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Updates

Clinton proposes tax credit to encourage COBRA use

WASHINGTON—In its proposed federal budget for fiscal 2001, the Clinton administration next month will ask Congress to pass legislation that would give COBRA beneficiaries a tax credit equal to 25% of their COBRA premiums, a change that could reduce the number of uninsured but also increase employer costs.

Under the Consolidated Omnibus Budget Reconciliation Act, employees who terminate employment, and divorced or widowed spouses, can retain group health care

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Funding retiree care at issue in California

By JOANNE WOJCIK KOCHANIEC

SACRAMENTO, Calif.—Despite Gov. Gray Davis' popular efforts to improve the quality of public education in California, the level of health care benefits for retired teachers is almost embarrassing, according to a consultant's report.

While many other states offer some type of health benefit to retired educators, up to 20% of California's retired teachers either have no health insurance or have to pay for the coverage on their own.

The problem is exacerbated by the fact that many retired teachers in California never paid into Medicare, according to a report by benefit consultant William M. Mercer Inc.

This is because until 1986, the federal government did not require public employees to pay into the federal program that provides health benefits to retirees age 65 and over. To be eligible for benefits, however, participants must have paid into the program for at least 10 years.

To solve the retired teacher health care problem, the Health Benefits Task Force of the California State Teachers Retirement System, or CalSTRS, is looking into a variety of options ranging from direct contracting to collaborating with the much-larger California Public Employee Retirement System, or CalPERS.

While CalPERS has provided health benefits to more than 1 million active public employees and retirees since the early 1960s, CalSTRS has stuck to

See **Retirees** *on page 30*

Risks seldom examined

Are workers safe at home?

By JUDY GREENWALD

Few employers are addressing their potential liability exposures arising from the growing practice of telecommuting.

The issue of workplace safety for telecommuters was the center of a recent controversy, when the federal Occupational Safety and Health Administration issued—then quickly rescinded—an advisory concerning safety rules for at-home workers (*BI*, Jan. 10).

Employers complained they would be required to inspect the homes of their telecommuters to ensure that OSHA safety standards, intended for traditional workplaces, had been met. Responding to employer criticism, Labor Secretary Alexis Herman called for a "national dialogue" on the issue.

The issue is likely to grow in importance, as the number of telecommuters continues to increase. An estimated 19.6 million Americans now telecommute either full- or part-time, according to a study jointly conducted by the Washington-based International Telework Network & Council and AT&T Corp.

The most obvious liability faced by employers with regard to tele-

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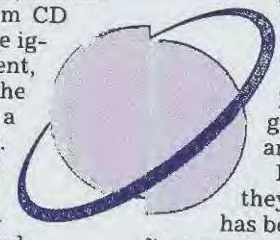
Managing e-commerce risks

New coverage introduced to protect against first-, third-party risks

By ROBERTO CENICEROS

An extortionist's theft and recent disclosure of credit card numbers belonging to customers of Internet music retailer CD Universe illustrates the emerging perils for which new e-commerce insurance policies are available.

The extortionist and Internet intruder called himself Maxim and claimed to live in Russia. He demanded $100,000 from CD Universe, an online music store and business unit of Wallingford, Conn.-based eUniverse Inc. According to media reports, Maxim claimed to have stolen 300,000 customer credit card files from CD Universe. When CD Universe ignored his demand for payment, Maxim posted some of the credit card information on a Web site for anyone to pilfer.



To draw attention to his intrusion and make good on his threat, Maxim also contacted news organizations and gave them CD Universe customer credit card information.

Third-party liability and first-party property exposures are at stake in such situations, and specialty policies for e-commerce companies have emerged in the past year to address both categories of losses, brokers and insurers say.

In the past few months, they say, greater emphasis has been placed on introducing first-party coverage for online businesses as potential cyber-property losses—such as those posed by Maxim's theft of credit card information—

See **Risks** *on page 29*

Folksamerica gains ground

Nine months ending Sept. 30,1999

	Premiums written	Combined ratio
Folksamerica Reinsurance Company	$152,412,000	106.9%
Risk Capital Reinsurance	$232,703,000	127.9%
Total	$385,115,000	—

Source: Reinsurance Assn. of America

Folksamerica to acquire Risk Capital Re

By JUDY GREENWALD

NEW YORK—Folksamerica Holding Co. Inc.'s announcement last week that it plans to buy substantially all the reinsurance operations of Risk Capital Reinsurance Co. evinces the bigger-is-better mentality of the current reinsurance marketplace, analysts say.

The deal would make New York-based Folksamerica Reinsurance Co. the 11th-largest reinsurer in the United States—up considerably from its current No. 20 spot.

This ranking is based on the two companies' combined premium volume of $385.1 million for the nine-months ended Sept. 30, according to the Washington-based Reinsurance Assn. of America.

Risk Capital Re, a Greenwich, Conn.-based unit of Risk Capital Holdings Inc., ranked No. 14, with $232.7 million in premium volume for the nine-month period. Folksamerica, which is a subsidiary of Hamilton, Bermuda-based White Mountains Insurance Group Ltd., posted $152.4 million in net premiums for the period, according to the RAA.

Risk Capital Re's reinsurance business will be absorbed into Folksamerica's underwriting operation, said Michael E. Tyburski, executive vp and CFO for Folksamerica in New York. He noted that Risk Capital Re's business includes marine and accident and health risks, neither of which Folksamerica now writes, so the deal will increase the breadth as well as the size of its operations.

Analysts, who contend the deal will not have a major impact on the market, say it reflects the prevailing attitude that only larger reinsurers can ultimately survive in today's market environment.

They also say the deal represents the failure of a theoretically sound, but poorly timed, strategy by Risk Capital Re to simultaneously invest in and provide reinsurance to primary insurers. Risk Capital posted a $21.6 million loss for the nine-month period.

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NEWSPAPER

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Updates

COBRA tax credit proposed

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coverage by paying 102% of the group rate.

The administration says many beneficiaries can't afford to pay COBRA premiums, which can be several hundred dollars a month. The 25% tax credit would make it more affordable and reduce the number of Americans without group coverage, the administration says.

Since beneficiaries opting for COBRA are those most likely to use health care services, however, the plan could raise employer costs.

The administration also is recycling an earlier proposal that would require employers that terminate health care plans for retirees age 55 and older to extend COBRA coverage until the retiree reached age 65 and was eligible for Medicare. COBRA now only has to be offered for 18 months to former employees and for 36 months to widowed or divorced spouses.

Also under the proposal, employees as young as age 55 who lose their jobs and exhaust their COBRA coverage would be eligible to enroll in Medicare by paying monthly premiums of roughly $400. Retirees would receive a tax credit equal to 25% of the Medicare buy-in premium.

RIMS blasts ergo proposal

NEW YORK—The Risk & Insurance Management Society Inc. opposes a mandatory federal ergonomics standard but acknowledges that voluntary programs benefit employers and workers alike.

In a 2½-page position paper released last week, RIMS' External Affairs Team outlined its concerns with the Occupational Safety and Health Administration's proposal to mandate federal ergonomics standards for many employers (*BI*, Jan. 17; Nov. 29, 1999).

The paper says the proposed mandates are "unnecessary" and "would undermine the well-established and successful state workers compensation system," among other things. The paper suggests instead a comprehensive education effort, undertaken by OSHA with the business community's cooperation, to support and enhance the "significant" trend of voluntary ergonomics programs. Maintaining an ergonomically correct work environment can reduce worker injuries and save employers billions of dollars in related costs, New York-based RIMS said in a statement.

"RIMS also encourages employers to implement and conduct ongoing assessments of ergonomics programs as part of a comprehensive risk control program in each organization," said Lance Ewing, chairman of RIMS' External Affairs Team and director of insurance and loss prevention at GES Exposition Services in Las Vegas.

RIMS plans to send OSHA a copy of the paper and follow up with a comment letter, said Daniel Barry, RIMS director of government affairs.

Court reviews gun decision

SAN FRANCISCO—The California Supreme Court last week agreed to review a controversial appellate court decision that allowed shooting victims to sue a gun manufacturer for negligent marketing.

California's 1st District Court of Appeal had held that victims of the 1993 shooting at the San Francisco offices of a law firm could sue Miami-based Navegar Inc. for negligence. A San Francisco Superior Court judge dismissed the suit in 1997, though it was later reinstated. The suit was an effort to use a product liability action on behalf of violence victims.

In its petition for review by California's highest court, Navegar argued it should not be held responsible for how its products are used. Plaintiffs say Navegar's marketing negligently led to Gian Luigi Ferri's 1993 rampage in the office building that housed the now-defunct law firm Pettit & Martin. Armed with two semiautomatic weapons made by Navegar, he killed eight people and wounded six others before taking his own life.

Job bias cases on the rise

WASHINGTON—The number of employment-related discrimination cases skyrocketed during the 1990s, according to a report released last week by the Department of Justice's Bureau of Justice Statistics.

The bureau says 23,735 employment discrimination cases were filed in U.S. District Courts in 1998, the last year for which data was available. That was up more than 280% from the number of such cases in 1990. The vast majority of such suits involved disputes between private parties.

In all, employment bias cases accounted for more than half of the 42,354 cases alleging violation of federal civil rights laws filed in federal district courts in 1998.

Mitsubishi faces race bias suit

NORMAL, Ill.—Two years after settling a high-profile sexual harassment lawsuit, Mitsubishi Motor Manufacturing of America Inc. is facing a similar suit alleging racial discrimination at the same plant.

A suit seeking class-action status was filed in U.S. District Court in Peoria, Ill., by more than 200 current and former African-American employees of Mitsubishi's Normal, Ill., manufacturing and assembly plant. The suit accuses Mitsubishi of tolerating racial discrimination and harassment, among other things. The plaintiffs contend the automaker discriminated against them in job training, promotion and assignments, and that they were subject to bullying, racial epithets and other acts.

Further, the complaint alleges that the stringent "zero-tolerance" consent decree Mitsubishi implemented as part of its 1998 sexual harassment settlement does not extend to racial harassment.

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Errors & omissions

• A Jan. 17 article incorrectly quoted a Reliance Group Holdings executive as saying the company renewed 90% to 95% of its business. Senior Vp and Treasurer Albert A. Benchimol said Reliance retained 90% to 95% of the business it would normally expect to renew, varying by line.

• Due to an editing error, an article explaining the impact of a change to a 401(k) plan safe harbor requirement was omitted from the Jan. 17 issue. The story appears on page 25.

Going public on privacy law

California comp access too restrictive: Employers

By DAVE LENCKUS

SACRAMENTO, Calif.—The California legislator who spearheaded a new state law that dramatically limits employer access to injured workers' medical records says she would be willing to fix the act if employers can show that it is "overly restrictive."

The act, though, "perhaps" has raised unwarranted fears among employers due to "a tortured reading of the statute," according to Assemblywoman Ellen M. Corbett, D-San Leandro, who drafted the law.

A.B. 435, which the Legislature passed in September and Gov. Gray Davis signed Oct. 7, went into effect Jan. 1.

The law eliminated a broad workers comp exception to a state law that guarantees the privacy of medical records. The law applies to insurers, third-party administrators engaged by self-insured employers and any individual a self-insured employer designates to administer its workers comp claims. With two exceptions, the law now bars those entities and individuals from divulging to employers any medical information on an employee who has filed a workers comp claim.

One exception would allow an employer to obtain a "diagnosis" regarding a workplace injury if the diagnosis would affect the

*See **Privacy** on page 27*

Record fine in fraud case

By DOUGLAS McLEOD

LEXINGTON, Mass.—The nation's top kidney dialysis provider will pay a record $486.3 million to settle charges of defrauding Medicare, though it still faces civil racketeering charges filed by Aetna Life Insurance Co. over allegedly similar fraudulent claims.

Fresenius Medical Care North America Inc. last week agreed to the penalties to resolve a five-year federal investigation of fraudulent practices by subsidiary National Medical Care Inc. At the same time, three NMC units pleaded guilty to criminal charges that they conspired to:

- Submit false claims to Medicare for nutritional therapy given to patients during dialysis.
- Submit hundreds of thousands of phony blood testing claims, including duplicate bills and claims for unnecessary tests.
- Pay kickbacks to doctors at dialysis centers to obtain their blood-testing business.

Fresenius, a unit of Fresenius Medical Care A.G. of Bad Homburg, Germany, acquired NMC in 1996 from W.R. Grace & Co. Most of the alleged fraud occurred before the acquisition, and Fresenius has cooperated with federal investigators, prosecutors said.

Under the settlement, Fresenius will pay $385.1 million in civil penalties and $101.2 million in criminal fines. The civil penalties will resolve the govern-

*See **NMC** on page 29*

Employers' expectations

Hewitt survey finds health plans lacking in some areas

By JERRY GEISEL

Employers say that health plans need to dramatically improve how they deliver information using the Internet and how they analyze health data, according to a new survey.

Sixty-two percent of employers surveyed by Hewitt Associates L.L.C. said that health plans needed to improve Internet information access and plan site links, while 57% said the plans needed to improve health plan data analysis and tracking.

"Employers don't just want aggregate cost numbers, but they want to see costs broken down on an illness-by-illness basis so they can connect individuals with disease management programs," said Jack Bruner, national health care practice leader for Lincolnshire, Ill.-based Hewitt.

Employers said that health plans are doing a better job in handling administrative functions, but that many improvements still are needed in those areas.

For example, 30% said plans need to improve their performance in enrolling employees, while 27% reported that transactions with the plans needed improvement and 31% reported

*See **Survey** on page 28*

Panel reviews P/C challenges

By PAUL D. WINSTON

NEW YORK—Finding more effective ways of deploying capital, tapping new distribution methods and expanding globally are among the issues facing property/casualty insurers today.

Those topics, among others, were discussed in a broad panel discussion at the Property/Casualty Insurance Joint Industry Forum, held Jan. 11-12 in New York and co-sponsored by nine insurance industry trade associations.

Alan M. Levin, managing director of Standard & Poor's Insurance Rating Services in New York and moderator of the panel of insurer and reinsurer executives, asked whether the industry is overcapitalized.

"I never met a rating agency that thought there was enough capital," quipped Donald Kramer, vice chairman of ACE Ltd. in Hamilton, Bermuda.

The property/casualty industry's capital base, however, must be viewed in light of its exposure to a high level of underwriting losses, inadequate pricing in past years, higher expenses and lit-

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Inside

- Risk managers opposed to OSHA's proposed ergonomics standard have only one week left in which to voice their opinions, this week's editorial warns. **PAGE 8**
- International shipping regulators are calling for a tougher stance on maritime safety after the oil tanker Erika broke up last month off the coast of France. **PAGE 23**
- Stress-related claims by workers are a growing liability exposure for U.K. employers, as illustrated by two recent court awards and a survey of British risk managers' top concerns. **PAGE 23**

Departments

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Benefits: Improving Quality

Employers urged to focus on quality, not cost of plan

By MICHAEL PRINCE

Many employers, it seems, are buying the equivalent of health care lemons.

While most organizations would reject substandard goods and services from their suppliers, few apply the same high standards when buying health care, experts say. For example, a 1998 study showed that only 5% of employers use data from the National Committee for Quality Assurance, the leading evaluator of health plan quality, when choosing a health plan (*BI*, Sept. 28, 1998).

Although many employers assume they are purchasing quality health care services, in fact many well-meaning and well-trained doctors are "not practicing medicine to the highest possible standard," said Michael Millenson, a consultant with William M. Mercer Inc. in Chicago and author of a book on health care quality.

Several studies support Mr. Millenson's claim. Last year, a study by the Institute of Medicine, a private non-profit institute under the National Academy of Sciences in Washington, noted some glaring problems with the U.S. medical system. For example, different studies found that medical errors, such as wrong drug treatments, kill between 44,000 and 98,000 hospital patients each year. Even the lower figure represents more deaths than from highway accidents or breast cancer, the study states. According to the studies analyzed by the institute, most errors stem not from recklessness by medical providers, but from flaws in hospital treatment processes.

Another study, published in 1999 by public policy analyst RAND Corp. in Santa Monica, Calif., showed that patients with acute or chronic conditions receive only about two-thirds of the care they need. And about one-fifth to one-third of acute and chronic care that is delivered is unnecessary, according to the study.

"No employer would tolerate its own products being made right only 70% of the time," Mr. Millenson said, referring to the RAND study.

Unlike other services that employers buy, however, health care has not seen a general push by purchasers for better quality.

Often employers do a half-hearted job of purchasing health care, as it's not their area of expertise, said Uwe Reinhardt, a professor of economics and public affairs at Princeton University.

Employers tend to judge a plan's quality based on the number of providers in the network. This tendency undermines health plans' attempts to eliminate poor providers from the network, he explained.

Purchasers need to push their plans to meet quality standards, said Helen Darling, senior consultant with Watson Wyatt Worldwide in Stamford, Conn.

Rather than just looking at costs, employers need to focus on purchasing value in health plans—viewing cost and quality together—just as they do when making other purchases, said Bruce Bradley, director of managed care plans for General Motors Corp. in Detroit.

This will require employers to change their thinking about medical care, according to Mr. Millenson of Mercer. Employers generally regard "affordable access" as the key in evaluating health care, he said. Affordability, though, "also includes whether the system of health care does its job more efficiently," he added.

Laurel Pickering, executive director of the New York Business Group on Health, said that most

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Wellness programs could be the cure

Targeting unhealthy behavior can pay dividends

By AMANDA MILLIGAN

As grim forecasts tell of the ever-ballooning cost of providing health care benefits, some frustrated employers have sought savings through wellness programs.

Such programs aim to curb future treatment costs by targeting unhealthy behaviors, such as smoking and alcohol abuse, as well as by addressing general health factors, including nutrition and stress management.

Approximately 80% to 90% of employers offer employees at least one wellness program, said Bruce Kelley, a senior consultant with Watson Wyatt Worldwide in Minneapolis. The number of employers offering a comprehensive wellness program, however, is closer to 35% to 40%, he said.

"Today, one of the main attractions to employers is that investments in wellness address the (health care cost) dilemma they're in," Mr. Kelley said. "If you invest more in a cost-effective wellness program, that will help restrain future benefit costs."

Although some companies "just throw their hands up" when asked what they are doing to control their swelling health care costs, Mark Correia, a senior vp of wellness for wellness provider Healthtrax Inc., said such programs may be a solution.

Some employers target wellness factors directly, while others offer employees a "wellness account," where each employee is given money and limited discretion on how the funds may be spent, said Ken Berkowitz, a senior consultant in the Miami office of PricewaterhouseCoopers L.L.P.

Wellness account funds, for example, may be used to pay for a smoking cessation class or a fitness club membership.

"There are some employers who see the light—that wellness programs continue to hold health care costs down and (are) a great way to retain workers in today's competitive environment," said Mr. Berkowitz.

But wellness programs will succeed only if there is a commitment on the part of both the employee and the employer, said Mr. Correia, who is based in Glastonbury, Conn. Companies can't expect a strong return on their investment by offering what he dubs "random wellness," that is, by providing a program or series of programs that address wellness topics but are not comprehensive and continuous.

"One of the challenges with wellness is how to measure the cost payback,"

See **Wellness** *on page 12*

Steps to create a successful wellness program:

1. Gain senior management support.
2. Poll different department heads about employee needs.
3. Create wellness team to collect data on health care costs, absenteeism, employee needs.
4. Devise an operating plan based on company data.
5. Plan out program offerings.
6. Adjust corporate culture to support wellness initiatives.
7. Evaluate impact of programs.

Source: David Hunnicutt, president, Wellness Councils of America

Giving employees bigger role in selecting health plans

Defined contribution, self-serve market almost here

By JOANNE WOJCIK KOCHANIEC

When Christa Carone was considering changing health plans during last year's open enrollment, the Xerox Corp. employee found the information she needed to do so on an Web site her employer had created.

Employees could access the site at work via the company intranet or at home using the Internet. The site, introduced last year, provides employees information on the various health plans available in a geographical area, as well as side-by-side comparisons of the benefits offered by each.

"I was so impressed by the site this year," said Ms. Carone, Xerox media relations manager in Rochester, N.Y. "If you have any questions on a specific plan, you can link directly to that provider's site."

For example, because Ms. Carone's husband was planning to undergo orthopedic surgery this year, the couple wanted to make sure his current doctor was included in a plan they were considering. They also used the site to compare their out-of-pocket costs for the surgery based on the benefits each plan paid.

"The research took about an hour," she said, adding that "we could do it from home."

In the end, the couple opted to remain in Blue Choice, the Blue Cross & Blue Shield affiliate in their area.

The Xerox Web site is very much like that envisioned for other U.S. employers as they shift to employees more of the responsibility for selecting—and paying for—health plans as part of a trend toward so-called defined contribution health care financing.

"Managed care has failed to manage care," observed Regina Herzlinger, a Harvard Business School professor who recently hosted a seminar on "Consumer-Driven Health Care" attended by some 100 large employers and industry experts.

"Premiums are increasing at double-digit rates, employees are not happy, and if ERISA is breached, self-insured employers will be open to all kinds of lawsuits that will bleed their pockets," she said.

To counter this trend, Ms. Herzlinger, like

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employers focus on cost and network size when picking a health plan and don't generally look at plan quality.

"For an employee benefit manager, a measure of quality is when their phone isn't ringing off the hook" by employee calls complaining about doctors not being in the network, she said. This mindset stems, in part, from satisfying employees who generally care most about which doctors are in the network, she said.

One barrier to purchasing value is the lack of information available to employers on plan and provider quality.

The leading measure of health care quality is the Health Plan Employer Data and Information Set, which was created in 1991 and taken over by the NCQA in 1992. HEDIS measures the performance of health plans on various health care quality issues, such as treatment practices for various diseases and customer satisfaction with plans.

For benefit managers, 'a measure of quality is when their phone isn't ringing off the hook' with employee complaints about doctors not being in the network, says Laurel Pickering.

HEDIS and the NCQA accreditation of health plans have achieved mixed results, some observers say.

HEDIS' strength is that it established a "system of how to measure the quality of actors in the health care system," Princeton's Mr. Reinhardt said.

Ultimately, though, HEDIS has not lived up to its expectations, Mr. Reinhardt said, in part because employers have not used the data for their purchasing. Also, the NCQA is funded by the health plans that it evaluates, and those plans have representatives on the NCQA board, Mr. Reinhardt said.

Perhaps most importantly, the plans the NCQA evaluates can withdraw their data from being published, he said, preventing exposure of lower-quality plans.

So, on one hand, the NCQA is better than nothing; but on the other, the NCQA's prominence might have prevented the emergence of a better system, Mr. Reinhardt said.

NCQA President Margaret O'Kane agrees that voluntary participation by health plans undermines her efforts, but she disagrees with the Princeton economist's characterization of her organization. "I think that's unfair," she said. "I doubt if we've been a barrier to a better evolution."

Ms. O'Kane also noted that only 38% of the NCQA budget comes from health plans; the rest comes from grants.

Beyond making the HEDIS measures more complete, she agreed the tool needs to be used more widely by employers. Buying on quality "is not widely followed," she said.

There are some aspects of plan quality that HEDIS data do not address.

GM's Mr. Bradley said that the current measures don't examine outcomes. Currently, the measures look at best practices for treatment processes as a substitute for outcomes. For example, measuring the percentage of heart attack patients who receive beta-blocker treatments presumes that patients who receive the drug will have a better outcome than those who do not. While this is generally true, measuring actual outcomes presents a more difficult challenge, Mr. Bradley said.

Another drawback is that current measures don't examine individual providers, focusing more broadly on entire health plans. In some regions of the country, comparing plans might not reveal much about their providers, said Mercer's Mr. Millenson.

"Employers have to realize that, in many markets, the doctor networks overlap so significantly that measuring quality at the health-plan level is close to meaningless," he said.

Ms. O'Kane said that the NCQA doesn't directly measure outcomes because that data is very difficult to obtain. She said she recognizes the need for more outcomes measuring and added that the NCQA plans to add some in the future. HEDIS "is a work in progress," she said.

Ms. O'Kane also said that measuring and rating health plans instead of individual providers is the best place to start because it's how employers purchase health care. The NCQA believes that health plans can exert strong pressure on the doctors in their networks to change behavior. For critics to focus on a lack of provider information "reflects a limited understanding of what a health plan can do," she said.

Beyond trying to improve how quality is measured, many employers fail to realize the financial advantages of higher-quality plans.

"Employers need to understand that there is a strong business case for quality," said Mr. Bradley, adding that putting employees in higher-quality plans will ultimately save employers money.

Ms. O'Kane noted that part of the NCQA's mission is to promote the idea among health plans that "if you do better quality, you will do better in the marketplace," she said.

As the RAND study showed, providers perform a significant amount of unnecessary care. Eliminating that would reduce costs without hurting quality, Mr. Millenson said. "There is no downside to doing things right the first time in medical treatment," he said.

In addition, it's in the interest of health plans to push for better quality, Watson Wyatt's Ms. Darling said, as doing so would save them money and give them a marketing advantage.

To improve the current system, Ms. Darling recommends that the NCQA require health plans to submit data on their hospitals' clinical quality to become accred-

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Spotlight report

Quality

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ited. For instance, she said, the number of a hospital's patients who contracted infections or had adverse drug reactions because the wrong drug was administered should be submitted and evaluated.

Improvements are needed on three levels, said Douglas Ley, vp and director-compensation and benefits practice for Willis in Milwaukee. More data on outcomes needs to be gathered, employers need to act on the data when selecting plans, and they must communicate the data to employees, he said.

GM, for example, distributes to employees quality reports on the different health plans it offers, Mr. Bradley said. The automaker also charges employees less to sign up for the higher-quality plans than it charges for the lower-quality plans, which has resulted in a large migration into the high-quality plans, he explained. GM uses HEDIS data, NCQA accreditation of health plans and other measures, as well as its own onsite investigation, to determine a plan's quality, he said.

Mr. Reinhardt recommends that the government fund the NCQA and pass laws requiring hospitals and physicians to submit data to the NCQA, without the ability to avoid publication of that data.

Ms. O'Kane acknowledged that HEDIS would benefit from government funding and mandatory reporting laws.

Another barrier to better health care quality is the current culture of blame, Mr. Bradley said. A combination of fear of litigation and reprisals for admitting mistakes has created an environment that discourages providers from reporting errors. Instead, the focus should be on solving problems, he said.

Perhaps one such approach now exists.

A project under way in Pittsburgh has brought together employers, unions, insurers and health care providers to work on improving quality of health care in the Pittsburgh area. Called The Working Together Consortium Health Care Initiative in Pittsburgh, its goal is to become "the world standard for outcomes for clinical care," meaning the right thing is done at the right time for patients, said Ken Segel, the consortium's director.

After discussions on how to improve the health care system, all the participants agreed to focus on clinical quality, or "what happened to the patient that hit the door," he said.

One advantage the project has is that under Pennsylvania law, hospitals must submit to a state agency data on every patient discharged. The data is then adjusted based on the severity of the patient's illness.

Using this data, the group creates reports from criteria submitted by doctors. To date, the project has produced two reports. One concerns total knee and hip replacement operations; the other measures Caesarean section rates.

The reports allow comparisons between different hospitals and physicians, as well as an overall look at the issue. The report on joint replacement, for example, showed a wider variation in complication rates between hospitals than originally thought and a higher overall rate of complications than was anticipated, Mr. Segel said.

The reports, however, are not made public as long as the providers move to use the reports to improve quality. If the medical community does not aggressively improve quality over the next two years, then the consortium might publish the information or employers will drop plans that score poorly, he explained.

But the Pittsburgh consortium remains a new and unique project. For everywhere else, the verdict remains out on whether quality purchasing will become commonplace.

Mr. Reinhardt, the Princeton professor, said that even if employers and individuals have reams of information, they won't use it to choose plans or providers. Health care may be an area with few empowered consumers, and most people might make health care selections for other reasons, he said.

GM's Mr. Bradley sees more and more employers in the future looking to buy on value. And he sees more providers wanting to be rewarded based on delivering value. Employers need to acknowledge quality just as much as they need to punish its absence.

"If we as purchasers don't reward quality, then we can't really criticize them," he said. BI

Studies illustrate ailing areas

Studies published in medical journals point to areas where medical care quality can improve. Michael Millenson, a consultant with William M. Mercer Inc. in Chicago, culled several examples:

- The Centers for Disease Control and Prevention estimate 2 million hospitalized patients develop a treatment-caused infection each year.
- A 1998 article in the Journal of the American Medical Assn. said there are 2.2 million adverse drug reactions per year for hospitalized patients. Of those, 106,000 are fatal. Each adverse drug reaction adds $2,262 to the cost of the hospital stay, according to a 1997 study published in JAMA.
- JAMA in 1997 published a study concluding that one-quarter to one-half of eligible heart attack victims receive a beta blocker drug even though it has been shown to reduce the risk of death by 40%.
- The American Heart Assn. estimates that 32,000 people die each year because they don't receive the proper therapy after a heart attack.
- Fewer than one in three patients with congestive heart failure are given ACE inhibitors, the recommended drug treatment, according to a 1997 JAMA article.
- Seventy-five percent of women with first-stage breast cancer could get a lumpectomy, a less intrusive treatment, but only 44% do, according to the American College of Surgery.

—By Michael Prince

Opinions

Last chance to be heard

TIME IS RUNNING OUT for employers to voice their concerns about and suggestions for the Occupational Safety and Health Administration's controversial ergonomics proposal.

In fact, there's little more than a week left in the federal safety agency's comment period, and we urge employers to make the most of it if they hope to see their recommendations reflected in whatever actions OSHA ultimately takes.

It's unfortunate that OSHA ignored the quite reasonable request of the National Assn. of Manufacturers and other employer groups for a deadline extension beyond the Feb. 1 cutoff for comments.

Employers complain that the regulations OSHA is contemplating would be unjustifiably expensive, open to abuse and inflexible. The OSHA proposals generally would require employers to conduct a hazard analysis and adopt a broad program of ergonomic injury prevention, recording and treatment in response to a single complaint of ergonomic injury—an injury that may be impossible to prove was caused by work environment.

The proposal goes far beyond setting standards for how employers respond to employees' claims of musculoskeletal disorders, however.

Putting aside the valid concern about exactly how some musculoskeletal disorders could be proved to be work-related, the proposal also would intrude on the state-based workers compensation system by setting a new and more generous schedule of benefits for workers who suffer ergonomic-related injuries and illnesses that can be justified. The measure, in short, would create a federally favored class of injured workers.

As Daniel Barry, director-government affairs for the Risk & Insurance Management Society Inc., put it in last week's *Business Insurance*, RIMS "absolutely opposes imposition of any federal compensation scheme," and the society continues to support allowing individual companies to create their own ergonomics programs that best meet their own unique needs—as so many companies have already done—rather than imposing a federal standard that would unreasonably attempt to apply to all employers and all injuries.

We couldn't agree more: ergonomics risk management efforts should be voluntary and designed to fit the employer's—and the workforce's—unique circumstances.

No one should confuse support for a voluntary approach, however, with any less of a desire to protect workers from these injuries. It remains incumbent on all employers to take reasonable steps to identify and eliminate workplace hazards that can cause or exacerbate musculoskeletal disorders. To ignore the issue could be construed as negligent.

OSHA has heard employers' concerns about its proposed ergonomics standard for years, but the agency needs to hear them again, and hear them soon. The safety agency wants to promulgate a final rule by the end of the year, despite a congressional call that it wait until the National Academy of Sciences finishes a federally funded review of ergonomic studies.

With the deadline for written comments fast approaching, employers that are concerned about the ergonomics proposal need to get their concerns on paper and into OSHA's hands by Feb. 1.

Written comments should be mailed to: OSHA Docket Office, Docket No. S-777, U.S. Department of Labor, 200 Constitution Ave., N.W., Room N-2625, Washington, D.C. 20210.

If written comments are 10 pages or less, they may be faxed to the OSHA Docket Office at 202-693-1648.

Comments also can be e-mailed to: http://ecomments.osha.gov/docket/ecom/genpage.asp?form=1019

"OH...AND IF SOMETHING DOESN'T SEEM RIGHT, NOW IS THE TIME TO SPEAK UP!!!"

Letters

George Head thanked for contributions

To the editor: Risk management professionals owe a debt of gratitude and thanks to Dr. George L. Head.

Dr. Head is a giant of the profession, whose theories and risk management philosophies are used by risk managers worldwide.

Where would we be today if it were not for innovative leaders of our industry such as George Head, H. Felix Kloman, Bob Hedges, Robert Spencer and others.

George, I want to personally thank you for your contributions to risk management as I, among many, have benefited from them, as well as your insight and educational philosophies. Fortunately for risk managers, you have only partially retired and we will have the benefit of your friendship and expertise for many more years.

John R. Rath
Director of Risk Management and Insurance
Milwaukee County, Wis.
Milwaukee

Let non-profit set standards

To the editor: Regarding the Dec. 13 editorial, "A Single Standard Needed," I think the reason there isn't and won't be a group effort for loss data is the potential profit in developing such standards.

Marsh Inc., for example, would not be in the loop if not for a good chance of monetary gain.

Maybe a national non-profit would be the best way to keep this idea honest and kee the integrity intact.

Bruce Foster
Cress Insurance Consultants Inc.
Albuquerque, N.M.

Letters to the editor

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Wellness

Continued from page 3

said Mr. Correia. "The paradox with wellness is, in order to save money, you have to spend money, and it's difficult to tell companies to take that leap (when) they've tried this random-wellness approach unsuccessfully."

Rather than taking an arbitrary approach to addressing employee wellness, Mr. Correia suggests that a company establish objectives and then determine how the success of the program will be measured, such as its effect on health care costs, absenteeism or retention rates.

'The paradox with wellness is, in order to save money, you have to spend money,' says Mark Correia.

And employers must realize that the impact of a wellness program may not be felt immediately, said David Hunnicutt, president of Wellness Councils of America, an Omaha, Neb.-based organization that promotes the building of "well workplaces."

Nor will all programs ultimately save the employer money, cautioned Mr. Hunnicutt, and the length of time necessary to see results will depend on the behavior that is targeted.

Further, Mr. Hunnicutt said,"giving someone a pamphlet on smoking is going to do little other than raise awareness, but if you want to help them quit smoking, you'll have to give them much more intensive attention."

Other wellness initiatives, such as offering immunizations or sponsoring infant wellness programs, may generate more-immediate cost savings, he said.

Regardless of the programs instituted, employers should consider evaluation a critical component of their wellness approach, Mr. Hunnicutt said.

"Running a program without evaluation is like bowling without pins, because you never know if you're getting better," he said.

Another element to the success of a wellness program is management support, observers say.

Watson Wyatt's Mr. Kelley said he believes management support is one of the "best predictors" of a program's success. How a program is introduced into the company culture is as important as its offerings, he said.

Medical device manufacturer Medtronic Inc., which has about 14,000 employees nationwide, has offered some of its wellness initiatives for more than 10 years, said Roger Chizek, manager of U.S. benefits for Medtronic Inc.

In the company's Minneapolis headquarters, employees are given many opportunities to improve their health, including access to an in-house fitness center, free flu shots, online health risk assessments, smoking cessation programs and healthy living courses.

Medtronic has just engaged in a period of intense merger activity; it made six acquisitions in the past 18 months and nearly doubled its employee population. The expanded company plans to increase its wellness options, offering them to employees in new facilities. Medtronic is also considering adding early-detection screening programs to its wellness suite.

Earlier this month, Medtronic's chairman and chief executive officer, William George, announced a commitment to "Total Well-being," an approach that links worker productivity with how employees are feeling, both physically and emotionally, said Mr. Chizek.

"Our CEO is a very strong supporter of the employee wellness initiatives we are putting in place through the Total Well-being communication," he said, noting that top-down support is critical to the success of such programs.

Companies considering wellness programs, though, must ensure that the programs target the right individuals, said Stephanie Pronk, principal and national practice leader for health management at William M. Mercer Inc. in Minneapolis and a co-author of the 1999 National Worksite Health Promotion Survey.

At the same time, Ms. Pronk said, issues of data confidentiality and privacy are "always" present when a company gathers medical information through such means as health risk assessments.

Support from management can help allay employees' fears of being singled out, said wellness consultants. The degree to which employees will be receptive depends on the extent to which the corporate culture accepts both wellness programs and discussions about individuals' health in the workplace.

"People need to feel that they're safe within the organization in terms of pursuing issues of health at work," said Mr. Hunnicutt.

Health risk assessments not

'Running a (wellness) program without evaluation is like bowling without pins,' says David Hunnicutt.

only help employers evaluate health risk factors among their employees but they establish benchmarking data, said C. Sherri Martin, coordinator of health promotion for Northwestern Memorial Wellness Institute of Chicago.

They also give employers a way to plan future benefit offerings, she said.

Wholesale produce distributor W.D. Class & Son Inc. established its program, dubbed Wellness Incentive Now, in 1993, said Ralph Dudek, director of human resources in Jessup, Md.

Once each year, Class & Son has its wellness provider hold for its 280 employees free health screenings that evaluate factors such as cholesterol levels, blood pressure and levels of aerobic activity. The results of these assessments, which are voluntary, ultimately affect the amount of premium employees pay for their medical insurance.

An employee can get a refund of as much as $41 per fortnightly paycheck on his or her insurance premium for being labeled "low risk," though those employees who are classified as "high risk" do not pay above the 20% deductible. Mr. Dudek said each employee received, on average, a $33 credit per paycheck in 1999.

"It means something to the employees if they can get healthy

See **Wellness** *on page 14*

Spotlight report

Wellness

Continued from page 12

scores," said Mr. Dudek, who noted that nearly all the company's employees willingly submit to the evaluations. "It's a win-win situation."

"It's a win for the employees, because if they have some health problems, the screening can help identify that," Mr. Dudek said. "From the company point of view, you tend to have fewer health care claims if your employees have identified (problem areas). These (screenings) are contributing to reduced medical claims, so it saves the company money."

In 1998, Class & Son's medical claims were $140,000 lower than it had projected for the year, Mr. Dudek said. Last year, the company saved only $11,500, but the savings were skewed by a few large claims, he noted.

In the near future, employers may mandate that covered employees submit to health risk assessments, said Mr. Hunnicutt. It may be an "issue of tough love," he said. "Health promotion is moving from secondary types of programs to core business objectives."

Wellness programs should not be standardized, said Ms. Martin, but should be crafted to meet a company's specific needs.

Corporations, she said, "really want us to tailor the information to their specific employees," noting that stress management programs are especially popular among Northwestern Memorial's corporate clients.

'A happy, healthy employee equals a competitive, productive company,' says Brenda Loube.

But despite the many advantages wellness programs seem to offer, two factors may have hindered the rapid advancement of wellness programs, according to Mr. Berkowitz.

"It's more difficult to demonstrate savings, and the long-term benefits of wellness programs don't always accrue to the present employer," because of the mobility of today's workforce, he said.

Ms. Martin also noted that the changing demographics of workers sometimes fuel skepticism about wellness programs.

"An employer really has a lot to look at in offering these wellness programs, because people don't stay with a company for as many years as in the past," said Ms. Martin. "Now, you see people staying with an organization for two to five years, and then they might go somewhere else. But to stay within the market, it's important to offer employee benefits, with wellness being one of them."

A comprehensive wellness program can give a company "the competitive edge," said Brenda Loube, president and co-owner of wellness provider Corporate Fitness Works Inc. in Montgomery Village, Md. Ms. Loube is also a vp of the Assn. for Worksite Health Promotion, based in Northbrook, Ill. "A happy, healthy employee equals a competitive, productive company," Ms. Loube said.

For Robert Mendonsa, general manager for Aetna U.S. Healthcare in Chicago, the decision to offer a wellness program is simple. "Today's consumer and today's employee really value health and prevention," he said. BI

Most worksites promoting employee health: Study

By AMANDA MILLIGAN

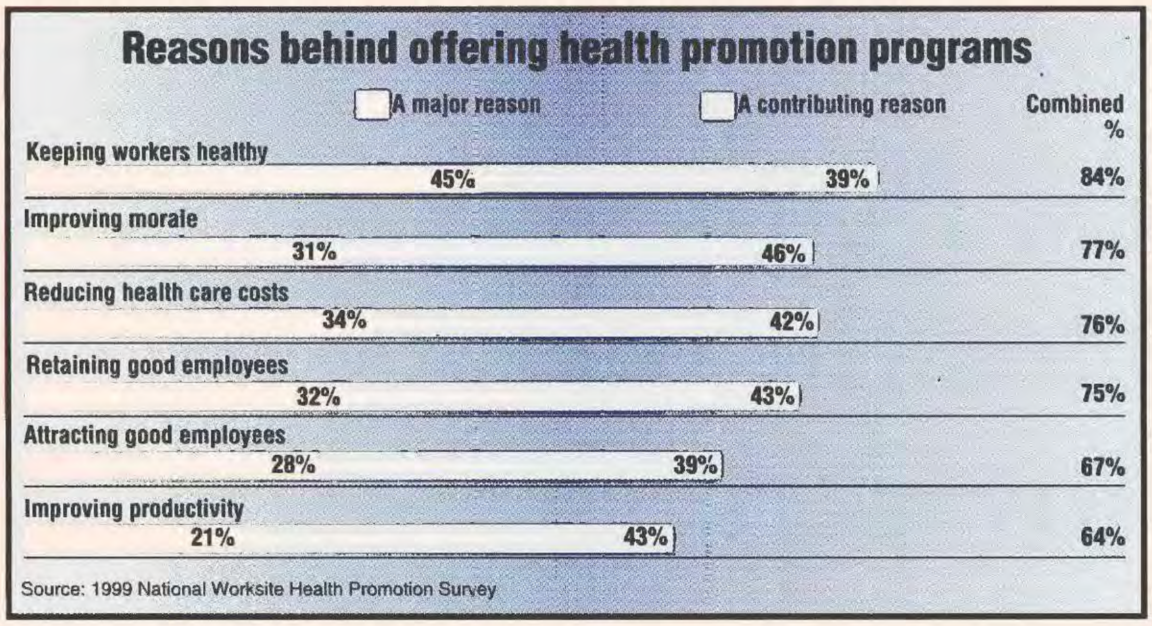
Although many worksites have taken steps to promote employee health, wellness concepts have not yet drawn broad support from upper management, a new survey shows.

Ninety percent of survey respondents indicated that their worksite offers at least one health promotion—or wellness—activity, according to the survey conducted by William M. Mercer Inc., the Assn. for Worksite Health Promotion, the U.S Department of Health and Human Services, and the Office of Disease Prevention and Health Promotion. The survey sought information on individual worksites, rather than on companies as a whole.

Overall, however, only slightly more than half of the respondents cited improving employee health as part of their company's mission.

The industry category with the least interest in this goal was the wholesaler/retail category, with 43% of those respondents saying that improving employee health was a company mission.

And management support, which some consultants and wellness providers say is crucial to the success of such programs, does not appear to be widespread. Only 39% percent of survey respondents noted that senior management consider employee health and well-being "at or near the top" of their business priorities, according to the survey.



At the same time, more than 50% of respondents at worksites where senior management supports health promotion/wellness programs have been able to quantify a return on that investment, the survey found.

Among wellness programs offered, health risk assessments were especially popular among the largest worksites in terms of number of employees, with 46% conducting the assessments. Overall, though, the assessments were conducted by only 18% of worksites.

Health screenings, such as checks of blood pressure and cholesterol, were conducted by about 30% of worksites.

According to the survey, measures to prevent back injuries and violent behavior were used at 53% and 36% of all worksites, respectively. "Awareness education," a term used for shorter-term programs such as one-time seminars on health topics, was offered by 35% of worksites. Education on cholesterol and on AIDS and HIV, the virus that causes AIDS, topped the list of topics most frequently discussed.

The survey found that "lifestyle behavioral change programs," which differ from awareness education programs in that they are ongoing, had been embraced by worksites of all sizes. The most popular category of these programs, offered by 36% of those surveyed, was physical activity. Other popular programs address substance abuse and stress management, offered by 28% and 26% of survey respondents, respectively.

Disease management and demand management are both areas of growing interest, the survey found, even though only a small percentage of worksites currently offer such programs. "Demand management" is a term for programs that aim to eliminate unnecessary utilization of medical services by providing health care information, such as books on self-care or access to nurse-staffed telephone lines for health advice.

The survey found that, increasingly, employers can offer health promotion programs because more health plans are offering such services.

The survey involved the participation of 1,544 respondents, most of which were service providers or manufacturing companies.

•

Copies of the 1999 National Worksite Health Promotion Survey can be obtained through the Assn. for Worksite Health Promotion, 847-480-9574. The cost of the survey is $49 for association members and $199 for non-members.

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Benefits

Continued from page 3

many health care economics experts, advocates "using the 401(k) concept. . .take the money used to buy insurance and deposit it in flexible spending accounts" that employees can direct, just as they do their retirement investments.

While a defined contribution approach sounds like something new, it really isn't, benefit consultants say.

"Defined contribution is already here," said Greg Kuhn, national practice leader for employer health care at Pricewaterhouse Coopers in St. Louis.

Most employers already pay a fixed dollar amount for each employee's health care coverage, he said, with employees picking up the remainder of the tab. And because the employer contribution is fixed, that is, "defined," the employee contributions vary by the cost of the plan they select.

For example, if an employer agrees to pay $150 per month for single employees and offers three different health maintenance organizations with premiums ranging from $160 to $200, the employee pays the difference, $10 to $50 per month, depending on the plan selected.

This cost shift to employees has been tempered somewhat in recent years by managed care, which, for a time, slowed year-to-year health care cost increases. Now that double-digit health care inflation has returned, though, the cost shift to employees will also return, health care experts say.

Watson Wyatt Worldwide and the Washington Business Group on Health recently surveyed 35 large employers representing 2.1 million full-time employees, and 36% of respondents said they have passed on all of their year 2000 health plan cost increases to their employees.

In addition, more than 60% of employers surveyed for PwC's "HealthCast 2010" plan to adopt a defined contribution approach for funding health care by the end of this decade.

More employers are moving toward defined contribution not only because of cost, but also as a way to insulate themselves from liability, explained Mike Lichman, a senior vp at Willis in New York.

"Remember, we're dealing with plaintiffs lawyers with a ton of money in their pockets because of the tobacco suits," he said, referring to the recent multibillion-dollar settlement reached by state governments and tobacco companies.

"They're already filing racketeering suits against HMOs," he said.

Federal class-action suits have been filed against Humana Inc. and Aetna Inc., alleging the HMOs misled plan members about how treatment decisions are made (*BI*, Oct. 11, 1999).

"When HMOs get sued, employers will get sued as well because of limits on coverage. It's perceived as implicit denial of care," Mr. Lichman explained.

Although the best way for employers to avoid liability entirely would be to "give employees the cash and don't give them any guidance," the prudent employer will give their employees as much information as possible to use in selecting among health plans, he said.

"I do not believe there's much an employer can do to avoid being named in a suit. But there's much they can do to make sure they prevail," he said.

PwC's Mr. Kuhn agrees that employers—with the help of their consultants and Internet vendors—will be the suppliers of information on price, quality and access as a more consumer-driven health care marketplace emerges.

'We want to enable our employees to make the best choices, and we want to give them the best data available to do that,' says Cathy Diamond of Xerox Corp.

"The marketplace is ripe for it, and we have the technology to do it. Web technology will help," he said.

In fact, the Internet is well-suited to helping employees select health plans because it's already being used by employees for other types of health care information, Mr. Kuhn pointed out.

"Health sites get the greatest number of hits on the Internet," he said. "There's a lot of content information out there. It's just not organized."

Attempts by employers like Xerox to organize that information is only the beginning, benefits experts say.

"There will be more emphasis on self-serve," predicted Rich Ostuw, global health care practice director at Watson Wyatt in Stamford, Conn.

To avoid overwhelming employees with too much information and not enough interpretation, employers will provide a "digestible" amount of information, he said, including:

•Report cards on how well plans are performing.

•Plan design.

"Employers will make plan designs as similar as possible so the burden is more on cost and quality than on additional benefits," Mr. Ostuw said.

•Access.

"We can do more with the network provider directories," he suggested. "There's easy technology available to do mapping. It wouldn't be very hard to make that kind of tool available to employees."

In fact, many health plan Web sites with online provider directories already sort physicians by ZIP code.

"Five years from now, employee benefits communication will be online, very, very user friendly, and voluminous," Mr. Ostuw predicts. "We'll do so much more over the Internet."

"And everybody is moving more toward disease management and telemedicine online," Mr. Ostuw said. "The advantage to being online is that the treatment can be customized with claims history and knowledge of pre-existing conditions."

For example, many health plans are already giving physicians hand-held computers, which they use in making specialist referrals and writing prescriptions, he said.

To improve the quality of the online information, Harvard's Ms. Herzlinger envisions the creation of a disclosure organization similar to the Securities and Exchange Commission.

After the 1929 stock market crash, "when FDR became president, he created the SEC to be the 'truth agency' to give information to consumers" about investing, she said.

"I think that's what we need in health care. We need a federal government requirement to collect, standardize and disseminate information," she asserted.

Cathy Diamond, manager of health, welfare and work and family programs for Xerox, said she would welcome some kind of oversight to ensure the quality of the information available on the Internet.

While the data included on the Xerox site was already standardized—it was collected from the automated request-for-proposal process Xerox uses each year to select plans—"the Web sites weren't always up to date," she said, referring to the provider Web sites linked to the Xerox site.

Xerox also didn't include report card information on its site this year because such data, collected by the National Committee on Quality Assurance, isn't easily interpreted, she said.

"We're always looking at how to upgrade our system," Ms. Diamond said.

"We want to enable our employees to make the best choices, and we want to give them the best data available to do that." BI

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Compensation: per employee per month, $1.50 to $2.00; per hour, $100.

Officers: Richard L. Blomquist, president/CEO; Richard Nemitz, COO; Patricia Price, vp-utilization management.

Contact: Julie Moore, 262-879-0100 ext. 3011.

ASU Group - Recovery Unlimited
2173 Commons Parkway,
P.O. Box 1520,
Okemos, Mich. 48805-1520;
800-968-2417; fax: 517-349-1332
www.asugroup.com

1999 revenues	
Total gross revenues	$5,200,000
Case management revenues	$4,000,000
Staff	
Total case management employees	64
Certified Case Managers	52
Medical professionals	46
Registered nurses	46
Total medical professionals on retainer	10
Physicians on retainer	10
Clients	
Total	200
Corporate/institutional employer clients	200
Covered lives/managed cases	
Total cases managed	15,500
Employer clients	25%
Insurer/managed care clients	75%
Workers compensation claims	65%
Group health claims	35%

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

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

Utilization management services: utilization review, integrated disability management.

Compensation: per hour, $77.

Officers: Tara LaRose, COO; Nancy Hillard, vp-operations; Bruce Stubbs, vp-sales.

Contact: Bruce Stubbs, 800-968-4668; bru1095@asugroup.com.

Action Healthcare Management
301 E. Bethany Home Road,
Suite C-278,
Phoenix, Ariz. 85012;
602-265-0681; fax: 602-265-0202

1999 revenues	
Total gross revenues	$1,200,000
Case management revenues	$750,000
Staff	
Total case management employees	5
Certified Case Managers	3
Medical professionals	7
Physicians	2
Registered nurses	4
Licensed practical nurses	1
Total medical professionals on retainer	3
Physicians on retainer	1
Nurses on retainer	2
Clients	
Total	1,225*
Covered lives/managed cases	
Total cases managed	72,000
Insurer/managed care clients	100%
Workers compensation claims	5%
Group health claims	95%

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, 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.

Contact: Jean Rice, president, 800-433-6915 or 602-265-0681; jrice@interacs.com.

**Estimate.*

AdvoCare Inc.
4645 Richmond Road,
Cleveland, Ohio 44128;
216-514-1451; fax: 216-514-1227
www.advocare-inc.com

1999 revenues	
Total gross revenues	$2,000,000
Case management revenues	$1,000,000
Staff	
Total case management employees	14
Certified Case Managers	6
Registered nurses	9
Licensed practical nurses	2
Physicians on retainer	1
Clients	
Total	3,800
Corporate/institutional employer clients	3,800
Covered lives/managed cases	
Total cases managed	4,000*
Employer clients	30%
Insurer/managed care clients	70%
Workers compensation claims	60%
Group health claims	40%

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-term/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, $1.40 to $2.00; per case, $350 to $700; per hour, $75 to $125.

Officers: Joseph Cannelongo, president; Karen M. Agnich, vp/COO; George Cyphers, secretary/treasurer.

Contact: Karen M. Agnich, kagnich@advocare-inc.com.

**Estimate.*

Alicare Medical Management
730 Broadway,
New York, N.Y. 10003;
212-539-5287; fax: 212-473-1354
www.alicaremedmgt.com

1999 revenues	
Total gross revenues	$4,000,000
Case management revenues	$400,000
Staff	
Total case management employees	5
Certified Case Managers	5
Medical professionals	30
Physicians	1
Registered nurses	27
Licensed practical nurses	2
Total medical professionals on retainer	4
Physicians on retainer	3
Nurses on retainer	1
Clients	
Total	68
Corporate/institutional employer clients	28
Covered lives/managed cases	
Total cases managed	11,082
Employer clients	80%
Insurer/managed care clients	20%
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-term/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.

Branch Offices: Salem, N.H.

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

Contact: Cynthia Hom.

Allegro*
1820 Post Road, Suite 8,
Plover, Wis. 54467;
715-344-2300; fax: 715-344-2320

Officers: Elizabeth S. Thompson, president; Aloha M. Daniels, vp-direct services; Mary O'-Connor Drout, CFO.

Contact: Buzz Rusmussen, director of sales;

Continued on next page

Continued from previous page

lwendorf@allegrowi.com, 800-828-2727.
*For full corporate information, see Innovative Resource Group.

American Health Holding Inc.

921 Eastwind Drive,
Columbus, Ohio 43081;
614-818-3230, ext. 232;
fax: 614-818-3222
americanhealthholding.com

1999 revenues
Total gross revenues ... $10,000,000
Case management revenues ... $5,000,000
Staff
Total case management employees ... 27
Certified Case Managers ... 2
Medical professionals ... 27
Physicians ... 1
Registered nurses ... 25
Licensed practical nurses ... 1
Total medical professionals on retainer ... 15
Physicians on retainer ... 15
Clients
Total ... 30
Covered lives/managed cases
Total cases managed ... 2,900
Employer clients ... 10%
Insurer/managed care clients ... 90%
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, 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, $95.

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

Branch Offices: Little Rock, Ark.; Columbus, Ga.; Indianapolis; Charthage, Mo.; Philadelphia; Pittsburgh.

Officers: Michael J. Reidelbach, president; Joan M. Yockel, vp-operations; Merry P. Korn, vp-marketing.

Contact: Merry P. Korn.

B

Beech Street Corp.

173 Technology Drive,
Irvine, Calif. 92618;
800-877-1666; fax: 949-753-9025
www.beechstreet.com

1999 revenues
Total gross revenues ... $65,000,000
Case management revenues ... $1,900,000
Staff
Total case management employees ... 19
Certified Case Managers ... 6
Medical professionals ... 47
Physicians ... 3
Registered nurses ... 44
Total medical professionals on retainer ... 8
Physicians on retainer ... 8
Clients
Total ... 136
Covered lives/managed cases
Total cases managed ... 437,717

Case management services: 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, short-term/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

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

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

Officers: Janice Walker, vp-healthcare management/customer service; Nancy Neslen, director-healthcare management; Caroline Aicone, case management supervisor.

Contact: Janice Walker, administration@beechstreet.com.

Bluegrass Health Network Inc.

P.O. Box 23770,
Louisville, Ky. 40223;
502-244-1343; fax: 502-426-5935

1999 revenues
Total gross revenues ... $3,300,000
Case management revenues ... $1,750,000
Staff
Total case management employees ... 48
Certified Case Managers ... 20
Physicians ... 1
Registered nurses ... 43
Total medical professionals on retainer ... 86
Physicians on retainer ... 86
Clients
Total ... 52
Corporate/institutional employer clients ... 26
Covered lives/managed cases
Total cases managed ... 4,000
Employer clients ... 40%
Insurer/managed care clients ... 60%
Workers compensation claims ... 50%
Group health claims ... 50%

Case management services: onsite case management, telephone case management, outcomes measurement, 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, dental, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-term/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, integrated disability management.

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

Officers: Scott C. Ferguson, president; Maggie Eden, manager-case management; Mary Jane Whitty, case management/utilization review supervisor.

C

CCMI Associates

1163 New Boston Road,
Francestown, N.H. 03043;
603-547-2245; fax: 603-547-2246

1999 revenues
Total gross revenues ... $2,000,000
Case management revenues ... $2,000,000
Staff
Total case management employees ... 5
Certified Case Managers ... 4
Medical professionals ... 4
Registered nurses ... 4
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 18
Corporate/institutional employer clients ... 8
Covered lives/managed cases
Total cases managed ... 500
Employer clients ... 20%
Insurer/managed care clients ... 80%
Workers compensation claims* ... 40%
Group health claims* ... 30%

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

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

Compensation: per hour, $65.

Contact: Sandra Lowery, ccmi@lowery.mv.com.
*The remaining 30% of the cases managed are either strictly disability or auto insurers.

CareAdvantage Inc.

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

1999 revenues
Total gross revenues ... $17,000,000
Case management revenues ... $17,000,000
Staff
Total case management employees ... 167
Certified Case Managers ... 7
Medical professionals ... 67
Physicians ... 11
Registered nurses ... 49
Licensed practical nurses ... 7
Total medical professionals on retainer ... 130
Physicians on retainer ... 130
Clients
Total ... 4
Covered lives/managed cases
Total cases managed ... 2,610,000
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, 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: utilization review, disease management.

Compensation: flat fee.

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

Branch Offices: Buffalo, N.Y.; Providence, R.I.; Montpelier, Vt.

Officers: David G. Noone, CEO; Dr. Richard W. Freeman, president/COO; Dennis J. Mouras, executive vp.

Contact: Dennis J. Mouras.

ComPsych Corp.

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

1999 revenues*
Total gross revenues ... $100,000,000
Case management revenues ... $12,000,000
Staff
Total case management employees ... 95
Medical professionals ... 94
Physicians ... 2
Registered nurses ... 3
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 80
Corporate/institutional employer clients ... 70
Covered lives/managed cases
Total cases managed ... 4,500,000
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, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, demand management, absence management, written case reports.

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

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

Compensation: per employee per month, $1.50 to $6.00; per case, $250 to $700; percent of savings.

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

Contact: Mary Paskell, director-marketing, 312-595-4015, info@compsych.com.
*Estimate.

Concentra Managed Care Inc.

312 Union Wharf,
Boston, Mass. 02109;
617-367-2163; fax: 617-367-8519
www.concentramc.com

1999 revenues
Total gross revenues ... $675,000,000
Case management revenues ... $146,000,000
Staff
Total case management employees ... 1,306
Certified Case Managers ... 1,200
Medical professionals ... 1,306
Physicians ... 306
Registered nurses ... 700
Total medical professionals on retainer ... 61
Clients
Total ... 2,346
Covered lives/managed cases
Total cases managed ... 57,000
Employer clients ... 8%
Insurer/managed care clients ... 92%
Workers compensation claims* ... 90%
Group health claims* ... 2%

Case management services: onsite case management, telephone case management, patient education, online case reports, outcomes measurement, disease management, specialty referral review, integrated disability management, demand management, 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, short-term/long-term disability, skilled nursing facilities.

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

Compensation: per hour, $63.

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

Branch Offices: Throughout 49 states and Canada. Concentra has 89 service locations providing medical management and vocational rehabilitation and 85 locations specializing in cost containment.

Officers: Daniel J. Thomas, president/CEO; Scott Henault, president-case management services; Thomas Kiraly, executive vp-finance/CFO.

Contact: Anne E. Kirby, vp-product development, anne_kirby@concentramc.com.
*The eight percent not represented is accounted for in auto and disability services.

CORE Inc.

18881 Von Karman Ave., Suite 1750,
Irvine, Calif. 92612;
800-258-2673; fax: 949-442-2101
www.coreinc.com

1999 revenues
Total gross revenues ... $65,563,000
Case management revenues ... $47,205,360
Staff
Total case management employees ... 503
Certified Case Managers ... 20
Medical professionals ... 175
Physicians ... 6
Registered nurses ... 163
Licensed practical nurses ... 6
Clients
Total ... 37
Corporate/institutional employer clients ... 2
Covered lives/managed cases
Total cases managed ... 750,000
Employer clients ... 90%
Insurer/managed care clients ... 10%
Workers compensation claims ... 100%

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

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

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month.

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

Branch Offices: Los Angeles; Burlington, Mass.; Silverspring, Md.

Officers: George C. Carpenter IV, chairman/CEO; Craig Horton, president/COO; William Nixon, executive vp/CEO.

Contact: Mona Winn, manager-corporate communications, contactus@coreinc.com.

CorVel Corp.

2010 Main St., Suite 1020,
Irvine, Calif. 92614;
949-851-1473; fax: 949-851-1465
www.corvel.com

1999 revenues*
Total gross revenues ... $182,000,000
Case management revenues ... $109,000,000
Staff
Total case management employees ... 1,650
Certified Case Managers ... 800
Medical professionals ... 1,190
Registered nurses ... 1,150
Licensed practical nurses ... 40
Total medical professionals on retainer ... 200
Physicians on retainer ... 200
Clients
Total ... 535
Corporate/institutional employer clients ... 95
Covered lives/managed cases
Total cases managed ... 152,293
Employer clients ... 26%
Insurer/managed care clients ... 74%
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, 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, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-term/long-term disability, skilled nursing facilities, organ transplants.

Compensation: per employee per month, $1.25 to $1.40; per case, $110 to $125; per hour, $70 to $115.

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

Officers: Gordon Clemens, president/CEO; Lou Silverman, COO; Daniel H. Davis, vp-marketing/business development.

Contact: Daniel H. Davis, 215-953-5060, dan_davis@corvel.com.
*Estimate.

Crawford & Co.

5620 Glenridge Drive N.E.,
Atlanta, Ga. 30342;
800-241-2541; fax: 404-847-4404
www.crawfordandcompany.com

1999 revenues
Total gross revenues ... $695,000,000
Case management revenues ... $72,500,000
Staff
Total case management employees ... 695
Physicians ... 1
Registered nurses ... 240
Clients
Total ... 2,750
Corporate/institutional employer clients ... 1,500
Covered lives/managed cases
Total cases managed ... 104,050
Employer clients ... 52%
Insurer/managed care clients ... 48%
Workers compensation claims ... 90%
Group health claims ... 10%

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, outpatient psychiatric and substance abuse referrals, demand management, absence management, written case reports.

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

Utilization management services: utilization review.

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 L. Davis, president/COO; Victoria Holland, executive vp.

Contact: Wanda L. Gross, project manager.

Continued on page 19

Directory terms explained

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

To be included, companies were required to report their 1999 gross revenues or an acceptable estimate. Companies that did not report gross revenues were not included.

Business Insurance defines case management as providing planning and monitoring treatment for catastrophic, complex or prolonged illnesses and injuries, including discharge planning, onsite or telephone case reviews and/or patient referrals, as well as managing communication among patients, providers and payers throughout the course of a claim.

Listings begin with the company name and address. Financial/statistical information includes total **1999 gross revenues**, followed by the actual dollar amount of revenues generated by case management services.

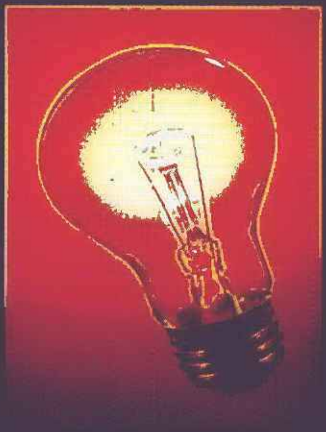
Staff information lists total staff assigned to case management, including a breakout of total professional staff members and staff members on retainer. Staff numbers are provided in full-time equivalents, except for those on retainer.

Business volume is represented by the number of **case management clients** and **covered lives**, including the percentage of cases managed for employer clients or insurer/managed care clients, as well as the percentage of claims that were workers compensation or group health.

Specific **case, health care and utilization management** services the company provides are described next in the listing, followed by the means of **compensation**, the method used to bill for services. American Accreditation HealthCare Commission/URAC status is noted, if applicable.

Branch offices are other locations performing case management, followed by the names and titles of **officers** and a **contact**.

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



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Issue Date	Editorial Feature	Demographic Section	Ad Closing
Jan 17	Information Resource: Risk Management	IT Financial Modernization	Jan 5
Jan 24	Benefits: Improving Quality *Directory: Case Management Services*		Jan 12
Jan 31			Jan 19
Feb 7	Environmental Risks *Directory: Environmental Risk Management Consultants* *Distribution: Commercial Insurance Legislative Summit*	ABT Global Strategies	Jan 26
Feb 14			Feb 2
Feb 21	Self-Insurance: Property/Casualty & Employee Benefits *Directory: Third-Party Administrators*	IT Global Strategies	Feb 9
Feb 28			Feb 16
Mar 6	Benefits: Technology Solutions *Directory: Benefit Information Systems*	ABT Consolidation	Feb 23
Mar 13	*Distribution: NAIC*		Mar 1
Mar 20	Risk Financing Options *Directory: Risk Securitization Specialists* *Distribution: IAIS*	IT Consolidation	Mar 8
Mar 27			Mar 15
Apr 3	Risk Management Services *Directory: Risk Management Consultants*	ABT Agency/Insurer Relations	Mar 22
Apr 10			Mar 29

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D

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

1999 revenues
Total gross revenues ... $315,000
Case management revenues ... $315,000
Staff
Total case management employees ... 4
Registered nurses ... 3
Physicians on retainer ... 1
Clients
Total ... 105
Covered lives/managed cases
Total cases managed ... 41,000
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, psychiatric and substance abuse, pediatric care, short-term/long-term disability, skilled nursing facilities.
Utilization management services: utilization review, demand management, disease management.
Compensation: per employee per month; per hour, $80.
American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.
Officers: Arthur W. Chandler, chairman; Joseph Colosi, president; Cynthia Craig, senior vp-operations.
Contact: Joseph Colosi, joecol@chandler-group.com.

Diversified Healthcare Services
2430 Camino Ramon, Suite 240,
San Ramon, Calif. 94583;
925-355-1423; fax: 925-355-1433
www.dhsi.com

1999 revenues
Total gross revenues ... $7,000,000
Case management revenues ... $200,000
Staff
Total case management employees ... 37
Certified Case Managers ... 1
Registered nurses ... 1
Licensed practical nurses ... 2
Total medical professionals on retainer ... 2
Nurses on retainer ... 2
Clients
Total ... 20
Corporate/institutional employer clients ... 4
Covered lives/managed cases
Total cases managed ... 1,000
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, disease management, specialty referral review, integrated disability management, written case reports.
Health care services: workers compensation.
Utilization management services: utilization review.
Compensation: per hour, $85.
Officers: Jorge Garratt, president; Tara Ambrose, vp-product development; Tori Henson, vp-business development.
Contact: David A Dyess, director-client services, ddyess@dhsi.com.

E

EM Ernst Management Inc.
111 Grant Ave., Suite 206,
Endicott, N.Y. 13760;
800-724-0825; fax: 607-786-3470
www.emmgt.com

1999 revenues*
Total gross revenues ... $1,600,000
Case management revenues ... $600,000
Staff
Total case management employees ... 10
Certified Case Managers ... 6
Medical professionals ... 9
Registered nurses ... 7
Licensed practical nurses ... 2
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 11
Corporate/institutional employer clients ... 11
Covered lives/managed cases
Total cases managed ... 1,040
Employer clients ... 70%
Insurer/managed care clients ... 30%
Workers compensation claims ... 10%
Group health claims ... 90%

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, disease management, 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-term/long-term disability, skilled nursing facilities, organ transplants.
Utilization management services: utilization review, integrated disability management.
Compensation: per employee per month, $1.85 to $3.00; per hour, $65 to $120.
Officers: Carl R. Ernst, president; Sharon Miller, vp-quality and development; Mary Lou Conrow, vp-workers compensation and disability.
Contact: Sharon Miller, 800-494-1561, sharon@emmgt.com.
*Estimate.

Employee Benefit Management Services Inc.*
2075 Overland Ave., P.O. Box 21367,
Billings, Mont. 59104-1367;
406-245-3575; fax: 406-655-4311
www.ebmstpa.com

1999 revenues
Total gross revenues ... $7,628,395
Case management revenues ... $796,759
Staff
Total case management employees ... 6
Certified Case Managers ... 3
Registered nurses ... 6
Licensed practical nurses ... 4
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 164
Corporate/institutional employer clients ... 136
Covered lives/managed cases
Total cases managed ... 1,328
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, high-risk maternity management, written case reports.
Health care services: group health care, psychiatric and substance abuse, pediatric care, skilled nursing facilities, organ transplants.
Utilization management services: utilization review, disease management.
Compensation: per employee per month; per case; per hour.
Officers: Frederick H. Larson, president; Nicki Larson, vp.
*Operates under a program named Care Link.

ENCOMPASS Health Management Systems
6000 Westown Parkway, Suite 350 E.,
West Des Moines, Iowa 50266-7771;
800-383-2856; fax: 515-222-2407
encompas.com

1999 revenues
Total gross revenues ... $39,385,000
Case management revenues ... $3,500,000
Staff
Total case management employees ... 16
Certified Case Managers ... 10
Medical professionals ... 16
Physicians ... 3
Registered nurses ... 13
Total medical professionals on retainer ... 267
Physicians on retainer ... 265
Nurses on retainer ... 2
Clients
Total ... 35
Corporate/institutional employer clients ... 15
Covered lives/managed cases
Total cases managed ... 1,700,000
Employer clients ... 84%
Insurer/managed care clients ... 16%
Workers compensation claims ... 39%
Group health claims ... 61%

Case management services: 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, short-term/long-term disability, skilled nursing facilities, organ transplants.
Utilization management services: utilization review, demand management, disease management, integrated disability management.
Compensation: per hour, $100.
American Accreditation HealthCare Commission/URAC status: Case Management Organization Standards, Health Utilization Management Standards, Workers Compensation Utilization Management Standards.
Branch Offices: Chicago; Baltimore; Minneapolis; Lincoln, Neb.
Officers: Fred Ferree, executive vp; John Clark, CFO; Kathy Fliehler, vp.
Contact: Kathy Fliehler, kfliehle@encompas.com.

F

FARA-F.A. Richard & Associates Inc.
2360 Fifth St.,
Mandeville, La. 70471;
504-624-8383; fax: 504-624-8489
www.fara.com

1999 revenues
Total gross revenues ... $17,200,000
Case management revenues ... $3,400,000
Staff
Total case management employees ... 38
Certified Case Managers ... 26
Medical professionals ... 26
Registered nurses ... 26
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 210
Corporate/institutional employer clients ... 210
Covered lives/managed cases
Total cases managed ... 12,080
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, specialty referral review, outpatient psychiatric and substance abuse referrals, written case reports.
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 $3.00; per case, $250 to $500; per hour, $74 to $85; percent of savings*, 15%.
Branch Offices: Mobile, Ala.; Long Beach, Calif.; Boca Raton, Fla.; Alpharetta, Ga.; Baton Rouge, Lafayette, New Orleans and Shreveport, La.; Gulfport, Miss.; Corpus Christi and Houston, Texas; Norfolk, Va.
Officers: M. Todd Richard, president/CEO; Reed A. Bell, executive vp; Dan Clark, senior vp.
Contact: Kay Martin, vp-FARA Healthcare Management, kay.martin@fara.com.
*Estimate.

G

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

1999 revenues
Total gross revenues ... $116,500,000
Case management revenues ... $70,030,000
Staff
Total case management employees ... 1,700
Certified Case Managers ... 1,100
Medical professionals ... 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 ... 127,000
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-term/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 case management offices.
Officers: Peter C. Madeja, president/CEO; Paul M. Bode, senior vp-sales and marketing; Delphia B. Frisch, senior vp-operations.
Contact: Carolyn Hildenbrand, director-marketing, carolyn.hildenbrand@genexservices.com.

H

HHS, Health Options
5363 44th St. S.E.,
Grand Rapids, Mich. 49512;
800-634-2712; fax: 616-956-6843
hhs-inc.com

1999 revenues
Total gross revenues ... $5,773,577
Case management revenues ... $5,631,384
Staff
Total case management employees ... 104
Certified Case Managers ... 3
Medical professionals ... 50
Registered nurses ... 50
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 461
Corporate/institutional employer clients ... 457
Covered lives/managed cases
Total cases managed ... 22,500
Employer clients ... 95%
Insurer/managed care clients ... 5%
Group health claims ... 100%

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, 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, $.45 to $1.95; per case, $375 to $510; per hour, $50 to $90; percent of savings, 20%.
American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.
Officers: Denise Zoeterman, president/CEO; Richard J. Hodson Jr., director-customer relations; Montelle Evans, director-clinical programming.

Health Care Evaluation Inc.
6702 N. Inglewood, Suite G,
Stockton, Calif. 95207;
209-951-6711; fax: 209-951-2731

1999 revenues
Total gross revenues ... $1,900,000
Case management revenues ... $1,900,000
Staff
Total case management employees ... 19
Medical professionals ... 11
Physicians ... 2
Registered nurses ... 7
Licensed practical nurses ... 2
Total medical professionals on retainer ... 210
Physicians on retainer ... 210
Clients
Total ... 52
Corporate/institutional employer clients ... 50
Covered lives/managed cases
Total cases managed ... 7,500
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, absence management.
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-term/long-term disability, skilled nursing facilities, organ transplants.
Utilization management services: utilization review.
Compensation: per employee per month, $1.20 to $1.90; per hour, $95 to $110.
American Accreditation HealthCare Commission/URAC status: Health Utilization Management Standards.
Officers: Barbara Rodin, CEO; Jeff Roby, president; Peggy Hoover, vp-review operations.
Contact: Richard Bukar, 714-281-7846.

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

1999 revenues
Total gross revenues ... $1,100,000
Case management revenues ... $1,100,000
Staff
Total case management employees ... 26
Medical professionals ... 13
Registered nurses ... 13
Total medical professionals on retainer ... 1
Physicians on retainer ... 1
Clients
Total ... 9
Corporate/institutional employer clients ... 9
Covered lives/managed cases
Total cases managed ... 20,000
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, outpatient psychiatric and substance abuse referrals, high-risk maternity management, written case reports.
Health care services: group health care, dental, chiropractic, physical therapy/rehabilitation, pre-

Continued on next page

Largest case management service providers by revenues
Based on 1999 gross revenue from case management services

1.	Intracorp	$304,000,000
2.	Concentra Managed Care Inc.	146,000,000
3.	CorVel Corp.	109,000,000[1]
4.	Crawford & Co.	72,500,000
5.	Genex Services Inc.	70,030,000
6.	CORE Inc.	47,205,360
7.	National Healthcare Resources Inc.	29,000,000
8.	Resource Opportunities Inc.	20,000,000
9.	CompPsych Corp.	12,000,000
10.	Innovative Resource Group[2]	8,032,000

1 Estimate 2 Formerly CNR Health Inc.
Source *BI* survey. Firms that derive 100% of case management revenues from insurer/managed care clients are not ranked

Continued from previous page

scription drugs, 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; percentage of savings, 30% home care/ancillary service negotiations, 33% retrospective claims review program.

Officers: M. Ruth Coleman, president/CEO; Connie Jones, vp-health services.

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

Health Risk Management

10900 Hampshire Ave. S.,
Minneapolis, Minn. 55438;
800-824-3882; fax: 612-946-7694
www.hrmi.com

1999 revenues
Total gross revenues $200,860,000
Case management revenues $3,500,000
Staff
Total case management employees 35
Certified Case Managers 2
Medical professionals 70
Physicians 2
Registered nurses 67
Licensed practical nurses 1
Total medical professionals on retainer 32
Physicians on retainer 32
Clients
Total 67
Corporate/institutional employer clients 67
Covered lives/managed cases
Total cases managed 5,010
Employer clients 22%
Insurer/managed care clients 78%
Group health claims 100%

Case management services: 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, home health care, psychiatric and substance abuse, pediatric care, short-term/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, $120 to $150.

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

Officers: Dr. Gary McIlroy, chairman/CEO; Marlene Travis, president; Thomas Clark, CFO.

Contact: Pamela Hursh, president-incemnity business unit, phursh@hrmi.com.

I

Innovative Resource Group*

2514 S. 102nd St., Suite 100,
Milwaukee, Wis. 53227;
800-499-0267 ext. 8408;
fax: 414-327-0886
www.cnrhealth.com

1999 revenues
Total gross revenues $30,300,000
Case management revenues $8,032,000
Staff
Total case management employees 191
Certified Case Managers 42
Medical professionals 140
Physicians 3
Registered nurses 133
Licensed practical nurses 4
Total medical professionals on retainer 45
Physicians on retainer 45
Clients
Total 158
Corporate/institutional employer clients 76
Covered lives/managed cases
Total cases managed 44,192
Employer clients 40%
Insurer/managed care clients 60%
Workers compensation claims 3%
Group health claims 97%

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, prescription drugs, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-term/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 hour.

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

Branch Offices: Phoenix; Houston; Pewaukee, Plover and Waukesha, Wis.

Officers: Dr. James E. Hartert, president/COO; Dianne Kiehl, senior vp; Dr. David Burnett, vp/medical director-medical services.

Contact: Elizabeth Ferris, director of business development, eferris@i-r-group.com.

Formerly CNR Health Inc.

Integrated Care Management

5 Dunwoody Park,
Atlanta, Ga. 30075;
800-500-3270; fax: 770-730-9055
www.integratedcare.com

1999 revenues
Total gross revenues $4,000,000
Case management revenues $3,600,000
Staff
Total case management employees 60
Certified Case Managers 21
Medical professionals 16
Physicians 1
Registered nurses 12
Licensed practical nurses 3
Total medical professionals on retainer 1
Physicians on retainer 1
Clients
Total 60
Corporate/institutional employer clients 4
Covered lives/managed cases
Total cases managed 859
Employer clients 40%
Insurer/managed care clients 60%
Workers compensation claims 100%

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

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

Compensation: per case, $450 to $1000; per hour, $65 to $70; flat fee.

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

Officers: Dan Barta, president; Mark Pergolini, director-business development; Amy Ahems, practice leader.

Contact: Mark Pergolini, mark.pergolini@integratedcare.com.

Intercare Network*

285 Forest Grove Drive,
Pewaukee, Wis. 53072;
262-695-2500; fax: 262-695-2525

Officers: Victoria Hekkers, president; Duffy Johnson, director; Teresa Staka, manager.

Contact: Victoria Hekkers, vicky.hekkers@mail.inpartners.com.

For full corporate information, see Innovative Resource Group.

Intracorp

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

1999 revenues
Total gross revenues $365,000,000
Case management revenues $304,000,000
Staff
Total case management employees 3,148
Certified Case Managers 254
Medical professionals 1,074
Physicians 47
Registered nurses 1,027
Total medical professionals on retainer 527
Physicians on retainer 527
Clients
Total 1,757
Corporate/institutional employer clients 569
Covered lives/managed cases
Total cases managed 1,690,098
Employer clients 17%
Insurer/managed care clients 83%
Workers compensation claims 16%
Group health claims 84%

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-term/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; percentage of savings.

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

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

Officers: Kirk Rothrock, president; Ken Ross, senior vp-disability management; Eileen Auen, senior vp-health care management.

Contact: Colleen Bergin, manager-public relations, cbergin@mail.intracorp.com, 215-761-7152.

J

Jordan Services Inc.

900 Merchants Concourse, Suite 112,
Westbury, N.Y. 11590;
516-683-0100; fax: 516-683-0309
www.jordanservices.com

1999 revenues
Total gross revenues $7,443,333
Case management revenues $4,884,300
Staff
Total case management employees 80
Certified Case Managers 42
Registered nurses 45
Physicians on retainer 2
Clients
Total 715
Covered lives/managed cases
Total cases managed 260,000
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-term/long-term disability.

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month, $1.25 to $4.00; per hour, $79 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, CEO; Phyllis Snow, director-marketing.

Contact: Phyllis Snow, www.phyllissnow@jordanservices.com.

L

Liaison Inc.

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

1999 revenues
Total gross revenues $2,000,000
Case management revenues $1,800,000
Staff
Total case management employees 23
Certified Case Managers 10
Medical professionals 19
Registered nurses 18
Licensed practical nurses 1
Total medical professionals on retainer 20
Physicians on retainer 5
Nurses on retainer 15
Clients
Total 125
Corporate/institutional employer clients 12
Covered lives/managed cases
Total cases managed 900
Employer clients 25%
Insurer/managed care clients 75%
Workers compensation claims 100%

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, written case reports.

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

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

Compensation: per case; per hour; flat fee.

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

Officers: Catherine Marrs, president; Karen Kyle, general manager.

Contact: Catherine Marrs, cmarrs@liaisoninc.com.

Magellan Behavioral Health

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

1999 revenues
Total gross revenues $1,500,000,000
Case management revenues NA
Staff
Total case management employees 1,179
Total medical professionals on retainer 230
Clients
Total 1,094
Corporate/institutional employer clients 775
Covered lives/managed cases
Total cases managed 1,247,265*
Employer clients** 28.1%
Insurer/managed care clients** 62%

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.

Officers: John J. Wider Jr., president/COO; Clarisse Marques, executive vp-clinical/quality management; Paul D. Barnes, chief marketing officer.

Contact: Paul Barnes.

**Covered lives numbers are for 1998, figures for 1999 will be available in late February. **Nine-tenths of a percent of total cases managed are for the public sector.*

M

Managed Care USA Services Inc.

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

1999 revenues
Total gross revenues $100,000,000
Case management revenues $7,500,000
Staff
Total case management employees 50
Certified Case Managers 29
Physicians 1
Registered nurses 43
Licensed practical nurses 1
Clients
Total 6,000
Covered lives/managed cases
Total cases managed 11,000
Employer clients 50%
Insurer/managed care clients 50%
Workers compensation claims 100%

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

Health care services: workers compensation.

Utilization management services: utilization review.

Compensation: flat fee, $255 to $500.

Branch Offices: Rancho Cordova, Calif.; Maitland, Fla.; Alpharetta, Ga.; Voorhees, N.J.; Franklin, Tenn.

Officers: Steven M. Mariano, chairman/CEO; David Smith, vp-claims; Dr. Deborah Day, chief medical officer.

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

MedCost L.L.C.

165 Kimel Park Drive,
Winston-Salem, N.C. 27103;
336-760-3090; fax: 336-760-2352
www.medcost.com

1999 revenues
Total gross revenues $14,700,000
Case management revenues $650,000
Staff
Total case management employees 11
Certified Case Managers 4
Medical professionals 9
Registered nurses 9
Clients
Total 2,000
Corporate/institutional employer clients 20
Covered lives/managed cases
Total cases managed 2,235
Employer clients 1%
Insurer/managed care clients 99%
Group health claims 100%

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

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

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

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

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

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

Contact: Joy Neal, marketing services manager, 800-433-9178 ext. 4281, jneal@medcost.com.

Medical Management Services

8620 S.W. 179 St.,
Miami, Fla. 33157;
305-378-2567; fax: 305-251-0246

1999 revenues
Total gross revenues $60,000
Case management revenues $60,000
Staff
Total case management employees 1
Certified Case Managers 1
Medical professionals 1
Registered nurses 1
Clients
Total 52
Covered lives/managed cases
Total cases managed 52
Insurer/managed care clients 100%
Workers compensation claims 92%
Group health claims 8%

Case management services: onsite case management, telephone case management, patient education, outcomes measurement, 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.

Utilization management services: integrated disability management.

Compensation: per case, $40 to $60.

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

Contact: Audree Theobald, case manager.

Med-Valu Inc.

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

1999 revenues
Total gross revenues $6,000,000
Case management revenues $572,000
Staff
Total case management employees 7
Certified Case Managers 3
Registered nurses 5
Physicians on retainer 42
Clients
Total 20
Covered lives/managed cases
Total cases managed 12,000
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, dental, chiropractic, physical therapy/rehabilitation, prescription drugs, home health care, psychiatric and substance abuse, pediatric care, short-term/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, disease management.

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

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

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

Contact: Mary Ellen O'Grady.

N

National Healthcare Resources Inc.

555 North Lane,
Conshohocken, Pa. 19428;
610-238-0630; fax: 610-238-0639
www.nhrinc.com

1999 revenues
Total gross revenues $113,000,000
Case management revenues $29,000,000
Staff
Total case management employees 330
Certified Case Managers 227
Medical professionals 290
Physicians 2
Registered nurses 200

Continued on next page

Continued from previous page

Licensed practical nurses	25
Total medical professionals on retainer	82
Physicians on retainer	12
Nurses on retainer	70
Clients	
Total	175
Corporate/institutional employer clients	26
Covered lives/managed cases	
Total cases managed	23,200
Employer clients	15%
Insurer/managed care clients	85%
Workers compensation claims	95%
Group health claims	5%

Case management services: onsite case management, telephone case management, specialty referral review, integrated disability management, absence management.

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

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month; per hour, $62 to $85; flat fee, $225 to $2,750.

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

Branch Offices: Atlanta; Chicago; Owings Mills, Md.; Minneapolis; Southfield, Miss.; Englewood and Woodbridge, N.J.; Charlotte, N.C.; Lebanon and Pittsburgh, Pa.; Dallas and Houston; South Charleston, W. Va.

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

National Utilization Management Corp.

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

1999 revenues	
Total gross revenues	$3,000,000
Case management revenues	$3,000,000
Staff	
Total case management employees	25
Certified Case Managers	6
Medical professionals	31
Physicians	1
Registered nurses	25
Licensed practical nurses	5
Total medical professionals on retainer	60
Physicians on retainer	60
Clients	
Total	120
Covered lives/managed cases	
Total cases managed	2,000
Employer clients	90%
Insurer/managed care clients	10%
Workers compensation claims	50%
Group health claims	50%

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-term/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.

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

Officers: Constance Lambert, president; Dr. James Gerace, medical director; Karen M. Beamer, director-medical management.

Contact: Constance Lambert, 800-354-2464.

Nationwide Case Management Services

P.O. Box 6146,
Laguna Niguel, Calif. 92677;
949-753-2757; fax: 949-496-3667

1999 revenues	
Total gross revenues	$500,000
Case management revenues	$480,000
Staff	
Total case management employees	40
Certified Case Managers	30
Registered nurses	2
Physicians on retainer	1
Clients	
Total	15
Corporate/institutional employer clients	15
Covered lives/managed cases	
Total cases managed	275
Employer clients	75%
Insurer/managed care clients	25%
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, integrated disability management, referrals to alternative settings, outpatient psychiatric and substance abuse referrals, written case reports.

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

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

Compensation: per case, $250 to $500; per hour, $70 to $90.

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

Branch Offices: Ogden, St. George and Salt Lake City, Utah.

Officers: Sally Swenson, president; Kelly Hinds, office manager.

Contact: Sally Swenson, ncmservice@aol.com.

O

Options Unlimited

76 E. Main St.,
Huntington, N.Y. 11743;
516-673-1150; fax: 516-673-8369
www.optionsunlimited.org

1999 revenues	
Total gross revenues	$1,500,000
Case management revenues	$1,300,000
Staff	
Total case management employees	22
Certified Case Managers	5
Medical professionals	17
Total medical professionals on retainer	140
Physicians on retainer	10
Nurses on retainer	130
Clients	
Total	15
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, 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-term/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 $150; percent of savings, 10%.

Officers: Catherine M. Mullahy, president; Julia Graziano, director-services; Nancy Peters, director-utilization review.

Contact: Marylou Beeck, executive administrator.

P

PHA Review

1350 Old Bayshore Highway,
Suite 560,
Burlingame, Calif. 94010;
650-375-5800; fax: 650-375-5820

1999 revenues	
Total gross revenues	$2,000,000
Case management revenues	$850,000
Staff	
Certified Case Managers	1
Medical professionals	4
Physicians	1
Registered nurses	3
Total medical professionals on retainer	2
Physicians on retainer	1
Nurses on retainer	1
Clients	
Total	18
Corporate/institutional employer clients	6
Covered lives/managed cases	
Total cases managed	1,260
Employer clients	25%
Insurer/managed care clients	75%
Workers compensation claims	1%
Group health claims	99%

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

Utilization management services: utilization review.

Compensation: per employee per month, $0.75 to $1.45; per case, $100 to $500; per hour, $80 to $125; flat fee.

Branch Offices: Fresno and Sacramento, Calif.

Officers: Lawrence Cappell, CEO; Robert Mackler, executive vp; Lynn Patasini, director-utilization management.

Contact: Lynn Patasini.

Parman Associates Inc.

2211 Lake Club Drive, Suite 105,
Columbus, Ohio 43232;
614-575-9400; fax: 614-575-9399
www.parman.com

1999 revenues	
Total gross revenues	$3,600,000
Case management revenues	$3,000,000
Staff	
Total case management employees	50
Certified Case Managers	30
Medical professionals	9
Registered nurses	6
Licensed practical nurses	1
Total medical professionals on retainer	100
Physicians on retainer	100
Clients	
Total	100
Corporate/institutional employer clients	30
Covered lives/managed cases	
Total cases managed	30,000
Employer clients	15%
Insurer/managed care clients	85%
Workers compensation claims	95%
Group health claims	5%

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

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

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month; per case; per hour, $75; flat fee; percent of savings.

Branch Offices: Cincinnati, Cleveland, Kent and Toledo, Ohio.

Officers: Jamie Parman, president; Karl Shuster, director-marketing; Chris Moranda, operations.

Contact: questions@parman.com.

Prism Health Networks

37 Central Ave.,
Lancaster, N.Y. 14086;
716-681-1112; fax: 716-685-6314
www.prismnetwork.com

1999 revenues	
Total gross revenues	$5,500,000
Case management revenues	$1,000,000
Staff	
Total case management employees	20
Certified Case Managers	8
Physicians	8
Clients	
Total	30
Covered lives/managed cases	
Total cases managed	100,000
Insurer/managed care clients	100%
Workers compensation claims	3%
Group health claims	97%

Case management services: outcomes measurement, disease management, written case reports.

Health care services: chiropractic, physical therapy/rehabilitation, home health care, workers compensation.

Utilization management services: utilization review.

Compensation: per employee per month; per case.

Officers: Arthur Wingerter, CEO; Kevin Cichocki, president; Steve Zajac, secretary.

Contact: Art Wingerter, 716-681-1112, ext. 220, awingerter@prismnetwork.com.

Private Healthcare Systems Inc.

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

1999 revenues	
Total gross revenues	$117,248,000
Case management revenues	$2,851,000
Staff	
Total case management employees	27
Certified Case Managers	3
Physicians	7
Registered nurses	75
Physicians on retainer	19
Clients	
Total	4
Corporate/institutional employer clients	5
Covered lives/managed cases	
Total cases managed	5,639
Employer clients	64%
Insurer/managed care clients	36%
Group health claims	100%

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

Health care services: group health care, psychiatric and substance abuse.

Utilization management services: utilization review.

Compensation: per employee per month; per hour.

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

Branch Offices: Irvine, Calif.

Officers: Joseph Driscoll, president/CEO; Armand Morin, chief information officer; Barbara Daily, CFO.

Contact: Eric Swain, director-national sales, 800-253-4417, ext. 7558, eswain@phcs.com.

PRO-West, A Professional Review Organization

10700 Meridian Ave. N., Suite 100,
Seattle, Wash. 98133-9075;
206-364-9700; fax: 206-368-2419
www.pro-west.org

1999 revenues	
Total gross revenues	$14,000,000
Case management revenues	$8,000,000
Staff	
Total case management employees	17
Certified Case Managers	12
Medical professionals	65
Physicians	6
Registered nurses	56
Licensed practical nurses	3
Total medical professionals on retainer	143
Physicians on retainer	143
Clients	
Total	60
Corporate/institutional employer clients	60
Covered lives/managed cases	
Total cases managed	551
Employer clients	100%
Group health claims	100%

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

Health care services: group health care, dental, chiropractic, 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 case; per hour; flat fee.

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

Branch Offices: Anchorage, Alaska; Boise, Idaho.

Officers: Dr. William McKee, chairman; John W. Daise, CEO; Dr. Jonathan R. Sugarman, corporate medical director/principal clinical coordinator.

Contact: Michael B. Garrett, executive director.

Professional Case Management Consultants Inc.

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

1999 revenues	
Total gross revenues	$910,000
Case management revenues	$600,000
Staff	
Total case management employees	33
Certified Case Managers	20
Medical professionals	1
Registered nurses	1
Total medical professionals on retainer	29
Physicians on retainer	1
Nurses on retainer	28
Clients	
Total	48
Corporate/institutional employer clients	7
Covered lives/managed cases	
Total cases managed	700
Employer clients	40%
Insurer/managed care clients	60%
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, 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-term/long-term disability, skilled nursing facilities, organ transplants.

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

Compensation: per hour, $65 to $120; flat fee.

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

Officers: Belinda Brice, president; Harry Greene, director-customer relations.

Contact: Harry Greene.

R

Resource Opportunities Inc.

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

1999 revenues	
Total gross revenues	$20,000,000
Case management revenues	$20,000,000
Staff	
Total case management employees	305
Certified Case Managers	175
Medical professionals	228
Physicians	2
Registered nurses	220
Licensed practical nurses	2
Total medical professionals on retainer	16
Physicians on retainer	1
Nurses on retainer	15
Clients	
Total	590
Corporate/institutional employer clients	110
Covered lives/managed cases	
Total cases managed	37,589
Employer clients	28%
Insurer/managed care clients	72%
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, demand management, high-risk maternity management, absence management, written case reports.

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

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

Compensation: per hour, $58 to $115.

American Accreditation HealthCare Commission/URAC status: Workers Compensation Utilization Management Standards. **Branch Offices:** Branches in 23 locations throughout the U.S.

Officers: Richard Mastalar, CEO; Michael Leep, president; Gerald Osband, chief medical officer.

Contact: Jeff Odell, jodell@ccnusa.com.

S

Spectrum Review Services Inc.

3845 FM 1960 W., Suite 110,
Houston, Texas 77068;
800-258-5055; fax: 281-444-2482
www.spectrumreview.com

1999 revenues	
Total gross revenues	$1,034,586
Case management revenues	$375,000
Staff	
Total case management employees	5
Certified Case Managers	1
Medical professionals	9
Registered nurses	7
Licensed practical nurses	2
Total medical professionals on retainer	175
Physicians on retainer	125
Nurses on retainer	50
Clients	
Total	95
Corporate/institutional employer clients	3
Covered lives/managed cases	
Total cases managed	5,355
Employer clients	90%
Insurer/managed care clients	10%
Workers compensation claims	3%
Group health claims	97%

Case management services: 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, home health care, psychiatric and substance abuse, workers compensation, pediatric care, short-term/long-term disability, organ transplants.

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

Compensation: per employee per month, $1.50 to $2.50; per case, $60 to $70; per hour, $100.

Continued on next page

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

Officers: Frank J. Berrier Jr., chairman/president/CEO; Ernest C. Munshower, COO; Nancy Anecelle, director.

Contact: Frank J. Berrier Jr.

Strategic Health Development Corp.

9315 N.E. Sixth Ave., Suite A1,
Miami Shores, Fla. 33138;
800-874-2378; fax: 305-751-1029

1999 revenues	
Total gross revenues	$5,000,000
Case management revenues	$3,000,000
Staff	
Total case management employees	24
Certified Case Managers	12
Medical professionals	24
Registered nurses	24
Total medical professionals on retainer	20
Physicians on retainer	20
Clients	
Total	250
Covered lives/managed cases	
Total cases managed	3,000
Employer clients	50%
Insurer/managed care clients	50%
Workers compensation claims	80%
Group health claims	20%

Case management services: onsite case management, 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, 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, short-term/long-term disability, skilled nursing facilities, organ transplants.

Utilization management services: utilization review, integrated disability management.

Compensation: per employee per month, $1.50; per hour, $105.

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

Contact: Mary Vanek, vp-marketing/customer service.

T

(Total) Care Management

P.O. Box 5500,
Greenville, S.C. 29606;
800-638-6829, ext. 853;
fax: 864-233-5337
www.hewittcoleman.com

1999 revenues	
Total gross revenues	$5,800,000
Case management revenues	$1,650,000
Staff	
Total case management employees	14
Certified Case Managers	6
Medical professionals	7
Registered nurses	7
Total medical professionals on retainer	5
Physicians on retainer	1
Nurses on retainer	4
Clients	
Total	120
Corporate/institutional employer clients	105
Covered lives/managed cases	
Total cases managed	863
Employer clients	85%
Insurer/managed care clients	15%
Workers compensation claims	50.3%
Group health claims	49.7%

Parent: Hewitt, Coleman & Associates.

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, physical therapy/rehabilitation, prescription drugs, workers compensation, pediatric care, short-term/long-term disability, organ transplants.

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

Compensation: per hour, $75 to $90; percent of savings, 33%.

Officers: Charles R. Warne, president; S. Dianne Matthews, director-managed care; Maureen Davis, senior analyst.

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

V

Valuecheck

8625 King George,
Dallas, Texas 75235;
214-267-3370; fax: 214-267-3380
www.mdcl.com

1999 revenues	
Total gross revenues	$300,000
Case management revenues	$100,000
Staff	
Total case management employees	8
Physicians	1
Registered nurses	4
Physicians on retainer	1
Nurses on retainer	1
Clients	
Total	30
Corporate/institutional employer clients	10
Covered lives/managed cases	
Total cases managed	120
Employer clients	50%
Insurer/managed care clients	50%
Group health claims	100%

Case management services: telephone case 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, skilled nursing facilities, organ transplants.

Utilization management services: utilization review.

Compensation: per hour, $95.

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

Officers: John D. Weimer, president/CEO; Dwight Mankin, senior vp-sales; Stephanie McVay, chief counsel/secretary.

Contact: Dwight Mankin, ddm@mdcl.com.

W

WellPoint Health Networks Inc.*

1 WellPoint Way,
Thousand Oaks, Calif. 91362;
805-557-6797;
www.wellpoint.com

1999 revenues	
Total gross revenues	$7,500,000,000
Case management revenues	NA
Staff	
Total case management employees	491
Medical professionals	751
Physicians	43
Registered nurses	448
Licensed practical nurses	260
Clients	
Total	764
Corporate/institutional employer clients	603
Covered lives/managed cases	
Total cases managed	16,379

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, 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; flat fee; percent of savings.

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

Branch Offices: Atlanta; Hoffman Estates, Ill.; Springfield, Mass.; Jackson (Ridgeland), Miss.

Officers: Leonard D. Schaeffer, chairman/CEO; Ryan Trimble, vp-medical care management; Randy Schwartz, vp-operations, medical care management.

Contact: Randy Schwartz, randy.schwartz@wellpoint.com, 714-842-4909, ext. 3312.

**Subsidiaries include Unicare Life & Health Insurance Co. and Blue Cross of California.*

Z

Zenith Administrators Inc.

201 Queen Anne Ave. N., Suite 100,
Seattle, Wash. 98109;
206-282-4100; fax: 206-285-1701

1999 revenues	
Total gross revenues	$52,000,000
Case management revenues	$525,000
Staff	
Total case management employees	12
Certified Case Managers	6
Medical professionals	7
Registered nurses	7
Total medical professionals on retainer	30
Physicians on retainer	30
Clients	
Total	29
Corporate/institutional employer clients	22
Covered lives/managed cases	
Total cases managed	2,160
Employer clients	100%

Case management services: telephone case management, patient education, disease management, referrals to alternative settings, high-risk maternity management.

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, disease management.

Compensation: per employee per month.

Branch Offices: San Francisco; Denver; Indianapolis.

Contact: Tierney D. Hogan. BI

Prescriptions, health care costs on the rise

By MICHAEL PRINCE

Higher prescription drug costs are expected to drive increases in health care costs in 2000, two surveys report.

Employee and retiree health care plan costs are expected to increase by an average of 12% this year, according to a survey conducted by Towers Perrin. The projected increase for active employees only is somewhat lower, with an increase of 10% expected.

"Moreover, most of the 228 employers surveyed say they expect health care cost increases to continue for the next several years at roughly the same rapid pace," Towers Perrin states.

A major factor in the increase is the enormous rise in prescription drug costs.

Prescription drugs costs are expected to rise by 18.1% for retail sales in 2000, according to a separate survey by The Segal Co. This compares with an actual 14.2% increase in drug costs in 1999, which includes both retail and mail order sales, Segal reported.

Health care claims costs in 2000 are expected to increase between 8.9% for health maintenance organizations and 13.8% for traditional fee-for-service plans, the Segal survey shows. In addition, costs for preferred provider organizations are expected to increase by 11.0% and point of service plans are expected to cost 9.6% more in 2000 than in 1999.

The Segal survey is based on surveying 49 insurers, third-party administrators, prescription benefit managers and managed care organizations. In addition, the survey looked at data from more than 200 Segal clients to determine the actual increases for 1999.

The Towers Perrin survey is based on responses from 228 employers about their own health care costs.

Despite the steep increases, the 1999 actual increase for prescription drug costs was lower than forecast.

For 1999, the Segal survey projected retail drug costs to rise by 16.6%, while they actually rose by 14.2%. In addition, the actual increase for 1999 was lower than the 16.8% increase experienced in 1998, possibly indicating that the surge in prescription drug costs has crested, Segal reported.

"This peak may be the result of greater use of PBMs' cost management controls, managed care organizations' involvement with prescribing physicians, and plan sponsor plan modifications," the survey states.

The survey also showed that actual medical claims costs rose in 1999 at a lower rate than in 1998. For example, in 1999, HMO claims' costs rose 5.6% in 1999, compared with 6.2% in 1998. Similarly, PPO claim costs rose 6.5% in 1999 vs. 8.5% in 1998.

These figures, however, vary substantially from those in the Towers Perrin survey. That survey found that costs for all health plans combined increased 7% in 1999, up from 4% in 1998.

A recent survey by William M. Mercer Inc. of 3,166 employers found that total health care costs for active employees in 1999 climbed 7.3%, up from 6.2% in 1998 (*BI*, Dec. 20, 1999).

The Segal survey figures "definitely contradict what everyone else is saying," acknowledged Ed Kaplan, a vp with Segal in New York. "Our data says that we turned a corner and we're definitely going down," he said. Mr. Kaplan noted that the figures are based on actual claims costs rather than premiums charged by insurers, which often have been higher.

Despite the varying figures, it's clear that health care costs will increase sharply this year. In fact, the Towers Perrin survey predicts 2000 will see the largest health care cost increases since 1993. And the impact will now fall more heavily on employers than it did then. With tight labor markets, it's becoming more difficult for employers to pass on higher health care costs to their employees, the Towers Perrin survey states.

Employers, however, are not passively absorbing higher health care costs. The most common strategy they employ is to change the plan design and cost-sharing with employees, Towers Perrin reported. In the past two years, 57% of employers surveyed indicated they pursued this course and 48% said they were considering such an option, the survey stated.

"Given the fact that the employee contribution share at companies generally stayed the same this year, and that employers expect large cost increases to continue during the next several years, these findings suggest that cost-sharing will become an important issue for many companies," the survey states.

The next most popular strategy adopted was to introduce carve-out programs. Forty-four percent of employers have done this in the past two years and 34% anticipate adopting this measure in the future, the survey states. Other popular strategies include changing the employee contribution, done by 37% of employers surveyed, consolidating health plan options, 34%, and introducing a Web-based enrollment or communication tool, 31%.

The Segal survey also showed less variance in projected cost increases for different types of plans. For 2000, the largest cost difference among plans is the 8.9% increase for HMOs and 13.8% for traditional fee-for-service plans. In 1998, however, the difference was much larger with projected increases for HMOs at 4.8% and fee-for-service plans at 13.0%.

Beyond soaring pharmacy prices, the Towers Perrin survey notes that strong demand for services by enrollees and pressure from shareholders in health care companies to increase profits are other factors pushing up health care costs.

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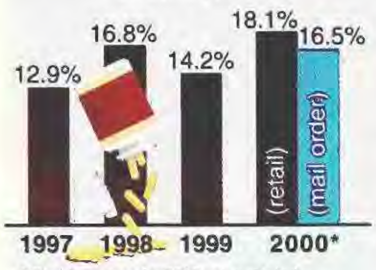
Free copies of the 2000 Towers Perrin Health Care Cost Survey are available by calling the company at 800-525-6741. The 2000 Segal Health Plan Cost Trend Survey can be obtained through the company's web site at www.segalco.com.

Drug cost increases

Prescription drug trend for active employees and retirees under age 65



* Cost increases for 2000 are projected; 1997-1999 are actual.
Source: The Segal Co.

GRAPHIC BY MIKE GARVEY

Global Briefs

Tony Baker is leaving the Assn. of British Insurers at the end of February after 29 years. Mr. Baker, the ABI's deputy director general, said he is leaving to seek a new challenge. His successor has not yet been named. . . .A consortium of the London Financial Futures & Options Exchange, Intelligent Financial Solutions and WIRE Ltd. has launched a Web-based marketplace for weather derivatives. **I-WeX.com** offers over-the-counter trade in instruments to allow companies to hedge against the impact of weather on their businesses. . . .**Zurich Commercial**, part of Zurich Financial Services Group, has teamed up with Cognos, a vendor of enterprise business intelligence solutions, to design financial packages tailored to individual customers' needs. Andy Stephens, management information manager at Zurich Commercial, said the company can now more clearly determine client profiles and needs and build customer-specific products. . . .Lincoln Re, a unit of Lincoln National Corp. of Fort Wayne, Ind., and Kyoei Life Insurance Co. of Tokyo have formed a joint venture, **Kyoei Lincoln Reinsurance Services Co.**, scheduled to start operations in Tokyo on March 1. Ninety percent of the initial capital of 10 million yen ($94,920) for the new consulting company is being provided by Lincoln National. . . .French reinsurer **SCOR S.A.** has installed a new management team for its large industrial risks. Renaud de Pressigny, formerly deputy general manager of large corporate accounts with Aon Group Inc., has been named general manager. Victor Peignet, previously the manager of SCOR's energy unit, was named deputy general manager for large risks. . . .Moody's Investors Service Inc. has issued a report on **Nordic non-life insurers**, saying they still warrant a stable rating outlook and the "A" rating awarded to most of them. The credit rating agency said Nordic insurers have "good franchises, stable and strong market shares and positive cash flows." Moody's also noted that the competitive position regionally of Nordic insurers could be strengthened over the long term by the creation of larger players through mergers, as has been happening. . . .A.M. Best Co. has downgraded **Reinsurance Australia Corp.** of Sydney and its subsidiary **Monegasque de Reassurances** of Monaco to B++ from A- and placed the ratings under review for a possible downgrade. The action follows the group's recent forecast of a significant loss for the year stemming from a number of catastrophes, including European storms this winter. Best said the insurer had a disproportionate share of these losses, leading to a severe contraction of its capital base. . . . **Lloyd's of London** has elected four new members to its governing council. Graham McKean, chairman of Ballantyne, McKean & Sullivan, and Paul Archard, managing director of PXRE Managing Agency Ltd., were elected to three-year terms as working members of Lloyd's. Peter Morgan and Bill Loschert were elected to three-year terms as external, or non-working, members. . . . French credit insurer **Groupe Coface** has expanded its U.K. interests beyond trade credit insurance and into the provision of integrated credit management solutions. The expansion resulted when Coface LBF, the insurer's U.K. unit, acquired Cimco Ltd. and its sister company, The Creditors Group Ltd. Cimco and The Creditors Group are credit insurance management and receivables management companies. . . .**Quincy Mutual Fire Insurance Co.** of Quincy, Mass., has launched a U.K. underwriting operation with the opening of a branch office in London. John Warwick, senior underwriter and general manager in London, said the unit will underwrite a short-tail non-marine reinsurance account.

Spill prompts safety focus

By EDWIN UNSWORTH

LONDON—International shipping regulators are calling for a tougher stance on maritime safety following the breakup last month of an oil tanker off France.

A visit by French President Jacques Chirac last week to Brittany, where the tanker broke apart, highlighted the seriousness of the economic and ecological damage caused by France's worst offshore oil spill since 1978.

The Dec. 12 accident involving the 24-year-old tanker Erika is raising questions in many quarters about the vessel's safety and who is responsible for the spill.

About 10,000 metric tons of oil, approximately one-third of the Maltese-registered tanker's cargo, washed ashore in an area reliant on tourism and fishing. Erika had been chartered by French oil company Totalfina to carry oil from Dunkirk, France, to Livorno, Italy (*BI*, Dec. 20, 1999).

Totalfina Chairman Thierry Desmarest has insisted that the tanker's owner, Tavere Shipping Co. of Malta, is responsible for the pollution. A member of the family that owns Tavere, however, has maintained in the press that the tanker was well-maintained and managed.

Following an outcry from the French public and government, Totalfina pledged to finance the removal of the remaining fuel oil in the tanker's wreckage and create a 40 million franc ($6.2 million) fund to assist onshore cleanup. Totalfina said its contribution will free up insurance coverage to indemnify those with economic losses.

See **Spill** *on next page*

PHOTO: AFP

Workers in northwestern France clean up oil following one of the country's worst tanker accidents. The Dec. 12, 1999, spill has spurred the international shipping community to propose stricter regulations on tanker safety.

Code lowering claims: Study

By EDWIN UNSWORTH

GOTHENBURG, Sweden—Implementation of the International Safety Management Code has led to "significant" improvement in the claims experience of ships that have had to meet its requirements, compared with ships that do not follow the new standards, according to The Swedish Club.

An analysis by the club, a major protection and indemnity and hull insurance mutual for shipowners, shows that over a four-year period ending June 30, 1999, vessels that have had to comply with the ISM code had virtually no increase in P&I and hull claims, while ships not yet required to comply had a 30% increase in claims incidence.

On July 1, 1998, the ISM Code took effect for passenger and merchant ships of 500 gross tons or more. Beginning July 1, 2002, it will apply to smaller vessels as well.

In contrast to other international regulations, which set standards for the safe construction and maintenance of ships, the ISM Code was designed to set standards for safe ship management. It was devised by the International Maritime Organization, the London-based shipping arm of the United Nations.

To meet ISM standards, a ship must earn a Document of Compliance, certifying that the ship owner's shore-based management systems meet ISM standards, and a Safety Management Certificate, issued to each individual vessel following a successful audit of its shipboard management system.

Martin Hernqvist, loss prevention officer of The Swedish Club in Gothenburg, said the study offers a clear message: "Vigorous application of the

See **Code** *on next page*

Large settlements in two U.K. suits

Stress claims spur litigation

By CAROLYN ALDRED

LONDON—A pair of record compensation settlements in past weeks are among the most recent indicators that stress has become a significant organizational risk.

Earlier this month, two local authorities and their insurers settled two individual claims of £200,000 ($327,540) each, the largest stress claims settled so far in the United Kingdom.

On Jan. 10, the Worcestershire County Council agreed to pay a settlement of £203,000 ($332,450) to a former employee forced to retire from his job in 1997 at the age of 39, due to ill health caused by stress. The next day, Test Valley Borough Council, in Hampshire County, and its insurance company, Zurich Municipal, agreed to pay damages of £200,000 to a former employee who claimed to have had a "nervous breakdown" caused by stress at work.

Risk managers have also identified stress as the fastest-growing risk companies face, according to a new survey conducted by the Assn. of Insurance & Risk Managers (see related story).

And stress is also recognized as a "significant issue" by local authority risk managers, according to a spokesman from the Assn. of Local Authority Risk managers.

"One way of alleviating this concern, which many ALARM members will be undertaking, is a review of the human resources risk management program within an authority. This assessment will highlight the organization's level of control of the risks relating to employment, some of which, ultimately, could lead to stress-related claims against the employer, and enable any appropriate improvements to be made to prevent the risk arising or increasing in the future. Key to this issue is early preventative action and a human resource risk management system which is sensitive to employee's abilities and needs," according to a written ALARM statement prepared for *Business Insurance*.

Stress is fast becoming the most common risk in any organization, according

See **Stress** *on next page*

Survey forecasts U.K. risk outlook

Risk managers call stress, e-commerce among areas to watch

By CAROLYN ALDRED

Stress will be the fastest-growing risk organizations face in the 21st century, according to a survey of U.K. risk managers.

Eighty-eight percent of risk managers who responded to the survey predict that stress will increase as a risk factor for their organizations in the future. E-commerce risks came in a close second, cited by 80%, followed by: mergers and acquisitions, 66%; litigation, 65%; and loss of reputation, 64%.

But risk managers judged loss of reputation to be the most important of those risk for organizations and cited genetically modified organisms as the most important risk faced by society as a whole.

The AIRMIC 2000 survey was conducted in late December and early January using fax and e-mail responses. The results are based on responses from more than 50 risk managers operating within a representative sample of the U.K. risk management sector from fields such as manufacturing, retailing, finance, communications, utilities, travel, health, publishing, leisure, local municipalities, charities and education, according to AIRMIC.

Terrorism is the only risk that most risk managers predict will become less of a threat to their organizations.

The survey also asked AIRMIC members to grade 24 risks separately according to their importance to society and to their organization. Respondents were asked to predict if the risks would increase or decrease in the coming year. Emerging risks were established based

See **Risks** *on next page*

Spill

Continued from previous page

The French government itself has pledged assistance of 4 billion francs ($618 million) for losses from the oil spill and severe storms that battered the country late last month.

Insurance and other compensation is available to third parties who have suffered pollution damage from the spill. About $11.7 million is available from the shipowner's liability insurer, the Steamship Mutual Protection & Indemnity Club. Above this, compensation of around $173 million is available from the International Oil Pollution Compensation Fund Ltd., a London-based fund to which shipowners contribute to provide compensation for oil spills.

Earlier this month, Steamship Mutual and the IOPCF set up a joint claims office near the scene of the spill. To date, a small number of claims has been filed.

Meanwhile, the incident has drawn attention to numerous issues.

- Crew training. Within a week of Erika's accident, the tanker's master, Krun Mathur, was charged with putting life in danger and causing marine pollution.
- French Transport Minister Jean-Claude Gayssot called on oil and chemical companies to tighten controls over their shipping operations immediately.
- French Environment Minister Dominique Voynet called for tighter international controls on shipping companies. She called for the International Maritime Organization, the London-based shipping unit of the United Nations, to be strengthened and for countries to have more powers to prevent unsafe vessels from using their ports.
- The London-based International Assn. of Classification Societies, which represents the leading groups responsible for assessing the seaworthiness of ships, said it will not hesitate to expel members found failing to do their job properly.
- The European Commission said early this month that it may introduce tougher maritime regulations. Georgette Lalis, E.C. maritime policy director, said the measures could include tougher scrutiny of vessel seaworthiness and larger compensation funds.

She criticized classification societies, warning that European class rules might need to be tightened. Ms. Lalis has asked the Italian government to look into the classification, or seaworthiness, certificate given to the Erika by Italian ship classification society, Registro Italiano Navale.

Ship classification societies are responsible for inspecting ships on behalf of owners, governments and insurers. The leading classification societies, including RINA, belong to IACS.

Alfons Guinier, secretary general of the European Community Shipowners' Assn., said further investigation into the spill is needed, but he welcomed Ms. Lalis' request for a report on the Erika's seaworthiness.

Robin Bradley, IACS permanent secretary, said he "would not hesitate" to take action against RINA if it was proved to be negligent in classifying the Erika. BI

Code

Continued from previous page

ISM Code can significantly reduce claims exposure."

Mr. Hernqvist said that, while it is difficult to tell how much of the improvement shown in the study resulted directly from the ISM Code, "it is clear that those who have adopted the ISM Code and implemented modern safety management systems have been able to keep the number of claims down."

He added that the significance of code compliance is suggested by the preliminary findings of a club survey regarding the standards. The survey revealed that many members have seen a positive change in their incident rate since implementation and that they view ISM as a possible factor.

The Swedish Club's analysis covers ships' claims experience on an annual basis for the four years to June 30, 1999, comparing the claims experience of those vessels currently subject to the ISM Code—Phase 1 vessels—against those not yet required to be in compliance,

While the number of claims for Phase 1 vessels had hardly changed, claims rose by 30% for Phase 2 vessels.

the Phase 2 vessels.

Mr. Hernqvist explained that, due to a lowering of the deductible in most policies during the period examined, the actual number of claims reported to the club over that period remained fairly constant. Nevertheless, he explained, the important finding is that while the number of claims for Phase 1 vessels has hardly changed, claim numbers rose by 30% for Phase 2 vessels.

What particularly supports the view that the ISM Code is responsible for this difference, he said, is that it is only in the final two years of the study that there was a marked difference between the number of claims involving Phase 1 vessels and Phase 2 vessels—a time frame that coincides with the period when owners of Phase 1 ships began taking steps to comply with the code.

Mr. Hernqvist said the Swedish Club plans to continue monitoring the situation, but it expects the gap between claims trends for the two vessel groups to narrow as ships in the second category improve their ship management procedures in preparation for their July 2002 deadline for ISM Code compliance. BI

Stress

Continued from previous page

to the ALARM statement. The statement also says that stress often goes undetected and unmanaged.

"Stress is not always easy to recognize, diagnose and treat," said ALARM's chief executive officer, Liz Taylor. "But it is essential that early preventative action is taken and an HR risk management strategy implemented which is sensitive to employee's abilities and needs, as well as meeting the demands of the business."

According to ALARM, essential components in an HR risk management strategy include:

- Pre-employment health checks to ensure existing medical problems are identified;
- Regular reviews of competency, followed by training, where required;
- Adequate systems of promotion and advancement;
- High-quality supervision;
- A management culture that recognizes performance;
- A clearly understood reward structure; and
- Effective anti-discrimination policies.

According to ALARM, organizations should tackle stress by:

- Removing the causes of stress by, for example, reviewing resources and implementing better work practices, improving communications and offering better support and greater participation by employees in decision-making;
- Managing stress, which involves equipping individuals to cope with the problem and changing working practices to minimize the risk; and
- Providing occupational health therapy, counseling and rehabilitation services, in recognition of the fact that there will always be individuals who develop stress-related problems.

UNISON, the public service union that represents employees who work in public authorities and local municipalities, represented Randy Ingram, a former warden at a transient trailer park, in his fight for compensation.

According to UNISON, problems began when the responsibility for running the caravan sites was transferred from the district council to the county council, leading to "a loss of authority on the sites" and "a lack of support."

Site residents soon recognized the warden's lack of power and took advantage of the situation, according to UNISON. Mr. Ingram

'Stress is not always easy to recognize, diagnose and treat,' says ALARM's chief executive officer Liz Taylor.

was the third warden on the site to suffer from stress-related illness, according to UNISON, which noted that an internal inquiry conducted in 1998 by the council criticized the way sites were being managed.

Since then, "Worcestershire County Council has improved procedures by giving (transient) liaison staff more support," said Chris Carter, head of planning at the council.

Most of the settlement will be covered by insurance, said a council spokesman, who added that the council's insurer did not wish to be named.

UNISON, which is pursuing other stress compensation cases against local authorities, admitted that Mr. Ingram's case was one of the most extreme cases with which the union has had to deal.

"Good employers have nothing to fear from cases like these," said Dave Prentis, deputy secretary of UNISON. "They know that if they carry out risk assessments and take complaints about difficult work situations seriously and give them proper backup, these problems can be avoided. UNISON would prefer never to take another stress case, but when we come up against bad employers who are damaging our members' health, we will continue to pursue them for damages through the courts," Mr. Prentis said.

It was UNISON that, in 1994, took on the first such case, involving social worker John Walker. In that case, the High Court in London ruled that the stress that Mr. Walker suffered was caused by his employer, the Northumberland County Council. The council settled out of court for an estimated £150,000 ($234,750).

The day after the Worcestershire County Council case was settled, Test Valley Borough Council and its insurer, Munich Municipal, agreed to pay Roderick Keith McLeod £200,000 in a settlement reached shortly before the compensation case was about to be heard in London's High Court.

"The settlement reached was at a figure substantially less than the amount claimed and was recommended by the council's insurers," according to a statement issued by Test Valley.

Mr. McLeod left his job with the council in 1994 due to stress-induced mental illness caused, he claimed, by being bullied by his manager. An earlier industrial tribunal dismissed his claim of unfair dismissal, ruling that the council had acted properly in retiring Mr. McLeod due to ill health.

"Prior to joining Test Valley Borough, Mr. McLeod had suffered a psychological illness whilst in the employment of another local authority, and this may have made him more vulnerable to stress whilst in the employment of the council," said the council statement. BI

Risks

Continued from previous page

on their level of importance and expected rate of increase.

For organizations, loss of reputation seems to be the most worrying of the increasing risks for risk managers, topping both lists with an 80% rating, followed by risks related to e-commerce, mergers and acquisitions, litigation and stress, information technology malfunction, extreme weather, IT external sabotage, internal fraud and political decisions.

Risk managers were also asked to predict the most important risks that society as a whole will face and if they would increase or decrease.

Genetically modified organisms received the highest rating, followed by e-commerce, stress and pollution, IT malfunction and extreme weather.

"Our survey provides a fresh insight into the changing face of modern risk. Stress and e-commerce appear to be issues of general concern, but the results also indicate a growing need for a risk management focus on specific areas. For organizations, in areas such as reputation, IT and litigation; for society, in areas such as climate change, environmental pollution and GMOs," said AIRMIC Chairman Mark Butterworth.

"Above all, the survey underlines the all-important need of 21st century companies to underpin their activities with a fully integrated corporate governance system," Mr. Butterworth observed. BI

Forum

Continued from page 2

tle new capital entering the industry via the stock market, Mr. Kramer said.

"I think you have to be careful looking at snapshots in time," said Edward M. Liddy, chairman, president and chief executive officer of Allstate Corp. in Northbrook, Ill. The P/C industry may appear to have excess capital now, but one can't assume that will always be so, he said.

Mr. Levin asked how the panelists measure their capital.

ACE's Mr. Kramer said that risk-based capital guidelines used by regulators are a step in the right direction, but more should be done to consider the degree to which capital is at risk. Using such tools as dynamic financial analysis, ACE strives to determine appropriate pricing and capital levels, he said. Such information allows the company to determine a risk-adjusted return on individual risks, he said.

"We use the same tools of dynamic financial modeling to examine possible demands on capital from multiple events," said Robert C. Gowdy, president and CEO of CGU Corp. in Boston.

SCOR U.S. Corp. also tries to set a rate of return in pricing the risks it assumes, said Jerome Karter, president and CEO of the reinsurer in New York.

Such efforts to define more accurately a company's capital needs, however, are not always recognized, he said.

"In the U.S., the rating agencies don't ask if a company is using its capital wisely, but just how much it has in relation to others," Mr. Karter said. "This penalizes some companies by requiring them to have excess capital," relative to their actual needs, he said.

The panelists also discussed the potential for new distribution channels.

"Folks want more choices," said Mr. Liddy of Allstate. In addition to its agency system, Allstate may use the Internet and call centers, he said.

"Prospects are brighter if you give customers more ways to reach you," he said.

At the same time, Mr. Liddy added, "I don't think the era of single distribution is over, but there are more growth opportunities with multiple distribution."

There may be a danger to some companies, though, in creating too many distribution channels, said Mr. Gowdy of CGU.

"In any distribution channel, you have to be very good to win business," he said. By trying to work with too many channels, "you run the risk of diluting your strengths," he said.

CGU is looking at the Internet not as an alternative to agency distribution, but rather as a means of boosting its agents' abilities, Mr. Gowdy said.

ACE uses multiple distribution channels, but it is not necessarily sold on the power of the Internet, noted Mr. Kramer.

"Because no one *wants* to buy insurance, passive marketing models like the Internet really haven't taken off. I have yet to see the 'killer app' for insurance," he said.

Another industry trend the panelists discussed was globalization.

"Being global helps balance portfolios, balance cat exposures and helps meet customers' global needs," said Mr. Karter of SCOR U.S., whose parent is based in Paris.

"It's important to be where clients' needs are," he said, adding that companies must also be prepared to meet differing needs in different markets.

CGU's Mr. Gowdy agreed. "While many of us talk about globalization in terms of serving multinationals, most of our international business is very local," he said.

This point was brought home by a mutual insurer executive serving on the panel.

"There's still a niche for small companies," said Douglas C. Ryder, president and CEO of Holyoke Mutual Insurance Co. of Holyoke, Mass. "I don't worry about the globe, but what happens 30 miles from home." BI

Europe ready to grow, change: Chairman

NEW YORK—Despite tremendous changes and currently weak growth, the prospects for the European property/casualty insurance industry remain bright, a German insurer executive says.

"We are in the midst of a process of tremendous change. The '90s changed our industry more than any preceding decade," said Henning Schulte-Noelle, chairman of Allianz A.G. Holding of Munich.

One of the more dramatic events for European companies was the launch of the the single European currency, the euro, said Mr. Schulte-Noelle during a speech at the Property/Casualty Insurance Joint Industry Forum, held Jan. 11-12 in New York and co-sponsored by nine industry trade associations.

The euro's introduction has created larger and more liquid securities, has made comparison of prices easier, greatly reduced currency exchange risk and has broken down national barriers, Mr. Schulte-Noelle said.

"Europe is moving to a more unified political, social and legal environment," he said. "The emergence of a truly European market will strengthen the continent's role in global markets."

From the European perspective, there is plenty of growth potential in insurance, the Allianz chairman said.

"The weakness of social security systems worldwide clearly favors growth," he said.

On the property/casualty side, growth has stagnated in the United States and Europe, but Mr. Schulte-Noelle said he expects that to change.

"The need for property/casualty products will not disappear," he said.

European insurers also are realizing that deregulation brings not only the freedom to cut prices, but also to raise prices if needed, he said.

Although the industry's capital abundance does not portend strong growth at this time, "there are more services and products we can deliver to our customers," Mr. Schulte-Noelle said. "Growth will be a reality if insurers fully realize their position as problem solvers for their customers."

—By Paul D. Winston

P/C execs surveyed

NEW YORK—Insurer executives predict reduced profits, more consolidation, and new ventures involving the Internet and banking in the months ahead, an informal survey found.

The survey, taken at the Property/Casualty Insurance Joint Industry Forum, held Jan. 11-12 in New York, asked attendees about a variety of issues facing property/casualty insurers.

Seventy-nine percent of respondents expect the industry's combined ratio to worsen in 2000 compared to 1999, while 21% do not.

Viewed by line, only one, workers compensation, attracted a majority—51%—who expect improvement in profitability, with the remainder saying profitability will not improve. For other commercial property/casualty lines as a whole, 45% predicted increased profitability, while 55% predicted no improvement.

Consolidation was predicted to increase by 90% of survey respondents, while only 10% said it would not increase.

The Internet will pose a major challenge to traditional property/casualty distribution systems over the next five years, according to 69% of respondents, while the rest said it would have a minor impact. In addition, 64% of respondents said their company would be using the Internet as a distribution channel by year end.

Passage of financial services modernization legislation will also yield changes for insurers, respondents predicted. All respondents expect more strategic and marketing alliances between banks and property/casualty insurers, the survey found. Only 39% expect mergers and acquisitions between the industries, though, with 61% saying such deals are not likely.

The Joint Industry Forum is jointly sponsored by: the Alliance of American Insurers, American Institute for Chartered Property/Casualty Underwriters, American Insurance Assn., Insurance Information Institute, Insurance Services Office Inc., National Assn. of Independent Insurers, National Assn. of Mutual Insurance Cos., National Council on Compensation Insurance and Reinsurance Assn. of America.

For more information about next year's joint forum, to be held Jan. 9-10, 2001, contact the III at 212-669-9203; www.iii.org. BI

Medicare leads health reforms

HHS secretary reviews achievements, goals of program

NEW YORK—The Medicare system is at the forefront of efforts to bring needed change to the health care system, according to the Clinton administration official who heads that program.

Medicare's reach has included efforts to improve health care efficiency, eliminate waste and fraud and improve quality, said Donna E. Shalala, secretary of the U.S. Department of Health and Human Services in Washington.

The Medicare system has cut errors in its payment system to the point where such errors are below those of the private health care sector, she said. Also, cost increases for the federal program are less than those of the private sector, she added during an address before the Property/Casualty Insurance Joint Industry Forum, held Jan. 11-12 in New York and co-sponsored by nine industry trade associations.

"We've also taken steps to eliminate fraud and waste that have made lasting changes," she said. This effort also "has put some people in jail," she added.

Despite savings achieved to date, the administration will seek more money from Congress for Medicare, she said. "We can't cover the growth of eligible people from savings alone."

The program also hopes to expand its benefits, she noted.

"We need to introduce a pharmaceutical benefit more analogous to what the private sector has," Ms. Shalala said.

Medicare won't pick up all the costs but could share some of the expense with seniors who want to purchase this prescription drug benefit.

Health care legislation before Congress is supported by the HHS secretary.

The patients' bill of rights will improve health care services and doctor/patient relationships, Ms. Shalala contends.

It would achieve this by setting basic, straightforward rules for organized care, without adding to cost, she contends.

"I believe managed care has enormous potential for improving quality, but we have to move away from managed cost to managed care," she said.

Since government spending accounts for 40% of all health care, Medicare must play a role in pushing for improvement in quality and in helping identify appropriate measures, she said.

Medical records privacy legislation is also supported by the administration, though the HHS currently is drafting such standards for electronic records in the absence of congressional action (*BI*, Dec. 20, 1999).

It's easier to get access to someone's medical records than it is to see their Blockbuster rental record, she said, citing a federal law that clamped down on disclosure of video rental histories after former Supreme Court nominee Robert Bork's viewing habits were disclosed amid intense media scrutiny.

No federal law currently would prevent similar release of a person's medical history, she noted.

Property/casualty insurers may feel the impact of rules that HHS drafts, though those rules will not directly apply to workers comp and automobile medical records, she said.

"We have struggled with the issue of workers comp. At the same time, we recognize the special circumstances in workers comp and that the employer and insurer have a legitimate interest in workers comp information," she said.

—By Paul D. Winston

IRS removes 401(k) safe harbor restrictions

WASHINGTON—New Internal Revenue Service guidance on requirements employers must meet to offer 401(k) safe harbor plans removes a major administrative hassle and expense for employers that want to offer the plans.

Under an earlier IRS notice—now revoked—employers' matching contributions had to satisfy the safe harbor based on employees' compensation for the entire year. Problems could occur when employees during a year deferred more than what was needed to get a full employer match and at other times deferred less than was needed for the full match.

Benefit consultant PwC Kwasha offers an example that illustrates how the requirement to "true up" can add to the cost of offering a 401(k) safe harbor plan.

The example assumes a 401(k) safe harbor plan matches 100% of a participant's deferrals, up to the first 4% of an employee's annual compensation. Matches are made at the end of every quarter.

Under this example, an employee earns $20,000 a quarter and $80,000 for the full year. During each of the first two quarters, the employee defers 6% of compensation, or $1,200 per quarter, and makes no deferrals during the last two quarters.

The employer makes matching contributions of $800—4% of $20,000—during each of the first two quarters and no contributions for the last two quarters.

At the end of the year, the employee will have deferred $2,400, or 3% of annual compensation, to the plan.

However, because the matching contribution formula requires the employer to match 100% of salary deferrals up to 4% of compensation, the employer would have to "true up" its match by an additional $800.

Under the new notice, employers can satisfy the safe harbor by matching salary deferrals on the basis of employees' compensation for a payroll period, such as every two weeks or every month. No additional contributions would be required.

As a result, under the new IRS notice, the employer's match in the PwC example would be only $2,400.

—By Jerry Geisel

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LEGAL NOTICE

In the Matter of the Conservation of the Trust Funds in the State of New York of
NJORD INSURANCE COMPANY, LIMITED
New York County Supreme Court
Index Number 42301/92
To all American Policyholders of
NJORD INSURANCE COMPANY, LIMITED;

NOTICE

Neil D. Levin, Superintendent of Insurance of the State of New York, as Conservator ("the Conservator") of the Trust Fund deposited by Njord Insurance Company, Limited ("NJORD") in New York hereby gives notice that all claims, as defined below, must be presented to him in a manner set forth below by MAY 6, 2000. **Any claims not presented by MAY 6, 2000 will not be considered in this proceeding and will not share in the distribution of the Trust Fund Assets.**

NJORD was declared bankrupt by the Local Court of Stockholm, Sweden on September 4, 1991. NJORD was not licensed to do business in the United States. NJORD deposited a Trust Fund in the amount of $2,500,000 for the benefit of U.S. policyholders with Manufacturers' Hanover Trust Co., as trustee. The purpose of the Trust Fund was to protect U.S. policyholders with respect to policies issued on an excess and surplus lines basis. The Trust Fund was maintained as security for the payment of claims or losses under insurance contracts issued on an excess and surplus lines basis and, upon payment of all claims for losses, for the payment of claims for unearned premium. As a result of NJORD's insolvency, the Supreme Court of the State of New York, on July 7, 1992, entered an order placing the Trust Fund into Conservation.

A "claim" for the purposes of this proceeding means a liquidated claim or a reported outstanding claim. Incurred but not reported claims will not be considered.

Claims shall be presented to the Conservator by mailing all relevant documentation concerning the claim, including a copy of the NJORD policy or policies to:

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New York, NY 10038-3889
Attention: Nicholas Cremonese

Each timely filed claim shall be examined to determine if it is a valid obligation of the Security Fund.

If you have any questions, please call Mr. Cremonese at (212) 341-6706.

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REQUEST FOR PROPOSALS

DOCKET NO. CV-97-0572384S : **SUPERIOR COURT**

IN THE MATTER OF WESTBROOK INSURANCE COMPANY, IN LIQUIDATION : **JUDICIAL DISTRICT OF HARTFORD/NEW BRITAIN**

AT HARTFORD

REQUEST FOR PROPOSAL

George M. Reider, Jr., Insurance Commissioner of the State of Connecticut (the "Commissioner"), as Liquidator of Westbrook Insurance Company ("Westbrook") hereby requests proposals for the assumption of the remaining policyholder liabilities of Westbrook.

BACKGROUND

Westbrook is a Connecticut-domiciled property and casualty insurance company which had its principal office at 1062 Barnes Road, Wallingford, Connecticut. It was incorporated on June 7, 1994 and is licensed only in Connecticut. Westbrook commenced underwriting direct insurance and reinsurance on auto liability and auto physical damage risks (both personal lines and commercial lines) in late 1995. Westbrook was a subsidiary of Home State Holdings Company, Inc. and was a member of the Home State Group of insurance companies.

On July 11, 1997, Westbrook's Board of Directors authorized Westbrook to consent to the commencement of rehabilitation proceedings for Westbrook in Connecticut. On July 17, 1997, a Stipulated Order of Rehabilitation was entered for Westbrook. Because Westbrook's administrative functions were performed by affiliated companies which were in financial difficulty, the Rehabilitator concluded that the continuation of Westbrook's business would be hazardous to policyholders and the estate. Accordingly, the Rehabilitator determined that it was in the best interest of policyholders, creditors and the public to promptly sell Westbrook's ongoing business and transfer Westbrook's claim handling functions to financially reliable parties. The Rehabilitator accomplished these goals under three agreements.

The Rehabilitator entered into a certain Policy Acquisition Agreement dated as of August 15, 1997 and a certain Reinsurance Agreement dated as of August 15, 1997 with Eagle Insurance Company ("Eagle"). Pursuant to these agreements, Eagle assumed all of the obligations of Westbrook under all direct policies issued by Westbrook for losses with dates of accident on and after August 15, 1997. Eagle issued cut through endorsements to all of the policyholders and offered to renew all personal lines policies as they expired. Commercial auto policies were not renewed.

After the transaction with Eagle, the estate was left to administer claims on Westbrook policies arising out of accidents which occurred prior to August 15, 1997 (the "Remaining Direct Losses"). Because Westbrook's claims had been handled by affiliates which were the subject of insolvency proceedings, the Rehabilitator entered into a certain Claims Service Agreement (the "Service Agreement") dated as of August 15, 1997 with Material Damage Adjustment Corp. ("MDA"), an affiliate of Eagle. Pursuant to the Service Agreement, MDA administers all Remaining Direct Claims.

On October 26, 1998, the Superior Court entered an order of liquidation with respect to Westbrook and appointed George M. Reider, Jr., Insurance Commissioner of the State of Connecticut as liquidator of Westbrook (the "Liquidator"). In connection with the liquidation of Westbrook, the Liquidator seeks to transfer the Remaining Direct Claims to a financially sound insurance company in consideration of a payment to be made by the Westbrook estate to such transferee.

DESCRIPTION OF REMAINING DIRECT BUSINESS TO BE TRANSFERRED

The Remaining Direct Business consists of claims on commercial and private passenger automobile policies issued during 1995 through 1997 with dates of accident on or before August 15, 1997. Claims have been administered by MDC since August 1997, and MDC has estimated reserves for the Remaining Direct Business of 1.75 million as of November 30, 1999 without regard to incurred but not reported losses. MDC would be willing to negotiate an arrangement with an interested purchaser to continue the handling of claims.

The Liquidator will accept offers for the Remaining Direct Business through and including March 10, 1999. If you are interested in obtaining information in order to make a bid, please contact Harold S. Horwich, Esq., Bingham Dana LLP, 1 State St. Hartford, CT 06103, 860-240-2722. Information available includes claim and premium reports, financial statements and information concerning reinsurance. Also interested parties may make arrangements through the Liquidator to review the claim files. It is anticipated that the Liquidator will accept the lowest and best offer for the transfer of the liabilities, and will seek approval of the Connecticut Superior Court for the transfer.

Dated at Hartford, Connecticut
this 12th day of January, 2000

George M. Reider, Jr., Insurance Commissioner
of the State of Connecticut as Liquidator of
Westbrook Insurance Company

HELP WANTED

Risk Management
Curriculum Development

The Center for the Advancement of Risk Management Education (CARME) and the Insurance Institute of America (IIA), sponsors of the Associate in Risk Management (ARM), seek a high level professional to develop curriculum for the ARM. The successful candidate must have demonstrated writing skills and knowledge of risk management. A Ph.D., J.D., or other advanced degree is strongly preferred. Send resume and salary history to: Personnel, P.O. Box 3016, Malvern, PA 19355-0716, or fax 610-651-7645, or email **personnel@cpcuiia.org**. EOE, M/F.

HELP WANTED

COMPLIANCE OFFICER

Houston-based P & C and Life Insurance company seeks Compliance Officer. Ideal candidates must possess a minimum of seven years of regulatory experience with state insurance departments. Have experience with rate and form filings, agency licensing, and certificates of authority for insurance companies and agency subsidiaries.

This position will have the responsibility of directing and coordinating all subsidiary compliance requirements. Qualifications include: Bachelor's degree, ability to communicate effectively, management/ supervision of personnel and processes, proficient with PC applications, experience with compliance software is a plus. Please forward your resume to Business Insurance, Box 3125, 740 N. Rush Street, Chicago, Illinois 60611-2590.

REQUEST FOR INFORMATION

REQUEST FOR INFORMATION
STATE BOARD OF ADMINISTRATION
OF FLORIDA

The State Board of Administration (SBA) is soliciting competitive responses from firms offering reinsurance-related administrative services in support of the legal obligations of the SBA in administering the Florida Hurricane Catastrophe Fund (FHCF). The Request For Information (RFI) will be available on February 1, 2000, and may be obtained by contacting: Anne T. Bert, State Board of Administration, Florida Hurricane Catastrophe Fund, 1801 Hermitage Boulevard, Suite 100, Tallahassee, Florida 32308, Telephone (850)413-1349. The deadline for submitting responses is 5 PM EST on March 3, 2000.

Business Insurance

Circulation Breakdown
Commercial Consumers

Administrative:	
CEO's, Presidents, and Owners,	4,194
Vice Presidents, General Managers and Other Administrative Personnel	3,965
Financial:	
Chief Financial Officers and Vice Presidents of Finance	4,190
Secretaries, Treasurers, controllers and other Financial Personnel	4,945
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	13,572
Sub-total	**30,866**
Associations	237
Government, Unions and Educational Institutions	972
Commercial Consumers	
Sub-total	**32,073**
Insurance Agents and Brokers	7,763
Insurance Companies	6,357
Accountants, Actuaries, Attorneys & Consultants	2,361
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,347
Others Allied to the Field	1,008
Total Qualified	**50,909**
Non-qualified/Paid Subscriptions	21
Single Copy Sales	3
TOTAL CIRCULATION	**50,933**

★ *Source Business/Occupational breakdown of qualified circulation, May 31, 1999 Issue, as submitted to BPA for June 1999 BPA Publisher's Statement*

PHOTO: AP/ WIDE WORLD

Seton Hall dorm fire investigated

SOUTH ORANGE, N.J.—Investigators are trying to determine the cause of a pre-dawn fire in a campus dormitory that took the lives of three Seton Hall University students and injured more than 50 others.

The smoky fire began in a third-floor common area of Boland Hall on the South Orange, N.J., campus around 4:30 a.m. last Wednesday. The cause had not been determined as of late last week.

The Essex County Prosecutor's Office is investigating the blaze, said Charlotte L. Smith, executive assistant prosecutor.

Several false alarms had been sounded at Seton Hall since September in student pranks, said Dan Taylor, the university's director of business affairs.

Damage amounts were not available, but Mr. Taylor said the structure was damaged more by smoke and heat than flames. The dorm will be restored, he said.

"It's fully covered," said Mr. Taylor, who would not disclose limits. He said the university's property and liability coverages are written by General Security Property & Casualty Co., a unit of SCOR U.S. Corp. The coverage was placed by broker William H. Connolly & Co. in Montclair, N.J., Mr. Taylor said.

EPA fines hit record level

WASHINGTON—Enforcement actions and civil penalties imposed by the U.S. Environmental Protection Agency reached record-setting levels in fiscal 1999, the agency reported last week.

Penalties for environmental cleanup, pollution control equipment and better monitoring were up 80% over 1998 figures at \$3.6 billion. Civil penalties were 60% higher in 1999 at \$166.7 million, and civil judicial and administrative actions reached a three-year high at 3,935 actions.

In a statement, EPA Administrator Carol M. Browner said: "The Clinton/Gore administration is committed to ensuring that industrial polluters pay the price for disregarding America's environmental laws and jeopardizing the public's health. This year's enforcement statistics again send a strong signal that we will unfailingly take action" against polluters, she said.

Meanwhile, the EPA earlier this month launched a voluntary compliance program to minimize the leakage of vapors from above-ground petroleum product refinery storage tanks.

MRM Group brokerage units merged

HAMILTON, Bermuda—Two brokerage units of MRM Group have merged to form H&H Park International Ltd.

The merger brings together Park International Ltd., the longtime reinsurance and excess liability brokerage unit of MRM, and H&H Reinsurance Brokers Ltd. H&H Reinsurance Brokers, formerly a unit of International Advisory Services Ltd., places mainly captive reinsurance. MRM acquired H&H Reinsurance Brokers when it bought IAS in 1998.

The new brokerage will have a premium volume of about \$100 million and gross revenues of about \$10 million, said Simon Everett, chairman of H&H Park. Mr. Everett previously was president of H&H Reinsurance Brokers. Paul Scope, the former chairman of Park, is chief executive officer of the new brokerage.

The combined brokerage is able to offer a wider array of services to policyholders, Mr. Everett said. For example, clients of the former H&H will now be able to use the single brokerage to place captive reinsurance and excess liability business, he said.

"We used to do excess insurance placements as an accommodation, but now we are specialists," Mr. Everett said.

MRM has also created a holding company for all its brokerage units, MRM Specialty Brokerage Ltd. The holding company will comprise H&H Park; MRM Hancock Ltd., a London market broker; and IAS Insurance Management Inc., a San Francisco-based intermediary.

Alternative medicine law upheld

OLYMPIA, Wash.—The Washington Supreme Court has upheld a law requiring health insurers to cover care provided by massage therapists, chiropractors, naturopaths and any other alternative medical providers licensed by the state.

The state Legislature approved the "any willing provider law" in 1995, and health insurers soon after began a court fight to block its implementation (*BI* April 22, 1996). The state Supreme Court's recent ruling in *Hoffman and Snow vs. Regence Blue Shield*, however, appears to be the final hurdle to full implementation, Insurance Commissioner Deborah Senn said.

Aetna takes aim at hospital errors

BLUE BELL, Pa.—Confident that many medical errors are preventable, Aetna U.S. Healthcare recently announced initiatives aimed at reducing avoidable mistakes at health care facilities.

The first initiative is a \$1 million grant from Aetna's Quality Care Research Fund. It will be used to research ways that hospitals can improve patient safety, such as identifying good patient safety programs and successful facility procedures, and then share the best practices with other facilities, said Dr. John T. Kelly, Aetna's director of physician relations.

Another step involves developing and circulating regular reports on the topic to the 3,000 hospitals within Aetna's network, said Dr. Kelly. These reports would be generated using health care data collected by the managed care organization, which routinely produces a similar report for its network physicians.

Aetna anticipates the first hospital report will be sent in the third quarter of this year.

In the past, an Aetna spokeswoman said, hospitals shied away from sharing what they learned from medical errors or "near misses" out of concerns about liability. Aetna, however, follows "the philosophy of finding out what the best practices are and communicating them," she added. BI

Privacy

Continued from page 2

employer's "premium."

The other exception would allow an employer to obtain "medical information" regarding an injury when the employer is attempting to modify the injured worker's job duties.

Employers that are concerned about the new law may not have "as much cause for concern" when the state's Department of Industrial Relations, which oversees workers compensation, promulgates regulations for the law later this year, Ms. Corbett said.

The department, though, has not determined whether regulations are necessary, a spokesman said.

The law has sparked a firestorm of criticism in recent weeks among California employers, many of whom were unaware of the law until after they returned from their holiday break on Jan. 3.

Many risk managers complain that the inability of their workers comp specialists to routinely access injured workers' medical information will cripple their efforts to track the recovery of injured workers, return injured employees to work as soon as possible, pursue fraudulent claims, monitor insurers' reserving practices and ensure that worksites are safe.

"We respect the privacy of employees," said John Pinner, assistant treasurer for El Segundo-based Mattel Inc., which has 2,500 to 3,000 employees in California.

Mr. Pinner said neither he nor Mattel Risk Manager Todd Marumoto request medical information on injured workers. Mattel's workers comp specialists, though, need access to that information to help the company's injured employees return to work and to assess reserves for their claims, he said.

The new law also contains ambiguities and inconsistencies, according to employers and two insurance industry organizations that support the statute as a "workable" response to employees' privacy concerns. Those groups are the California Workers Compensation Institute, an Oakland-based research organization, and the Assn. of California Insurance Cos. The 25 members of the Sacramento-based ACIC write about 50% of the state's workers comp business, according to Doug Widfeldt, vp.

In addition, the law may prevent employers from providing all of the workplace injury documentation required by the state's workplace safety regulatory agency, according to some employers and Michael McClain, general counsel for the CWCI.

Not all employers, however, object to the new law.

Donald N. Norris, risk manager for the City of Modesto, Calif., said the law will "not be detrimental to our operation" as a self-insured and self-administered employer.

The situation for employers that do not self-administer claims "could get a little stickier," he acknowledged. Independent audits of TPAs, however, could eliminate employers' uncertainties about workers comp claims handling, he said.

To Lori Kammerer, managing director of Californians for Compensation Reform, however, the law is a big problem for employers. The Sacramento-based non-profit CCR represents more than 5,000 insured and self-insured private- and public-sector employers on workers comp issues.

"It's a serious case of bad law," Ms. Kammerer asserted.

The CCR and the Alliance of American Insurers last week were drafting so-called cleanup language designed to clarify several perceived ambiguities in the law and to ease its restrictions on employers. The groups planned to submit the proposal to Ms. Corbett this week.

Ms. Corbett said she was unaware of the groups' efforts but that she "would be glad to sit down and talk with them."

"It was never our intent to cause any trouble for employers but to shield confidential medical records from those who shouldn't have them," she said.

She noted, however: "We took great care to make sure that those who needed the information for analysis had the information."

The ACIC's Mr. Widfeldt said he was "not going to disagree that the bill goes a little too far—is too restrictive." He said the ACIC would be glad to participate in clarifying some provisions of the act.

He would oppose, though, an effort to rescind the law. "The bill appropriately places the onus on claims administrators to determine what information should be released to employers."

A literal interpretation of the law, though, does not give claims adjusters any authority to release that information, contend some employers and the CWCI. The law charges only insurers with that responsibility, they say.

Some employers and Willie Washington, a lobbyist with the California Manufacturers Assn. in Sacramento, suggested that insurers supported the law because it gives them the upper hand against employers in bad-faith litigation over insurers' reserving practices. Over the past few years, California employers have filed an increasing number of such lawsuits, charging that excessive reserving by insurers has led to unnecessarily higher premiums.

Without access to injured workers' medical information, employers argue they will have trouble evaluating whether insurers are reserving properly.

The Alliance's Mr. Webb said insurers would not attempt to deal with the reserving controversy "in this narrow of a forum."

Mr. Widfeldt of the ACIC said the reserving issue "is an ancillary issue to all of this."

In addition, he noted, an early version of the bill would have charged physicians with determining what information to disclose to insurers.

Insurers lobbied hard against that version. Representatives for the Alliance, ACIC and CWCI said that version would have prevented workers comp insurers from fulfilling their statutory obligations of making timely liability decisions, delivering benefits promptly and pursuing fraudulent claims.

Messrs. Widfeldt and Webb said that while they worked on the compromise provision, they did not see the final language before the Legislature approved it.

Mr. Widfeldt, however, said he warned an employer group about the compromise and that employers may not like it. He would not identify the group.

Ms. Kammerer said the CCR opposed the bill's early version but had to focus on other workers comp measures the Legislature was considering.

The CMA's Mr. Washington said he dropped his initial opposition to the bill after insurers assured him that the compromise provision would allow insurers to release all of the medical information that employers needed.

Sheri Pemberton, a senior consultant for Assemblywoman Corbett, explained that the impetus of the law was the case of an injured worker whose HIV status was revealed to his employer's workers comp insurer and eventually to his employer. The worker claimed that revelation prompted his employer to fire him.

The disclosure of the worker's HIV status was permissible under a 1993 California "Employer Bill of Rights" law. While another California law safeguards the privacy of medical records, the 1993 law exempted employers as long as they obtained the information in the course of handling a workers comp claim.

A.B. 435 eliminated that exemption.

As Ms. Corbett's staff further studied the privacy issues surrounding injured workers' medical files, other concerns arose, Ms. Pemberton said. Privacy rights advocates related that some injured workers refuse to file workers comp claims, because they fear how their employers would respond after seeing the workers' entire medical histories, she said. She also said the advocates noted that other injured workers with similar concerns do file claims but withhold their medical histories from treating physicians.

Among the ambiguities and inconsistencies in the law that employers and insurers have raised are:

- The breadth of the provision that allows an employer to obtain a "diagnosis" about an injury that could affect the employer's premium. Employers and insurers noted that all injuries could affect their workers comp premium.
- "Diagnosis" is not defined.

David Dolnik, risk manager for The Brady Cos., a San Diego-based construction subcontractor with 600 employees, questioned whether the law would restrict his company's ability to learn if a worker's congenital health problems contributed to a workplace injury. That information would be vital in assessing whether a workplace hazard existed, he said.

- Self-insurers could end up with either much more or much less information than insured employers could obtain.

Because self-insured employers do not pay premiums, they might not be eligible for any information on a claimant's diagnosis. Also, since the law allows only insurers to release medical information, self-insured employers that use TPAs may have nowhere to turn for medical information.

Pragmatically, though, self-insured employers that self-administer claims have no restrictions on their access to injured workers' medical information.

The Department of Industrial Relations currently is analyzing whether the law is causing any confusion among the parties it regulates, a spokesman for the department said. Its conclusion will factor heavily into its decision on whether to promulgate regulations, he said.

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Those who wish to comment about A.B. 435 should submit written remarks to The Administrative Director, Department of Industrial Relations—Division of Workers Compensation, P.O. Box 420603, 9th Floor, San Francisco, Calif. 94142.

At home

Continued from page 1

commuters—and the one focused on by OSHA—is claims for workers compensation, including injuries stemming from poorly designed work spaces.

"What we don't want to do is to have someone working off an ironing board in the basement," said Robert Mauerman, corporate safety specialist for Long Grove, Ill.-based Kemper Insurance Cos., which has several hundred telecommuters.

There are other, perhaps less obvious, risks as well.

These include problems that could arise because an employee's home computer has less-effective security firewalls or virus protections than do corporate systems. Employers also face potential discrimination charges if their telecommuting policies are not seen as even-handed.

To date, telecommuting has not led to a significant number of claims, though claims may increase as the practice becomes even more popular.

The best way to avoid potential problems, consultants say, is to have a clearly defined telecommuters' policy. This should include an agreement between the employer and employee covering issues such as ergonomically correct furniture, adequate lighting, periodic work breaks and, if appropriate, perhaps even the supervision of young children.

In this process, though, employers must balance safety concerns and issues of employee privacy.

"Obviously, the more control the employer has without infringing on the person's personal rights" the better, said Ray Clarkson, vp and casualty risk control consultant with Willis in New York.

Attention to this issue varies widely, and many employers have not yet addressed it.

"I think they're paying no attention to the whole issue, or very little," said Michael A. Rodman, president of Needham, Mass.-based J.H. Albert International Insurance Advisors Inc.

"Probably some more attention will be paid to it now that this matter of the OSHA regulation and the withdrawal of it has made the news," he said.

"I don't see any big concern, other than that little blip," said Barry Thompson, national practice co-leader of disability management services for Deloitte & Touche L.L.P. in Hartford, Conn. "I think folks right now are maybe just hoping that nothing happens with it," he said.

"I think the employers will start paying attention when the claims start showing up," said Bruce Zaccanti, director of the property/casualty risk management consulting practice for Arthur Andersen L.L.P. in Chicago.

The most commonly expected liability stems from workers compensation concerns, and working at home can create ambiguities in this issue.

"The definition and scope of employment is usually a trigger for accepting a workers comp claim," said Deloitte & Touche's Mr. Thompson. The situation becomes harder to define, though, when someone working at home on a laptop computer falls down the stairs, he said.

Although trips and falls in a home office environment are a concern, most workers comp concerns generally focus on the appropriateness of the work space itself.

"Most people do not have ergonomically correct work stations at home," with many employees working, for example, at their kitchen table, said Jack Fitzsimmons, a vp of Marsh Risk Consulting in San Francisco.

Telecommuting thus far has not become a workers comp problem and, in some cases, claims that could be filed under workers comp, are being filed under group health policies.

A reluctance to file workers comp claims may be at least partially a reflection of the people who tend to telecommute: Because they generally have relatively high salaries, a smaller workers comp check may hold little appeal.

"The type of people who like to telecommute are people who are generally very dedicated. They are trustworthy. . .self-starters who have learned to work in environments where there is minimal onsite supervision," said John Roskopf, a vp at Aon Corp. in Chicago. "That type of person is less likely to submit a fraudulent workers compensation claim, or perhaps a questionable claim," he said.

"There's no greater incidence we know of at this time of home office injuries or liabilities" compared with those in the office, said Gail Martin, executive director of the International Telework Network. There may be an increase, though, as the number of telecommuters grows, she said.

In addressing this issue, employers must recognize they cannot control home worksites to the extent they can the office environment.

"You lose control over what you would consider standard safety aspects," said Deloitte & Touche's Mr. Thompson.

"I think an employer that tries to tell its employees how to arrange their furniture is probably not going to get very far," said Richard S. Betterley, president of Sterling, Mass.-based Betterley Risk Consultants Inc. He suggests employers give advice, not issue orders, on the subject.

Employers should take a middle road—somewhere between worrying about what to do in the unlikely event the delivery man attacks and not paying any attention to the issue, said Joseph Gibbons, a senior consultant with Towers Perrin in New York. Ignoring the problem is "probably running the risk of some sort of difficulty down the road," he said.

Many consultants recommend that employers develop a telecommuting policy, which could include an agreement between employer and employee as to the conditions of the telecommuting arrangement.

"The telecommuting agreement should specify duties, job functions, how often they should come to the office, specifically how often their performance should be measured, how they will pick up new assignments, how they will interact with their supervisors, and anything else related to job performance," said Aon's Mr. Roskopf.

Mr. Zaccanti of Arthur Andersen said that when he was a risk manager, his firm even called for some basic dress requirements. "No pajamas, but the bunny slippers were in," he quipped.

'There's no greater incidence we know of at this time of home office injuries or liabilities,' says Gail Martin.

Employees may also be asked to undergo some training and preparation before telecommuting, including viewing video tapes, working with a checklist or using an interactive computer program.

Some employers also reserve the right to inspect an employee's home if they suspect a problem, though in practice this is rarely done, say consultants.

"To me, this raises huge issues of privacy," said Marsh's Mr. Fitzsimmons.

Employers may be paying all, or part, of the cost of the equipment telecommuters use at home, and will often direct their employees about where to purchase that equipment.

At Minneapolis-based Teltech Resource Network Corp., an information services company where 27% of the employees telecommute, "we've got strict guidelines on what we've approved to be ergonomically correct," said facilities services manager Debbie Pasvogel. This policy encompasses desk and writing surface areas as well as chairs and keyboard trays.

If the telecommuter decides to stop telecommuting within a year, he or she is obligated to reimburse Teltech for half the cost of the furniture and the full cost of any setup charges, such as extra phone lines, said Ms. Pasvogel.

Individuals who qualify to telecommute also fill out home evaluation forms so the company can evaluate the size of the room where they will work, their lighting, and any potential interferences, including distractions from noise or other people, said Ms. Pasvogel, whose company began its telecommuting pilot program in 1994.

This includes children in the employee's home, she said. "If there's children under the age of 12 who are in the home while the employee is telecommuting, they must have some other kind of adult supervision at hand. This is not a substitute for day care," Ms. Pasvogel said of telecommuting arrangements.

Employees also fill out a form on emergency evacuation, used to ensure they have a planned escape route for emergencies.

At Kemper, "Basically we offer guidelines to the employees on how they should go about designing a home workstation," said Mr. Mauerman. This also includes basic home safety tips, such as not keeping flammable material in the basement, he said.

Telecommuting practices generally reflect companies' corporate policies, said Jane Anderson, director of the Minneapolis-based Midwest Institute for Telecommuting Education, a nonprofit consultant group. "What we found is if an employer observes safety and ergonomics and monitors it, then their telecommuters do that, too."

At the same time, if a company ignores ergonomics, "they probably won't put much effort into doing it for telecommuters either. The same standards seem to exist," Ms. Anderson said.

Telecommuting involves other, non-workers comp liability concerns as well, say consultants.

"We see it less of a workers compensation issue and more of a potential professional liability issue," said William Granaham, senior consultant with Milliman & Robertson Inc. in Wakefield, Mass. "Employees now working out of their home in some sense feel fewer constraints on the way they do business on behalf of their corporation," because they are working in a "fairly relaxed and uncontrolled environment," he said.

An employee at home may also be divorced from the normal everyday work process, said Mr. Zaccanti of Arthur Andersen. This means there could be a potential exposure if, for example, an employee writing a technical document at home is rushed, and the document does not go through a normal peer review process.

In addition, Marsh's Mr. Fitzsimmons said telecommuters can misuse company data, including sharing it with a competitor. The security firewall arrangements may also not be as strong in a home computer as those in the office, and so are more easily breached by hackers, said Mr. Fitzsimmons.

A home computer may also lack current anti-virus software, said James R. Jones, director of claims education at Malvern, Pa.-based American Institute for CPCU and the Insurance Institute of America.

"What you can end up with is a home computer potentially infecting the computers at work, and you also have, in many cases, multi-users at home, such as teenagers who might download infected files," said Mr. Jones. "Even if you're very cautious about what kinds of files you download, they're downloading all kinds of stuff that could potentially cause problems.

"Also, I think the backup of information is probably a little more diligent at work than people have at home, so you may work on information for a week or two and not think to back it up, while if it's on a network system it might be backed up every night."

And the security issue is not necessarily limited to computers, said Mr. Jones. "If you're shredding paper at work because you have potential proprietary information that you don't want leaked out, are you going to do the same thing at home, or are you just putting it in your wastebasket, that gets put out on the street, that gets blown around the neighborhood?"

Another potential liability involves clients visiting a telecommuter at his or her home, though most consultants say this is less likely to happen, as clients generally tend to meet telecommuters either at their own offices or the employee's corporate office.

In addition, an employer's telecommuting policy must be evenhanded. Employers permitting telecommuting must offer the option to entire classes of employees, said Mr. Roskopf of Aon. An insurance company, for instance, must offer the option to all its loss adjusters or loss control people, not just select individuals, he said.

"The class of 'people that you trust and think will do a good job telecommuting' is not available as far as discrimination standards are concerned," he said.

Problems could arise if an employer turns down, for example, a woman who wants to be home when her children come home from school, but then offers the telecommuting option to a childless man, said Mr. Jones of the Institutes.

"I think there's a potential there, if there's not a well-thought out communications policy, for employment liability claims to seep into telecommuting," said Mr. Jones. "Companies just now are starting to think about these issues and developing formal policies." BI

Survey

Continued from page 2

that plans' benefit support centers needed improvement.

The findings, based on the responses of 600 employers, are "significant indicators that changes are needed in the industry," Mr. Bruner said.

Health insurers and managed care plans, for several reasons—including, until recently, competitive pressures to keep the lid on premium increases—haven't made the investments in technology that buyers want, said Mr. Bruner, who added that this may be beginning to change.

Most employers are convinced that new technology, particularly the Internet, will be critical in improving health care plan operations, the survey found.

Thirty percent of employers say the Internet will be "revolutionary" in improving employees' direct access, allowing them to schedule provider appointments and fill prescriptions. Another 63% say the Internet will add significant efficiency or be helpful in filling those needs.

In addition, 86% say the Internet will add significant efficiency or be helpful in supporting plan enrollment, and 88% believe the Internet will add significant efficiency or be helpful in providing electronic, real-time provider directories.

"The Internet is a superb way of providing information. It can deliver instantly a depth of information on a personalized basis. It may be one of our best hopes for improving the health care plan system," Mr. Bruner said.

The survey also reveals decidedly ambivalent attitudes toward managed care. Most employers surveyed—85%—said managed care has had a positive impact on controlling costs. On the other hand, employers were divided on its impact on the quality of care, with equal percentages—37%—saying it has had a positive and a negative impact.

At the same time, 62% of employers say managed care has had a negative impact on employee satisfaction, and 52% say managed care has had a negative impact on administrative ease.

Still, most employers say that employees are satisfied with the health plans offered. Fifty-eight percent of respondents said employees were moderately satisfied, while 33% said employees were very satisfied with the plans. Only 7% of employers said their employees were less than satisfied with their health care plans.

Looking ahead, 59% of employers said they expect employee satisfaction to remain stable, while 25% expect employee satisfaction to decline and 16% expect it to improve.

Employers expect health care plan costs to continue to increase at fairly significant levels. Overall, employers expect health maintenance organization costs to increase by 34% over the next five years, while they expect preferred provider organization costs to rise by 30% and point-of-service plan costs to go up by 30.5% over that period.

The ongoing trend of employers terminating or paring back retiree health plans is expected to continue. Thirty percent of respondents say they might, over the next three to five years, terminate coverage for future Medicare-eligible retirees, while 81% say they might increase premiums or cost-sharing obligations for post-65 retirees.

Just over half of employers said they might shift to a defined contribution approach, giving post-65 retirees a fixed amount of money to purchase coverage.

With retiree health care plan costs increasing anywhere from 12% to 16% annually, "Employers don't think they can take on those costs indefinitely," Mr. Bruner said, referring to employer interest in either eliminating coverage or looking at new ways to hold down their liability.

More than one-third of employers—36%—also would consider terminating their health care plans for active employees if Congress passes legislation that would hold them liable for damages under state law in coverage disputes, the survey found. Such a provision is part of a House-passed patient protection bill, while a Senate-passed bill lacks such a provision.

"Added liability could be the straw that breaks the camel's back. Congress should be very wary" of making changes, Mr. Bruner said.

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Free single copies of "Health Care Expectations: Future Strategy and Direction," are available from Hewitt Associates L.L.C., Publications Desk, 100 Half Day Road, Lincolnshire, Ill. 60069; 847-295-5000.

Commentary

Y2K brings massive cartoon disruption

What a relief!

I think we can all now breathe easy and state with confidence that we have survived the transition to 2000, unscathed by the predicted computer meltdown that was supposed to have set society back hundreds of years.

Doesn't it feel like we got a new lease on life, having avoided the cataclysmic consequences of the Y2K bug? I, for one, was not looking forward to the prospect of selling my children in exchange for food, water and a Coleman stove, but having stockpiled virtually nothing, I was mentally steeling myself for the possibility. The little buggers have no idea how close they came to living la vida loca.

Some may feel like George Bailey in "It's a Wonderful Life" or Ebenezer Scrooge in "A Christmas Carol" being given a second chance.

On the other hand, those who had a hand in spending an estimated $600 billion to eliminate the "problem" may instead feel like suckers, as if hoodwinked by an elaborate con game. Do you feel as if every bottle of water and every can of tuna fish now consumed from your stockpile is mocking you?

Might there be a message we can take from all this? Perhaps: Don't place too much faith in computer consultants, and definitely don't pay them up front.

Dilbert has been trying to warn us about programmers for years now. If only we had listened.

Paul D. Winston

Yet many of the Y2K fearmongers are not going quietly.

Just like the tradition of religious zealots interpreting the Bible and predicting, and re-predicting, the date of the Apocalypse, many of these computer Cassandras are not willing to throw in the towel and admit they were wrong, wildly wrong.

Some of them are feigning bafflement as to why the predicted problems did not emerge.

Others, sticking to their guns, insist that computer problems created by calendars switching to 01-01-00 are simply lurking beneath the surface, ready to strike any day now.

And some are sneering at any notion of safety and saying that if 01-00-00 didn't get us, then 02-29-00 surely will. If not that, then 10-10-00, or maybe 01-01-01, and so on and so on.

And some are confidently declaring: "Of *course* there's no problem; we *fixed* it."

It is true that the date change did cause some hiccups and errors to occur, but nothing that would rend the fabric of society or cripple the economy.

My own computer, on which I am now writing, "crashed," if you can call it that, but I managed to save it without draining my life savings or relying on some programming druid to fix some basic code.

When I turned it on for the first time in the New Year, I noticed the clock was wrong. My pulse began to race and I shouted for my wife and kids to put on their winter clothes and grab some blankets.

Double-clicking on the clock, I muttered a silent prayer.

My worst fears, however, were realized: Not only was the time wrong, but the computer had not rolled over to year 2000. The date displayed was Jan. 4, 1980!

A cold trickle of sweat moved down my scalp and my hands began to shake. I yelled to my wife to lock the door and get the kids in the basement. She began to question why I was raving as if an F5 tornado were bearing down on our house.

Returning my attention to the screen, I wiped the sweat from my eyes and clicked on the year button. The years were going backwards! Oops, wrong button. I clicked on the other one. Click. Click. Click. The years moved forward. 1981, 1982, 1983. . . Finally I reached 1999. With my eyes squeezed shut, I clicked one more time: 2000.

I opened one eye to peek and saw that the calendar for January 2000 was displayed, and the dates seemed to correspond to the days of the week. The electricity in my house was still on, water ran from the taps and the solitaire program on the computer still wouldn't let me win. Thank goodness! I had averted disaster and saved my family from ruin.

In that moment, I knew the world was going to be OK.

When my family came up from the basement, my kids resumed watching the "Scooby Doo" episode I had interrupted when the Y2K crisis loomed, looked at me with unfeigned exasperation and said, "Dad, you're weird."

My wife said, "You're an idiot."

That, I think, says it all as far as Y2K is concerned.

Editor Paul D. Winston's commentary appears fortnightly. He can be reached at pwinston@crain.com

Risks

Continued from page 1

have come into sharper focus.

The emerging first-party policies vary. Brokers say the coverages generally include: payment for losses arising from extortion, theft of money, computers, securities, finished goods or work in process; destruction of data and software by virus attacks or other malicious code; business interruption stemming from hacker attacks; denial of Web site service because of tampering; and virus clean up.

While some experts say traditional property insurance policies will respond to some e-commerce exposures, proponents of specialized policies say that these new products specifically mention cyber concerns, such as damage caused by hackers, whereas traditional policies do not.

"I don't think you can rely on a traditional property insurance policy to cover that exposure," said Dick Clarke, vp and corporate resource for retail broker Palmer & Cay Inc. in Atlanta. "To me, you must have the definitions in (the policy) to give it credibility. I don't think underwriters of five years ago intended traditional inland marine or traditional property coverage forms to cover cyber property exposures."

Unlike property in the brick-and-mortar world, e-commerce property exposures and potential perils often are intangible. Traditional property policies often require physical damage to tangible property before coverage is triggered; therefore, specialty coverage may be necessary to cover online exposures, some experts argue.

Viruses, Web sites, Web-site content and Web-site interaction all can be considered intangible, according to Peter R. Taffae, vp-financial services division in Los Angeles for wholesale broker Brown & Riding Insurance Services Inc.

In addition, e-commerce companies have business characteristics that differ from traditional retailers, he added.

Take loss-of-income coverage, for example. Traditional business interruption policies provide coverage for loss of net income, explained Mr. Taffae. Many e-commerce companies—even some of the largest and best known—are not yet reporting net income, however, because they are heavily re-investing revenues in advertising, research and development and Internet infrastructure.

So, for e-commerce business interruption, Mr. Taffae negotiates coverage based on the cost of the goods that would have been sold subtracted from a site's gross revenues.

"E-commerce companies do not have net income, so when a loss comes in, they cannot prove it under the old policies made for tangible property," he said. "So we have redefined net income as the difference between gross revenues and cost of goods sold. But some insurers have dropped the ball by cutting and pasting from traditional property policies to cyber exposures."

Other considerations also have to be weighed, Mr. Taffae said. For example, online companies are known for their exceptionally rapid growth. It would not be unusual to find one with gross revenues that rocket from, for example, $2 million to $80 million within a year.

Therefore, Mr. Taffae arranges for business interruption coverage payout amounts to be determined on a sliding scale based on the company's current gross revenues.

As more companies shift from brick-and-mortar operations to Internet-based sales and distribution, the threats to their revenue also are shifting to online channels, explained Brad Gow, assistant vp for ACE USA's Information Technology Products Group in Philadelphia. Therefore, he said, interest in specialty Internet programs is growing.

'I don't think you can rely on a traditional property insurance policy' for cyber risks, says Dick Clarke.

Awareness about the need for specific coverages also has grown because of high-profile incidents, such as the spread of viruses, hacker intrusions, and the recent attack on CD Universe.

Surplus lines insurers have been leaders in the early development of policies that address related first-party losses for e-commerce companies, but a growing number of admitted companies also are offering these products.

Currently, there are significant differences among the property coverages that are being offered to address cyber concerns, said Mr. Clarke of Palmer & Cay.

"I don't even see the normal procedure of somebody taking another underwriter's form and copying it and adding a few modifications," he said. "It's even to early to have that occur. That probably will be happening over the next year."

One significant distinction among existing policies involves system security, with some underwriters requiring purchasers to undergo a detailed security assessment to uncover any system vulnerabilities. Observers liken the practice to the engineering inspections required by boiler and machinery insurers.

One of the broker's clients declined the best policy available for its operation and purchased the second best because it did not want to participate in such a security assessment, Mr. Clarke said.

The declined policy would have required that a "friendly" hacker probe the client's system. The client decided, however, that it had too much invested in its computer technology to allow even a friendly hacker to try to gain knowledge of its workings, he explained.

Because properly underwriting first-party cyber risks requires unique skills to asses those risks, Mr. Gow said cyber property policies likely will remain stand-alone products, sold apart from traditional property policies.

One attorney who represents policyholders argues that policyholders should explore whether they already have coverage for cyber losses under some existing insurance policies.

Although a named-peril property policy won't provide coverage for hacking or damage to a Web site, an all-risk policy will, unless the form has specific exclusions, said Kirk A. Pasich, a policyholder attorney and chairman of the insurance coverage group at Troop Steuber Pasich Reddick & Tobey in Los Angeles. Computer code used to create Web sites is tangible property, he argued.

Precedent setting e-commerce coverage issues have yet to reach the courts. There are, however, a few appellate cases, unrelated to e-commerce, in which courts have ruled that software is a tangible product, or is close enough to trigger coverage, Mr. Pasich said. Additionally, tax courts treat software as tangible property that can be taxed.

Ultimately, whether a company requires a specialized e-commerce policy depends on its existing coverage, its specific needs and the cost of coverage, Mr. Pasich said.

Compare the coverage provided by available policies, he advised. Some of the new policies make blanket statements about what is covered, and they might not specifically address the perils that a particular purchaser is vulnerable to, he said.

As new cyber perils come to light, though, insurance professionals are either working to specifically address those perils or they are letting potential customers know their products will provide protection for such incidents.

For example, after news broke of the CD Universe extortion, Lansing, Mich.-based J.S. Wurzler Underwriting Managers L.L.C. quickly issued a press release stating that had eUniverse Inc. purchased a Website Insurance and Security Program it has available, the retailer would have a valid claim. The cost of $1 million in coverage with a $2,500 deductible would have cost the company less than $50,000.

"The extortion feature (of WiSP) would have protected the insured from loss of any property, or other consideration actually surrendered as a payment by the insured due to an extortion," J.S. Wurzler's statement said. WiSP is underwritten by certain Lloyd's of London syndicates.

As of last week, CD Universe had yet to determine the extent of any monetary losses and what coverage, if any, it has available for either first-party losses or third-party claims from banks that issued the credit card accounts made public by Maxim, said Bill Wagner, chief financial officer for eUniverse. BI

NMC

Continued from page 2

ment's investigation of NMC and will settle six whistle-blower lawsuits, most filed by former NMC employees. The whistle-blowers will receive $65.8 million of the settlement.

Fresenius has also agreed to withdraw $196 million of nutritional therapy claims against Medicare in return for a $59.1 million payment from the government. In addition, the company has signed a "corporate integrity agreement" with the U.S. Department of Health and Human Services, under which Fresenius will appoint compliance officers and maintain a compliance training program and a hot line for employees to report suspected misconduct.

While the settlement clears up Fresenius' disputes with the government, it has yet to resolve a 1997 racketeering suit in which Aetna levels many of the same allegations (*BI*, Jan. 19, 1998).

Howard S. Veisz, a lawyer representing Aetna, said the federal settlement "is certainly a welcome development in our case that will make it difficult for (Fresenius) to deny liability."

The NMC units' criminal guilty pleas may actually preclude them from denying allegations in the Aetna case, said Mr. Veisz of Kornstein, Veisz & Wexler in New York.

Ronald Kuerbitz, general counsel for Fresenius in Lexington, Mass., however, called the Aetna case "a separate proceeding" in which claims will be governed by Aetna's contract rather than the rules applied to Medicare claims.

"We have always thought we had good defenses to the Aetna case," he said. "The fact that we have settled (with the government) certainly will not automatically take care of Aetna." BI

Retirees

Continued from page 1

managing the teachers' pensions since its inception in 1913.

CalSTRS' Health Benefits Task Force is studying "four parallel tracks" aimed at providing health care benefits to retired teachers, according to James D. Mosman, CalSTRS' chief executive officer.

The options include whether to: "provide financial help to retirees without Medicare Part A; explore the direct contracting concept; hold further discussions on a possible CalPERS collaboration; or provide pharmacy benefits only," he said. Legislation will be needed to proceed, he said.

"Funding is the significant question that has to be addressed," Mr. Mosman said.

Under California law, "we can't use pension trust funds to subsidize health care benefits," he said, which is something other states have done.

Currently retired CalSTRS members either receive health care coverage through their local school district or must obtain coverage on an individual basis. In some cases, the local school district may purchase coverage through CalPERS. Only 98 of the state's about 1,100 school districts, however, have contracted with CalPERS to provide health care coverage.

In response to Gov. Davis' interest in education, lawmakers in 1998 authorized CalSTRS to study the feasibility of providing health care coverage, including vision and dental insurance, for active, disabled and retired teachers, their beneficiaries, children and dependent parents.

The study, conducted by Mercer's San Francisco office, found that only a few school districts in the state offered health benefits to retirees, and usually only until they reach age 65 and are eligible for Medicare. Most retirees pay all or a significant portion of the premium for the coverage, the study found.

Mercer found that almost 80%of the retirees over age 65 have Medicare Part A coverage at no cost to themselves, either through their own Medicare eligibility or that of a spouse. Another 5%buy Medicare Part A coverage on their own for $309 a month.

The remaining CalSTRS—about 22,000—are not eligible to receive Medicare benefits, though.

To become eligible, retirees must have paid in to Medicare for at least 40 quarters, or 10 years. Many CalSTRS member-retirees did not accumulate sufficient credits by working elsewhere or because they only began paying in after 1986, when it was mandated.

Of CalSTRS members not eligible to receive Medicare benefits, about 10% or 2,200, have no health care coverage at all, the Mercer study found.

"This is still a staggering number," the study said. "The main reason survey respondents gave for not having medical coverage was cost-related, and most retirees without coverage are those at the lower income levels."

This finding was particularly disturbing to the CalSTRS board given that these retirees, who dedicated their lives to public service by being teachers, now must seek public assistance or go to county hospitals to receive health care treatment.

"That's exactly why the board has made them its highest priority," said Bob Blum, a consultant in Mercer's San Francisco office, who worked on the CalSTRS feasibility study. "There are retired teachers in California who have to go on welfare to get health care coverage."

In its report, Mercer provided to the CalSTRS board "a full spectrum of options" ranging from direct contracting to offering medical savings accounts, he said.

Mercer did not, however, suggest that CalSTRS attempt to unite with CalPERS, though Mr. Mosman said the board is considering this option.

Mr. Blum said Mercer did not suggest this option because many school districts haven't wanted to join CalPERS in the past since CalPERS requires employers to provide equivalent coverage to active employees and retirees. This can be expensive, especially for smaller districts with less public funding, Mr. Blum explained.

At a CalSTRS board meeting earlier this month, CalPERS executives said they would consider extending coverage to CalSTRS, he said.

CalPERS cannot waive or amend the "equivalent coverage" requirement for retirees without legislation, however, a spokesman for CalPERS said. He would not say whether CalPERS would consider seeking such a change.

But, "staff has been directed to prepare a written report on joint purchasing with STRS," to be presented at CalPERS' next board meeting Feb. 15 in Sacramento, the spokesman said.

'There's a whole lot of stars in alignment right now,' Bob Blum says of legislative support for the coverage issue.

Still, removing the equivalent coverage requirement for retirees would not solve CalSTRS' immediate problem of providing health care coverage to its over-65 members ineligible for Medicare, note Messrs. Mosman and Blum.

While direct contracting was offered as an option, it is not feasible if the Medicare-ineligible retirees are the only members included in such an arrangement, Mr. Blum said. "They would have to be pooled with others, actives and retirees together, to really spread the risk."

Furthermore, direct contracting may not be an option in California, where many medical groups reportedly are having financial troubles as a result of alleged underpayment in capitation arrangements with HMOs and insurers, Mr. Blum said.

The recent mergers of insurers and health maintenance organizations have created organizations with much more bargaining clout with provider groups than an entity like CalSTRS would have with its 350,000 members, said John Erb, area vp for Gallagher Benefit Services in Boca Raton, Fla.

"Direct contracting works best where you have a high percentage of the population in one geographic area," and California's teachers are spread throughout the state, noted Steve Richter, a consultant in the Los Angeles office of Watson Wyatt Worldwide.

CalPERS has considered direct contracting but shelved that idea for the past several years as it was able to negotiate caps on premium increases with HMOs, the CalPERS spokesman said. Now, with the CalSTRS task force interested in direct contracting, that issue has moved "to the front burner for us."

With support from Gov. Davis as well as the state treasurer and comptroller, who are ex-officio members of the CalPERS and CalSTRS boards, legislation may be enacted to solve the retired teachers' health care issue.

"There's a whole lot of stars in alignment right now," Mr. Blum said.

Other states also are struggling to provide health benefits to retired teachers, many of which also are not Medicare-eligible.

The Connecticut Teachers Retirement System in Hartford, for example, faces similar challenges but on a smaller scale, noted Bill Sudol. Mr. Sudol is administrator of the Connecticut system, which has 21,000 retired members. He estimates perhaps 400 or 500 of those over 65 are not eligible for Medicare.

Although the number of non-Medicare-eligible retirees is declining and will eventually disappear, "the retiree population overall is growing faster than the revenue," he said.

This crisis is particularly endemic to education because many teachers retire before they reach 65—the age required for Medicare eligibility, Mr. Sudol added.

"When I started working here 30 years ago, the ratio of active workers to retirees was 10-to-1," he recalled. "We'll be close to 2-to-1 in the next year or two."

Connecticut has provided health benefits to retired teachers over age 65 by statute since the 1950s. Funding comes from a 1%tax on active teacher salaries, supplemented by an allocation from the state's general fund, Mr. Sudol explained. Retirees not yet 65 or who are not Medicare-eligible receive coverage from their local school districts, but the premiums are subsidized by TRS, he said.

Currently, 10,500 Connecticut teacher retirees receive a Medicare supplement, which includes prescription drug coverage, from TRS, he said. Another 14,000 receive coverage from their local school districts.

Because of increased prescription drug costs, Connecticut's Legislature authorized requiring an $80 per month premium contribution from retired teachers beginning in July 1999.

"That's $80 per person, up from zero before," Mr. Sudol said. "We've been heading for a crisis. You can only do so much tinkering with plan structure. You can keep passing on the costs (to retirees). But it's the subsidies for our retirees who are not yet Medicare-eligible that's the biggest problem."

Colorado's Public Employee Retirement System, which provides coverage to 31,227 teachers, is in a little better shape, a spokesman in Denver said. "Most retired teachers in Colorado are Medicare-qualified," he said.

And gains made in the stock market enabled the system to transfer excess pension funds to the health plan trust fund, he added. This will let the system double its monthly contribution toward retiree health insurance premiums to $230 from $115. Retirees pick up the difference in premium costs.

In addition, the Colorado Legislature voted to increase employer contributions to the trust fund to 1.1%of payroll from 0.8%starting July 1, 1999, the spokesman said.

Colorado began providing health care benefits to retired teachers in 1986.

The stock market also has helped out the State Teachers Retirement System of Ohio in Columbus, said Executive Director Herbert Dyer.

Ohio has been providing health care benefits to retired teachers for 30 years, funded by a 14%assessment on school district payroll. The funds are first allocated to the pension fund, with the remainder used to finance health care.

While "the extra money is there today, it's not guaranteed for the future," Mr. Dyer warned.

"The issue really isn't today's problem," he said. "The issue is, we don't see large growth in financial resources, but we see significant growth in the number of future beneficiaries. It's a cause for concern." BI

Updates

Mitsubishi faces race bias suit

Continued from page 2

In a statement, a Mitsubishi spokeswoman said: "discrimination of any kind has no place in our workplace. We have policies and procedures to address any violations to our zero-tolerance policy." She would not comment further on the suit.

Mitsubishi has a general harassment policy prohibiting negative comments or jokes, offensive language, graffiti aimed at a person, sabotage, and threatening or intimidating language or behavior. This policy includes harassment based on gender, race, religion, color, national origin, disability, age or sexual orientation, according to the company.

Several plaintiffs sought relief by talking to monitoring staff who oversee the sexual harassment consent decree's enforcement, "but were told that the monitors had no jurisdiction or authority" over racial discrimination claims, said Patricia Benassi of Benassi & Benassi P.C. in Peoria, an attorney for the plaintiffs.

Wyatt files statement for IPO

BETHESDA, Md.—A registration statement Watson Wyatt & Co. filed last week with the Securities and Exchange Commission provides new details about the benefit consultant's proposed stock offering.

The offering will include newly issued shares of Watson Wyatt & Co. Holdings—a new parent company—as well as the sale of shares by existing Watson Wyatt shareholders, virtually all of whom are current employees of the Bethesda, Md.-based consulting firm.

As part of the deal, shares of newly issued class A common stock will be sold to the public and listed on the New York Stock Exchange.

An employee who enters into an agreement with underwriters would be able to sell up to the equivalent of 500 Watson Wyatt shares, plus 10% of the remainder of shares, in the IPO.

After the IPO, Watson Wyatt expects that 25% of outstanding shares will be held by the public, with 75% held by existing stockholders.

Proceeds from the sale could, "if advisable," be used for strategic acquisitions, though none have yet been identified, the company said.

Cat losses in '99 hit $8.2 billion

NEW YORK—U.S. insurers sustained about $8.2 billion in catastrophe-related claims last year, making 1999 the fifth-worst of the past 50 years in terms of insured property damage, according to the Property Claim Services unit of the Insurance Services Office Inc.

Relatively little of last year's cat damage occurred during the fourth quarter, when losses from hurricanes Irene and Lenny totaled $265 million, compared with $460 million in insured damage during the same period of 1998, PCS said last week. The year's total represents a significant drop from the about $10 billion in insured catastrophe losses incurred in 1998, and it is far below 1992's record of approximately $22.9 billion.

PCS recorded 27 catastrophic events—defined as events that cause at least $25 million in insured property losses and that affect a significant number of policyholders and insurers—last year. By state, Oklahoma suffered the largest cat loss, an estimated $1.1 billion in insured property damage, from a series of tornadoes that ravaged the state last May.

HIAA revives 'Harry and Louise'

WASHINGTON—"Harry and Louise," the fictional middle-age couple created by the Health Insurance Assn. of America for advertisements attacking the Clinton administration's ambitious health care plan, will be revived to push a new HIAA plan to reduce the number of uninsured.

The new ad campaign will plug an HIAA proposal that calls for tax breaks to make health insurance less costly for small employers and individuals. The campaign, with an initial cost of $1 million, will run this month in several national newspapers and on CNN and network affiliates in Washington.

"During the 1993-94 health care debate, Harry and Louise captured the imagination of the public. Today, we hope their familiar faces will get the ball rolling on a solution to this country's most pressing domestic issue—lack of health coverage," said HIAA President Chip Kahn in a statement.

The previous "Harry and Louise" campaign drew the ire of Hillary Rodham Clinton, who headed an administration task force charged with developing a reform package. Her attacks on the ads gave the campaign invaluable publicity, HIAA officials earlier said.

Briefly noted

Claude Bebear, who built Paris-based AXA Group into one of the world's largest insurers, will step down as group chief executive May 3 and become chairman of its supervisory board. Mr. Bebear, who turns 65 in July, will be succeeded by his deputy of the past two years, Henri de Castries, who joined AXA in 1989 from France's treasury department. . . .**Lincoln National Corp.** will take a $40 million charge against fourth-quarter 1999 earnings for liabilities stemming from its role as a member and retrocessionaire of the Unicover Managers Inc. workers compensation reinsurance facilities. The insurer also will take an added $13 million charge for U.K. pension misselling liabilities and will receive a related $42 million tax benefit, producing a net charge of $11 million. . . . The District of Columbia is suing more than 20 **gun manufacturers and distributors** in federal court to collect potentially millions of dollars in damages for costs associated with gun violence. The District is the 30th jurisdiction to file such a suit. . . A California bill proposed Jan. 12 by Assemblywoman Sheila Kuehl, D-Santa Monica, would assure **health plan members** the right to court hearings in disputes with their insurers. A.B. 1751 would prohibit health plans from requiring new members to agree to arbitration hearings instead of court proceedings. . . .The **U.S. property/casualty industry's surplus** fell about 3% for the nine months ended Sept. 30, to $323.4 billion, the first such drop since 1990, according to the Insurance Services Office Inc. and the National Assn. of Independent Insurers. Factors cited included a 24.1% drop in net income.

Deal

Continued from page 1

In addition to providing traditional and finite risk reinsurance, Risk Capital Re's Integrated Solutions program has offered insurers a blend of reinsurance and capital investment. It has also offered, on a stand-alone basis, either contingent capital or direct investments to insurers. Folksamerica will not acquire any of Risk Capital's publicly traded securities or private-placement investments in the deal.

Under terms of the complex deal, Folksamerica Re, a subsidiary of Folksamerica Holding, will assume $440 million of Risk Capital Re's liabilities and an equal amount of its assets, and it will pay $20.3 million in cash for the reinsurance operations.

In addition, $20 million will be held in escrow for five years to cover adverse loss-reserve development related to business produced by a managing underwriter. New York-based Capital Protection Insurance Services L.L.C. wrote long-tail and umbrella casualty business, now in runoff, on Risk Capital Re's behalf (*BI*, Nov. 1, 1999).

The transaction, which is expected to close in the first quarter, is subject to shareholder and regulatory approval.

In a separate transaction, which is not contingent on the Folksamerica deal, Risk Capital will repurchase all the common stock from one of its major investors, XL Capital Ltd., for an estimated $71.3 million.

Hamilton, Bermuda-based XL and Risk Capital's other major investors, Marsh & McLennan Risk Capital Holdings Ltd. and investment pool The Trident Partnership, currently own about 37.5% of Risk Capital's outstanding voting shares. They have already agreed to vote in favor of the transaction.

The Folksamerica deal leaves Risk Capital with a book value of about $300.8 million based on third-quarter numbers, said Peter Appel, executive vp and chief operating officer. This reflects about $260 million in private equity, public equity and fixed income investments plus the stock value of Risk Capital Re and of Cross River Insurance Co., an excess and surplus lines insurer formed by Risk Capital Re about a year and a half ago that has not yet written any business. Both units have about $20 million in statutory capital, noted Mr. Appel.

Mr. Appel said the company decided this deal would bring the best value to Risk Capital Re's shareholders in light of several quarters of poor earnings and a depressed stock price, which ruled out a transaction involving the holding company's stock. The stock closed at $14.88 per share on Monday, the day before the deal was announced. Its 52-week high was $22.25.

"We felt we had to remove the uncertainty that surrounded the company by selling the business the way we did," said Mr. Appel. This deal should "be able to get us to trade closer to book (value) than any other transaction before us" and leaves the company free to make new plans, he said, adding that those plans have not yet been determined.

Officials of both companies said the future of Risk Capital Re's highly regarded management, led by President and CEO Mark D. Mosca, has not yet been determined either.

Risk Capital, which raised $240 million in its 1995 initial public offering, fell victim to poor timing, analysts say. It began operations in a highly competitive market that was already awash in capital, and the insurer stocks in which it invested became depressed in value.

The Folksamerica deal leaves Risk Capital with a book value of about $300.8 million based on third-quarter numbers, says Peter Appel.

With M&M's backing and its experienced management, "Risk Capital Re was able to generate substantial premium volume from Day One," said Donald Watson, a director at rating agency Standard & Poor's Corp. in New York.

"The problem is, in a soft market environment, generating premium growth is difficult, and to get the business you typically underprice the competition," said Mr. Watson. "To some degree, that would appear to be the case at Risk Capital Re, given the underwriting performance that we've seen.

"The other aspect that was difficult with Risk Capital Re was with their making equity investments in insurance companies in order to garner a certain share of their reinsurance business," he added.

"There is a longstanding tradition of this by European reinsurers, but there was a larger difficulty for a startup company to engage in this strategy" because it did not have the large capital base needed to effectively diversify its investments, said Mr. Watson.

"The problem is that at the point in time that your primary insurance companies are producing losses that you have to pay out under the reinsurance policy, there's a reasonable likelihood that, because they are producing those losses, their equity values will be under pressure. And so at the point in time that you're paying out losses, your investment portfolio is also depreciating in value, which produces a credit squeeze on the reinsurer," Mr. Watson said.

Sarah Hibler, vp and senior analyst with rating agency Moody's Investors Service Inc. in New York, said that the relatively new Risk Capital Re was offering the same types of solutions as longer-established reinsurers.

In addition, given its limited operating experience, the company's rapid growth, which averaged nearly 80% over the last three years, created uncertainty about the profitability of its existing business, said Ms. Hibler.

The drive to grow in today's marketplace also encouraged the deal, analysts say.

"Reinsurers the size of Risk Capital Re aren't seeing the good business, apparently," said Michael Frinquelli, an analyst with Renaissance Fund Advisers in New York.

"Folksamerica is bulking up, so in a sense they're both doing the right thing," said Mr. Frinquelli. While Folksamerica is getting bigger, Risk Capital is selling a reinsurance operation it realized was just too small to compete, he said.

"Folksamerica will be able to bring a lower cost structure by spreading its administrative cost of handling the claims over a much larger base of business," said S&P's Mr. Watson.

"It's really an economies-of-scale play for Folksamerica. It also provides them access to a renewal book of reinsurance that could considerably increase their profile," he said.

White Mountains, which last year changed its name from Fund American Enterprise Holdings Inc., has a long history in the property/casualty business. It sold Fireman's Fund Group to Allianz A.G. Holding in 1991.

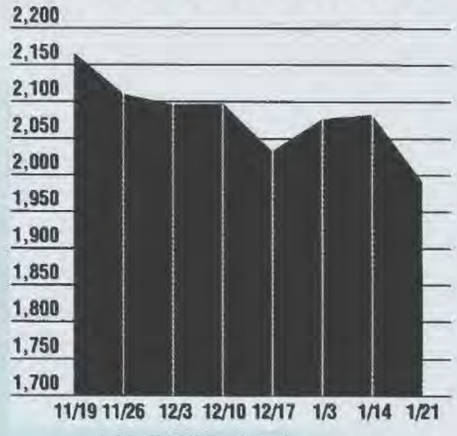
White Mountains, which redomesticated to Bermuda from New Hampshire last October, also owns about 25% of financial guarantee insurer Financial Security Assurance Inc., which is based in New York, among other insurer investments.

Karen Davies, a Moody's vp and senior analyst, noted that White Mountains sold a money-losing mortgage lending subsidiary, Source One Mortgage Corp. of Farmington Hills, Mich., to Citibank Mortgage last year.

The property/casualty business, though, is one the company knows well, said Ms. Davies. "They've gotten their best returns from that business," she said.

Donaldson, Lufkin & Jenrette Securities Corp. advised Risk Capital Re on the deal. Lehman Bros. advised Folksamerica. BI

BI Insurance Index



Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.

PCS catastrophe options

As of Jan. 21

Call spread	Price bid/ask	Call spread	Price bid/ask
National Annual 2000		**California Annual 2000**	
60/80	5.0/—	150/155	0.1/0.3
100/150	7.5/—		
150C	6.0/—	**Western Annual 2000**	
190/195	0.3/0.5	150/155	0.2/0.4
200/250	3.7/—	300/350	0.5/—
		Eastern March 2000	
Midwest June 2000		20/30	—/2.0
10/20	0.8/3.3		
20/30	0.4/1.5	**Eastern Sept. 2000**	
		40/60	1.5/—

Total volume: 0 Total open interest: 792

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high-low
Legal & Gen	153	17.9	3.6	2.5	237-137
Royal & Sun	419	NA	23.0	5.6	633-351
Brokers					
Lmbrt Fenchurch	140	14.0	4.2	3.0	145-58
JLT	282	12.4	12.0	4.4	286-166

Note: Prices are Jan. 21 closings; other numbers from Jan. 20.

Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.

BI Industry Stock Report JAN. 17, 2000, THROUGH JAN. 21, 2000

		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
BROKERS							
Aon Corp.	NYS	25.56	-14.61	-36.09	46.69	25.56	6856
Clark Bardes Holdings	NDQ	14.88	-1.65	3.48	21.00	11.63	32
E.W. Blanch Holdings Inc.	NYS	48.50	-10.39	-20.82	71.75	48.00	419
Gallagher Arthur J. & Co.	NYS	57.13	-4.19	-11.78	64.88	43.63	219
Hilb, Rogal & Hamilton	NYS	28.13	0.22	-0.44	29.13	15.56	52
Kaye Group Inc.	NDQ	9.00	3.97	7.46	9.56	5.00	16
Marsh & McLennan	NYS	101.50	-2.29	6.07	104.75	57.13	4580
Brown & Brown	NYS	37.75	-5.33	-1.47	40.63	29.31	65
BROKERS	AVERAGE		-3.00	-3.49			
INSURERS/REINSURERS							
ACE Ltd.	NYS	20.06	-2.43	20.22	35.25	15.19	2793
Accel International Corp.	NDQ	1.00	3.31	0.00	3.00	0.50	177
Acceptance Insurance Cos.	NYS	4.19	-8.22	-27.17	18.44	3.81	543
AEGON N.V.	NYS	80.81	-5.76	-15.38	116.94	69.63	473
Aetna Life & Casualty	NYS	55.69	-1.00	-0.22	99.88	46.50	2836
AFLAC Inc.	NYS	38.75	-9.75	-17.88	56.75	37.50	8737
Allmerica Financial Corp.	NYS	46.94	-11.02	-15.62	64.81	46.06	517
Allstate Corp.	NYS	23.50	-2.84	-2.34	40.75	22.63	11276
Ambac Financial Group	NYS	46.69	-8.00	-10.54	63.00	25.06	969
American Financial Group	NYS	22.75	-6.19	-13.74	38.38	22.50	204
American General	NYS	57.19	-17.12	-24.63	82.19	57.19	4600
American Intl Group	NYS	103.94	-8.88	-3.87	114.50	76.50	12394
American Safety Insurance	NYS	6.88	-0.90	5.77	10.38	6.00	18
Argonaut Group	NDQ	18.38	-2.65	-7.55	27.94	18.38	72
AXA-UAP Group	NYS	63.88	-5.37	-10.04	76.75	53.75	309
Baldwin & Lyons Inc.	NDQ	20.00	2.24	-9.60	24.03	19.09	270
Berkley W.R. Corp.	NDQ	18.13	-5.23	-13.17	31.75	18.13	263
Berkshire Hathaway Inc.	NYS	52900.00	1.34	-5.70	81100.00	51600.00	2
Capitol Transamerica Corp.	NAS	10.94	8.02	8.70	18.25	9.38	28
Chubb Corp.	NYS	55.88	-2.30	-0.78	76.38	44.00	3729
CIGNA Corp.	NYS	74.56	-7.52	-7.45	98.63	63.44	2715
Cincinnati Financial Corp.	NYS	30.06	-1.03	-5.69	42.50	28.94	1951
Citigroup	NYS	56.44	-2.69	1.35	60.13	33.44	48170
CNA Financial Corp	NYS	34.63	-5.30	-11.08	45.31	33.00	299
CNA Surety	NYS	10.94	-1.13	-15.87	15.56	9.75	153
EMC Insurance Group Inc.	NDQ	9.38	-3.85	2.74	13.38	9.00	7
ESG Re Limited	NDQ	6.50	8.33	-6.31	20.25	5.13	283
Enhance Financial Services	NYS	14.69	-6.75	-9.62	27.38	14.69	194
Everest Reinsurance	NYS	26.56	0.47	19.05	36.25	20.50	788
Fremont General Corp.	NYS	8.13	-4.41	10.17	23.38	4.69	1879
Frontier Insurance Group	NYS	3.13	4.17	-9.09	17.25	2.38	937
Gainsco Inc.	NYS	6.31	4.12	17.44	6.94	3.94	53
Harleysville Group	NDQ	13.00	-2.80	-8.77	23.50	12.63	93
HSB Group Inc.	NYS	28.56	-4.79	-15.53	42.25	28.38	468
HCC Insurance Holdings	NYS	14.25	8.57	8.06	25.13	8.00	399
ING Groep N.V.	NYS	55.63	-4.30	-8.81	63.94	21.00	306
IPC Holdings Ltd.	NDQ	15.25	-1.61	2.52	22.50	14.25	65
Hartford Financial Services	NYS	37.94	-13.16	-19.92	66.44	36.50	3448
LaSalle Re Holdings Ltd.	NYS	13.44	-11.89	-18.56	20.25	10.88	184
Lincoln National	NYS	35.81	-7.88	-10.47	57.50	34.38	2639
MAIC Holdings Inc.	NYS	22.75	-0.27	7.37	32.06	19.88	153
Markel Corp.	NYS	141.50	-6.29	-8.71	193.00	141.50	48
MBIA Insurance Group	NYS	49.50	-2.10	-6.27	71.88	45.00	1449
Meadowbrook Insur. Group	NYS	6.38	-8.93	-2.86	17.44	4.75	34
MMI Cos. Inc.	NYS	8.81	0.00	2.17	17.44	3.31	268
Mutual Risk Mgmt. Ltd.	NYS	16.63	6.40	-1.12	43.25	9.81	906
Navigators Group	NDQ	10.63	3.66	8.97	16.00	9.13	36
NYMagic Inc.	NYS	13.56	0.00	2.84	19.50	12.00	19
Ohio Casualty Corp.	NDQ	13.75	-4.35	-14.40	21.69	13.38	926
Old Republic Int'l	NYS	12.75	-0.97	-6.42	20.69	12.06	1214
Partner Re Ltd.	NYS	29.06	-2.72	-10.40	46.19	28.38	2223
Penn-America Group Inc.	NYS	7.63	15.09	-1.61	11.44	6.63	57
PMA Capital Corporation	NDQ	18.13	-8.23	-8.81	21.13	17.56	39
Philadelphia Cons. Holding	NDQ	14.88	0.85	2.59	25.50	10.81	56
PXRE Corp.	NYS	11.81	-8.25	-9.13	22.13	9.94	178
Reliance Group Holdings	NYS	6.06	4.30	-8.49	12.44	2.81	3044
ReliaStar Financial Corp.	NYS	30.38	-9.83	-22.49	49.81	28.56	2438
RenaissanceRe Holdings Ltd.	NYS	40.75	1.40	-0.31	43.19	30.00	152
Risk Capital Holdings	NDQ	15.63	5.04	23.76	22.25	11.00	420
RLI Corp.	NYS	33.13	-1.67	-2.57	38.81	27.88	70
St. Paul Cos.	NYS	31.50	-7.35	-6.49	37.06	25.38	3878
SCOR	NYS	51.50	6.46	16.38	59.00	42.94	18
SAFECO Corp.	NDQ	24.38	-3.70	-2.01	46.75	21.81	2241
SCPIE Holdings Inc.	NYS	29.00	-2.32	-9.73	36.06	23.69	NA
Seibels Bruce Group	NDQ	1.50	-7.69	-14.29	6.25	1.47	180
Selective Ins. Group	NDQ	15.31	-7.55	-10.91	22.50	15.19	201
Terra Nova Ins Co. Ltd.	NYS	28.88	-3.75	-3.75	32.63	21.25	245
Tokio Marine & Fire	NDQ	53.00	-0.24	-10.36	67.00	50.00	118
Torchmark Corp.	NYS	23.31	-14.84	-19.78	38.00	23.31	3051
Transatlantic Holdings	NYS	74.94	-0.50	-4.00	80.50	69.06	32
Travelers Property Casualty	NYS	36.75	-1.67	7.30	41.88	27.69	2274
Trenwick Group Inc.	NYS	14.75	-7.09	-12.92	35.25	14.38	194
Unico American Corp.	NDQ	7.00	-2.18	0.00	13.75	6.38	24
United Fire & Casualty	NDQ	20.25	-7.82	-10.50	33.00	19.25	21
Unitrin	NDQ	37.22	1.36	-1.08	42.38	30.50	373
UNUM Corp.	NYS	26.75	-9.13	-16.57	62.50	26.00	3198
Vesta Insurance Co.	NYS	4.88	2.63	25.81	8.38	3.38	114
XL Capital Ltd.	NYS	49.81	-3.39	-3.98	67.19	41.94	1851
Zenith National Ins.	NYS	20.94	-2.05	1.52	26.69	19.25	38
INSURERS/REINSURERS	AVERAGE		-2.85	-4.79			
HEALTH MAINTENANCE ORGANIZATIONS							
Foundation Health Systems Inc.	NYS	10.75	2.99	8.18	10.75	0.00	1815
Humana Inc.	NYS	7.81	-5.30	-4.58	19.81	5.88	5411
Oxford Health Plans	NDQ	15.31	1.03	20.69	24.25	9.75	4128
Pacificare Health Sys.	NDQ	47.50	-6.98	-10.38	100.38	31.13	804
Sierra Health Services	NYS	7.00	0.90	4.67	20.88	4.63	275
United HealthGroup	NYS	58.38	-5.27	9.88	70.00	39.38	4313
Wellpoint Health Networks	NYS	71.25	0.00	8.06	97.00	48.25	996
HMOs	AVERAGE		-1.80	5.22			
ALL COMPANIES	AVERAGE		-2.55	-1.02			

Top advancing issues: Penn-America Group Inc., HCC Insurance Holdings, ESG Re Ltd. Leading decliners: American General, Torchmark Corp., Aon Corp. Most active issue: Citigroup. The *BI* Index fell 4.4%; the Dow Jones 30 Industrials decreased 4.0%; the S&P 500 declined 1.6%, and the NYSE Composite fell 1.6%. Average P/E: Brokers, 18.1; Insurers/reinsurers, 17.7; HMOs, 14.0.

Source: *CNET Investor* (investor.cnet.com) Boulder, Colo.