr. Green previously was employed by Marsh in London.

Riskclick's e-business infrastructure product also costs less than in-house systems that companies must purchase, install and maintain themselves because it uses an application service provider model, being stored on an offsite server and accessed via the Internet, he added.

But even though users reach Riskclick via the Internet, the application is protected from nonsubscribers because it is hosted in a high-security data center and access is controlled by the latest password security, Mr. Green explained.

Riskclick permits brokers, insurers and insurance buyers—all the parties to an insurance transaction—to communicate on one platform that manages and stores documents, allows multiple users simultaneous access and provides both research tools and transaction support.



Riskclick Inc.'s product permits the sharing of information in real time.

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INSIDE

- It is time for Congress to cut the insurance premiums that employers with fully funded defined benefit pension plans pay to the federal Pension Benefit Guaranty Corp., this week's editorial says. **PAGE 8**
- Several of the world's major airlines are introducing measures aimed at reducing the risk of passengers developing blood clots, the so-called economy-class syndrome, on long-distance flights. **PAGE 19**
- Final Internal Revenue Service regulations will give more flexibility to employers that provide tax-favored transportation benefit programs for their employees. **PAGE 24**
- The Internal Revenue Service has issued proposed regulations that would simplify the calculation of minimum distribution amounts from 401(k) plans and individual retirement accounts. **PAGE 24**

Departments

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BENEFITS: IMPROVING QUALITY

Obstacles remain to putting outcomes data to use

By MICHAEL PRINCE

As employer interest in promoting quality in health care continues to grow, many employers are finding that data on clinical outcomes, which would help them carry out such efforts, is scarce at best.

Employers have realized that a higher level of quality in health care will lead to lower costs and a healthier, more productive workforce, said Dr. David Spratt, vp of medical administration at Crown Cork & Seal Co. Inc. in Philadelphia.

"All of a sudden, the idea of a higher quality and a more efficient health care system has become important," said Michael Millenson, principal with William M. Mercer Inc. in Chicago.

Rising health care costs has been the principal catalyst for employer interest in quality issues, Mr. Millenson said. As part of that, he said, there is a growing interest in enabling employees to make more cost-effective health care decisions. But to make informed decisions, he said, employees need comparative data on health care providers—including data on treatment outcomes.

"We have to give them some information other than price information, so we desperately need performance information," he said. Aiding such efforts is the growth of online technology and services, which allow information to be disseminated easily and inexpensively, Mr. Millenson added.

But employers are finding that such information, particularly data on clinical outcomes, can be difficult to obtain.

Outcomes data, for example, would indicate how patients fared following medical procedures, such as how many patients got infections after surgery or what percentage of patients died following a certain procedure.

The biggest hindrance to obtaining outcomes data is the providers themselves, who are reluctant to disclose such information. In addition, providers often argue that the outcomes data that is publicly available is not reliable.

Outcomes data is not uniform and is not collected "at the state and national levels that will allow you to make interesting comparisons," said Dr. Kenneth Kizer, president and CEO of National Quality Forum in Washington, a public/private nonprofit group created last year to gather quality information and set standards on how to use such data.

Each hospital or region has its own method of collecting data and its own definitions, Dr. Kizer said. So what is classified a "post-op infection" in one hospital may have an en-

See **Outcomes** *on page 4*

Doctors in several nations see deterioration in medical care

By CAROLYN ALDRED

Many doctors in industrialized nations believe that health care in their countries has deteriorated during the last five years, according to a recent survey.

No more than one-quarter of physicians in Australia, Canada, New Zealand, the United Kingdom and the United States—the five nations covered in the study—believe that their ability to deliver effective health care has increased in the last five years, the survey found. Meanwhile, about half the doctors surveyed believe that health care actually has become worse, despite increased health care spending and medical advances.

The survey was conducted by Harris Interactive Inc., a research firm based in Rochester, N.Y. The survey was sponsored by the Harvard School of Public Health in Boston and The Commonwealth Fund, a New York-based non-profit organization focused on promoting health care quality.

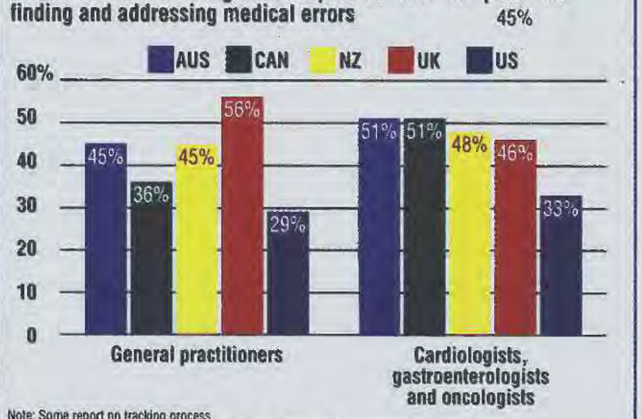
About 400 general practitioners and 100 specialists—cardiologists, gastroenterologists and oncologists—were interviewed by Harris Interactive in each of the five countries during a three-month period last year. The survey covered countries that are heavily dependent on private health insurance as well as those with systems funded largely by the state.

More doctors in North America noted a decline in health care than in the other geographic areas, according to the survey results. In the United States, 56% of generalists and 60% of specialists believe health care standards have dropped, while in Canada the level of dissatisfaction was slightly greater, with 59% of generalists and 67% of specialists responding that their ability to provide quality health care has gotten worse. In New Zealand, 54% of generalists and 42% of specialists pointed to a fall in health care, compared with 45% and 49% in the United Kingdom and 38% and 41% in Australia.

See **Health** *on page 6*

Protecting against medical errors

Percent of doctors rating their hospital as "fair" or "poor" on finding and addressing medical errors



Note: Some report no tracking process
Source: 2000 International Health Policy Survey of Physicians, Commonwealth/Harvard/Harris.

GRAPHIC BY JOHN HALL

Top case management providers

Ranked by 2000 gross revenues from case management services

1	Intracorp	$313,000,000
2	Concentra Managed Care Inc.	$142,000,000
3	CorVel Corp.	$110,000,000
4	GENEX Services Inc.	$96,480,000 [1]
5	Crawford & Co.	$72,000,000
6	National Healthcare Resources Inc.	$46,000,000
7	Private Healthcare Systems Inc.	$26,200,000
8	Horizon Behavioral Services	$23,200,000
9	Resource Opportunities Inc.	$20,000,000
9	Health International Inc.	$20,000,000

1. Estimated.
Firms that derive 100% of case management revenues from insurer/managed care clients or from specialized case management services are not ranked.
Source: *BI* survey.

New models for group plans spur questions about quality

By ROBERTO CENICEROS

Proponents of consumer-directed health care purchasing say that, under this new model, employees—not employers—will promote high-quality health care; but some observers are concerned that a shift to such systems may lower the level of quality, particularly if the consumers make price their principal concern.

Several of the so-called "self-directed models" are still evolving and vary in regard to how they function, and their long-term role in health care purchasing remains unclear. Many of the systems call for employers to provide vouchers or set amounts of money to their employees, who can then pay for the doctors, hospitals or health plans of their choice. In addition, under certain approaches, employees can choose from other options, such as differing copayment levels for a variety of medical services (*BI*, Nov. 6, 2000).

The new plans aim to give employees greater choice with regard to the health care they receive. In addition, such systems seek to reduce the time employers spend on employee health care matters, turning over much of the purchasing responsibility to consumers.

Advocates of these self-directed health care plans say that, employees will shape the health care they receive and, in doing so, will promote high quality, at least to the extent that they consider high quality to be important. The employees will do that via the market forces they exert by spending their health care dollars on specific providers and medical services, they say.

"One of the things about consumers defining quality is they may define it differently than an employer does," said Dr. Lee Newcomer, medical director for Minneapolis-based Vivius Inc. Vivius' focus-group research has found that consumers' main quality consideration is with service, particularly whether physicians listen to their concerns.

"The consumer will drive the push to quality, particularly when you look at our model," Dr. Newcomer said.

Vivius' promotional materials say the company allows employers to take their medical benefits "to a new level, one that moves away from defined benefits and toward a more self-directed plan."

One feature of Vivius' model is that it allows an employee to select a primary care physician and 22 medical specialists for each covered family member. Under the Vivius approach, an employer works with a sponsoring insurer that helps administer the plan. The 23 doctors who make up a member's personalized panel are paid a set fee, an approach that is similar to the way doctors are paid under a capitated system.

Vivius' model lets the doctors compete on the basis of

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INSIDE:

Outcomes

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tirely different label in another, he explained. "That is why doctors and hospitals object to these comparisons being made—because they are often not apples-to-apples comparisons," he said.

Currently, the National Quality Forum is attempting to establish standards to measure the quality of care provided at acute-care hospitals. One measure it is looking at is whether patients are receiving the correct drug when they leave the hospital. And while some of the measures deal directly with patient outcomes, they generally involve drawing inferences from certain so-called process measures, Dr. Kizer explained. Such measures look, for example, at how often a medical provider or facility performs a certain procedure or what prescriptions are being given for particular illness.

Another organization working to raise quality standards in health care, the National Committee for Quality Assurance, focuses on health plans, rather than specific providers or facilities. The NCQA, in assessing health plan quality, relies largely upon process measures, such as the percentage of patients advised by a physician to stop smoking and the percentage of heart attack victims who are given a beta-blocker drug, a proven treatment to prevent future heart attacks.

"In an ideal world, we would have outcome measures," said Suzanne Delbanco, executive director of The Leapfrog Group in Washington. Formed last year, The Leapfrog Group is an organization made up of 60 large employers—including General Motors Corp., General Electric Co. and Motorola Inc.—that seeks to use its joint purchasing power to pressure providers to raise the quality of care they provide.

Because of the difficulty of obtaining outcomes data, The Leapfrog Group also relies largely upon process measures, such as the number of times a hospital performs a procedure, in measuring the quality of providers and hospitals. Although such measures often are reliable alternatives to actual outcomes data, they still fall short of the ideal, Ms. Delbanco said.

She also noted that provider perceptions of outcomes data have frustrated employers' efforts to make use of such information.

When quality ratings are assigned to providers, she explained, the low scorers often contend that they have sicker patients than their peers and that the rating does not reflect such differences. And because there is no consensus with regard to the methods used to "risk-adjust" this data, the lower-rated providers often attack the conclusions, Ms. Delbanco explained.

Although the difficulty in obtaining information is not new, employers' response to that challenge is changing, observers note.

"There is a lot more awareness by employers that providers are not reporting publicly their outcomes," Ms. Delbanco said.

Perhaps more importantly, some employers are no longer relying upon health plans to provide data and are looking at other ways to get the information, including obtaining it directly from the providers.

"Employers have backed off on the idea that health care plans will provide this information in a useful format," said Derek Kruizenga, director at UNIFI Network in Westport, Conn., a unit of PricewaterhouseCoopers. Mr. Kruizenga said this shift came about because more and more employers understood that health plans lack the size and clout to change how providers practice. Also, the process of collecting data and changing providers' behavior is costly, and plans have not received more money for providing such services.

'In an ideal world, we would have outcome measures,' says Suzanne Delbanco of The Leapfrog Group.

One relatively new source for information is a Web site created by DoctorQuality Inc. in Philadelphia.

The company gathers information—both process and outcomes measures—on hospitals and providers. But rather than give a number or letter grade for each provider, the company lists those providers that meet its proprietary standards, explained Dr. David Shulkin, the company's CEO.

The service is sold to employers, which then provide their employees with access to the site, *www.doctorquality.com*. The company's goal is change the health care system so that high-quality providers are paid more than those that are lower performing, Dr. Shulkin said.

Information for the rating is obtained from billing data, which contains such information as the mortality rate associated with a certain procedure, or the number of times a procedure has been performed. The data is obtained from the federal government, which collects it as part of the Medicare program, and from 27 states that require hospitals to report such information. The company also gathers assessments from patients as well as information on outcomes given by the providers themselves.

Once the data has been gathered and analyzed, employers hope that employees will use the information to choose quality providers, leading, ultimately, to lower overall health care costs for the employer.

"When people focus on quality, there are substantial savings to achieve," Dr. Kizer said.

Ford Motor Co., along with automakers General Motors Co. and DaimlerChrysler Corp., has created a program that rates hospitals in the Detroit metropolitan area. The program started in 1986, and since 1997, the three companies have provided the hospital ratings to their employees and retirees. In 1999, the program was expanded to include five other cities where the automakers have substantial employee populations. The ratings are available to the public at *www.hiag.org*.

"We realized that the natural audience to share this information with is our employees and retirees," said Diane Bechel, manager of health care consumer and community initiatives at Ford in Dearborn, Mich. The group collects data—for example, information on the percent of cardiac patients who are given ACE inhibitors or the amount of time patients waited in an emergency room before being treated—from the hospitals that voluntarily agree to participate in the program. An outside firm analyzes the data and the hospitals are rated from one (below national average) to three stars (above the national average) on a variety of categories. Although the poorly rated hospitals in some cases have attacked the ratings as faulty, numerous facilities have taken their low ratings to heart and have made quality improvements in the low-rated areas, she said.

But more than providers need to change their behavior, observers note. One large question that looms above the entire issue is "if you provide this information, will people use it and will it change their behavior?" said Dr. Shulkin of DoctorQuality.

"If it doesn't change people's behavior, it doesn't add value," he said. BI

Health

Continued from page 3

The health care systems in the countries surveyed differ in the way that they are funded, according to an earlier report by The Commonwealth Fund, titled Equity in Health Care across Five Nations.

According to The Commonwealth Fund, most U.S. citizens have private health insurance—often sponsored by employers—while private health insurance in the United Kingdom still plays a minor role. Meanwhile, the public health systems in Australia and New Zealand are relying increasingly on user fees to provide basic public health care. Many citizens in these countries also depend relatively heavily on private health insurance to supplement the public benefits.

Canada prohibits health insurers from covering benefits included in the national plan and, like the United Kingdom, generally covers medical costs in full for included benefits. Canada's state-provided benefit package, though, is less comprehensive than is the United Kingdom's. Private insurance in Canada mainly covers benefits left out of the basic public package, such as prescription drugs.

'These findings are alarming. What's worse is that many doctors in all five countries fear this decline in quality will continue,' says survey author Robert J. Blendon.

Among the major concerns expressed by the doctors in the survey were the inability of hospitals to identify and address medical errors; shortages in health care resources, particularly nursing shortages; the inability of doctors to spend more time with their patients; and the number of patients unable to afford care, particularly prescription drugs.

"These findings are alarming. What's worse is that many doctors in all five countries fear this decline in quality will continue," said Robert J. Blendon, the survey's lead author and a professor of health policy at the Harvard School of Public Health.

Thirty-three percent of specialist physicians in the United States rated hospitals' systems for the tracking or correction of medical errors as only fair or poor; approximately half of those in the other four countries—Australia, 51%; Canada, 51%; New Zealand, 48%; the United Kingdom, 46%—also rated those systems as only fair or poor. The percentages of generalists who reported fair or poor tracking of correction of hospital medical errors were similar—29% in the United States, 45% in Australia and New Zealand, 36% in Canada, and 56% in the United Kingdom. Many doctors said they are discouraged from—or, at least, not encouraged to—report errors.

When asked about hospital resources, the doctors identified a shortage of nurses as a serious problem. This was true particularly in the United Kingdom, where 83% of the specialists rated nursing levels as fair or poor. Those figures were slightly lower in the other nations but still alarmingly high, with 70% of doctors in New Zealand responding that nursing levels were fair or poor, 66% in Canada, 65% in Australia and 64% in the United States.

While emergency room facilities were described as fair or poor by 62% of Canadian specialists and 55% of British specialists described emergency room facilities as fair or poor, fewer than half the specialists in the other nations reported emergency room facilities to be fair or poor.

Most physicians in Australia, Canada, New Zealand and the United Kingdom expressed concern over the inadequate supply of hospital beds, home care and long-term care facilities. According to the survey, primary care physicians in all five nations also said they did not have enough time to spend with patients; this was particularly the case in the United Kingdom, where 60% of doctors considered time constraints a major problem.

More than half the primary care doctors surveyed outside the United States said that referrals to specialists take too long, with most saying that a 65-year-old patient would have to wait at least six months for a routine hip replacement. Only 1% of U.S. physicians reported a similar delay for this procedure, though.

Most doctors in the United States and New Zealand believe that high out-of-pocket costs "pose a serious barrier to care," according to the study. More than 60% of primary care physicians in the United States and New Zealand said patients often have difficulty affording care, with half of the U.S. doctors stating that drug costs are a major problem for their patients.

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Copies of the survey are available from the Commonwealth Fund at www.cmwf.org *or by calling 888-777-2744.*

Self-direct

Continued from page 3

both price and the more-subjective notion of value, Dr. Newcomer said. Like other proponents of self-directed models, Dr. Newcomer maintains that such competition will spur doctor networks to provide good service in order to attract consumer dollars.

Advocates of the new systems say that doctor networks will have to provide the best care if they want to attract customers and charge market value—or even fees that are above market value—for their services.

But skeptics maintain that, if employers back away from their quality initiatives and turn over purchasing responsibility to employees, it is likely that quality standards will drop, particularly if price becomes the principal motivator.

"There are ways that quality can become part of the process," said Eileen Raney, e-business leader in the Human Capital Advisory Services for Deloitte & Touche L.L.P. in Los Angeles. "But we may swing the pendulum so far back to choice that we may ignore that."

In addition, she said, it is not clear yet whether doctors who are vying for customers will compete more on the basis of price than on quality.

Ms. Raney is not alone in her concern that quality could go by the wayside under such systems.

"I think the intermediaries in this approach will not be motivated to spend as much time dealing with quality as employers do," said Rich Ostuw, global health care practices director for Watson Wyatt Worldwide in Stamford, Conn.

The models' role in promoting quality will be to provide information to employees, Mr. Ostuw said. But the information provided may be minimal and likely will be used by only a small number of employees, chiefly those who are already assertive about researching their providers, he said.

'I think the intermediaries in this approach will not be motivated to spend as much time dealing with quality as employers do,' says Rich Ostuw of Watson Wyatt.

"Therefore, I think, there will be nothing," Mr. Ostuw said.

Indeed, some leading advocates for high-quality health care, such as the Leapfrog Group, which consists of 60 employer members (*BI*, Nov. 20, 2000), say the best way to make a difference is for employers to use their purchasing power, individually and collectively, to recognize and reward those care providers that produce the best outcomes.

But several of the companies developing self-directed systems assert that they plan to influence quality precisely by making more information about medical providers available to consumers. They point out that most of the information about quality that is now available focuses on health plans overall, rather than on the individual physicians who provide the care—a point with which consultants do not disagree.

Currently, the various models make available only limited consumer information about a provider, such as his or her educational background and specialty, data about consumer satisfaction with office visits and comparisons of the provider's charges with those of other physicians.

Tony Miller, chief executive officer for Minneapolis-based Definity Health, said consumers need information on physicians' clinical outcomes. But providers won't make such information available, Mr. Miller said, unless doctor reimbursement is directly tied to outcomes. If such a connection were to be made, he said, physicians who would want to charge more for their services would eventually have to show consumers they can consistently produce good medical outcomes as well as provide good service.

Under Definity's model, employers fund employee personal care accounts, which can be spent on doctor visits, alternative care, pharmaceuticals and other health care services. Employees also are covered under a high-deductible plan for catastrophic events, and preventative care is covered on a first-dollar basis. Definity contracts with discounted doctor networks, and employees who wish to obtain services outside of the network can do so at greater cost.

Definity Health will promote quality by pushing providers in its networks to make available more information about their services, including data on outcomes, Mr. Miller said.

But Ms. Raney of Deloitte & Touche said that the new models may not be any more successful than established health plans and employers have been in obtaining more clinical-outcomes data on physician practices.

Other companies in the still-emerging self-directed health care market include Minneapolis-based eBenX Inc. The company, which already helps large employers administer their health care benefits, is counting on the emergence of defined contribution systems, according to Chairman Mark Tierney. To help employers in that arena, eBenX plans to launch pilot programs that would enable employers to provide self-directed health care plans, Mr. Tierney said.

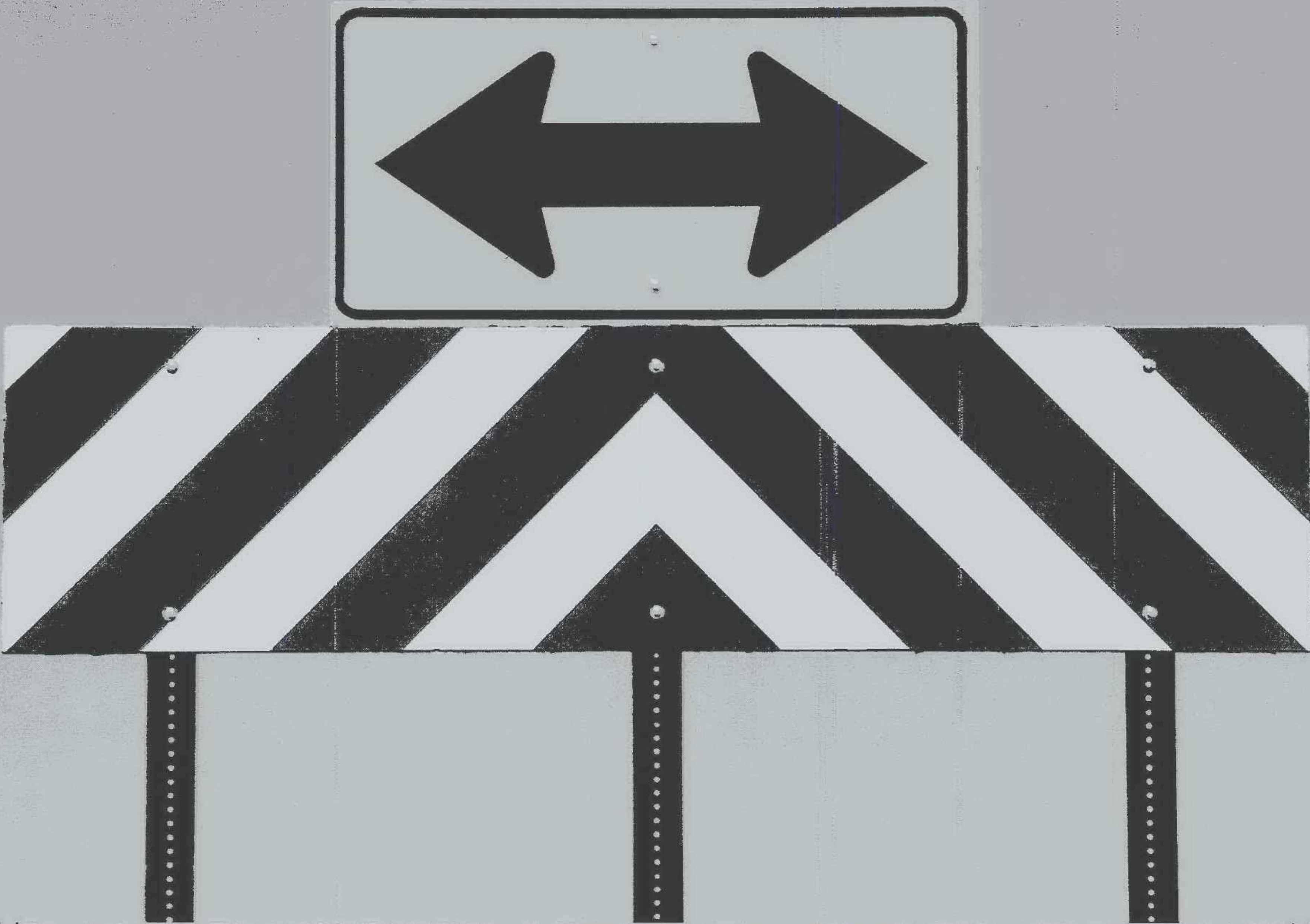
Under one such approach, eBenX would set up an online exchange that an employee could access using a personal identification number. The employee would use the exchange to buy health care services with employer-provided vouchers. By making their own contributions, employees could buy additional health care services or buy up from a basic employer plan.

In addition, in response to employer and consumer interest in health care quality issues, eBenX will eventually provide information on quality, such as reports provided by the National Committee for Quality Assurance, Mr. Tierney said. But because perceptions of quality are subjective, Mr. Tierney acknowledged that some employees may be motivated principally by price under such a system.

Thomas J. Davies, regional health care manager for Verizon Communications in San Ramon, Calif., said he welcomes the emergence of new health plan designs that will make it easier for corporations to manage their health care costs while offering employees greater choice.

Quality does not have to suffer as long as employers remain involved and insist on obtaining information for their employees, he said.

"Employers that are the thought leaders today in quality improvement—the groups that are active in the coalition movement and committed to value pricing—are not going to abandon quality," Mr. Davies said. BI



OPINIONS

Cut the PBGC's premiums

"I THINK WE CAN START SCALING BACK ON HIS SUPPLEMENTS!"

It is time for Congress to cut the insurance premiums that employers with fully funded defined benefit pension plans pay to the federal Pension Benefit Guaranty Corp.

Ever since the agency's financial situation moved in the late 1990s to having a surplus from a deficit, many have urged that premiums be cut. We have opposed those calls, though, arguing as recently as last year that it was too soon. Despite the remarkable financial turnaround of the PBGC, we said, there was still enough uncertainty about the duration of this turnaround and whether the agency could withstand an economic downturn.

Now, however, the evidence in support of trimming the premiums for employers with fully funded plans is overwhelming.

Not least of those signs is the recommendation of David Strauss, the agency's outgoing executive director, who supports reducing the premiums paid by employers with well-funded plans (*BI*, Jan. 15).

The PBGC was created to guarantee workers' and retirees' pension benefits. The agency's surplus in its insurance program for single-employer plans now exceeds $10 billion, up from $7 billion in 1999 and a sea change from the nearly $3 billion deficit the agency faced in 1993, which was the PBGC's low point.

Not only is the PBGC's surplus now more substantial, it also is roughly double what the agency calls its reasonably possible exposures: underfunded pension plans sponsored by employers with below investment-grade bond ratings. In short, even if the PBGC is hit with a big loss, it has ample resources to cover the exposure without significantly eroding its cushion.

Currently, employers with fully or overfunded pension plans pay the PBGC an annual premium of $19 for each person in their pension plans, or a total of about $650 million a year. While a premium cut would reduce its revenue flow, the PBGC can well afford a reduction in premium income. Last year alone, it earned about $2.4 billion in investment income on assets it holds.

While the agency's financial health is much better today, the risk of assuming responsibility for underfunded plans has not disappeared. Many companies in the domestic steel industry, for example, are in financial trouble and some companies with significantly underfunded pension plans could fail. But that exposure has been reduced thanks to a 1994 law that eliminated many of the loopholes that made it relatively easy for employers to underfund their pension plans. Because of that law, the size of these potential losses likely will be much less than before the law was enacted.

Cutting premiums would send a very positive message to employers. Just as they have had to pay higher premiums when losses from terminated plans the PBGC took over proved higher than expected, they now should enjoy lower premiums as the PBGC's financial condition has dramatically improved.

It would be naive to believe that lowering PBGC premiums by itself would reverse the ongoing decline in the number of employers that offer defined benefit plans. For that to happen, Congress, in addition to cutting PBGC premiums, would need to take other, more far-reaching steps, such as boosting the maximum benefits that can be funded through the plans and eliminating many of the complex rules that discourage employers from offering the plans. Toward that end, we are pleased to see Sen. Charles Grassley, R-Iowa, the new chairman of the Senate Finance Committee, is readying legislation for imminent introduction that would do just that.

Meanwhile, employers owe a debt of gratitude to the PBGC's outgoing executive director.

Mr. Strauss did his best during his three and one-half years at the helm of the PBGC to eliminate some of the hassles that employers faced in dealing with the agency. Mr. Strauss, for example, directed the trimming back of a premium audit program, reducing administrative burdens on employers while still protecting the fiscal integrity of a vital program. Other welcome changes during his tenure included giving employers written guidance on when the agency would intervene in corporate transactions involving employers with underfunded plans and making it much easier for employers to get their questions answered by PBGC officials.

From the start, Mr. Strauss said he viewed employers as customers. We hope that refreshing attitude is maintained by whomever George W. Bush names to succeed Mr. Strauss as head of the PBGC.

And we hope that Congress agrees that the PBGC's customers deserve a break on the price they pay for federal insurance protection for benefits promised to their pension plan participants.

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SPOTLIGHT REPORT

Medical errors are top consumer quality concern: Study

By LEE FLETCHER

The frequency of medical errors and malpractice suits are among the principal measures many Americans use to gauge the quality of physicians, hospitals and health plans, a recent survey found.

The survey was conducted jointly by the Henry J. Kaiser Family Foundation and the Agency for Healthcare Research and Quality, which is part of the U.S. Department of Health and Human Services. It found that patients look most often to the number of medical errors committed and the number of malpractice liability suits filed against a provider when evaluating quality.

Quality continues to be one of Americans' "biggest concerns when choosing a health plan or choosing a provider. First and foremost, you don't want to be harmed or have a bad treatment outcome when you're getting medical care," said Mollyann Brodie, vp of public opinion and media research at the Kaiser Family Foundation in Menlo Park, Calif.

Although consumers' main concern is with medical errors, another important factor is the medical experience of a physician, hospital or health plan, Ms. Brodie said.

In addition to identifying the factors that consumers consider important to quality, the study examined consumers' sources of data.

The survey found that 61% of respondents believe that employers are not a good source of information about health care quality. Reasons include suspicion that the employer's primary concern is cost, the study said.

Sixty-seven percent, however, cited the opinions of family and friends as good sources of information about health plans, the study found.

The average person, "when push comes to shove," is going to rely on the recommendations and the advice of people with whom he or she is familiar, Ms. Brodie said.

"In fact, while your family and friends might not know whether the provider is an expert at delivering the procedures, they know how they were treated while they were there and they know whether their issue was resolved or not," she said.

Additionally, the survey found that, currently, Americans are more likely to recognize that there are big differences in the quality of local health plans, hospitals and specialists than they were in 1996, when Kaiser conducted a similar survey. Fifty-five percent of Americans surveyed in the recent poll said there are big differences in the quality of care among local health plans, compared with only 47% in the 1996 study. The survey results were based on a random telephone poll of 2,014 adults nationwide.

Health care consultants and other observers suggest that consumers need to consider several issues in assessing the quality of health care providers and facilities.

Karen Ignagni, president and chief executive officer of the American Assn. of Health Plans in Washington, said that "we need to get consumers to use measures of quality," such as how frequently certain medical procedures are performed. Health care providers' "experience and effectiveness are very important variables," Ms. Ignagni said.

Mary Case, New York-based principal with Unifi Network, a unit of PricewaterhouseCoopers L.L.P., said health care purchasing is not something that people carefully research. "Right now, I think a lot of people don't go into Consumer Reports the way they do when they buy a printer or a car," she said.

That's starting to change in some quarters, though, because of the growth of information that is available on the Internet, according to Ms. Case.

Right now, employees take little responsibility when it comes to choosing health care, she said.

"The employer selects the plan, selects the vendor, designs the benefits. The employee has one time a year when he makes a choice at open enrollment and then he's stuck. You've completely delegated responsibility over this stuff to someone else," she said.

Ms. Case said that employees, in order to become more educated consumers, must take more responsibility in the process.

Helen Darling, a senior consultant with Watson Wyatt Worldwide in Stamford, Conn., said that although discussions of medical errors may be sobering, it's important that the public now is getting this message.

"The medical field has known about patient safety and medical errors as an issue for many, many years. Some of the studies actually were done five or 10 years ago. It's safe to say that we've had solid evidence, multiple studies of high quality, documenting this problem," Ms. Darling said.

Michael Millenson, Chicago-based principal with the health care practice at William M. Mercer Inc., emphasized that much more medical information, including malpractice statistics, is available today than was available just five years ago.

"I think that given the fact that most people have not seen quality information, there's a groundswell of people who are understanding how important that information can be. It validates what leading-edge employers are doing to promote the dissemination of quality of care information," Mr. Millenson said.

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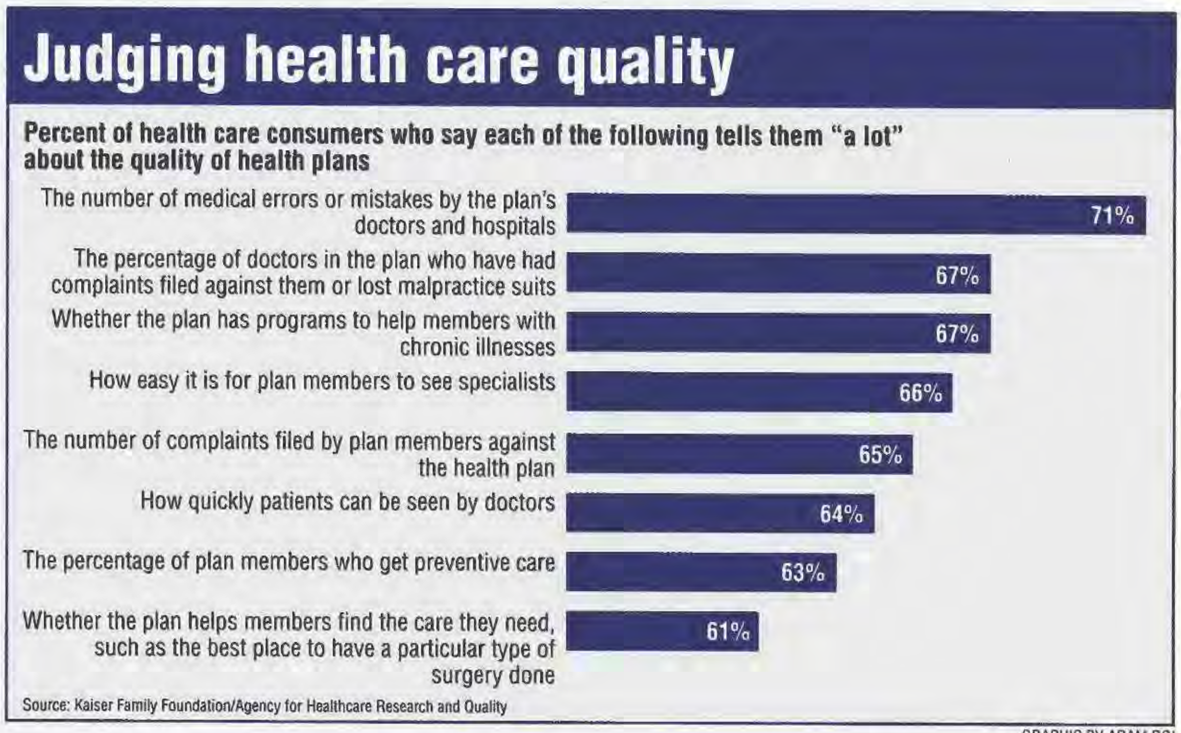
Copies of "National Survey on Americans as Health Care Consumers: An Update on the Role of Quality Information" are available online at www.kff.org.



GRAPHIC BY ADAM DOI

Tougher privacy rules seen as threat to research, care

By LEE FLETCHER

Few would argue against an individual's right to privacy, but if federal privacy protections restrict medical researchers' access to patient information, concern is being raised about whether the quality of health care could suffer.

"People will say, 'I can't do it, so I will no longer do the research, do studies of quality,' because the front-end costs of getting the permission of hundreds or thousands of people" to use their medical information will be so high, said Helen Darling, a Stamford, Conn.-based senior consultant with Watson Wyatt Worldwide.

Ms. Darling said that adequate privacy safeguards already were in place in most states when the Department of Health and Human Services released new federal privacy regulations in late December. Although the new regulations provide a wall of privacy for consumers, they will do more harm than good and will jeopardize future medical research, she said.

The final privacy rules, which take effect in two years, will require health plans and health providers to disclose how medical information is used and to whom it is released. Under most circumstances, physicians will have to get written permission from patients before releasing information—even for routine purposes. Self-insured employers won't be allowed access to medical information for purposes unrelated to health care (*BI*, Jan. 1).

"The concern here is that the regulations have taken a big leap forward without any recognition of the importance and the need to do quality studies. Frankly, biomedical research—all research—is affected by this because so much of it is based on data about patients," said Ms. Darling.

Karen Ignagni, president and chief executive officer of the Washington-based American Assn. of Health Plans, said the AAHP's concern, with respect to the new regulations, is that "the balance is off" between a provider's need for information and a patient's right to privacy, which could reduce the quality of care.

"There is a requirement now that there be a judgment made by a range of individuals who have access to patient records about the minimum data necessary for a practitioner to treat a patient," Ms. Ignagni said.

She said that, from the beginning of discussions about privacy rules, the AAHP has maintained that having individuals other than a patient's physician making such judgments is ill-advised.

"Even if the individuals are the primary care physicians, they may inadvertently leave something out that's important for a specialist to know," Ms. Ignagni said.

Far more attention needs to be paid to the issue of who controls access to patient data, according to Ms. Ignagni.

'The concern here is that the regulations have taken a big leap forward without any recognition of the importance and the need to do quality studies,' says Helen Darling.

"It could affect how a patient is treated; it could affect decisions that physicians make. And, I think, experience dictates that physicians need more, not less, information," Ms. Ignagni said.

Mary Case, a New York-based principal with Unifi Network, a unit of PricewaterhouseCoopers L.L.P., expressed less concern about the new regulations. She said that it is often sufficient, when analyzing the quality of a health care program, to look at trends and to rely more on aggregate information than at specific personal medical histories.

"For an employer or any entity seeking to discern quality, the individually identifiable part is not going to be that essential. So, on that level, it is not going to be a problem," Ms. Case said.

It is important, though, that an individual be able to obtain health care without fearing that his or her job could be in jeopardy because of medical data available to his or her employer, she said.

"The concern is making sure that employers are really trying to do the right thing, (which is to) manage plans carefully and design them to be responsive and cost-effective," Ms. Case said.

Alissa Fox, vp and executive director of policy for the Blue Cross & Blue Shield Assn. in Washington, said the Blues association needs to assess the regulations and determine what they mean for its consumers, subscribers and its employer count. Additionally, she said, Blue Cross needs to examine how the regulations will affect its approaches to dealing with providers, doctors and hospitals.

Because the new regulations encompass not only disclosure but also the use of information, Ms. Fox said, "you almost need to go little division by division throughout a health plan's entity to think through what you're going to use and disclose the information for."

"We're having more questions than we are answers right now," she said.

Susan Kornetsky, an attorney in William M. Mercer Inc.'s Washington Resource Group, said the greatest burden of complying with the privacy regulations is going to be on those companies that provide health plan administration services.

"There will be a level of complexity that wasn't there before. We'll have to train a workforce about policy and procedures," Ms. Kornetsky said.

But Watson's Ms. Darling finds some irony in that those in the just-ended Clinton administration who created the new rules may find themselves frustrated by the rules' implementation. "Maybe some of the people who put the regulations together, now that they'll be working in the private sector, will discover that they're suddenly not going to be able to do things that, I think, they would agree are valuable," she said.

"When they see what this does to the quality movement and research in all these areas—especially over the next five years while we get it sorted out—maybe they will go back and say, 'We were overly aggressive on this,'" Ms. Darling said.

BI directory of case management providers

A

AHC (Associates for Health Care Inc.)

P.O. Box 981,
Brookfield, Wis. 53008-0981;
800-952-8661; fax: 262-879-0876
www.ahcppo.com

2000 revenues
Total gross revenues $10,000,000
Case management revenues $4,000,000

Staff
Total case management employees 10
Medical professionals/full-time 1
Physicians 1
Total medical professionals on retainer 18
Physicians on retainer 18

Clients
Total 332

Covered lives/managed cases
Total cases managed 19,115
Employer clients 50%
Insurer/managed care clients 50%

Case management services: telephone case management, patient education, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management.

Officers: Richard L. Blomquist, president/CEO; Richard Nemitz, COO; David Dobias, senior vp-administration.

Contact: Dirk W. Carson, vp-marketing; 800-952-8661, ext. 3032; dcarson@ahcppo.com.

Action Healthcare Management

301 E. Bethany Home Road, Suite C-278,
Phoenix, Ariz. 85012;
602-265-0681; fax: 602-265-0202
www.actionhealthcare.com

2000 revenues
Total gross revenues $950,000
Case management revenues $700,000

Staff
Total case management employees 12
Certified Case Managers 6
Medical professionals/full-time 15
Physicians 2
Registered nurses 6
Licensed practical nurses 1
Total medical professionals on retainer 2
Nurses on retainer 2

Clients
Total 110
Corporate/institutional employer clients 45

Covered lives/managed cases
Total cases managed 1,500
Employer clients 26%
Insurer/managed care clients 72%

Case management services: telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per case, $350 to $600; per hour, $95 to $105; percent of savings, 25%.

Branch offices: Carlsbad, Calif.

Contact: Jean Rice, president/CEO; 800-433-6915; jeanr@actionhealthcare.com.

ADVO-CARE

103 Laurel Lane,
Branson West, Mo. 65737;
417-338-9871; fax: 417-338-9112

2000 revenues
Total gross revenues $50,000

Staff
Total case management employees 1
Certified Case Managers 1
Medical professionals/full-time 1

Clients
Total 58
Corporate/institutional employer clients 30

Covered lives/managed cases
Total cases managed 58
Employer clients 50%
Insurer/managed care clients 50%
Workers compensation claims 99%
Group health claims 1%

Case management services: onsite case management, telephone case management, referrals to alternative settings.

Health care services: physical therapy/rehabilitation, home health care, workers compensation, short-/long-term disability.

Compensation: per hour, $65.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards.

Officers: Sharon Peterson.

Explanation of terms

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

To be included, companies were required to report their gross revenues for last year or to provide an acceptable estimate.

BI defines case management as coordinating and monitoring of treatment for catastrophic, complex or prolonged illnesses and injuries. Case management services include discharge planning, onsite or telephone case reviews and/or patient referrals, as well as the management of communication among patients, providers and payers throughout the course of a claim.

Each listing begins with the company name and address. Listed next is information on **2000 revenues**, including total gross revenues and the amount of revenues generated by case management services.

Staff information provided includes total staff assigned to case management as well as a breakout of total professional staff members and staff members on retainer. Figures are provided in full-time equivalents, except for staff on retainer.

Business volume is represented by the number of case management **clients**; **covered lives**, including employee benefit plan and workers compensation lives served as well as the percentage of claims that were workers compensation vs. those that were group health.

Specific **services** the company provides are also listed, followed how a section on how the company charges for its services. If applicable, the company's **American Accreditation HealthCare Commission/URAC status** is noted.

Branch offices are also listed, as are the names and titles of **officers** and a **contact** for readers seeking additional information.

This directory is published as an editorial service; there is no charge to be listed. Directory listings are based on each company's response to a *BI* questionnaire. Although every effort is made to publish complete and accurate listings, *BI* is unable to verify all information.

If your company would like to be included in next year's directory of case management service providers, please contact the *Business Insurance* directory department at 312-649-5313.

Alicare Medical Management

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800-863-8688; fax: 603-894-7067
www.alicaremed.com

2000 revenues
Total gross revenues $4,390,000
Case management revenues $300,000

Staff
Total case management employees 4
Certified Case Managers 2
Medical professionals/full-time 14
Physicians 1
Registered nurses 12
Licensed practical nurses 1
Total medical professionals on retainer 60
Physicians on retainer 40
Nurses on retainer 20

Clients
Total 56
Corporate/institutional employer clients 24

Covered lives/managed cases
Total cases managed 165
Employer clients 50%
Insurer/managed care clients 50%
Group health claims 100%

Case management services: onsite case management, telephone case management, patient education, online case reports, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per employee per month; per case; per hour; flat fee; percent of savings.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Officers: Claire Levitt, president; Annette Duclos-Watson, vp/COO; Seth Lewin, medical director.

Contact: Cynthia Hom, national sales executive.

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3525 Quakerbridge Road,
Hamilton, N.J. 08619;
609-631-0474; fax: 609-631-7642
www.altaservices.com

2000 revenues
Total gross revenues $24,000,000
Case management revenues $8,000,000

Staff
Total case management employees 80
Certified Case Managers 65
Medical professionals/full-time 93
Physicians 3
Registered nurses 75
Licensed practical nurses 15
Total medical professionals on retainer 3
Physicians on retainer 2
Nurses on retainer 1

Clients
Total 30,000
Corporate/institutional employer clients 30,000

Covered lives/managed cases
Total cases managed 35,000
Employer clients 75%
Insurer/managed care clients 25%
Workers compensation claims 75%
Group health claims 25%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, workers compensation, short-/long-term disability, skilled nursing facilities.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per employee per month, $5 to $20; per hour, $75 to $95; percent of savings, 25% to 45%.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: Sarasota, Fla.

Officers: Richard Eskow, president; William McPhaden, John Whitehead, senior vps.

Contact: Wiliam McPhaden; 609-631-0474, ext. 202; william.mcphaden@altaservices.com.

American Health Holding Inc.

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

2000 revenues
Total gross revenues $10,000,000
Case management revenues $2,300,000

Staff
Total case management employees 42
Certified Case Managers 8
Medical professionals/full-time 89*
Physicians 1
Registered nurses 88
Total medical professionals on retainer 16*
Physicians on retainer 16

Clients
Total 60

Covered lives/managed cases
Total cases managed 3,265
Employer clients 100%
Group health claims 100%

Case management services: telephone case management, patient education, disease management, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, disease management.

Compensation: per employee per month, $0.90; per hour, $87 to $97.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards.

Branch offices: Little Rock, Ark.; Columbus, Ga.; Indianapolis; Carthage, Mo.; Columbus, Ohio; Pittsburgh and Warminster, Pa.

Officers: Ivan Gilbert, chairman; Michael J. Reidelbach, president; Merry P. Korn, senior vp-marketing.

Contact: Merry P. Korn; mkorn@ahhinc.com.

**Medical professionals numbers are for both case management and utilization review management.*

Beech Street Corp.

25500 Commercentre Drive,
Lake Forest, Calif. 92630;
800-877-1444; fax: 949-672-1111
www.beechstreet.com

2000 revenues
Total gross revenues $76,000,000*
Case management revenues $2,400,000

Staff
Total case management employees 19
Certified Case Managers 5
Medical professionals/full-time 38
Physicians 3
Registered nurses 35
Total medical professionals on retainer 8
Physicians on retainer 8

Covered lives/managed cases
Total cases managed 457,000

Case management services: onsite case management, telephone case management, patient education, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per employee per month, $0.50**; per hour, $90 to $135; percent of savings, 30%.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Branch offices: Irvine, Calif.

Officers: Janice Walker, vp-health care management, customer service and network operations; Nancy Neslen, director-health care management; Caroline Aicone, case management supervisor.

Contact: Janice Walker; 800-877-1666; administration@beechstreet.com.

**Estimated. ** Maternity only.*

B

Bluegrass Health Network Inc. & BRI

P.O. Box 436177,
Louisville, Ky. 40253;
502-254-9981; fax: 502-426-5935

2000 revenues
Total gross revenues $3,700,000
Case management revenues $1,700,000

Staff
Total case management employees 25
Certified Case Managers 22
Total medical professionals on retainer 60
Physicians on retainer 55

Clients
Total 100

Covered lives/managed cases
Total cases managed 6,600
Employer clients 35%
Insurer/managed care clients 65%
Workers compensation claims 60%
Group health claims 40%

Case management services: onsite case management, telephone case management, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, written case reports.

Health care services: group health care, dental, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, integrated disability management.

Compensation: per hour, $60 to $90.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Officers: Scott C. Ferguson, president; Maggie Eden, general manager-BRI; Mary Lane Whitty, supervisor.

C

Cambridge Managed Care Services

413 Ceder Brook Drive,
Cranbury, N.J. 08512;
800-662-1170; fax: 609-860-7887
www.cambridgeintegrated.com

2000 revenues
Total gross revenues $22,600,000
Case management revenues $8,400,000

Staff
Total case management employees 90
Certified Case Managers 40
Medical professionals/full-time 71
Registered nurses 69
Licensed practical nurses 2
Total medical professionals on retainer 3
Physicians on retainer 2
Nurses on retainer 1

Clients
Total 246
Corporate/institutional employer clients 246

Covered lives/managed cases
Total cases managed 15,407
Employer clients 100%
Workers compensation claims 90%
Group health claims 10%

Case management services: telephone case management, online case reports, specialty referral review, integrated disability management, referrals to alternative settings, absence management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities.

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month, $1 to $2.50; per case, $300 to $450; per hour, $75 to $85.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: 22 offices nationwide.

Officers: Stephen Eisenmann, president-Cambridge Integrated Services Group Inc.; John Shea, COO-Cambridge Integrated Services Group Inc.; Allison Kalban-Gernett, COO-Cambridge Managed Care Services.

Contact: Frank Vidrik, senior vp-sales; 972-888-2412.

CareAdvantage Inc.

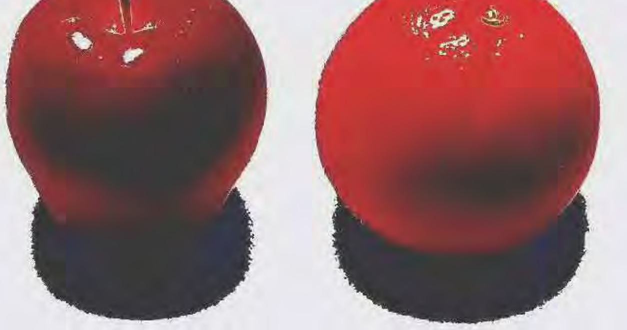
485-C Route 1 S.,
Iselin, N.J. 08830-3037;
732-602-7000; fax: 732-602-7027
www.careadv.com

2000 revenues
Total gross revenues $18,500,000
Case management revenues $17,500,000

Staff
Total case management employees 157
Certified Case Managers 7
Medical professionals/full-time 67

Continued on page 14

We are **NOT** Reliance Group Holdings, Inc.



We are **NOT** Reliance Insurance Company.

We are **NOT** Reliance National Insurance Company.

We are **NOT** even related.

We are Reliance Standard Life Insurance Company, an A rated company with a 93 year track record. We are enjoying continued financial success, providing a full spectrum of employee benefit coverages to employer groups of all sizes. We also market a complete portfolio of immediate and deferred annuities.

NOTE: Product availability varies by state. In New York benefits are underwritten by First Reliance Standard Life Insurance Company.

RELIANCE STANDARD
Life Insurance Company
a DELPHI company

WWW.RSLI.COM

Continued from previous page

Physicians ... 12
Registered nurses ... 47
Licensed practical nurses ... 8
Total medical professionals on retainer ... 125
Physicians on retainer ... 125
Clients
Total ... 3
Covered lives/managed cases
Total cases managed ... 1,600,000
Insurer/managed care clients ... 100%
Group health claims ... 100%

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, disease management, specialty referral review, referrals to alternative settings, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, prescription drugs, home health care, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: disease management.

Compensation: flat fee.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards.

Branch offices: Providence, R.I.; Montpelier, Vt.

Officers: David G. Noone, CEO; Dennis J. Mouras, president/COO; R. Christopher Minor, senior vp/CFO.

Contact: Mary Ellen O'Donnell, senior vp.

CompPsych Corp.

NBC Tower,
455 Cityfront Plaza, 24th Floor,
Chicago, Ill. 60611;
800-755-3050; fax: 312-595-4029
www.compsych.com

2000 revenues
Total gross revenues ... $100,000,000*
Case management revenues ... $30,000,000*
Staff
Total case management employees ... 140
Medical professionals/full-time ... 139
Physicians ... 2
Licensed practical nurses ... 3
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 98
Corporate/institutional employer clients ... 85
Covered lives/managed cases
Total cases managed ... 5,900,000
Employer clients ... 85%
Insurer/managed care clients ... 15%
Workers compensation claims ... 10%
Group health claims ... 90%

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, disease management, specialty referral review, integrated disability management, outpatient psychiatric and substance abuse referrals, demand management, absence management, written case reports.

Health care services: psychiatric and substance abuse, workers compensation, short-/long-term disability.

Utilization management services: utilization review, demand management, integrated disability management.

Compensation: per employee per month, $1.50 to $6; per case, $250 to $700; percent of savings.

Officers: Richard A. Chaifetz, chairman/CEO; Robert Jacobson, CFO; Craig Smith, executive vp.

Contact: info@compsych.com.

*Estimated.

Concentra Managed Care Inc.

130 Second Ave.,
Waltham, Mass. 02451;
781-290-5350; fax: 781-890-1535
www.concentramc.com

2000 revenues
Total gross revenues ... $750,000,000
Case management revenues ... $142,000,000
Staff
Total case management employees ... 1,650
Certified Case Managers ... 80
Medical professionals/full-time ... 1,395
Physicians ... 380
Registered nurses ... 935
Clients
Total ... 1,450
Corporate/institutional employer clients ... 200
Covered lives/managed cases
Total cases managed ... 63,294
Employer clients ... 6%
Insurer/managed care clients ... 94%
Workers compensation claims ... 94%
Group health claims ... 6%

Case management services: onsite case management, telephone case management, outcomes measurement, specialty referral review, integrated disability management, outpatient psychiatric and substance abuse referrals, absence management, written case reports.

Health care services: chiropractic, physical therapy/rehabilitation, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability.

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month; per case; per hour; flat fee; percent of savings.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: 82 offices nationwide, two in Canada.

Officers: Dan Thomas, president/CEO; Tom Cox, president-CMC services, FOCUS; Larry Carr, president-case management services.

Contact: Gina Farrar; 615-778-4032.

Corporate Care Management

1 Kattelville Road,
Binghamton, N.Y. 13901;
800-541-7403; fax: 607-648-3444
www.corporatecaremgmt.com

2000 revenues
Total gross revenues ... $3,000,000
Case management revenues ... $2,000,000
Staff
Total case management employees ... 25
Certified Case Managers ... 10
Medical professionals/full-time ... 11
Physicians ... 1
Registered nurses ... 10
Total medical professionals on retainer ... 50
Physicians on retainer ... 50
Clients
Total ... 50
Covered lives/managed cases
Total cases managed ... 80,000
Employer clients ... 80%
Insurer/managed care clients ... 20%
Workers compensation claims ... 30%
Group health claims ... 70%

Case management services: telephone case management, online case reports, outcomes measurement, specialty referral review, integrated disability management, outpatient psychiatric and substance abuse referrals, demand management, absence management, written case reports.

Health care services: group health care, dental, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month, $1 to $3; per hour, $70 to $100; percent of savings, 20%.

Officers: Patrick J. Kearse, CEO; Barbara S. Kane, executive vp/COO.

Contact: Bob Nugent, vp-marketing and development.

CorVel Corp.

2010 Main St., Suite 1020,
Irvine, Calif. 92614;
949-851-1473; fax: 949-851-1469
www.corvel.com

2000 revenues
Total gross revenues ... $202,000,000
Case management revenues ... $110,000,000
Staff
Total case management employees ... 1,200
Certified Case Managers ... 1,200
Registered nurses ... 900
Licensed practical nurses ... 300
Clients
Total ... 1,000
Corporate/institutional employer clients ... 50
Covered lives/managed cases
Total cases managed ... 127,000
Employer clients ... 20%
Insurer/managed care clients ... 80%
Workers compensation claims ... 95%
Group health claims ... 5%

Case management services: onsite case management, telephone case management, online case reports, outcomes measurement, specialty referral review, integrated disability management, referrals to alternative settings, demand management, absence management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, prescription drugs, workers compensation, short-/long-term disability.

Compensation: per employee per month; per case; per hour, $80 to $100; flat fee; percent of savings, 25%.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: 186 offices nationwide.

Officers: Gordon Clemons, president/CEO; Richard Schweppe, CFO.

Contact: Brian Cushard, product manager.

Crawford & Co.

5620 Glenridge Drive N.E.,
Atlanta, Ga. 30342;
404-256-0830; fax: 404-847-4025
www.crawfordandcompany.com

2000 revenues
Total gross revenues ... $712,000,000
Case management revenues ... $72,000,000
Staff
Total case management employees ... 690
Physicians ... 3
Registered nurses ... 245
Clients
Total ... 1,616
Corporate/institutional employer clients ... 1,098
Covered lives/managed cases
Total cases managed ... 105,345
Employer clients ... 50%
Insurer/managed care clients ... 50%
Workers compensation claims ... 90%
Group health claims ... 10%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, integrated disability management, referrals to alternative settings, absence management, written case reports.

Health care services: group health care, workers compensation, short-/long-term disability.

Utilization management services: integrated disability management.

Compensation: per employee per month; per case; per hour; flat fee; percent of savings.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: Branch offices are located in all 50 states.

Officers: Archie Meyers Jr., chairman/CEO; Grover Davis, president/COO; Vicki Holland, executive vp-health care.

Contact: Pat Sondor, strategic marketing manager; 404-845-3158; pat_sandor@us.crawco.com.

D

Direct Medical Management Inc.

4301 Darrow Road,
Stow, Ohio 44224;
330-686-7030; fax: 330-686-7015
www.chandler-group.com

2000 revenues
Total gross revenues ... $315,000
Case management revenues ... $315,000
Staff
Total case management employees ... 4
Medical professionals/full-time ... 4
Registered nurses ... 4
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 110
Covered lives/managed cases
Total cases managed ... 43,000
Insurer/managed care clients ... 100%
Group health claims ... 100%

Case management services: telephone case management, disease management, specialty referral review, referrals to alternative settings, demand management, high-risk maternity management, written case reports.

Health care services: group health care, home health care, psychiatric and substance abuse, pediatric care, short-/long-term disability, skilled nursing facilities.

Utilization management services: utilization review, demand management, disease management.

Compensation: per employee per month; per hour, $100.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Officers: Arthur W. Chandler, chairman; Joseph Colosi, president.

Contact: Joseph Colosi; joecol@chandler-group.com.

Diversified Healthcare Services Inc.

2430 Camino Ramon,
San Ramon, Calif. 94583;
925-355-1426; fax: 925-355-3269
www.dhsi.com

2000 revenues
Total gross revenues ... $10,000,000
Case management revenues ... $450,000
Staff
Total case management employees ... 9
Certified Case Managers ... 5
Physicians on retainer ... 12
Clients
Total ... 35
Covered lives/managed cases
Total cases managed ... 900
Employer clients ... 80%
Insurer/managed care clients ... 20%
Workers compensation claims ... 100%

Case management services: onsite case management, telephone case management, online case reports, outcomes measurement, written case reports.

Health care services: physical therapy/rehabilitation, prescription drugs, workers compensation.

Utilization management services: utilization review.

Compensation: per hour, $85.

Branch offices: Santa Ana, Calif.

Officers: Jorge Garrat, president; Tara Ambrose, COO; Tori Henson, vp.

Contact: David A. Dyess; ddyess@dhsi.com.

E

EM Ernst Management Inc.

111 Grant Ave.,
Endicott, N.Y. 13760;
800-724-0825; fax: 607-786-3470
www.emmgt.com

2000 revenues
Total gross revenues ... $1,524,000
Case management revenues ... $315,000
Staff
Total case management employees ... 9
Certified Case Managers ... 5
Medical professionals/full-time ... 9
Registered nurses ... 6
Licensed practical nurses ... 3
Total medical professionals on retainer ... 14
Physicians on retainer ... 14
Clients
Total ... 33
Corporate/institutional employer clients ... 13
Covered lives/managed cases
Total cases managed ... 37,000
Employer clients ... 75%
Insurer/managed care clients ... 25%
Workers compensation claims ... 80%
Group health claims ... 20%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, disease management, integrated disability management.

Compensation: per employee per month, $1.50 to $2.80; per case, $175 to $300; per hour, $70 to $120; flat fee, capitated rate for monthly activity.

Branch offices: Binghamton, Rochester and Syracuse, N.Y.

Officers: Kathleen A. Ernst, CEO; Carl R. Ernst, president; Sharon L. Miller, vp-market development.

Contact: Kathleen A. Ernst, kathy@emmgt.com; Sharon L. Miller, 800-494-1561, sharon@emmgt.com.

Employee Benefit Management Services Inc.

P.O. Box 21367,
Billings, Mont. 59104-1367;
406-245-3575; fax: 406-652-5380
www.ebmstpa.com

2000 revenues
Total gross revenues ... $11,000,000
Case management revenues ... $1,400,000
Staff
Total case management employees ... 7
Certified Case Managers ... 3
Medical professionals/full-time ... 11
Registered nurses ... 7
Licensed practical nurses ... 4
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 161
Covered lives/managed cases
Total cases managed ... 805
Employer clients ... 100%
Group health claims ... 100%

Case management services: telephone case management, patient education, outcomes measurement, referrals to alternative settings, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per employee per month, $0.85; per hour, $100.

Officers: Frederick H. Larson, president; Nicki L. Larson, vp; D. Scott Asay, COO.

ENCOMPASS Health Management Systems

6000 Westown Parkway, Suite 350 E.,
West Des Moines, Iowa 50266;
515-223-2857; fax: 515-224-2407
www.encompas.com

2000 revenues
Total gross revenues ... $42,000,000
Case management revenues ... $3,500,000
Staff
Total case management employees ... 28
Certified Case Managers ... 27
Medical professionals/full-time ... 331
Physicians ... 5
Registered nurses ... 322
Licensed practical nurses ... 4
Total medical professionals on retainer ... 278
Physicians on retainer ... 270
Nurses on retainer ... 8
Clients
Total ... 33
Corporate/institutional employer clients ... 24
Covered lives/managed cases
Total cases managed ... 4,500,000
Employer clients ... 63.5%
Insurer/managed care clients ... 36.5%
Workers compensation claims ... 19%
Group health claims ... 81%

Case management services: telephone case management, patient education, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per employee per month, $1.85 to $2.25; per case, $90 to $110; per hour, $90 to $110.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: Washington; Chicago; Baltimore; Minneapolis; Lincoln, Neb.; Las Vegas.

Officers: Fred Ferree, president; John Clark, CFO; Kathy Fliehler, vp.

Contact: Kathy Fliehler; kfliehle@encompas.com.

E-V Benefits Management Inc.

8720 Orion Place, Suite 300,
Columbus, Ohio 43240;
800-239-9088; fax: 614-796-2012

2000 revenues
Total gross revenues ... $3,500,000
Case management revenues ... $261,775
Staff
Total case management employees ... 3
Medical professionals/full time ... 2
Registered nurses ... 2
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients*
Total ... 23
Corporate/institutional employer clients ... 23
Covered lives/managed cases
Total cases managed ... 250**
Employer clients ... 100%
Group health claims ... 100%

Case management services: telephone case management, patient education, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management.

Health care services: group health care, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per hour, $100.

Officers: James Eggert, chairman; Gary VanArsdale, president; Greg Nickell, executive vp.

Contact: Daniel P. Snouffer, director-marketing and sales; dsnouffer@evbenefits.com.

*Provides case management services on unbundled basis to only one client. ** Cases managed are for unbundled client only.

F

FARA-F.A. Richard & Associates Inc.

2360 Fifth St.,
Mandeville, La. 70471;
985-624-8383*; fax: 985-624-8489*
www.fara.com

2000 revenues
Total gross revenues ... $21,691,434
Case management revenues ... $3,825,000
Staff
Total case management employees ... 40
Certified Case Managers ... 25
Medical professionals/full-time ... 26
Registered nurses ... 26
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 204
Corporate/institutional employer clients ... 204
Covered lives/managed cases

Continued on page 16

Continued from previous page

Total cases managed 14,001
Employer clients 90%
Insurer/managed care clients 10%
Workers compensation claims 85%
Group health claims 15%

Case management services: onsite case management, telephone case management, outcomes measurement, specialty referral review, outpatient psychiatric and substance abuse referrals.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, workers compensation.

Utilization management services: utilization review.

Compensation: per employee per month, $1.50 to $3; per case, $250 to $500; per hour, $78 to $85; percent of savings, 10% to 15%.

Branch offices: Mobile, Ala.; Long Beach, Calif.; Boca Raton, Fla.; Alpharetta, Ga.; Baton Rouge, Houma, Lafayette, Metairie and Shreveport, La.; Gulfport and Pascagoula, Miss.; North Charleston, S.C.; Corpus Christi and Houston, Texas; Norfolk, Va.

Officers: M. Todd Richard, president/CEO; Reed Bell, executive vp; Dan Clark, senior vp.

Contact: Kay Martin; 800-215-3272; kay.martin@fara.com.

**Area code is 504 and will be changing to 985 in February.*

Future Comp

P.O. Box 9040,
Springfield, Mass. 01102;
800-688-7256; fax: 413-739-9330
www.palmergoodell.com

2000 revenues
Total gross revenues $2,900,000
Case management revenues $610,000
Staff
Total case management employees 12
Certified Case Managers 5
Medical professionals/full-time 6
Physicians 1
Registered nurses 5
Total medical professionals on retainer 4
Physicians on retainer 2
Nurses on retainer 2
Clients
Total 49
Corporate/institutional employer clients 6
Covered lives/managed cases
Total cases managed 2,050
Workers compensation claims 95%
Group health claims 5%

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, specialty referral review, integrated disability management, referrals to alternative settings, high-risk maternity management, absence management, written case reports.

Health care services: workers compensation, short-/long-term disability.

Utilization management services: utilization review, integrated disability management.

Compensation: per case; per hour; flat fee.

Officers: Robert Carnevale, CEO; Timm Marini, president/COO; Anthony Szwez, vp.

Contact: Anthony Szwez; 413-750-4261; tszwez@palmergoodell.com.

G

GENEX Services Inc.

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

2000 revenues
Total gross revenues $134,000,000*
Case management revenues $96,480,000*
Staff
Total case management employees 1,700
Certified Case Managers 1,100
Medical professionals/full-time 787
Physicians 17
Registered nurses 770
Total medical professionals on retainer 165
Physicians on retainer 100
Nurses on retainer 65
Clients
Total 1,350
Corporate/institutional employer clients 1,000
Covered lives/managed cases
Total cases managed 160,000
Employer clients 70%
Insurer/managed care clients 30%
Workers compensation claims 83%
Group health claims 17%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, absence management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, prescription drugs, psychiatric and substance abuse, workers compensation, short-/long-term disability.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per case.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: 100 offices nationwide.

Officers: Peter C. Modeja, president/CEO; Delphia B. Frisch, senior vp-operations; Paul M. Bode, senior vp-sales and marketing.

Contact: Carolyn Hildenbrand, director-marketing; carolyn.hildenbrand@genexservices.com.

**Estimated.*

H

HHS, Health Options

5363 44th St. S.E.,
Grand Rapids, Mich. 49512;
616-956-9440; fax: 616-956-5091
www.hhs-inc.com

2000 revenues
Total gross revenues $9,113,446
Case management revenues $9,046,000
Staff
Total case management employees 48
Certified Case Managers 13
Medical professionals/full-time 47
Physicians 1
Registered nurses 46
Total medical professionals on retainer 1
Physicians on retainer 1
Clients
Total 722
Corporate/institutional employer clients 260
Covered lives/managed cases
Total cases managed 32,448
Employer clients 96%
Insurer/managed care clients 4%
Group health claims 100%

Case management services: telephone case management, patient education, disease management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per employee per month, $1.95 to $3.60; per case, $375 to $510; per hour, $90; percent of savings, 25%.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards.

Officers: Denise Zoeterman, president/CEO; Richard Hodsdon, director-customer relations; Montelle Evans, director-private pay clinical services.

Contact: Richard Hodsdon; 800-634-2712; richardh@hhs-inc.com.

Health Care Evaluation Inc.

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

2000 revenues
Total gross revenues $1,900,000
Case management revenues $250,000
Staff
Total case management employees 23
Medical professionals/full-time 13
Physicians 2
Registered nurses 8
Licensed practical nurses 3
Total medical professionals on retainer 230*
Physicians on retainer 200
Clients
Total 52
Corporate/institutional employer clients 50
Covered lives/managed cases
Total cases managed 8,000
Employer clients 88%
Insurer/managed care clients 12%
Workers compensation claims 1%
Group health claims 99%

Case management services: telephone case management, patient education, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, written case reports.

Health care services: group health care, dental, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per employee per month, $1.20 to $1.90; per hour, $105 to $125.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Officers: Barbara Rodin, CEO; Jeff Roby, president; Asim Ashary, CFO.

Contact: Rob Falkenberg, chief marketing officer; 800-334-5646; rfalkenberg@pponext.com.

**Estimated.*

Health Design Plus Inc.

1755 Georgetown Road,
Hudson, Ohio 44236;
330-656-1072; fax: 330-656-9387
www.hdplus.com

2000 revenues
Total gross revenues $1,100,000
Case management revenues $1,100,000
Staff
Total case management employees 26
Medical professionals/full-time 13
Registered nurses 13
Total medical professionals on retainer 1
Physicians on retainer 1
Clients
Total 4
Corporate/institutional employer clients 4
Covered lives/managed cases
Total cases managed 16,000
Employer clients 100%
Group health claims 100%

Case management services: telephone case management, patient education, outcomes measurement, disease management, specialty referral review, referrals to alternative settings, high-risk maternity management, written case reports.

Health care services: group health care, dental, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, disease management, integrated disability management.

Compensation: per employee per month, $3.63 to $4.56; per case, $450.

Officers: M. Ruth Coleman, president/CEO; Connie Jones, senior vp-case management.

Contact: Roberta Kordish, director-sales and marketing; rkordi@hdplus.com.

Health International Inc.

14770 N. 78th Way,
Scottsdale, Ariz. 85260;
800-333-3760; fax: 480-948-2523
www.health-intl.com

2000 revenues
Total gross revenues $20,000,000
Case management revenues $20,000,000
Staff
Total case management employees 231
Certified Case Managers 23
Medical professionals/full-time 167
Physicians 10
Registered nurses 157
Clients
Total 38
Corporate/institutional employer clients 36
Covered lives/managed cases
Total cases managed 44,400
Employer clients 99.5%
Insurer/managed care clients 0.5%
Workers compensation claims 1%
Group health claims 99%

Case management services: telephone case management, patient education, disease management, integrated disability management, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per employee per month, $4.50 to $7.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Officers: Donald K. Kelly, chairman/co-CEO; Suzanne D. Kelly, vice chairman/co-CEO.

Contact: Donald K. Kelly, 800-333-3760, ext. 4351; Mary Jo Jerde, 800-333-3760, ext. 4424.

Health Risk Management Inc.

10900 Hampshire Ave. S.,
Minneapolis, Minn. 55438-2306;
800-824-3882; fax: 952-946-7694
www.4yourcare.com

2000 revenues
Total gross revenues $210,000,000
Case management revenues $3,000,000
Staff
Total case management employees 24
Certified Case Managers 3
Medical professionals/full-time 70
Physicians 5
Registered nurses 65
Total medical professionals on retainer 25
Physicians on retainer 25
Clients
Total 60
Corporate/institutional employer clients 55
Covered lives/managed cases
Total cases managed 3,600
Employer clients 70%
Insurer/managed care clients 30%
Group health claims 100%

Case management services: telephone case management, patient education, outcomes measurement, disease management, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, disease management.

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

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Officers: Gary McIlroy, chairman/CEO; Marlene Travis, president; Thomas Clark, senior vp.

Contact: Pamela Hursh, president-4YourCare; phursh@4yourcare.com.

Horizon Behavioral Services

1500 Waters Ridge Drive,
Lewisville, Texas 75057;
972-420-8200; fax: 972-420-7762
www.horz.com

2000 revenues
Total gross revenues $38,700,000
Case management revenues $23,200,000
Staff
Total case management employees 30
Medical professionals/full-time 8
Physicians 8
Total medical professionals on retainer 20
Physicians on retainer 20
Clients
Total 270

Case management services: telephone case management, patient education, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, absence management, written case reports.

Health care services: psychiatric and substance abuse.

Utilization management services: utilization review, disease management, integrated disability management.

Compensation: per employee per month.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards.

Branch Offices: Winter Park, Fla.; Blue Bell, Pa.

Officers: James W. McAtee, president-Horizon Health Corp.; Linda Laitner, president-Horizon Behavioral Services; Dorothy T. Harrison, vp-Horizon Behavioral Services.

Contact: Ramonia Simpson, 972-420-7762.

Human Behavior Associates L.L.C.

191 Military E., Suite A,
Benicia, Calif. 94510;
707-747-0117; fax: 707-747-6646

2000 revenues
Total gross revenues $450,000
Case management revenues $90,000
Staff
Total case management employees 2
Total medical professionals on retainer 5
Physicians on retainer 3
Clients
Total 42
Corporate/institutional employer clients 42
Covered lives/managed cases
Total cases managed 1,500
Employer clients 100%

Case management services: telephone case management, outcomes measurement, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, written case reports.

Health care services: psychiatric and substance abuse.

Utilization management services: utilization review.

Compensation: per employee per month, $2.35 to $2.75.

Officers: James B. Wallace, president; Yolanda Calderon, operations manager; Diane Lansbarkis, supervising case manager.

Contact: James B. Wallace; humanbeh@ix.netcom.com.

I

Innovative Resource Group Inc.

20900 Swenson Drive, Suite 400,
Waukesha, Wis. 53186;
414-546-8799; fax: 262-798-2595
www.irgresources.com

2000 revenues
Total gross revenues $43,700,000
Case management revenues $7,900,000
Staff
Total case management employees 47
Certified Case Managers 31
Medical professionals/full-time 34
Physicians 3
Registered nurses 26
Licensed practical nurses 4
Total medical professionals on retainer 21
Physicians on retainer 21
Clients
Total 130
Corporate/institutional employer clients 81
Covered lives/managed cases
Total cases managed 4,500
Employer clients 40%
Insurer/managed care clients 60%
Workers compensation claims 10%
Group health claims 90%

Case management services: onsite case management, telephone case management, patient education, disease management, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, absence management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, disease management, integrated disability management.

Compensation: per employee per month; per case; per hour; flat fee.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: Phoenix; Sunrise, Fla.; Midland, Mich.; Houston and Lake Jackson, Texas; Madison, Milwaukee, Plover and Pewaukee, Wis.

Officers: James Hartert, president/COO; Tammie Miller, vp-health services; Kathryne McGowan, vp-business development.

Contact: Craig Roberts, director-marketing; 414-327-8039; croberts@irgresources.com.

InServices Inc.*

4401 Barclay Downs Drive,
Charlotte, N.C. 28209-4604;
704-945-2706; fax: 704-945-2634
www.inservecorp.com

2000 revenues
Total gross revenues $130,000,000**
Case management revenues $8,000,000
Staff
Total case management employees 50
Certified Case Managers 39
Medical professionals/full-time 48
Physicians 1
Registered nurses 45
Licensed practical nurses 2
Clients
Total 8
Covered lives/managed cases
Total cases managed 2,250
Employer clients 20%
Insurer/managed care clients 80%
Workers compensation claims 100%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management.

Health care services: chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, workers compensation, skilled nursing facilities.

Utilization management services: integrated disability management.

Compensation: flat fee, $250 to $2,000 per month.

Branch offices: Rancho Cordova, Calif.; Maitland, Fla.; Alpharetta, Ga.; Voorhees, N.J.

Officers: Steven M. Mariano, chairman/CEO-InServe Corp.; David Smith, president-InServices Inc.; Susan Sims, director-business development and marketing-InServices Inc.

Contact: Kevin M. McCarthy, director-corporate communications.

**Formerly Managed Care USA Services Inc. **Estimated for the parent company, InServe Corp.*

Integrated Care Management

5 Dunwoody Park, Suite 118,
Atlanta, Ga. 93338;
770-730-8400; fax: 770-730-9055
www.integratedcare.com

Continued on next page

A chart of the top 10 case management service providers ranked by 2000 case management revenues can be found on page 3.

Continued from previous page

2000 revenues
Total gross revenues $6,000,000
Case management revenues $3,500,000
Staff
Total case management employees 65
Certified Case Managers 34
Medical professionals/full-time 25
Registered nurses 24
Licensed practical nurses 1
Total medical professionals on retainer 1
Physicians on retainer 1
Clients
Total 50
Covered lives/managed cases
Total cases managed 834
Employer clients 50%
Insurer/managed care clients 50%
Workers compensation claims 60%
Group health claims 40%

Case management services: onsite case management, telephone case management, outcomes measurement, integrated disability management, absence management, written case reports.

Health care services: group health care, workers compensation, short-/long-term disability.

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month, $3.50 to $10; per case, $95; per hour, $60 to $70; flat fee, $85 to $450; percent of savings, 30%.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Workers Compensation Utilization Management Standards.

Branch offices: Nashville, Tenn.

Officers: Dan Barta, president; Mark Pergolini, director-business development.

Contact: Karen Ranger-Abron, marketing assistant; karen.ranger@integratedcare.com.

Interface EAP

7670 Woodway, Suite 350,
Houston, Texas 77063;
713-781-3364; fax: 713-781-4954
www.ieap.com

2000 revenues
Total gross revenues $2,500,000
Case management revenues $1,500,000
Staff
Total case management employees 24
Certified Case Managers 8
Medical professionals/full-time 2
Physicians 2
Total medical professionals on retainer 2
Physicians on retainer 2
Clients
Total 214
Corporate/institutional employer clients 214
Covered lives/managed cases
Total cases managed 2,900
Employer clients 100%

Case management services: telephone case management, patient education.

Health care services: psychiatric and substance abuse.

Utilization management services: utilization review.

Compensation: per employee per month.

Officers: Fred Newman, CEO; Lizz Scott, vp; Matthew Brams, medical director.

Contact: Lizz Scott, lscott@ieap.com; Luis Taborda, director-marketing, ltaborda @ieap.com.

Intracorp

1601 Chestnut St.,
Two Liberty Place, TL09J,
Philadelphia, Pa. 19192;
215-761-7100; fax: 215-761-5538
www.intracorp.com

2000 revenues
Total gross revenues $393,000,000
Case management revenues $313,000,000
Staff
Total case management employees 3,406
Certified Case Managers 306
Medical professionals/full-time 1,938
Physicians 43
Registered nurses 1,895
Total medical professionals on retainer 500
Physicians on retainer 500
Clients
Total 1,770
Corporate/institutional employer clients 609
Covered lives/managed cases
Total cases managed 1,710,639
Employer clients 26%
Insurer/managed care clients 74%
Workers compensation claims 14%
Group health claims 86%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, absence management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per employee per month; per case; percent of savings.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: Norcross, Ga.; Itasca, Ill.; Pittsburgh and Plymouth Meeting, Pa.; Chattanooga, Tenn.; Dallas.

Officers: Kirk Rothrock, president; Ken Ross, senior vp-disability management; Kathleen Leone, vp-product, marketing and health care management.

Contact: Colleen Bergin, manager-public relations; cbergin@mail.intracorp.com.

J

Jordan Services Inc.

900 Merchants Concourse,
Westbury, N.Y. 11590;
516-683-0100; fax: 516-683-0309
www.jordanservices.com

2000 revenues
Total gross revenues $7,815,500*
Case management revenues $5,128,515
Staff
Total case management employees 82
Certified Case Managers 45
Registered nurses 43
Total medical professionals on retainer 2
Physicians on retainer 2
Clients
Total 751
Corporate/institutional employer clients 38
Covered lives/managed cases
Total cases managed 273,000
Employer clients 20%
Insurer/managed care clients 80%
Workers compensation claims 35%
Group health claims 65%

Case management services: onsite case management, telephone case management, patient education, online case reports, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, written case reports.

Health care services: group health care, workers compensation, short-/long-term disability.

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month, $1.25 to $4; per hour, $84 to $150.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

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

Contact: Phyllis Snow; phylisssnow@jordanservices.com.

**Estimated.*

L

Laurel Rehabilitation Services Inc.

69 S. Black Horse Pike,
Blackwood, N.J. 08012;
856-346-9748; fax: 856-232-8430
www.laurelrehab.com

2000 revenues
Total gross revenues $1,300,000
Case management revenues $650,000
Staff
Total case management employees 15
Certified Case Managers 6
Medical professionals/full-time 11
Registered nurses 11
Total medical professionals on retainer 70
Physicians on retainer 70
Clients
Total 25
Covered lives/managed cases
Total cases managed 250
Employer clients 10%
Insurer/managed care clients 90%
Workers compensation claims 90%
Group health claims 10%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, high-risk maternity management, written case reports.

Health care services: group health care, dental, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, disease management, integrated disability management.

Compensation: per hour, $65 to $80.

Branch offices: Shallotte, N.C.

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

Contact: Kelly Uhrich, JoAnn Bocchese.

Liaison Inc.

17000 N. Dallas Parkway, Suite 103,
Dallas, Texas 75248;
972-380-6944; fax: 972-380-8629

2000 revenues
Total gross revenues $1,700,000
Case management revenues $1,400,000
Staff
Total case management employees 10
Certified Case Managers 7
Medical professionals/full-time 7
Registered nurses 7
Total medical professionals on retainer 14
Physicians on retainer 10
Nurses on retainer 4
Clients
Total 100
Corporate/institutional employer clients 25
Covered lives/managed cases
Total cases managed 575
Employer clients 60%
Insurer/managed care clients 40%
Workers compensation claims 100%

Case management services: onsite case management, telephone case management, outcomes measurement, specialty referral review, integrated disability management, referrals to alternative settings, absence management, written case reports.

Health care services: chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, short-/long-term disability.

Utilization management services: utilization review, integrated disability management.

Compensation: per case, $450 to $650; per hour, $65 to $75; flat fee, $150 to $175; percent of savings, 18 to 26%.

American Accreditation HealthCare Commission/URAC status: Workers Compensation Utilization Management Standards*

Contact: Catherine Marrs, president/CEO; cmarrs@liaisoninc.com.

**Texas only.*

M

Magellan Behavioral Health

6950 Columbia Gateway Drive,
Columbia, Md. 21046;
800-458-2740; fax: 410-953-5200
www.magellanhealth.com

2000 revenues
Total gross revenues $1,600,000,000
Case management revenues $1,100,000,000*
Clients
Total 1,100*
Covered lives/managed cases
Total cases managed 1,300,000*

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, disease management, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals.

Health care services: psychiatric and substance abuse.

Utilization management services: utilization review, disease management.

Compensation: per employee per month; per case; flat fee.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Branch offices: 37 regional service centers nationwide.

Officers: Henry T. Harbin, president/CEO; Daniel S. Messina, executive vp/COO; Dennis Moody, executive vp-behavioral health operations.

**Estimated.*

MedCost Medical Management

165 Kimel Park Drive,
Winston-Salem, N.C. 27103;
800-722-2157; fax: 336-760-2352

2000 revenues
Total gross revenues $16,800,000
Case management revenues $820,000
Staff
Total case management employees 11
Certified Case Managers 4
Medical professionals/full-time 37
Physicians 1
Registered nurses 36
Total medical professionals on retainer 70*
Physicians on retainer 70*
Clients
Total 3,200
Covered lives/managed cases
Total cases managed 2,200
Group health claims 100%

Case management services: telephone case management, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per employee per month, $0.60; per hour, $110.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Officers: Bill Ketner, CEO; Kathryn Showalter, vp-business development; Joel Groce, vp-administration.

Contact: Dana Best; dbest@medcost.com.

**Estimated.*

Med-Valu Inc.

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

2000 revenues
Total gross revenues $4,900,000
Case management revenues $480,000
Staff
Total case management employees 8
Certified Case Managers 4
Medical professionals/full-time 85
Physicians 1
Registered nurses 80
Total medical professionals on retainer 200
Physicians on retainer 200
Clients
Total 20
Covered lives/managed cases
Total cases managed 1,176
Insurer/managed care clients 100%
Group health claims 100%

Case management services: telephone case management, patient education, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per employee per month; per hour.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Branch offices: Hillard, Ohio.

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

Contact: Mary Ellen O'Grady; meogrady@medvalu.com.

N

National Healthcare Resources Inc.

555 North Lane, Suite 6183,
Conshohocken, Pa. 19428;
610-238-0630; fax: 610-238-0277
www.nhr.com

2000 revenues
Total gross revenues $148,000,000
Case management revenues $46,000,000
Staff
Total case management employees 500
Certified Case Managers 380
Medical professionals/full-time 355
Physicians 2
Registered nurses 318
Licensed practical nurses 35
Total medical professionals on retainer 120
Physicians on retainer 30
Nurses on retainer 90
Clients
Total 215
Corporate/institutional employer clients 40
Covered lives/managed cases
Total cases managed 40,000
Employer clients 21%
Insurer/managed care clients 79%
Workers compensation claims 70%
Group health claims 30%

Case management services: onsite case management, telephone case management, online case reports, outcomes measurement, specialty referral review, integrated disability management, demand management, absence management, written case reports.

Health care services: group health care, workers compensation, short-/long-term disability.

Utilization management services: utilization review, integrated disability management.

Compensation: per hour, $65 to $85; flat fee, $175 to $3,000.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: 31 offices nationwide.

Officers: Chris Garcia, president/CEO; Mike Angst, COO; Michael Lindberg, executive vp.

O

Options Unlimited

76 E. Main St.,
Huntington, N.Y. 11743;
631-673-1150; fax: 631-673-8369
www.optionsunlimited.org

2000 revenues
Total gross revenues $1,600,000
Case management revenues $1,400,000
Staff
Total case management employees 26
Certified Case Managers 6
Medical professionals/full-time 19
Registered nurses 19
Total medical professionals on retainer 140
Physicians on retainer 10
Nurses on retainer 130
Clients
Total 20
Corporate/institutional employer clients 5
Covered lives/managed cases
Total cases managed 10,000
Employer clients 75%
Insurer/managed care clients 25%
Workers compensation claims 5%
Group health claims 95%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, absence management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, disease management, integrated disability management.

Compensation: per employee per month, $1.50 to $2.75; per case, $100 to $150; per hour, $75 to $125; percent of savings, 10%.

Officers: Catherine Mullahy, president; Julia Graziano, vp/director-services; Nancy Peters, director-utilization review and case management.

Contact: Mary Lou Beeck, executive administrator.

P

Pacific Health Alliance

1350 Old Bayshore Highway, Suite 560,
Burlingame, Calif. 94210;
650-375-5800; fax: 650-375-5820

2000 revenues
Total gross revenues $2,000,000
Staff
Total case management employees 8
Medical professionals/full-time 8
Physicians 2
Registered nurses 6
Total medical professionals on retainer 25
Physicians on retainer 16
Nurses on retainer 9
Clients
Total 29
Corporate/institutional employer clients 29
Covered lives/managed cases
Total cases managed 114,000
Employer clients 65%
Insurer/managed care clients 35%
Group health claims 100%

Case management services: onsite case management, telephone case management, patient education, online case reports, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, written case reports.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per employee per month, $1; per hour, $100.

Officers: Lawrence Cappel, CEO; Lynn Patasini; Dennis Collins.

Continued on page 18

The directory begins on page 12.

THE FOLLOWING PREVIEW HAS BEEN APPROVED FOR ALL AUDIENCES.

COMING SOON IN *BUSINESS INSURANCE...*

Issue Date	Editorial Feature	Demographic Section	Ad Closing
Feb 19	Self-Insurance: Property/Casualty & Employee Benefits *Directory: Third-Party Administrators*	IT Global Strategies	Feb 7
Feb 26			Feb 14
Mar 5		ABT Consolidation	Feb 21
Mar 12	Risk Financing Options *Directory: Risk Securitization Specialists* *Distribution: CICA; CILS; NRRA*		Feb 28
Mar 19	Benefits: New Technology & Online Solutions *Directory: Benefit Information Systems* *Distribution: NMHCC*	IT Consolidation	Mar 7
Mar 26	*Distribution: NAIC*		Mar 14
Apr 2	Benefits: Managed Care Trends & Issues *Directory: Prescription Benefit Managers*	ABT Agency/Insurer Relations	Mar 21
Apr 9	*Distribution: ALARM*		Mar 28
Apr 16	RIMS Conference/Atlanta Tourism Preview	IT Insurer/Agency Relations	Apr 4
Apr 23			Apr 11
Apr 30	Captives/Risk Manager of the Year *Directory: Captive Managers* *Distribution: RIMS*		Apr 18
May 7	RIMS REPORT: Employee Benefits & Workers Comp	ABT Information Technology *Distribution: ACORD*	Apr 25
May 14	RIMS REPORT: Risk Management		May 2
May 21	*Distribution: AAMGA; ACORD*	IT Information Technology *Distribution: IASA*	May 9
May 28	Benefits: Pensions/Retirement Plans *Directory: 401(k) Plan Administrators*		May 16

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Continued from previous page

Private Healthcare Systems Inc.

1100 Winter St.,
Waltham, Mass. 02451;
800-253-4417; fax: 781-895-3477
www.phcs.com

2000 revenues
Total gross revenues $127,100,000
Case management revenues $26,200,000
Staff
Total case management employees 170.5
Certified Case Managers 6
Medical professionals/full-time 71
Physicians 11
Registered nurses 60
Clients
Total 27
Covered lives/managed cases
Total cases managed 2,686,837
Employer clients 36%
Insurer/managed care clients 64%
Group health claims 100%

Case management services: telephone case management, patient education, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management.

Health care services: group health care, chiropractic, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Branch offices: Irvine, Calif.

Officers: Joseph Driscoll, president/CEO; Spencer Falcon, executive vp-medical management; James Herrington, chief marketing officer.

Contact: Jacqueline DeCourcey, senior marketing and public relations specialist; 781-895-3183; jdecourcey@phcs.com.

PRO-West

10700 Meridian Ave., Suite 100,
Seattle, Wash. 98133;
206-364-9700; fax: 206-368-2419
www.pro-west.org

2000 revenues
Total gross revenues $14,941,032
Case management revenues $1,134,419
Staff
Total case management employees 19
Certified Case Managers 15
Medical professionals/full-time 60
Physicians 7
Registered nurses 50
Licensed practical nurses 3
Total medical professionals on retainer 157
Physicians on retainer 150
Nurses on retainer 7
Clients
Total 102
Covered lives/managed cases
Total cases managed 1,232
Employer clients 100%
Group health claims 100%

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, disease management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, disease management.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards.

Branch offices: Anchorage, Alaska.

Officers: William McKee, chairman; Jonathan R. Sugarman, president/CEO; Michael B. Garrett, executive director-utilization, case management and client relations.

Contact: Michael B. Garrett; 206-368-2402; michaelg@pro-west.org.

Professional Case Management Consultants Inc.

P.O. Box 940338,
Maitland, Fla. 32794-0338;
407-647-6347; fax: 407-643-1395
www.pcmcinc.com

2000 revenues
Total gross revenues $910,000*
Case management revenues $600,000*
Staff
Total case management employees 5
Certified Case Managers 1
Medical professionals/full-time 1
Registered nurses 1
Total medical professionals on retainer 16
Physicians on retainer 3
Nurses on retainer 13
Clients
Total 50
Corporate/institutional employer clients 50
Covered lives/managed cases
Total cases managed 400
Employer clients 25%
Insurer/managed care clients 75%
Workers compensation claims 95%
Group health claims 5%

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, disease management, specialty referral review, written case reports.

Health care services: group health care, workers compensation, short-/long-term disability.

Utilization management services: utilization review, disease management.

Compensation: per hour, $65 to $100; flat fee, $110 to $830.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards.

Officers: Belinda E. Brice, president; Freida D. Simmons, director-customer relations; Kathie Maloney, office manager.

Contact: Freida D. Simmons; pcmc@iag.net.

*Estimated.

R

Resource Opportunities Inc.

4122 Innslake Drive,
Glen Allen, Va. 23060;
804-527-1100; fax: 804-527-1509
www.roiusa.com

2000 revenues
Total gross revenues $22,000,000
Case management revenues $20,000,000
Staff
Total case management employees 450
Certified Case Managers 210
Medical professionals/full-time 9
Physicians 5
Licensed practical nurses 4
Total medical professionals on retainer 5
Physicians on retainer 3
Nurses on retainer 2
Clients
Total 1,021
Corporate/institutional employer clients 116
Covered lives/managed cases
Total cases managed 38,486
Employer clients 30%
Insurer/managed care clients 70%
Workers compensation claims 91%
Group health claims 9%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, high-risk maternity management, absence management, written case reports.

Health care services: group health care, workers compensation, pediatric care, short-/long-term disability.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per hour, $56 to $125; flat fee, $95 to $500.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards, Workers Compensation Utilization Management Standards.

Branch offices: 25 offices nationwide, one office in Puerto Rico.

Officers: Michael Leep, president.

Contact: Emily Harrison; eharrison@ccnusa.com.

S

Sandler Occupational Medicine Associates Inc.

125 Baylis Road, Suite 120,
Melville, N.Y. 11747;
631-756-2204; fax: 631-756-2213
www.somaonline.com

2000 revenues
Total gross revenues $2,000,000
Case management revenues $700,000
Staff
Total case management employees 1
Medical professionals/full-time 6
Physicians 4
Registered nurses 2
Total medical professionals on retainer 60
Physicians on retainer 50
Nurses on retainer 10
Clients
Total 50
Corporate/institutional employer clients 20
Covered lives/managed cases
Total cases managed 200,000
Employer clients 40%
Insurer/managed care clients 60%
Workers compensation claims 80%
Group health claims 20%

Case management services: telephone case management, outcomes measurement, disease management, specialty referral review, integrated disability management, written case reports.

Health care services: workers compensation, short-/long-term disability.

Utilization management services: utilization review, demand management, disease management.

Compensation: per hour, $85 to $255.

Branch offices: Rockville, Md.; Raleigh, N.C.

Officers: Howard M. Sandler, president; Richard Blume, Sheldon Rabinovitz, vps.

Contact: Wendy Walmsley; wendy@somaonline.com.

Strategic Health Development Corp.

9315 N.E. Sixth Ave.,
Miami Shores, Fla. 33138;
800-874-2378; fax: 305-751-1029
www.shdc.net

2000 revenues
Total gross revenues $5,000,000
Case management revenues $1,500,000
Staff
Total case management employees 30
Certified Case Managers 20
Total medical professionals on retainer 170
Physicians on retainer 100*
Nurses on retainer 70*
Clients
Total 100*
Covered lives/managed cases
Total cases managed 500,000*
Employer clients 75%
Insurer/managed care clients 25%
Workers compensation claims 2%
Group health claims 98%

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, disease management, specialty referral review, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per employee per month, $1.50; per case; per hour, $105; percent of savings.

American Accreditation HealthCare Commission/URAC status:
Case Management Organization Standards.

Officers: Nigel Wallbank, president; Al Karnicwicz, CEO.

***Contact:** Mary Vanek; nikitamv@aol.com.*

*Estimated.

Stirling Cooke Insurance Services, Managed Care Department

1515 S. Federal Highway, Suite 301,
Boca Raton, Fla. 33432;
800-961-7247; fax: 800-424-0687

2000 revenues
Total gross revenues $93,000,000*
Case management revenues $1,500,000
Staff
Total case management employees 13
Certified Case Managers 13
Medical professionals/full-time 19
Physicians 1
Registered nurses 13
Total medical professionals on retainer 12
Physicians on retainer 10
Nurses on retainer 2
Clients
Total 1,500
Corporate/institutional employer clients 1,500
Covered lives/managed cases
Total cases managed 3,000*
Employer clients 100%
Workers compensation claims 100%

Case management services: onsite case management, telephone case management, patient education, disease management, integrated disability management.

Health care services: chiropractic, physical therapy/rehabilitation, prescription drugs, home health care.

Utilization management services: utilization review, demand management, disease management, integrated disability management.

Compensation: per employee per month; per hour, $76; flat fee, $325 first month, lost time $280 thereafter; percent of savings, 30%.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Workers Compensation Utilization Management Standards.

Branch offices: Bradenton, Fla.; New York; Dallas; Hamilton, Bermuda, London.

Officers: Stephan Carane, CEO; Len Quick, CEO-North America; Scott Carde, vp-marketing.

Contact: Scott Carde, Ramona Farmer, manager-managed care department.

*Estimated.

<Total> Care Management

P.O. Box 6528,
Greenville, S.C. 29606;
800-638-6829, ext. 853; fax: 864-233-5337
www.hewittcoleman.com

2000 revenues
Total gross revenues $5,800,000
Case management revenues $1,885,000
Staff
Total case management employees 14
Certified Case Managers 6
Medical professionals/full-time 7
Registered nurses 7
Total medical professionals on retainer 5
Physicians on retainer 1
Nurses on retainer 4
Covered lives/managed cases
Total cases managed 1,814
Employer clients 85%
Insurer/managed care clients 15%
Workers compensation claims 47%
Group health claims 53%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, high-risk maternity management, absence management, written case reports.

Health care services: group health care, dental, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, disease management, integrated disability management.

Compensation: per hour, $75 to $135; percent of savings, 33%.

Officers: Charles R. Warne, president; S. Dianne Matthews; Maureen Davis.

Contact: S. Dianne Matthews; diannem@hewittcoleman.com.

United Review Services

67 Walnut Ave., Suite 405,
Clark, N.J. 07066;
732-815-0330; fax: 732-382-2035

2000 revenues
Total gross revenues $980,000
Case management revenues $750,000
Staff
Total case management employees 16
Certified Case Managers 6
Medical professionals/full-time 11
Registered nurses 10
Licensed practical nurses 1
Total medical professionals on retainer 2
Physicians on retainer 2
Clients
Total 9
Corporate/institutional employer clients 9
Covered lives/managed cases
Total cases managed 556
Employer clients 30%
Insurer/managed care clients 70%
Workers compensation claims 20%
Group health claims 80%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, specialty referral review, integrated disability management, referrals to alternative settings, high-risk maternity management, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, workers compensation, pediatric care, short-/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month, $1 to $2; per hour, $105; flat fee, $325 per case per month; $275 telephone case management.

American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards.

Officers: F.Y. Marie Chan, director-case management; Terry Wallace, general manager; Dorothy Maxemow, auditing manager.

Contact: F.Y. Marie Chan; 732-815-0330, ext. 106.

V

ValueCheck Inc.

8625 King George Drive, Suite 300,
Dallas, Texas 75235;
214-267-3346; fax: 214-267-3421
www.e-valuecheck.com

2000 revenues
Total gross revenues $1,000,000
Case management revenues $500,000
Staff
Total case management employees 16
Certified Case Managers 8
Medical professionals/full-time 16
Physicians 2
Licensed practical nurses 14
Total medical professionals on retainer 420
Physicians on retainer 420
Clients
Total 480
Corporate/institutional employer clients 25
Covered lives/managed cases
Total cases managed 407
Employer clients 8%
Insurer/managed care clients 92%
Group health claims 100%

Case management services: telephone case management, referrals to alternative settings, written case reports.

Health care services: group health care, physical therapy/rehabilitation, home health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per employee per month, $.50 to $.80; per hour, $95.

American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.

Officers: John D. Weymer, president/CEO; Dwight D. Mankin, senior vp-sales and marketing; William L. Amos, medical director.

Contact: Dwight D. Mankin; ddm@e-valuecheck.com.

BI

GLOBAL BRIEFS

Four Lloyd's of London associations have merged to form the **Lloyd's Market Assn.** The organizations—the Lloyd's Underwriters' Assn., the Lloyd's Underwriters' Non-Marine Assn., the Lloyd's Aviation Underwriters' Assn. and the Lloyd's Underwriting Agents' Assn.—have formed a single group to represent their business interests. A chief executive officer will soon be appointed to head the new group. The four groups will continue to perform technical work under their individual identities but will have unified representation on matters of strategic importance, the groups announced. In addition, the Lloyd's Motor Underwriters' Assn. is in discussions with the combined group....The **LMP2001 Steering Group**, the organization overseeing the implementation of new London market standards developed by the Lloyd's/International Underwriting Assn. joint forum, has appointed two chairmen for 2001. Stephen Riley, managing director of CNA Re in London, and Stewart McCulloch, U.K. information technology director of Willis Group P.L.C., will lead the group. In addition, two new members have joined the steering group in 2001. They are Richard Rycraft, managing director of client and market services at Marsh Inc. in London, and Chris Gordge, head of systems and strategy at Markel International in London....Ross McKenzie, director of Aon Ltd. and chairman of Aon Re International, has been named chairman of the **Lloyd's Insurance Market Brokers Committee**, formerly known as the Lloyd's Insurance Brokers Committee. David Spiller of Benfield Greig Ltd. and George Bowden of SBJ Group Ltd. have been appointed deputy chairmen....Moody's Investors Service Inc. in New York has changed its rating on Tokyo-based **Yasuda Fire & Marine Insurance Co. Ltd.** to stable from negative. Moody's said the ratings outlook reflected both company-specific actions and certain changes in the industry that should encourage underwriting discipline. Yasuda Fire plans to merge with Nissan Fire & Marine Insurance Co. Ltd. and Taisei Fire & Marine Insurance Co. Ltd. next year to create Japan's second-largest non-life insurer. Moody's said a recent spate of merger announcements in the Japanese insurance industry could slow the pace of competition and underwriting losses among Japanese insurers....Japan's Financial Services Agency, which regulates the Japanese insurance industry, plans to develop a **new solvency margin requirement**. The FSA said it would revise the standard in time for the fiscal year that begins in March. Under the current rules, regulators can intervene if an insurer's solvency margin falls below 200%; but in recent months, several insurers have collapsed despite being well within this range, the FSA said....London's Natural History Museum has pleaded guilty to charges that certain **exhibits featuring radioactive rocks** violated health and safety standards. The museum admitted that some rocks displayed in its minerals gallery emitted low levels of radiation, but the museum also said that such levels would not be harmful to visitors. The case, brought by the U.K. government's Health and Safety Executive, will now be referred for sentencing next month....Norwich, England-based **Norwich Union Healthcare** has named David Rogers managing director. Mr. Rogers was formerly Norwich Union Healthcare's finance director....**Heath Lambert Financial Services Ltd.**, a division of London-based broker Heath Lambert Group Ltd., has been selected to provide employee benefits services to Partnerships U.K., which works to help the public sector develop better public/private partnerships.

U.K. mulls malpractice reforms

By CAROLYN ALDRED

LONDON—As the frequency and severity of medical negligence litigation soar in the United Kingdom, the government is proposing new risk management measures to track mistakes and measure doctors' performance.

At the same time, professional liability insurers are calling for a change in the way patients are compensated for medical negligence following recent record court awards.

Some European countries already have adopted no-fault compensation systems for medical negligence claims, while others are looking at ways of coping with spiraling levels of compensation.

In the United Kingdom this month, the Department of Health announced that a new national agency, starting April 1, will provide a fast response to concerns about doctors' performance.

The National Clinical Assessment Authority will make recommendations to National Health Service hospitals and health authorities so "they can take appropriate action to check poor performance, ensure doctors are practicing safely and to discipline or suspend doctors whose practices give rise to serious concerns," a government statement explained.

It follows a recommendation by the government's chief medical officer, Liam Donaldson, who last year also suggested:

- Introducing a mandatory reporting system for adverse health care events and "near misses."
- Creation of a single database for analyzing and sharing lessons from incidents, as well as litigation and complaints data to identify common factors and consider action necessary to reduce risk to patients in the future.
- Encouraging a reporting and questioning culture in the NHS, rather than a "blame" culture.
- Improving NHS investigations and inquiries and ensuring that their results are entered into the national database.

He also recommended that the Department of Health set specific targets for the NHS to reduce the levels of incidents. For example, NHS could aim by 2005 to reduce by 25% the number of instances of negligent harm in obstetrics and gynecology that result in litigation, which now accounts for about half the annual NHS litigation bill, he said.

This month, David Davis, a member of Parliament and chairman of the House of Commons Public Accounts Committee, said doctors today are 13 times more likely to

See **NHS** *on next page*

Tough row to hoe

British farmers face growing risks

By CAROLYN ALDRED

LONDON—British farmers face losses of up to £500 million ($738.9 million), most of it insured, as a result of the flooding in the United Kingdom this winter, according to the National Farmers Union.

PHOTO: AFP

Floods have soaked North Wales.

The latest losses likely will compound the problems faced by the industry, which has seen farm incomes drop by 72% since 1995, including a fall in total income to £1.71 billion ($2.52 billion) in 2000, from £2.40 billion ($3.54 billion) in 1999, according to figures released by the London-based NFU.

Meanwhile, farming representatives have been meeting with farm insurers and officials from the government's Ministry of Agriculture, Food and Fisheries to find ways to protect themselves from livestock losses due to contagious diseases. Falling incomes have led many farmers to cut their insurance programs in recent years, leaving them exposed to potentially huge losses, according to a spokesman for NFU Mutual of Stratford upon Avon, one of the

See **Farms** *on next page*

Airlines warning of blood-clot threat

By SARAH VEYSEY

LONDON—Several of the world's major airlines are introducing measures aimed at reducing the risk of passengers developing blood clots, the so-called economy-class syndrome, on long-distance flights.

British Airways P.L.C. of Hounslow, England; Qantas of Sydney, Australia; Wellington, New Zealand-based Air New Zealand Ltd. and its subsidiary, Sydney-based Ansett Australia, all announced this month that they would provide passengers with safety advice about the potentially fatal condition.

PHOTO COURTESY OF BOEING

Some airlines are warning long-distance fliers of health risks.

The debate about the risk of developing blood clots on long-distance flights has been raging in the U.K. media since a 28-year-old British woman died just minutes after stepping off a 20-hour flight from Australia to London in October. The suspected link between long-distance flights and deep-vein thrombosis—a condition in which blood clots develop in the legs due to lack of circulation and can travel to the heart or lungs—has been discussed in both houses of the U.K. Parliament. The Australian minister of transportation has also ordered his department to look into the issue.

Two DVT lawsuits—one in the United Kingdom and one in Australia—are being planned. The Melbourne, Australia-based law

See **Flights** *on page 21*

PHOTO: AFP

A Jan. 13 earthquake of magnitude 7.6 triggered landslides that buried homes in Santa Tecla, a suburb of San Salvador, El Salvador. The quake has claimed hundreds of lives.

Insurers expect claims following deadly quake

By ROBERTO CENICEROS

SAN SALVADOR, El Salvador—Insured losses from a deadly quake in El Salvador are expected to be at least $150 million, according to a preliminary estimate from Swiss Reinsurance Co.

Swiss Re compiled its estimate from computer modeling, but other insurance experts believe claims could increase in the days ahead, as more is learned about the extent of damage.

Nearly 700 deaths have been reported, more than 65,000 homes suffered damage and 25,000 homes were destroyed as a result of the Jan. 13 earthquake and landslides it triggered, the San Salvador newspaper "El Diario De Hoy" reported last week. In just one suburban neighborhood outside the capital San Salvador, a landslide buried hundreds of homes.

Property destruction is widespread throughout the small Central American nation, but as loss adjusters for Seguros e Inversiones S.A. began their task last week they found relatively few major claims, a spokesman for the San Salvador-based insurer said.

But that could change, he added, because the insurer has been hampered by a lack of loss adjusters to evaluate the damage. So far, however, SISA's inspectors have found that commercial buildings sustained mostly superficial damage, with little structural harm.

That report matches what Peter I. Yanev, president of Oakland, Calif.-based EQE International, said he would expect to find. EQE is an engineering and risk management consulting company that evaluated a comparable earthquake that struck El Salvador in 1986.

The recent quake, of magnitude 7.6, is a large event, but most of its damage is likely to fall on poorly constructed buildings that are not reinforced, such as adobe structures typically found in Central America, Mr. Yanev said. Because it was centered off El Salvador's coast and not nearer to San Salvador, shaking in the urban center was only moderate, he added.

See **Quake** *on page 21*

INTERNATIONAL

NHS

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face claims of negligence than 10 years ago. He also predicted that the introduction of contingency fees in England and Wales, and more public information about the performance of the NHS, will mean that litigation over these claims will increase.

The Medical Defense Union, which represents many health professionals in the United Kingdom, reports that its members face increasing settlement costs for liability claims. MDU estimated that the value of known claims against its members at the end of 1999 was £287 million ($424.1 million)—nearly three times higher than the 1990 figure of £97 million ($143.3 million).

"The rise in litigation is not attributable to a fall in clinical standards—quite the opposite—but it is indisputable that the medico-legal climate has changed dramatically over the last 10 years," said Dr. Michael Saunders, MDU chief executive.

MDU Services Ltd., an agent for both The Medical Defense Union Ltd., which represents doctors throughout the United Kingdom, and for Zurich Insurance Co., a London-based unit of Zurich Financial Services which provides liability insurance for MDU members, last month called for a review in the way in which patients are compensated for medical negligence following two awards made to cerebral palsy patients totaling almost £9 million ($13.3 million).

'Every time a claim is paid by the NHS, precious resources are diverted from seriously injured patients who were not damaged by negligence,' says the MDU's Dr. Julia Neild.

"Compensation awards are spiraling and represent a significant drain on NHS funds. What is needed now is a public debate on this serious issue and a solution urgently found before the situation becomes critical," said Dr. Julia Neild, head of claims at the MDU.

"Every time a claim is paid by the NHS, precious resources are diverted from seriously injured patients who were not damaged by negligence but whose care needs are equally important," she said.

When patients are severely injured, the bulk of a compensation award is to fund their future care. Because of the Law Reform Act 1948, patients are entitled to the cost of privately funded care, even though the injury occurred in the NHS and the future care would be available in the NHS.

"In all these cases, this means vast sums of NHS money have to be used to fund private care. Funds are diverted from the NHS to set up individual care and rehabilitation regimes for a tiny number of patients," the MDU pointed out.

The MDU proposes an amendment to the Law Reform Act so that if a patient were injured in the NHS, they would be guaranteed additional care by the NHS.

"Funds that are used at present to set up expensive individual care regimes could then be used to set up specialized care units in the NHS. These units could provide care both for the small number of patients who have been harmed by negligence and for the very much larger number of patients with equally important needs caused by their illness where there has been no question of negligence," according to the MDU.

"We believe that this is a workable solution to the problem and are commissioning research to explore this option," said Dr. Neild.

Dr. Gerard Panting, head of policy for the Medical Protection Society Ltd., which also provides professional liability insurance for the medical profession, agrees that the number of injured patients "who obtain compensation are very small compared to those who actually suffer."

"We think there is plenty of scope for some active thinking that would result in a better system for everybody," he said. Dr. Panting suggested that the state health system could deal with the care requirements of injured patients but pain and suffering awards could be settled on a fault-based system.

The Nordic form of no-fault care and compensation seems to work very well, he said, noting that so far, Sweden, Finland, Norway, Denmark and, beginning this year, Iceland have adopted no-fault systems.

Meanwhile, Belgium "has a commission in place to look at no-fault," said Dr. Panting, adding that no-fault medical negligence compensation also is being discussed in the Netherlands.

Meanwhile, "France is going through its own malpractice crisis, and there is a lot of pressure in many European countries" to find a solution, said Dr. Panting. BI

Farms

Continued from previous page

United Kingdom's leading farm insurers.

With the bovine spongiform encephalopathy crisis, outbreaks of swine fever, the flooding of arable land and the high value of the pound adversely affecting exports, British farming is in the midst of a crisis. A census by MAFF last June showed that 54,000 farmers and farmworkers had left the industry in the preceding two years. The 8.9% drop, the NFU claims, is the "biggest exodus in living memory."

"Farmers are doing all they can to hang onto their businesses. All have cut their costs to the bone," said NFU President Ben Gill.

Canceling or dramatically cutting their insurance programs is one way farmers cut costs, NFU Mutual's spokesman noted. "Farmers are cutting their expenditure to stay in business," he said. Now the government has set up an informal working party with insurers to address the issue, the spokesman said.

Currently, farming losses, including the loss of livestock due to highly contagious diseases, are covered partly by insurance and partly by subsidies by the national government or the European Union.

Farming losses currently are covered partly by insurance and partly by government or E.U. subsidies.

"The NFU Mutual offers insurance programs for a whole range of notifiable diseases which provide extra compensation above that provided by government," the spokesman said. A "notifiable disease" is one that must be reported to MAFF.

Although the government provides a price per animal when a herd must be slaughtered due to an outbreak of illness such as hoof and mouth disease or swine fever, additional losses, such as the loss of income, are not covered by the government subsidy.

In recent years, livestock values have fallen significantly and the European Union and governments are providing less support to farmers.

"A working party with MAFF officials, representatives of farmers and the insurance industry is looking at ways that can be brought in to enable more farmers to protect themselves against highly contagious diseases in livestock, either by insurance or a levy on the whole farming industry," said the NFU spokesman.

A spokeswoman from MAFF confirmed that there had been informal talks but would not comment on them.

Meanwhile, farm insurers are considering increasing rates for auto and employers liability insurance, the NFU spokesman said.

"Sharp increases in the number of claims and amounts of compensation for personal injury and the industry's poor record of safety" will result in increased rates, he said. Government legislation due to go into effect soon and allowing the public greater access to farmland for recreational purposes likely will make the claims situation worse, he noted.

But property insurance rates probably will be unaffected by the recent flood losses, the spokesman said, estimating that the insured losses from the floods will reach only about £15 million ($22.1 million).

Most of the insured losses arose from damage to vehicles, farm buildings, stored crops and a small number of livestock. Crops that were growing at the time of the flood or that could not be planted because of the flooding are not covered by insurance, the spokesman said.

Total loss to the industry, though, will be huge—as high as £500 million, the NFU estimates.

Crops of grains, particularly winter wheat, and sugar beets and potatoes have suffered the most.

"The grain harvest in the coming year could well be several million tons lower than in 2000 because of poor growing conditions and because farmers have been unable to plant on waterlogged land. This could cost up to £300 million ($443.3 million)," said a statement released by the NFU this month.

About 13% of the national potato crop—some 904,420 tons—has been destroyed or remains in ground that is still too wet to be plowed almost two months after the first deluge, at a possible cost to the farming industry of £97 million ($143.3 million).

About 10% of the sugar beet crop in the East Anglia region is still in the ground, with up to 23% unharvested in other areas, "at a massive potential cost and continuing problems supplying processing factories," the statement added. BI

Flights

Continued from page 19

firm of Slater & Gordon has said it plans to sue 20 airlines on behalf of approximately 800 Australians who claim that they or their family members have been affected by DVT developed on long-distance flights. And Manchester, England-based Leigh Day Solicitors said it plans to bring a case against British Airways on behalf of the families of alleged DVT victims.

In the U.K. House of Commons last week, John Smith, Labour member of Parliament for the Vale of Glamorgan, described DVT as potentially a bigger problem than asbestos or bovine spongiform encephalopathy—known as mad cow disease. "Let's do something now before it is too late. There are a number of examples (of DVT cases) which are, quite frankly, scandalous," he told the house.

Ian Gibson, a Labour member of Parliament for Norwich North, said his wife was found to have suffered a blood clot five days after a long-distance flight from the United States. "There is a whiff of complacency in the air. One death really has to be too many in terms of public flying," Mr. Gibson said.

Airlines have stressed that the link between DVT and long-distance flights is unclear and that the exact number of DVT-related deaths is not known. But a physician at the Ashford Hospital in Middlesex, England, the nearest hospital to London Heathrow Airport—which handles more international flights than any airport in the world—said he has seen 30 deaths from DVT in three years and suggested that up to one person a month has died as a result of DVT after disembarking from a flight at Heathrow. A Japanese doctor said that at least 25 people have died from DVT at Tokyo's Narita airport in the past eight years.

The Australian flight attendants' union is currently in discussions with Qantas after a Qantas employee developed a blood clot following a flight from Los Angeles to Sydney. And, this month, Australian vascular surgeon David Grosser announced that three members of Great Britain's Olympic team suffered potentially fatal blood clots when they flew to Sydney for the Olympic Games last September.

A study undertaken by researchers at London's University College Hospital and Middlesex Hospital and due to be published in the medical journal The Lancet, revealed that, of 400 volunteers over the age of 50, 10% developed blood clots after a journey of eight hours. Most of these clots were minor and posed no threat to the passengers, but scientists have stressed that the DVT problem is likely to be greater among the over-50 age group.

Doctors have pointed out that the term "economy-class syndrome" is erroneous, because the condition can affect a passenger in any class of seating.

In November 2000, a House of Lords committee recommended that airline passengers be given more information about the health risks associated with flying on long-distance flights. The House of Lords Science and Technology Committee published a report saying that there should be health warnings on long-distance plane tickets and that airlines should consider giving passengers more legroom. The report also suggested that airlines should sell less alcohol and provide more water on long-distance flights and make health briefings part of the in-flight safety drill.

> **'Passengers intending to fly are not told enough to be able to make informed choices...' says Baroness Wilcox.**

Baroness Wilcox, who chaired the House of Lords Committee, said, "Passengers intending to fly are not told enough to be able to make informed choices about their air travel."

"While the health risk seems slight for the vast majority—indeed, millions fly safely every day—we recommend urgent research and development of user-friendly information for passengers to reduce any further risks," she said.

A spokesman for the Civil Aviation Authority, the United Kingdom's civil aviation regulator, said it would have no objection to including some health information directions with booking information.

"We recognize international public concern about the DVT issue," said Yap Kim Wah, Singapore Air senior vp. "Our plan is to make this information available before the journey as well, from the time the passenger books a ticket. We believe those with health concerns will feel more comfortable about air travel if they are given advice before they fly."

Singapore Air has called for an industrywide approach to passenger health issues amid increasing media interest in the risk of DVT.

British Airways said it would distribute leaflets detailing health tips about how to avoid blood clots with its long-distance tickets beginning in February. "We will also send leaflets to (general practitioners), so that they know what the risks are," said a spokeswoman for BA.

The BA leaflet advises long-distance travelers to get up and stretch their arms and legs every few hours, to take brief walks whenever possible, to limit their intake of caffeine and alcohol and to drink lots of water. The leaflet also advises that passengers exercise gently once they have landed at their destination to stimulate their circulation and then rest.

DVT risk is an important risk management issue, according to David Gamble, director general of the London-based Assn. of Insurance & Risk Managers.

"It is an important issue, and airlines are, clearly, now taking it on board more significantly," he said. "But, of course, if people don't die on the aircraft, it is difficult for (the airlines) to know what happens afterwards."

"Almost every human activity involves a risk to some part of the human population. People need to realize that sitting in the same position for a long period of time is not the way that human beings are built," Mr. Gamble said.

"The risk management view has to be that when a risk has been identified, you have to assess the relevance of that risk to yourself and then assess what you can do to mitigate that."

Mr. Gamble pointed out that public pressure for low-priced airline seats seemed to be at odds with calls for roomier aircraft. "It is a very interesting problem—the extent to which the public demands lower prices for everything but is not willing to put up with the higher risks associated with cutting corners," he said.

Graham Nichols, chief executive of the London-based Westminster Aviation Insurance Group, said that aviation underwriters are watching the DVT situation with interest. Mr. Nichols pointed out that, because no lawsuits have yet been filed, the problem has not yet affected aviation underwriters, but he stressed that they are monitoring the situation.

"I think it is an area we need to be very conscious of as insurers," Mr. Nichols said. "It's up to us as an industry to respond to what our clients do." Under the terms of the Warsaw Convention, retroactive DVT-related claims can be brought only within two years of the incident, thus limiting airlines' liability.

Quake

Continued from page 19

Therefore, Mr. Yanev said he would not expect to see extensive damage to well-constructed buildings owned by multinational corporations.

Still, at least one hotel in San Salvador suffered an estimated $8 million in damage, said Guillermo Rivera Palomo, president of Auditorres de Riesgos Internacionales, correspondents for Aon Group Inc. in San Salvador. Mr. Rivera said he expects other corporate clients have suffered similar losses.

That is a large amount of money in El Salvador, he said. But he also agreed the number of large losses could be relatively few in comparison to the widespread devastation.

Several public and commercial buildings suffered damage, according to another preliminary report by loss adjusters for London-based McLarens Toplis. El Salvador's international airport suffered damage, as did numerous government hospitals, several major hotels and other commercial buildings in San Salvador, according to the report. McLarens Toplis and other insurance industry companies immediately sent representatives from neighboring countries to assess the damage.

"Our hotel seemed to fare much better than some others," said Bradley Wood, vp-risk management for Bethesda, Md.-based Marriott International Inc. The Salvador Marriott hotel suffered minor damage, but it is operational and became a home base for workers involved in the rescue effort, he said.

Several Latin American insurance observers said they expect insured losses could remain relatively low because most of the structural damage has been to homes and small businesses that did not have insurance.

> **Insured losses could rise above $150 million if more damage becomes visible in the weeks ahead, says Guillermo Rivera.**

Swiss Re's insured loss estimate was based on an evaluation using the reinsurer's catastrophe modeling software, said Andrew Castaldi, senior member of management for Swiss Reinsurance's Americas division, Risk Hub/Cat Perils unit in Armonk, N.Y. That is a significant loss to residents of El Salvador and does not include all economic losses the nation faces, he said.

But the insured loss amount is not expected to drive up worldwide property reinsurance rates, he added. "The number is relatively low in comparison to some of the other disasters we have had over the last couple of years," Mr. Castaldi explained. "That is mostly due to the fact that in that area of the world there is very low insurance penetration. Most people and businesses are just not able to afford it."

Swiss Re is expecting to receive claims, mostly from local insurers, Mr. Castaldi said. But it is too early to determine the total amount of claims from cedents, he said.

The insured damage is likely to be nearly split among residences and commercial establishments, with a slight majority of damage to residences, he said. Overall, most economic damage is likely to fall on poorly constructed homes. Larger corporate structures are likely of better construction and are expected to see less damage, he agreed.

But Mr. Rivera said he expects the insured losses could rise above $150 million, because more damage could become visible in the weeks ahead. That could happen as workers tear away the obvious damage and find more problems underneath, such as cracked pipes.

Mr. Rivera said he expects to receive claims for property losses, business interruption and loss of inventory.

Meanwhile, Eduardo Montenegro, president of the nation's insurer association, the Asociación Salvadoreña de Empresas de Seguros, announced that El Salvador's insurers are financially sound and can pay claims. Claimants have already begun submitting their demands, he added.

USDA

Continued from page 2

The other is the need for retraining, as the agency is expected to replace about half its workforce over the next four years as current employees retire or leave the agency.

Many of the agency's employees have degrees in agriculture, the agency's associate administrator noted, adding, "That's great when you're going out into a farmer's field. But it's not as good when you're dealing with reinsurance or risk issues."

"We have a lot of good hard-working folks, who, when the emphasis was on corn and wheat, knew everything about corn and wheat," Mr. Zirschky said. But with the task having evolved into one of evaluating primary insurers' books of risk and taking on some of those exposures, it was clear some new skills were needed.

The USDA contacted the Malvern, Pa.-based Institutes in the summer of 1999, Ms. Luthardt said. "So I showed them the Insurance Essentials CD-ROM." Consequently, Mr. Zirschky recommended that all the department's risk management employees go through the program.

"We are willing to work with companies and other customers to customize things and this is a perfect example," Ms. Luthardt said. "We put the Intro program online for them and we've never done that before."

The initial program crafted by the agency and the Institutes involves three phases.

"They set out kind of an educational development path for their employees starting with (the Insurance Essentials) program and moving into our Introduction to Risk Management Program," Ms. Luthardt said.

The third phase of the program will be the Institutes' Risk Management for Insurance Professionals program.

From there, under Mr. Zirschky's plan, some USDA risk management employees would continue into the Associate in Risk Management program while others might pursue courses leading to the Chartered Property & Casualty Underwriter designation.

> **'We've tried to define a hierarchy. Everyone is basically going to get three types of training,' says John Zirschky.**

"We've tried to define a hierarchy," Mr. Zirschky said. "Everybody is basically going to get three types of training. Those who progress beyond that will have the opportunity to go on with the ARM program or the CPCU program."

Over half the agency's employees had completed the Introduction to Insurance Essentials program by the beginning of this year, scoring over 70% on the examination at the end of the course, Mr. Zirschky said.

"We can't actually require anybody to take tests in the government," the agency's associate administrator noted. "And the fact that over half of our employees were voluntarily willing to do it...."

The training program is funded through the next two courses in the sequence, "so those will at least continue, Mr. Zirschky said. Beyond that, however, it will be up to the appointees of the incoming George W. Bush administration to decide whether it will continue.

"It will be interesting to see whether the next administration continues the training," Mr. Zirschky said.

The risk management agency does have a training policy that permits employees to use up to eight hours per two-week pay period for training in an area consistent with the agency's mission.

Ms. Luthardt commended Mr. Zirschky for implementing the risk management-training program at his agency.

"John Zirschky, I think, deserves a lot of credit," she said, noting that as a political appointee he had made it clear that he believed that whatever the outcome of this past November's elections, he didn't expect to remain in his position when the new administration took over.

Still, "He made it a priority to push this through," Ms. Luthardt said.

"We have not had a culture in recent years of promoting training," Mr. Zirschky said of his agency. "And in government when you're looking for places to cut spending, you cut training."

On top of those obstacles, the transitory nature of government appointments further complicates efforts to implement training programs in federal agencies, he said.

"It's tough as a political employee to build support among other political employees to invest in the long-term health of an organization that you might not be with in two years," Mr. Zirschky said.

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BI Next Issue: January 29 • Closing: January 23

LEGAL NOTICES

SOVEREIGN MARINE & GENERAL INSURANCE COMPANY LIMITED
NOTICE OF ANNUAL GENERAL MEETING OF SCHEME CREDITORS

The Annual Meeting of Scheme Creditors of Sovereign Marine & General Insurance Company Limited ("the Company") has been summoned by the Scheme Administrators, pursuant to Clause 8.1 of the Scheme of Arrangement for the purposes of receiving a report ("the Report") on the conduct of the affairs of the Company and the operation of the Scheme of Arrangement since 26th January 2000, the date of the last report to Scheme Creditors.

The Meeting will be held at The Ostler Suite, The Insurance Institute, 20 Aldermanbury, London EC2V 7HY, on Thursday 1 March 2001 at 10:00 a.m. (London time). A brief presentation will be given on progress made to date and creditors will have the opportunity to ask the Scheme Administrators questions.

A copy of the Report is being sent to Scheme Creditors. Any person entitled to attend the Meeting who has not received the Report by 25th January 2001, can obtain a copy free of charge from the Scheme Administrators of the Company at KPMG, 20 Farringdon Street, London EC4A 4PP.

Queries regarding Creditors' claims should be directed to the helpline on +44 (0) 1452 413 982.

***A. J McMahon*, Scheme Administrator**

12 January 2001

REQUEST FOR PROPOSALS

NOTICE TO PROSPECTIVE PROPOSERS

RFP 01-04 PL/PD Third Party Claims Administration Services

The Santa Clara Valley Transportation Authority (VTA) seeks proposals from qualified firms to provide Third Party Claims Administration (TPA) services for VTA's Public Liability / Property Damage (PL/PD) self insured program. The TPA shall be responsible for the administration, investigation, appraisal, adjustment and resolution of litigated and non-litigated PL/PD claims arising out of, but not limited to, bus and light rail operations in Santa Clara County. Parties interested in obtaining a copy of this Request for Proposals may do so by faxing their request to (408) 955-9729. Please include the following information:

- **Name and Address of Firm**
- **Contact Person**
- **Telephone AND Fax Number**
- **Re: Request For Proposal (RFP) 01-04**

A pre-proposal conference is scheduled for Monday, January 29, 2001 at 1:00 PM in Building "A", Auditorium, 3331 N. First Street, San Jose, CA 95134-1906.

Proposals are due by close of business on February 12, 2001

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Vice Presidents, General Managers and Other Administrative Personnel	3,992
Financial:	
Chief Financial Officers and Vice Presidents of Finance	4,371
Secretaries, Treasurers, controllers and other Financial Personnel	4,428
Risk/Employee Benefits:	
Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	14,047
Sub-total	**31,334**
Associations	254
Government, Unions and Educational Institutions	935
Commercial Consumers Sub-total	**32,523**
Insurance Agents and Brokers	7,663
Insurance Companies	6,004
Accountants, Actuaries, Attorneys & Consultants	2,117
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,154
Others Allied to the Field	1,173
Total Qualified	**50,604**
Non-qualified/Paid Subscriptions	42
TOTAL CIRCULATION	**50,646**

★ *Source Business/Occupational breakdown of qualified circulation, May 29, 2000 issue, as submitted to BPA for June 2000 BPA Publisher's Statement*

Pollution

Continued from page 1

dictions have examined that earlier case and other Washington Supreme Court decisions while considering cases before them.

"There's always a value and influence by being the first out of the block," Mr. Lawrence observed.

But insurer attorney Jule Rousseau said he thought that the ruling would have little influence on other courts.

"Anything that comes out of Washington is not much of a surprise if it's pro-policyholder. Washington seems to be the best place to recover money if you're a policyholder," said Mr. Rousseau, a partner with London Fischer L.L.P. in New York.

Mr. Rousseau predicted that courts elsewhere would be more inclined to agree with a pro-insurer ruling from a California state appellate court on coverage for third-party property damage liability. He noted that the California appellate court rejected the federal appellate court ruling that influenced the Washington Supreme Court.

The Washington high court's ruling is the latest decision in a protracted pollution coverage dispute between Weyerhaeuser Co. of Tacoma, Wash., and Boston-based Commercial Union Insurance Co.

In March 1992, Weyerhaeuser sued dozens of insurers, including numerous Lloyd's of London syndicates and London underwriters, that wrote primary and excess CGL coverage for the wood products manufacturer from 1951 through 1985. Weyerhaeuser wanted the insurers to defend and indemnify it in pollution liability cases involving 42 hazardous waste sites across the nation.

Weyerhaeuser owns only some of the sites, but it has been named as a responsible party for all of the sites under the Comprehensive Environmental Response, Compensation and Liability Act, which created Superfund, and under various state laws. In some cases, Weyerhaeuser is the only responsible party that remains in business and therefore must fully fund the cost of cleaning those sites.

Prior to the first phase of the litigation, all but one of the insurers settled with Weyerhaeuser for undisclosed sums in return for Weyerhaeuser releasing them from all liability.

Only Commercial Union, the successor to Employers' Surplus Lines Insurance Co., did not settle. The Employers'/Commercial Union excess policy provided Weyerhaeuser with $1.5 million of limits per occurrence from Jan. 1, 1970, through Jan. 31, 1973.

In the first two phases of the litigation, juries awarded Weyerhaeuser coverage for six of nine sites.

Before the coverage dispute's third and final phase, Weyerhaeuser dropped its coverage demand for 23 sites so it could concentrate on recovering insurance to pay for cleaning the 10 largest sites. Commercial Union then settled that phase by agreeing to pay Weyerhaeuser $4 million plus certain future costs.

'Weyerhaeuser contracted—and paid higher premiums—for comprehensive coverage encompassing just such a situation,' says Justice Richard Sanders.

In January 1998, a trial court ordered Commercial Union to pay Weyerhaeuser more than $8.4 million in jury verdicts, a declaratory judgment and attorneys' fees. Commercial Union appealed several trial court rulings to a state appellate court, which directly passed the case to the state Supreme Court.

The December 2000 Supreme Court ruling that attorneys found most compelling was that CGL insurers must cover all sums that policyholders are legally obligated to pay to remediate third-party property damage that occurred during their policy periods, even if the policyholders did not cause any of the damage during that time.

The ruling benefits Weyerhaeuser in two cases in which it is responsible for cleaning landfills. Both a Wisconsin site and a Washington site for which Weyerhaeuser won coverage in earlier phases of the litigation began operating as sanitary landfills and were contaminated by third parties during the period that Commercial Union covered Weyerhaeuser. But Weyerhaeuser did not ship waste to either site until 1974, so it did not incur any liability for those sites due to its own actions until after its coverage period had expired.

Commercial Union argued that it should not be held responsible for the more than $1.6 million of total cleanup costs at the two sites, because the damage was "caused by a stranger to the policy." The insurer noted that a California appellate court in 1998 ruled that coverage exists only when a policyholder is liable for damage at the time it occurred.

But in a majority opinion written by Justice Richard Sanders, Washington's high court noted that another California appellate court had ruled oppositely years earlier.

Moreover, the state Supreme Court ruled, the 9th U.S. Circuit Court of Appeals, which has jurisdiction over both California and Washington, resolved the discrepancy between the California appellate courts by ruling for policyholders last year.

Washington's high court called the 9th Circuit's ruling "persuasive." It also stressed that CERCLA and a Washington cleanup statute impose strict, joint and several, and retroactive liability on Weyerhaeuser to clean up the damage that occurred at the landfills during Weyerhaeuser's policy period.

Therefore, "the nature of the liability imposed by the federal and state statutes compels coverage where the insurer has agreed to pay 'all sums which the insured shall become obligated to pay as damages by reason of the liability imposed upon the insured by law,'" the court ruled, quoting the Commercial Union policy.

"Although the parties may not have predicted liability of this nature would be imposed, it is nevertheless a legal liability imposed upon Weyerhaeuser by an occurrence as defined in Weyerhaeuser's insurance policy. Weyerhaeuser contracted—and paid higher premiums—for comprehensive coverage encompassing just such a situation," Justice Sanders wrote.

Mr. Lawrence, the policyholder attorney, said history suggests that the ruling will be influential with other courts, "though not determinative."

Insurer attorneys criticized the ruling, which they characterized as minority view among courts.

"The whole theory seems just incredible," said Laura Foggan, who represents the industry-supported Insurance Environmental Litigation Assn. The IELA filed an amicus brief in the case.

Both Ms. Foggan, a partner with Wiley, Rein & Fielding in Washington, D.C., and Mr. Rousseau noted that California's 1st Appellate Court decided one week after the *Weyerhaeuser* decision to reject the 9th Circuit's reasoning. In *Tosco Corp. vs. General Insurance Co. of America*, the California Appellate Court upheld a trial court's summary judgment that insurers are not required to defend or indemnify policyholders against environmental and asbestos liability claims arising from property that the policyholder did not own during its policy period.

"So *Tosco* is more important" than *Weyerhaeuser*, Mr. Rousseau asserted.

In other rulings that attorneys said were first-of-their kind decisions from a state supreme court, Washington's high court determined that:

- Commercial Union was not entitled to offset its Phase I and II liabilities by the settlement funds that Weyerhaeuser received from its other insurers. Commercial Union argued that those funds more than covered all proven and insured damages at the 42 original sites as well as attorneys' fees.

But the high court, which heavily weighed a 1996 state appellate court ruling on the same issue, ruled that the settlements covered far more than Weyerhaeuser's current pollution cleanup liabilities. They covered all past, present and future liability claims as well as "certainty by avoiding the risks of an adverse trial outcome...."

Because Commercial Union failed to prove what percentage of those settlements were earmarked for cleanup costs, the insurer is not entitled to offsets, the court ruled.

- Commercial Union's excess policy contained a property liability limit of $1.5 million per occurrence but no aggregate limit for such losses. The policy's aggregate limit applied only to product liability and personal injury claims, the court ruled.

Commercial Union argued that its total exposure under the policy is $4.5 million—a figure it arrived at by adding aggregate limits of $1.5 million for property liability, product liability and personal injury liability.

The Washington Supreme Court's majority rejected that argument, because the policy did not once reflect Commercial Union's contention that its total exposure would be capped at $4.5 million.

Policyholder attorneys say the ruling is important for all policyholders because many excess insurers used the same or a similar policy form.

The court, however, reversed the trial court and ruled that Commercial Union's policy imposes a $500,000 deductible per incident with no aggregate.

•

Weyerhaeuser Co. vs. Commercial Union Insurance Co., Washington Supreme Court, Dec. 21, 2000; No. 67694-1. Tosco Corp. vs. General Insurance Co. of America, California 1st Appellate Court of Appeal, Dec. 28, 2000; Nos. A082765, A084044, A086154.

Insurer appeals bar on exclusion

By DAVE LENCKUS

PHOENIX—A general liability insurer is appealing an Arizona state appellate court ruling that bars insurers from imposing the absolute pollution exclusion in cases that do not involve traditional environmental pollution.

In its 3-0 decision on Dec. 5, 2000, the court also ruled that bacteria fall outside of the exclusion's definition of substances that can cause losses the insurers would not cover.

The underlying claim in the case arose in February 1993 when a golf professional became seriously ill, allegedly due to consuming water contaminated with both total and fecal coliform bacteria at the Desert Mountain home and golf development in Scottsdale, Ariz. Home and golf facilities at the development were served by a water distribution system that Desert Mountain owned.

Desert Mountain's primary insurer, Northbrook Property & Casualty Insurance Co., and excess insurer, Transamerica Insurance Co., refused to defend and indemnify the development. Desert Mountain settled with the golf pro for $1.2 million in July 1997 and allowed her to intervene in the coverage suit it had filed against the insurers.

A trial court granted summary judgment for the insurers, but the appellate court overturned that ruling last month.

The appellate court ruled that the waterborne bacteria that allegedly caused the golf pro's illness do "not fit neatly" within either the explicit or the implicit list of pollutants, irritants or contaminants that the insurers' absolute pollution exclusions state would bar coverage if any of those substances contributed to a loss.

The insurers' lists of substances were limited to only inorganic materials, the court noted. That means that any pollutants that were not mentioned specifically but that still would trigger the exclusions also must be inorganic, the court ruled.

"Bacteria, as living organisms, are not similar to the (exclusions') enumerated list," the court ruled.

The court also decided that bacteria do not fall within the exclusions' definition of waste material, which is a substance that also would trigger the exclusions. The exclusions' definition of waste implies "industrial byproducts" but not the organic matter in Desert Mountain's water, the court ruled.

Regarding Northbrook's argument that the term pollutant means any kind of contaminant, the court said that "such an interpretation at best would render the clause ambiguous," and ambiguous clauses must be resolved in favor of policyholders.

The court concluded that the exclusion's drafting history and public policy compel the court to conclude that the absolute pollution exclusion bars coverage of only the "traditional environmental pollution" caused by "industrial insureds who must handle, store and treat 'hazardous waste' in conducting their daily operations."

Northbrook has asked the Arizona Supreme Court to review the ruling. Transamerica has asked the appellate court to reconsider its decision ordering the insurers to cover the golf pro's attorneys' fees. If the appellate court refuses, Transamerica would join Northbrook's appeal.

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Caroline Saunders Keggi vs. Northbrook Property & Casualty Insurance Co. et al., Arizona Appellate Court; 1 CA-CV 99-0566, Dec. 5, 2000.

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COBRA

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charge COBRA beneficiaries a premium of up to 102% of the group rate.

Since the statute was enacted, the IRS has issued various regulations to try to address the many questions employers and other plan administrators have raised. The latest regulations, published earlier this month, deal with a batch of practical COBRA-related situations that employers may face.

Some of these questions and answers, issued as final regulations, include:

Q: Does an employer have to offer COBRA to a beneficiary who has access to lower-cost group coverage?

A: If a qualifying event occurs, such as an employee being laid-off or retiring, the employer has to offer COBRA, even though there may be a less costly alternative for the beneficiary.

Take the situation of a company that pays 100% of the premium for its group health care plans. For employees who retire but are not yet eligible for Medicare, the company pays 50% of the premium, while the premium for COBRA coverage is 102% of the group rate.

The IRS says the employer still must offer COBRA and allow the employee to decide whether to opt for COBRA or the company-subsidized plan.

"Although in many cases a qualified beneficiary might prefer a lower premium," COBRA's procedural protections might be even more valuable to the beneficiary, the IRS said.

Among other such protections, COBRA gives beneficiaries 60 days from the time of a qualifying event to decide whether to opt for health care continuation coverage and another 45 days to make the first premium payment.

"The likelihood of the COBRA procedural protections being more valuable than the lower premium becomes substantial as the amount required to be paid for part-time or retiree coverage approaches the amount of the applicable premium," the IRS said in the final regulations.

What the IRS is saying is that the employer must offer COBRA coverage and then "let the beneficiary decide" which plan he or she wants, said Colleen Clearwater, a senior vp with COBRA Compliance Systems Inc.in Coldwater, Mich.

Q: Does the right to COBRA coverage begin at the time of a qualifying event or in anticipation of a qualifying event?

A: The right to COBRA starts at the time of a specific qualifying event, such as termination of employment or divorce. Take the case of an employee who knows he is going to divorce his spouse and asks his employer to change his health care plan to single from family coverage. Eight months later, the divorce occurs. It would be at that point that the spouse would have the right to obtain COBRA coverage for up to 36 months.

Q: What happens if an employer changes benefits offered under a plan between the time a beneficiary lost coverage under the group plan and the date the individual was eligible for COBRA?

A: Generally, a beneficiary is eligible for the same coverage he or she had before the event that qualified him or her for COBRA. However, if between the time of the elimination of coverage and the date of a qualifying event, coverage is modified for non-COBRA beneficiaries, then the COBRA beneficiary must receive the modified coverage, the IRS says.

Q: What happens when the COBRA premium paid by the beneficiary is short by a few dollars? Can the employer cancel coverage?

A: Under the final regulations, an employer has to treat the payment that is short by an "insignificant" amount as full unless the employer notifies the beneficiary of the deficiency and requests that the amount be paid within a reasonable amount of time.

The IRS, in the final regulations, defines an "insignificant" underpayment as one that is short by $50 or 10% of the required amount, whichever is less. The IRS says giving beneficiaries up to 30 days to pay the shortfall would be reasonable. BI

IRS proposes simplification

Minimum benefit rule to be updated

By MICHAEL PRINCE

WASHINGTON—The Internal Revenue Service has issued proposed regulations that would simplify the calculation of minimum distribution amounts from 401(k) plans and individual retirement accounts.

The new rules would make it easier for plan participants and plan administrators to determine the minimum benefit that must be distributed from qualified plans, beginning at age 70½. The proposed rules also would make it easier for plan participants to make changes in their plan distributions, such as choosing a beneficiary in case of death while the account still contains assets.

"On the whole, this is a very positive development for plan administrators," said Michael Kushner, regional compliance practice leader at The Segal Co. in Washington.

The old minimum distribution rules were issued in 1987 but never became final, though the IRS enforced them. The rules are basically intended to assure that the benefits are not sheltered from taxation indefinitely. But because of objections received over the years, the IRS recognized that revisions were needed.

Although the proposal is subject to public comment and hearings, the IRS is already following the new regulations, which were published in the Jan. 17 Federal Register.

The new regulations are designed to "make it much easier for individuals—both plan participants and IRA owners—and plan administrators to understand and apply the minimum distribution rules," the opening statement of the regulations says.

The old rules contained numerous ways to calculate the minimum distribution amount, according to Kyle Brown, retirement counsel for Watson Wyatt Worldwide in Washington. "It was a phenomenally complex set of rules," he said.

Under the new rules, which Mr. Brown said are much simpler, the IRS has created a table that is applicable to all people. For each age, the table provides a number that is divided into a person's account balance to determine the minimum distribution amount. The table's figures are based on life expectancy at various ages, among other factors.

"Most employees will be able to determine their required minimum distribution for each year based on nothing more than their current age and their account balance as of the end of the prior year," the regulations state.

Mr. Brown noted that this helps employers, as they often calculate the minimum distribution amounts for participants.

The new regulations also allow greater flexibility in changing certain information, such as beneficiaries.

"You can change your mind every year," Mr. Brown said. Under the old rules, the beneficiary could not be changed once selected.

Overall, "they have tried to give taxpayers as much flexibility as they can," he said.

One downside noted by Segal's Mr. Kushner is that the changes in the rules concerning beneficiaries of plan members mean payouts that employers make from the plan may last for many more years than under the old rules.

"It raises the specter that plan administrators will have to monitor minimum distributions over a longer period of time," he said.

But "in general, plan administrators will welcome these changes as it's so simplified" and will greatly reduce errors in calculating the minimum distribution amounts.

Although the new rules would not go into effect until Jan. 1, 2002, people may begin applying them this year, the IRS regulations state.

Comments regarding the proposed regulations may be submitted to the IRS until April 17. A public hearing will be held June 1 at IRS headquarters in Washington.

Transit benefit expanded

BY JERRY GEISEL

WASHINGTON—Final Internal Revenue Service regulations will give more flexibility to employers that provide tax-favored transportation benefit programs for their employees.

The final rules, published Jan. 11 in the Federal Register, largely affirm the proposed regulations the IRS issued last year. They deal with several federal laws that permit the establishment of such benefit plans.

The most recent of those laws, the Transportation Equity Act for the 21st Century, allows employees to make pretax salary contributions—currently up to a limit of $65 per month and rising to $100 per month in 2002—to pay for mass transit expenses, such as monthly commuter train passes or van-pooling arrangements.

The Taxpayer Relief Act of 1997 gives employees the right to make pretax contributions—currently set at as much as $180 a month—toward parking expenses.

Before these laws went into effect, employers could, up to certain limits, subsidize employees' mass transit and parking expenses without those contributions being added to employees' taxable income. Salary reduction arrangements, though, were barred.

The new laws, which permit employees to fund the benefit through salary reduction, have given employers a new incentive to offer transportation benefit programs. Under these new laws, employers need not pay any of the costs—other than administrative overhead—while employees have a tax-effective way to pay their commuting expenses.

In many employer-sponsored programs, an employer purchases vouchers directly from a transportation authority or from an independent vendor. These vouchers are distributed to participating employees, whose salaries are reduced by the amount of the vouchers. An employee can then redeem the voucher with a transit office or with a retailer acting as an agent for the transit authority for a transit pass for use on buses and trains. In other cases, an employee can have his or her salary reduced by a stipulated amount, purchase a transit pass and then be reimbursed by the employer.

The rules allow pretax contributions of up to $65 a month for mass transit and $180 a month for parking.

Under last year's regulations, an employer has to provide vouchers if they were "readily available." At the time, the IRS defined "readily available" as meaning that the administrative cost of providing the voucher did not exceed 1% of its value.

The final regulations retain this 1% limit, but they also say that vouchers will not be considered to be readily available if the provider of vouchers fails to make them available at reasonable intervals, in reasonable quantities or within a reasonable period after receiving payment from an employer.

"What the IRS is saying is that there are factors other than cost that can be considered to determine whether or not vouchers are readily available," said Sharon Cohen, an attorney with Watson Wyatt Worldwide in Washington.

In addition, the final regulations will modify earlier rules regarding situations in which employees receive transit passes for future travel but terminate employment before the passes are used.

Under an earlier IRS rule, to the extent that an employer did not recover the transit passes from a terminating employee, the employer had to include the value of the passes in the employee's wages for the purpose of withholding income and Social Security taxes. The final regulations slightly modify that rule; in general, they will eliminate the requirement that the value of the passes be regarded as income for Social Security tax purposes.

The final regulations also deal with a parking matter. Employers wanted to know if expenses for parking that is related to work but does not involve commuting from home to work—such as parking at an airport lot for a business trip—qualify for tax-favored status, such as a salary reduction.

But the IRS made clear that tax-favored parking includes only "parking on or near a work location at which the employee performs services for the employer." In other situations, as in the example of an employee parking a car at an airport lot, an employer can reimburse an employee for the expense without the reimbursement being added to the employee's taxable income. BI

HIAA

Continued from page 2

providers. According to HIAA, at least 11 states "have already expressed plans to explore strategies for reducing the cost of prescription drugs and expanding access to coverage for senior citizens and others without such coverage."

In addition, HIAA expects nearly every legislature to deal with some type of coverage mandate, including those involving mental health parity, clinical trials and contraceptive coverage. Last year, only Idaho and Louisiana did not consider any sort of coverage mandate.

HIAA also expects legislators in many states to continue pressing for managed care reforms. For example, no state has followed Texas' lead in enacting physician antitrust exemption legislation, and a similar effort at the federal level died quietly.

But HIAA predicts the issue will continue in several states in 2001, including California and Pennsylvania.

The notion of subjecting health care plans to legal liability for coverage decisions appears to be waning. Seven states have enacted such legislation, and HIAA expects the issue to emerge in 20 legislatures this year. That's only about half of the number of states that considered the issue in 1998, and is considerably fewer than last year.

"Conversely, 40 states and the District of Columbia have already passed external-review mechanisms," noted HIAA in a short review of legislative activity. "It is clear that many states have delayed serious consideration of liability bills in order to measure the impact of external-review laws."

Other issues states are likely to consider include small-group market reforms, expanding eligibility requirements for state high-risk pools to cover more of the uninsured population and creating new solvency standards for health maintenance organizations, HIAA said.

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More information on the HIAA state legislative forecast is available online at *www.hiaa.org/news/news-state/010118mediakit.htm.*

Fight back against meritless claims

I hope G-I Holdings Inc. has patience, money and good legal representation in its civil racketeering lawsuit against a trio of plaintiffs law firms if its allegations are true.

If history is any guide, it could be a very long time before G-I Holdings wins, if at all.

G-I Holdings, the successor to GAF Corp., charges in its lawsuit filed this month that the law firms "have orchestrated a scheme to inundate the judicial system with hundreds of thousands of asbestos cases without regard to their merit" (*BI*, Jan. 15).

G-I Holdings also alleges that the law firms not only forced the settlement of meritless cases but also threatened defendant companies that supported federal legislation to reform asbestos compensation with "nuclear war."

G-I Holdings just filed for bankruptcy after paying more than $1.5 billion in asbestos claims and expenses since the 1970s.

Asbestos kills; there is no doubt about that now. And the victims of asbestos exposure were due compensation. I certainly wanted a dear family friend who had sailed with my husband and me to be compensated when he was stricken with a disease traced to his employment in a shipyard during his youth. His estate accepted a settlement after he died.

But if some greedy plaintiffs' attorneys are now bringing meritless cases to keep their fees rolling in, they should be stopped in their tracks.

Kathryn J. McIntyre

The nearly 2,000 companies that are now defendants in asbestos lawsuits, and their insurers, are at risk as well as G-I Holdings and other bankrupt asbestos producers (*BI*, Jan. 8).

It could be years, however, before this case is resolved.

It took the Chicago-based economic consulting firm Lexecon Inc. and Dan Fischel, Lexecon's star expert witness in securities fraud cases, seven years to win a case alleging abuse of process against the highly successful plaintiffs class-action firm of Milberg, Weiss, Bershad, Hynes & Lerach and several of its partners. But after seven years of litigation, including a trip to the U.S. Supreme Court, Lexecon and Mr. Fischel, now dean of the University of Chicago Law School, won a $45 million abuse-of-process jury verdict in April 1999. The day after the verdict, just before the punitive damages phase of the trial was about to begin, the case was settled for $50 million, with no confidentiality restrictions. While Milberg Weiss denied that the settlement was a concession that the jury's verdict was correct, Lexecon specifically reserved the right to claim otherwise.

The money to pay the settlement came out of partners' pockets, according to several press reports available on the Internet.

There are interesting parallels between the G-I Holdings and Lexecon cases. Both allege not only meritless lawsuits but also threats by plaintiffs' attorneys.

G-I Holdings contends in its suit that the three law firms threatened "nuclear war" against asbestos defendants that supported last year's Fairness in Asbestos Compensation Act, telling defendants at an April 8, 1999, meeting that "they would financially cripple any company supporting the act."

The act died under heavy fire from plaintiffs' attorneys and only lukewarm support from defendant companies that may or may not have been deterred by the threats.

Ironically, the threats alleged in the G-I Holdings case were uttered just days before Lexecon won its suit.

The Lexecon suit alleged that the firm of Milberg Weiss financially damaged Lexecon because Mr. Fischel was an effective expert witness for defendants that Milberg Weiss had sued.

Indeed, it was alleged that name partner Melvyn Weiss told Mr. Fischel in 1988 that "I will destroy you" after Mr. Fischel's testimony in the high-profile securities case involving Nucorp Energy Inc. had been credited with winning the case for the defendants.

Not long after, Milberg Weiss sued Lexecon and Mr. Fischel in the billion-dollar class-action securities fraud case they had filed following the collapse of Lincoln Savings & Loan Assn. The suit against Lexecon and Mr. Fischel was "without regard to the merits of such a claim," and Milberg Weiss used it to "drag them through the mud when they appeared as witnesses in other cases," according to a summary of the litigation prepared for the business community by Lexecon's attorneys, Mayer, Brown & Platt.

That strategy worked, according to Lexecon's lawsuit. While the rest of Lexecon's business doubled over eight years, its securities business dropped about 65%.

It took the jury in federal court in the Northern District of Illinois only six hours to find for Lexecon and Mr. Fischel—after all the years of litigation.

G-I Holdings, take note, and take heart.

Publishing Director Kathryn J. McIntyre's commentary appears fortnightly and on www.businessinsurance.com. *She can be reached at* kmcintyre@crain.com.

Wiretap

Continued from page 1

and password. User names were provided to certain Hawaiian Airlines employees, but not to managers or union representatives. To obtain a password and see the site, eligible employees had to register and agree not to disclose the site's content.

An airline vice president, James Davis, contacted a Hawaiian pilot who had never used the Web site and received his permission to use his name to access it, Mr. Konop charged. Later, he claimed, Mr. Davis obtained another pilot's permission to log in using his name, as well. Mr. Konop also alleges that Mr. Davis shared information he saw on the Web site with the pilots' union.

Mr. Konop sued Hawaiian Airlines, charging its actions violated the Wiretap Act, the Stored Communications Act and the Railway Labor Act. A federal trial court granted Hawaiian Airlines' request for summary judgment dismissing those claims.

In considering whether the federal laws applied to the circumstances, the 9th Circuit noted that "civil damages are substantially greater" under the Wiretap Act, which prohibits unauthorized interception of electronic communications, than they are under the Stored Communications Act, which prohibits unauthorized access to "a facility through which an electronic communication service is provided."

The appellate court focused on whether data must be acquired just as it is being transmitted to be considered an unauthorized interception under the Wiretap Act. "If interception requires that acquisition and transmission occur contemporaneously, then unauthorized downloading of information stored on a Web server cannot be interception," says the decision.

The decision concluded otherwise, though. "We hold that the Wiretap Act protects electronic communication from interception when stored to the same extent as when in transit," says the opinion.

Although there are exceptions to this, such as when a Web site is intended to be readily accessible, or when it is accessed by an authorized user, Mr. Konop "has raised material issues of fact whether Davis had appropriate consent to view Konop's Web site," says the decision.

The appellate court also ruled the district court should not have granted summary judgment dismissing Mr. Konop's charges of violations of the Railway Labor Act, which governs labor disputes in the transportation industry. Among other issues, Hawaiian Airlines had argued that Mr. Konop had forfeited any protection he might ordinarily have had under the Railway Labor Act because of articles on the Web site that contained "malicious, defamatory and insulting material known to be false."

The appeals court held, though, that Hawaiian Airlines presented no evidence that Mr. Konop acted with the "requisite malice." The case was remanded to the district court for further proceedings on Mr. Konop's claims that the airline violated the wiretap and labor laws.

The appellate court did uphold a district court's rejection of Mr. Konop's claim that he was placed on sick leave in retaliation for protected labor activities.

A spokesman for Hawaiian Airlines said: "The company does not agree with the opinion and is considering an appeal."

Attorneys say the decision is notable for the added protection it will provide companies for their Web site data.

'I think the court believed that something untoward and nefarious was going on,' says Alan Charles Raul.

"If you're an employer or anyone else who has a Web site and if your Web site is protected by password or by a requirement that visitors agree to certain conditions, this case expands your rights beyond what the courts have previously recognized," said Charles Kennedy, an attorney with Morrison & Foerster in Washington.

"This case says if someone comes into your Web site under false pretenses, uses someone else's password or does not agree to abide by the terms and conditions for access, that's in violation of the wiretap statute," he said.

Mr. Kennedy noted, though, that the outcome would have been different if the employee had put the material on the employer's Web site. "The employer would have had every right to monitor the material, and that continues to be true," he said.

Doug Dexter, an attorney with O'Melveny & Myers in San Francisco, said the ruling will give employers added protection in those situations. "Often employers will find that their former employees are accessing their internal communications, Web-based internal communications systems or their networks and this provides another tool for employers to deter that behavior," he explained.

"Just as Mr. Konop or a labor union might have an interest in protecting the confidentiality of their communications, certain companies do as well," Mr. Dexter said.

Maureen Dorney, an attorney with Gray, Cary Ware & Freindenrich in Palo Alto, Calif., said the decision "will give a lot of ammunition to people" who are seeking to file suit for unauthorized access to their Web sites.

Ms. Dorney said the 9th Circuit's decision was not surprising. She said she has generally advised clients that if they secure access to a Web site under false pretenses "the court would probably bend over backwards to find liability."

"It's significant in that it challenges what to many was the prevailing view of what constitutes an interception under the (wiretap) law," said Robert Corn-Revere, an attorney with Hogan & Hartson in Washington.

Morgan W. Tovey, an attorney with Crosby, Heafey, Roach & May in San Francisco, said that while the crux of the case is that communication does not have to be in transit for interception to have occurred, "the broader significance of the case is the court's willingness to afford protection to a Web site where there is some security attached to it, even if that security is relatively minimal."

Some attorneys say the court may have been influenced by the facts in this particular case.

"I think the court believed that something untoward and nefarious was going on...but it seems to have stretched an existing statute in order to cover how it considered to be wrongful conduct," said Alan Charles Raul, an attorney with Sidley & Austin in Washington.

John Hancock, an attorney with Fenwick & West in San Francisco, said the court's opinion may have been influenced by its feeling that management "was just intruding unfairly on employee matters," and that it might have emerged with a different opinion had, for instance, the two parties in the case been businesses.

However, he added, "I think that it could be fairly influential, notwithstanding the labor-management context from which it arose, and that's because this whole area of online privacy is so novel, we don't really have a lot of cases that tell us what the law is in this area."

The case also has implications for employer-employee relations.

"If anything, it's another example of employee privacy rights that must be respected by employers," said attorney Brian T. Ashe an attorney with Seyfarth Shaw in San Francisco, who noted setting up anti-company Web sites is a growing trend.

Gerald L. Maatman Jr., a partner and chairman of the global employment law practice group at Baker & McKenzie in Chicago, said, "This case illustrates the dangers in terms of how management can go about monitoring or trying to figure out what is on the sites. It says to me employers need to revise their policies on Internet access and off-duty conduct of employees, which in this case was setting up a Web site criticizing management."

However, courts must also confront the issue of whether employees can be disciplined for off-duty conduct—including posting certain statements on Web sites—that may impact the work place. This "creates lots of gnarly issues for the courts," said Mr. Maatman.

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Robert C. Konop, plaintiff-appellant, vs. Hawaiian Airlines Inc., defendant-appellee, 01 C.D.O.S. 199, 9th U.S. Circuit Court of Appeals.

Directory deadline approaches

Business Insurance will publish its Directory of Risk Securitization Specialists in the March 12 issue, which will also feature a Spotlight report on risk financing options. To be included in the directory, a company must provide advice on packaging insurance risk using capital market instruments and/or underwrite and distribute these risk securitization products. The directory is an editorial service; there is no charge to be listed. If your company provides risk securitization services but has not received a questionnaire, please contact Michel Schwartz at 312-649-5313. Questionnaires must be returned by Feb. 9.

MSDs

Continued from page 1

Several major employer actions, including one that was joined by the Risk & Insurance Management Society Inc. earlier this month, challenged the agency's procedures and questioned whether OSHA had sufficient scientific backing to promulgate the rule. The release of the NAS report did nothing to stop those legal actions, which have been consolidated—along with an insurer review request and several union petitions for review—into one action that is before the U.S. Circuit Court of Appeals for the District of Columbia.

"Musculoskeletal disorders of the low back and upper extremities are an important national health problem, resulting in approximately 1 million people losing time from work each year," according to the NAS report, "Musculoskeletal Disorders and the Workplace." The report estimates that such disorders cost the economy about $50 billion annually.

But "because workplace disorders and individual risk and outcomes are inextricably bound, musculoskeletal disorders should be approached in the context of the whole person, rather than focusing on body regions in isolation," the report says. "The weight of the evidence justifies the identification of certain work-related risk factors for the occurrence of musculoskeletal disorders of the low back and upper extremities," holds the report. For example, the NAS study notes that there is "a clear relationship between back disorders and physical load" including frequent bending and twisting and whole-body vibration.

"The weight of the evidence justifies the introduction of appropriate and selected interventions to reduce the risk of musculoskeletal disorders of the low back and upper extremities. These include, but are not confined to, the application of ergonomic principles to reduce physical as well as psychosocial stressors. To be effective, intervention programs should include employee involvement, employer commitment and the development of integrated programs that address equipment design, work procedures and organizational characteristics."

But the report made clear that programs have to be tailored to the conditions of individual workplaces and that they must be reviewed over time. In addition, the report called for further study of the issue.

Charles N. Jeffress, the assistant secretary of labor in charge of OSHA who promulgated the rule, hailed the NAS report in a farewell press conference. He said the report confirms OSHA's analysis of the relationship between ergonomic risk factors and MSDs and said that OSHA's ergonomics standard meets the requirements listed by the NAS report as necessary for effective intervention programs.

"It's one more piece of evidence that there is good, sound science behind ergonomics programs," Mr. Jeffress said, adding that he was "not surprised" by the panel's conclusions.

"The NAS study confirms that MSDs are a real and costly problem for employers," said Daniel Barry, director-government affairs for New York-based RIMS. "That's why they have been devoting significant resources to reducing them in recent years and why RIMS encouraged OSHA to work with the business community to reduce MSDs. OSHA chose to put in place a broad rule covering nearly every employer, despite their own evidence—backed by the NAS study—that there are certain high-risk jobs where most of the injuries occur. NAS recognizes that the connection between an MSD and the workplace is 'complex,' which is why we are so concerned about the OSHA rule—it puts a tremendous burden on employers if an MSD is merely aggravated by workplace conditions," Mr. Barry said.

'The NAS study confirms that MSDs are a real and costly problem for employers,' says RIMS' Daniel Barry.

"What it says is there are significant MSDs in this nation. Some are workplace-related, some not, which is not surprising," said Arlene Ryndak, workers compensation specialist with the National Assn. of Independent Insurers in Des Plaines, Ill.

The insurer group remains concerned about the OSHA standard because "the way the standard is written, it may not hold the same causation standards that the workers compensation system does. We're concerned that doctors will be restricted from looking at non-workplace activities—it won't give them a clear view of whether something" is work-related, she said.

A spokeswoman for the Alliance of American Insurers in Washington said the NAS report underscores the Alliance's concerns about the ergonomics standard. "The findings don't suggest one simple prescriptive remedy. In fact, they support the employer and insurer community's view that there is no magic bullet. This very complex problem is not given to a one-size-fits-all solution," she said.

"It makes it clear that the issues are complex," said a spokeswoman for the American Insurance Assn. in Washington. "It bolsters the case that the ergonomics standard is not the right way to go, because federal regulations, by their very nature, are not flexible or nimble."

The spokeswoman added, however, that the insurer group has questions about the privacy implications of the NAS recommendations for data collection because the needed data would contain a lot of personal information.

The AFL-CIO, which supports OSHA's standard, praised the NAS report. "The new NAS report on musculoskeletal disorders in the workplace is a rock-solid affirmation of OSHA's new ergonomics standard," John J. Sweeney, president of the AFL-CIO, said in a written statement. "The report confirms that musculoskeletal workplace injuries are caused by exposure to ergonomics hazards, that they can be prevented and that the interventions required by the new OSHA rule are the most effective means to protect the health and safety of U.S. workers."

The National Assn. of Manufacturers, which has vehemently opposed the OSHA standard and has asked a federal court to review it, drew different conclusions from the report than did Mr. Jeffress. Jenny Krese, the NAM's director-employment policy, said in a statement that the NAS report showed OSHA based its standard on "a rickety foundation of questionable science and statistics," and she called upon Congress or the courts to overturn it.

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Pre-publication copies of "Musculoskeletal Disorders and the Workplace: Low Back and Upper Extremities" are available from the National Academy Press, 2101 Constitution Ave. N.W., Washington, D.C. 20418; 202-334-3313 or 800-624-6242. Single copies cost $60 plus $4.50 shipping for the first copy and 95 cents shipping per each additional copy.

Riskclick

Continued from page 2

For example, Riskclick's document management function enables all parties to an insurance transaction to convert the related paperwork, using ACORD-XML commercial lines standards, into electronic documents that can be stored, shared and even converted for other uses without manual retyping.

"Ninety percent-plus of the information used in insurance is in the form of documents, so it follows that any e-business solution must have the ability to manipulate and store large numbers of documents," Mr. Green said. "Yet, of the top 200 brokers and insurers globally, only a handful have a system to systematically manage electronic documents."

The collaboration feature allows multiple users at many different sites to access information simultaneously.

"A number of brokers and insurers have 'extranet' solutions that enable clients to get access to certain information. Collaboration takes this to the next step; it facilitates full two-way interaction with clients," Mr. Green said.

"Collaboration enables the broker, insurer and any number of client representatives to be formed into virtual teams that can work together on an assignment or transaction," he said. "In the background, Riskclick keeps track of every interaction, document and document version, so that there is a complete and reliable audit trail. Imagine an international program where there are dozens of client, broker and insurer representatives globally. Riskclick enables all of them to work together seamlessly, to interact, to collect, update and share information."

Riskclick's knowledge management feature provides access to 500 sources of content stored in its database. Among the resources is *Business Insurance*, which has licensed to Riskclick access to its current content.

So if, for example, one of Riskclick's users were working on a directors and officers liability claim, he or she could research the topic using *BI's* five most-recent issues, as well as other sources, such as Rough Notes and Standard & Poor's Corp.

"There is a vast amount of valuable information in insurance. The problem is that it is not in a format that supports decision making," Mr. Green said. "Our mission is to integrate valuable content, like *Business Insurance*, into the insurance process as a decision support tool."

The transaction support function helps brokers structure and place business and issue certificates of insurance.

Several U.S.-based brokers will be piloting Riskclick's infrastructure product beginning this month, Mr. Green said. And while the product targets primarily middle-market accounts, preparations also are being made to market Riskclick to players in the global risk, small commercial and international markets, he said.

"Insurance industry leaders see the benefits of e-business and are anxious to deploy modern methods to better serve their clients, differentiate and grow their business," Mr. Green said. "What holds them back is that insurance simply doesn't have the infrastructure to conduct e-business on a large scale."

The primary objective of the founders of Riskclick is to provide that infrastructure, he said. **BI**

UPDATES

Blanch exec to head new reinsurer

Continued from previous page

volved in developing the Markitas concept but that its role in any ongoing operations of the reinsurer "is yet to be fully determined."

Blanch announced that Mr. Ahlmann, who joined the brokerage in November 1999, will resign at the end of the first quarter to focus on Markitas' development. Mr. Ahlmann, a former chairman and chief executive officer of Employers Reinsurance Corp., will remain a Blanch director.

Separately, Blanch said it will report a net loss for 2000 and disclosed that a previously announced restructuring effort will result in a fourth-quarter 2000 charge against earnings of $9.5 million. Most of the total relates to contract termination and employee severance expenses connected with the restructuring, which involves selling non-core assets and cutting corporate overhead, the broker reported.

Blanch also expected to report a $7.8 million pretax capital gain from the sale of one of its non-core units, but the sale was not completed, the company said. Excluding the restructuring charge, Blanch expects to produce a net loss for 2000 of about $3.2 million to $4.5 million. In 1999, Blanch had net income of $39.7 million.

Quackenbush deputy enters plea

SACRAMENTO, Calif.—A deputy to former California Insurance Commissioner Chuck Quackenbush pleaded guilty last week to charges he defrauded a foundation that was funded with fines paid by insurers to settle allegations of mishandled Northridge earthquake claims, federal prosecutors say.

According to the office of the U.S. Attorney General for the Eastern District of California, former Deputy Insurance Commissioner George E. Grays pleaded guilty to three felony counts, including mail fraud and money laundering. Mr. Grays' sentencing is scheduled for April 12, and he faces up to 30 years in jail. But he has agreed to cooperate with authorities in an ongoing investigation into the Insurance Department's activities under Mr. Quackenbush.

Mr. Grays admitted to using settlement money that the Department had obtained to fund the non-profit foundation he controlled, prosecutors said. The foundation, the California Research and Assistance Fund, paid out $263,000 to a football camp that was supposed to help disadvantaged youth. The director of the camp, though, paid $170,000 in kickbacks to Mr. Grays and spent the remainder of the money for personal use, according to prosecutors. The camp's director has not been charged.

New pension reform bill expected

WASHINGTON—Hoping to win quick congressional approval, backers of comprehensive pension reform legislation are expected to introduce their measure this week.

The bill—to be sponsored by Sen. Charles Grassley, R-Iowa, who is the new chairman of the Senate Finance Committee, and Sen. Bob Graham, D-Fla.—will be similar to a measure the two senators introduced during the last congressional session. That bill unanimously cleared the Finance Committee, but the full Senate did not act on it after Senate Republican leaders attached a version of the measure to a broader tax-cut bill. President Clinton had warned he would veto the tax-cut bill if it reached his desk.

The previous measure, among other things, would have boosted benefits that can be provided through defined benefit and defined contribution plans and would have cut the administrative costs of running pension plans.

Pension plan enrollment steady

The percentage of U.S. workers who participated in employer-based retirement plans remained virtually unchanged between 1998 and 1999, according to a new study by the Employee Benefit Research Institute. This comes despite a slight decrease in the percentage of workers employed by organizations that sponsor such plans, the EBRI study shows.

In 1999, 46.8% of employees participated in employer-sponsored plans, up from 46.7% the year before. The figure for full-time, full-year workers between the ages of 18 and 64—the prime group targeted by employers—increased slightly more, though, to 60.8% in 1999 from 60.1% in 1998.

The longer-term trend has been toward greater employee participation in retirement plans, the study shows. In 1994, just 44.4% of employees participated, a rate that is 2.4% lower than that in 1999. In addition, the overall number of workers participating in such plans jumped in those five years, to 62.7 million in 1999 from 55.0 million in 1994.

Corporates faring poorly at Lloyd's

LONDON—Lloyd's of London syndicates exclusively backed by corporate capital are performing worse than those with mixed capacity, according to a new report by Chatset Ltd.

Chatset's "Lloyd's League Tables Review January 2001" reveals that the corporate syndicates showed a loss 2% greater than the market average for the 1997 year of account. And forecasts for the 1998 year predict an underwriting loss of 11.7% of stamp capacity for corporates, compared with a 9.6% loss figure for mixed capital. Predictions for the 1999 year are a loss of 14.9% of stamp capacity for the corporate-backed syndicates, compared with a 10.6% loss for those with mixed capital.

Chatset suggested that corporate syndicates, wanting to increase their presence at Lloyd's, may be taking on lower-quality business.

The 2000 year will show improved results in all sectors, thanks to a lack of major catastrophe losses, said Chatset. And 2001 may see Lloyd's return to profit.

"The renewal season has been a good one for underwriters, with a sudden contraction of capacity in the marketplace and brokers struggling to complete their orders unless underwriters can be offered better rates and higher deductibles," Chatset said. "The market seems to have turned up faster than expected and, given no major catastrophes, 2001 should return profits for its capital providers."

FOR THE RECORD

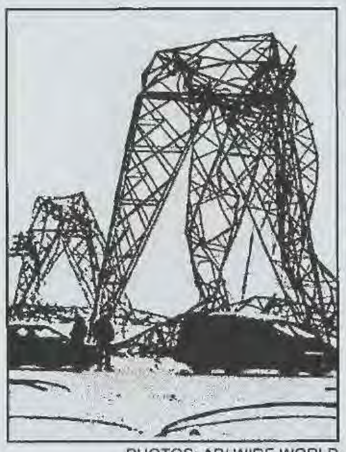
Excerpts from *BI*'s Daily Online Updates, Jan. 15 - Jan. 19, 2001

ASBESTOSIS CLAIMS THREATEN INSURER Chester Street Insurance Holdings Ltd., a London-based insurer specializing in employers liability risks, is facing liquidation as a result of asbestosis claims. Liquidators were called in earlier this month to Chester Street, formerly Iron Trades Holdings, when the company announced that its assets of £200 million ($295.5 million) would probably not be sufficient to meet its current and future liabilities. Chester Street insures about 2,000 employers. Chester Street's asbestosis liabilities arise from the pre-1990 insurance business of Iron Trades Employers Assn. Ltd., which was transferred to Chester Street as part of a restructuring program. The ongoing business of Iron Trades was sold last February to Sydney, Australia-based QBE International Insurance Ltd. Iron Trades, originally formed in 1898, insured U.K. industrial companies, particularly shipbuilding and engineering firms, according to A.M. Best Co. Accounting firm PricewaterhouseCoopers in London, which has been appointed the provisional liquidator of Chester Street, said it hoped that liquidation could be avoided. Instead, PwC hopes that creditors will vote in favor of a scheme of arrangement that was proposed on Dec. 19, 2000, according to PwC Partner Colin Bird.

HUMANA CUTS STAFF Humana Inc. will eliminate about 500 positions nationwide as a result of a 10% reduction in its membership. The employment cuts will be take place within the next few weeks and will occur throughout the company, a Humana spokesman said. The cuts are necessary "because of our intended reduction in membership," the spokesman said. He said that Humana's membership dropped by 600,000 members, to 5.4 million, between the third quarter of 1999 and the third quarter of 2000. The reduction in membership for the Louisville, Ky.-based provider of managed health care plans comes in response to the company's rate hikes and its withdrawal from unprofitable markets. Humana currently employs 15,000 people nationwide.

LLOYD'S OPENS CANADIAN UNIT Lloyd's of London has established a subsidiary in Montreal to handle its administration and brokerage services in Canada. The subsidiary, Lloyd's Canada Inc., will outsource many of its services to TELUS Enterprise Solutions, a subsidiary of one of Canada's largest telecommunications companies. Prior to the formation of Lloyd's Canada, Lloyd's services in Canada were provided by Deloitte & Touche L.L.P. Deloitte & Touche will continue to act as Lloyd's legal representative in Canada. "Canada now represents Lloyd's second-largest overseas market. This is a logical step for us and opportunity to explore ways of making it simpler and more efficient for Canadian clients and brokers to do business with us," said Julian James, director of worldwide markets at Lloyd's.

INSURERS SUE UTILITY Insurers have filed 14 lawsuits seeking a total of $263 million Canadian ($175.2 million) in damages from utility Hydro-Quebec because of widespread power outages caused by an ice storm that hit Quebec and other areas in Canada in January 1998. The suits charge that the utility was negligent because it failed to take measures to protect its grid against an ice storm. The largest claim was made by Factory Mutual Insurance Co., which is seeking $75 million ($50.0 million) for payments it made to 96 policyholders, a Hydro-Quebec spokeswoman said. Hydro-Quebec denies that it was negligent and says the storm was "an act of God." The utility has successfully defended several previous lawsuits making similar allegations that were filed by homeowners, the spokeswoman said. The ice storm froze large areas of Quebec, including Montreal, bringing down power lines and shutting down many businesses for several days.



PHOTOS: AP/ WIDE WORLD

1998 ice storms downed power lines in Quebec.

CIGNA PLANS EXPANSION CIGNA Corp. plans to significantly expand its health care business for expatriates working in Europe over the next year by opening operations in seven countries. The first two offices of CIGNA's Expatriate Health Care unit will be opened in Spain and Germany, with other offices to follow in Belgium, France, Italy, the Netherlands and Switzerland later this year, a statement from the Philadelphia-based insurer said. The Expatriate Health Care operation provides group benefits and services to expatriate employees of multinational companies. "Given the trend toward privatization of health care, pensions and other employee benefits in Europe, and thus the enormous potential here, we recognized the need to expand our European presence," said Jack Wright, senior vp at CIGNA Europe in Brussels, in a statement. The unit is also considering setting up offices in Singapore and Hong Kong.

NAMIC URGES REFORMS The National Assn. of Mutual Insurance Cos. has issued a paper calling on state legislatures to improve the regulation of insurers' market conduct. NAMIC's 38-page paper, "Market Conduct Regulation for a Competitive Environment," compares consumer protections afforded by regulatory models in insurance, banking and securities. The report also recommends reforms of the existing regulatory system, while still allowing the regulator in an insurer's state of domicile to assume responsibility for coordinating market conduct exams. "With this paper, NAMIC begins to suggest answers to genuine concerns about consumer protection in a purely competitive pricing and service system," said Roger Schmelzer, vp-regulatory affairs for the Indianapolis-based trade association. NAMIC plans to distribute copies of the paper to all state legislators and insurance regulators, as well as other interested parties. The text of the paper is available online at *www.namic.org*.

RELIANCE LONDON ARM IN RUNOFF Reliance National Insurance Co. (Europe) Ltd. has entered voluntary runoff. The London-based arm of troubled Reliance Group Holdings Inc. last week told the U.K. insurance regulator, the Financial Services Authority, of its decision to stop writing new business. "It was a business decision, made in the light of our parent's difficulties," said a spokesman for Reliance in London. "We are confident, in view of the fact that it is voluntary, that we will meet all obligations to clients and brokers," the spokesman added. Reliance National Insurance Co. (Europe) generated £158 million ($233.5 million) in gross written premiums in 1999. The insurer reported an underwriting loss of about £11 million ($16.3 million) for that year, but its pretax net income, including investment income, was £1.9 million ($2.9 million).

BRIEFLY NOTED The Health Insurance Assn. of America is bringing back **Harry and Louise**, the fictional couple from the association's 1993-94 ad campaign that was critical of the Clinton administration's sweeping health care reform proposals. Later this month, the HIAA will unveil a new advertising campaign featuring the characters to promote "InsureUSA," which is the HIAA's plan to provide health coverage to millions of uninsured Americans.…**Ford Motor Co.** announced last week that the recall of tires made by Bridgestone/Firestone Inc. of Nashville, Tenn., as well as liabilities associated with the tires, cost the automaker an estimated $500 million last year. A spokeswoman for the Dearborn, Mich.-based automaker said that Ford has "appropriate levels of liability insurance" to finance the lawsuits and settlements resulting from accidents associated with the faulty tires.…New York-based **The Segal Co.** has acquired Marjorie Gross & Co., an employee benefits and human resources communications consulting business also based in New York. BI

To get breaking news as it occurs, visit Business Insurance's free online Updates at www. businessinsurance.com. All of the material in the For The Record column, as well as other content in this week's issue, is generated from daily news postings that appeared on the Web site in the previous week.

Find daily coverage on Corporate Risk, Employee Benefit and Managed Health Care News at www.businessinsurance.com

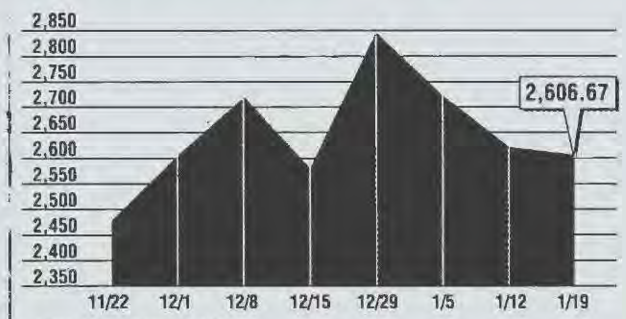
BI Industry Stock Report JAN. 15, 2001, THROUGH JAN. 19, 2001

BROKERS		Price	Weekly % change	Year to date % change	Year to date High	Low	Vol.(000)
Aon Corp.	NYS	33.00	3.73	-3.65	42.75	20.69	3116
Brown & Brown	NYS	32.75	-4.73	-6.43	35.88	15.63	140
Clark Bardes Holdings	NDQ	10.81	2.37	6.79	17.88	8.50	146
E.W. Blanch Holdings Inc.	NYS	13.63	-7.63	-21.86	62.00	13.00	489
Gallagher Arthur J. & Co.	NYS	22.00	-8.09	-30.84	34.25	11.63	2072
Hilb, Rogal & Hamilton	NYS	34.88	-4.78	-12.54	42.13	25.63	116
Kaye Group Inc.	NDQ	7.88	5.00	1.61	11.88	5.00	65
Marsh & McLennan	NYS	99.31	-0.94	-15.12	135.69	70.50	7565
BROKERS	AVERAGE		-3.53	-14.20			

INSURERS/REINSURERS		Price	Weekly % change	Year to date % change	Year to date High	Low	Vol.(000)
ACE Ltd.	NYS	35.56	2.15	-16.20	43.94	14.06	8220
Accel International Corp.	NDQ	0.23	0.00	-22.53	1.13	0.10	80
Acceptance Insurance Cos.	NYS	5.38	0.00	2.38	6.94	2.75	87
AEGON N.V.	NYS	36.00	-6.19	-13.12	49.13	31.50	612
AFLAC Inc.	NYS	56.69	-8.48	-21.47	74.94	33.56	5913
Allmerica Financial Corp.	NYS	59.25	0.32	-18.28	74.25	35.06	744
Allstate Corp.	NYS	34.75	-0.54	-20.23	44.75	17.19	14848
Ambac Financial Group	NYS	47.06	3.15	-19.29	58.31	25.91	3564
American Financial Group	NYS	24.31	3.18	-8.47	29.00	18.38	436
American General	NYS	74.50	1.62	-8.59	83.44	45.63	3175
American Intl Group	NYS	84.13	2.36	-14.65	103.75	52.38	27353
American Safety Insurance	NYS	6.13	4.26	0.00	7.38	3.25	34
Argonaut Group	NDQ	19.38	-6.06	-7.74	21.25	14.44	85
AXA-UAP Group	NYS	65.81	-3.39	-8.36	81.50	58.25	1217
Baldwin & Lyons Inc.	NDQ	27.13	21.57	16.67	28.75	15.25	105
Berkley W.R. Corp.	NDQ	38.06	-5.43	-19.34	47.63	14.00	784
Berkshire Hathaway Inc.	NYS	67600.00	2.11	-4.79	74600.00	40800.00	1
Capitol Transamerica Corp.	NAS	12.31	0.51	-1.01	13.25	9.38	8
Chubb Corp.	NYS	68.69	-0.54	-20.59	90.25	43.25	4855
CIGNA Corp.	NYS	109.50	-4.95	-17.23	136.75	60.75	4577
Cincinnati Financial Corp.	NYS	36.13	-4.46	-8.69	43.31	26.19	2033
Citigroup	NYS	54.38	2.35	6.49	59.13	35.34	54493
CNA Financial Corp.	NYS	34.38	-0.54	-11.29	41.94	24.56	322
CNA Surety	NYS	13.13	-0.94	-7.89	14.94	10.38	121
EMC Insurance Group Inc.	NDQ	12.63	1.00	7.45	13.13	6.81	16
ESG Re Limited	NDQ	2.31	5.71	25.42	7.00	1.72	503
Enhance Financial Services	NYS	11.69	-5.56	-24.29	17.00	8.63	611
Everest Reinsurance	NYS	58.75	6.09	-17.98	74.75	20.69	2753
Fremont General Corp.	NYS	2.69	-6.52	-4.44	9.63	1.50	979
Frontier Insurance Group	NYS	0.13	33.33	33.33	3.69	0.06	3169
Gainsco Inc.	NYS	3.63	20.83	38.10	6.38	2.19	128
Harleysville Group	NDQ	25.56	-10.31	-12.61	30.63	11.63	150
HSB Group Inc.	NYS	38.75	0.00	0.00	40.63	21.50	0
HCC Insurance Holdings	NYS	22.13	0.57	-17.87	27.19	10.94	1510
ING Groep N.V.	NYS	72.81	-7.76	-9.13	83.94	46.81	1219
IPC Holdings Ltd.	NDQ	21.88	-1.13	4.17	22.88	9.75	162
Hartford Financial Services	NYS	59.00	-2.38	-16.46	80.00	29.38	6443
John Hancock Financial Services	NYS	33.25	4.31	-11.63	38.25	13.44	5708
LaSalle Re Holdings Ltd.	NYS	16.88	0.00	0.00	19.38	10.88	0
Lincoln National	NYS	41.06	1.55	-13.21	56.38	22.63	3767
MAIC Holdings Inc.	NYS	16.00	6.27	7.87	23.13	10.00	124
Markel Corp.	NYS	163.25	1.48	-9.81	183.25	111.50	138
MBIA Insurance Group	NYS	61.88	-1.98	-16.53	76.19	36.31	3397
Meadowbrook Insur. Group	NYS	7.13	-2.56	-12.31	8.38	3.94	40
MetLife	NYS	31.06	0.20	-11.25	36.63	14.25	8622
Mutual Risk Mgmt. Ltd.	NYS	12.56	-4.74	-17.28	23.75	12.31	1774
Navigators Group	NDQ	13.00	0.00	-2.35	14.13	8.63	0
NYMagic Inc.	NYS	18.00	-1.37	-4.64	19.25	12.25	33
Ohio Casualty Corp.	NDQ	10.38	-2.35	3.75	17.88	6.13	1006
Old Republic Int'l	NYS	26.31	2.93	-17.77	32.06	10.63	1037
Partner Re Ltd.	NYS	50.19	4.29	-17.73	62.50	28.38	1910
Penn-America Group Inc.	NYS	7.63	0.00	0.00	9.75	6.63	47
PMA Capital Corp.	NDQ	13.25	5.04	5.80	20.06	15.19	236
Philadelphia Cons. Holding	NDQ	26.00	-0.48	-15.79	31.25	14.13	158
PXRE Corp.	NYS	16.56	5.16	-1.85	17.56	11.75	80
ReliaStar Financial Corp.	NYS	53.94	0.00	0.00	53.94	23.75	0
RenaissanceRe Holdings Ltd.	NYS	67.25	0.47	-14.13	81.50	35.88	780
RLI Corp.	NYS	44.25	4.89	-0.98	46.00	26.25	83
St. Paul Cos.	NYS	45.06	-0.14	-17.03	57.00	21.31	5335
SCOR	NYS	47.88	-6.13	-4.73	53.75	33.38	28
SAFECO Corp.	NDQ	23.25	-3.13	-29.28	35.88	13.00	6942
SCPIE Holdings Inc.	NYS	23.88	1.06	1.06	36.94	13.31	NA
Seibels Bruce Group	NDQ	0.63	-28.16	11.11	2.69	0.53	56
Selective Ins. Group	NDQ	23.69	-2.07	-2.32	25.88	11.63	142
Tokio Marine & Fire	NDQ	47.75	-6.26	-16.23	61.00	45.00	219
Torchmark Corp.	NYS	33.25	-0.37	-13.50	41.19	13.75	1765
Transatlantic Holdings	NYS	99.63	1.79	-5.90	107.06	63.75	36
Trenwick Group Inc.	NYS	24.38	2.09	-1.76	27.13	12.00	442
Unico American Corp.	NDQ	6.13	-2.00	4.26	7.88	4.50	8
United Fire & Casualty	NDQ	21.06	3.69	6.65	23.31	15.50	2
Unitrin	NDQ	37.13	-2.30	-8.62	41.94	27.19	254
UNUM Corp.	NYS	24.56	0.51	-8.60	31.94	11.94	2991
Vesta Insurance Co.	NYS	6.94	18.09	37.04	7.88	3.44	808
XL Capital Ltd.	NYS	75.31	0.84	-13.81	89.25	39.00	4023
Zenith National Ins.	NYS	28.38	3.42	-3.40	29.75	18.75	27
INSURERS/REINSURERS	AVERAGE		0.53	-6.06			

HEALTH MAINTENANCE ORGANIZATIONS		Price	Weekly % change	Year to date %change	Year to date High	Low	Vol.(000)
Aetna Inc.	NYS	35.56	-3.72	-13.39	42.69	32.94	2557
Health Net Inc.	NYS	19.94	-22.20	-23.87	26.94	7.63	4423
Humana Inc.	NYS	11.00	-19.27	-27.87	15.81	4.75	4473
Oxford Health Plans	NDQ	29.25	-13.33	-25.95	42.75	12.06	11233
Pacificare Health Sys.	NDQ	16.13	0.78	7.50	72.31	9.81	3193
Sierra Health Services	NYS	4.70	6.82	23.68	8.25	2.44	270
United HealthGroup	NYS	51.56	-4.84	-15.99	63.44	23.19	10756
Wellpoint Health Networks	NYS	88.88	-10.11	-22.89	121.50	56.94	3958
HMOs	AVERAGE		-8.88	-12.20			
ALL COMPANIES			-3.96	-10.82			

BI Insurance Index



Base=100 on Dec. 29, 1978

Top advancing issues: Frontier Insurance Group, Baldwin & Lyons Inc., Gainsco Inc. Leading decliners: Seibels Bruce Group, Health Net Inc., Humana Inc. Most active issue: Citigroup. The *BI* Index decreased 0.6%; the Dow Jones 30 Industrials went up 0.6%; the S&P 500 rose 1.8%; and the NYSE Composite increased 0.3%. Average P/E: Brokers, 20.2; Insurers/reinsurers, 28.1; and HMOs, 13.6.

Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.