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Update

Federal grand jury indicts Carlos Miro on fraud charges

NEW ORLEANS—A federal grand jury has indicted Carlos I. Miro on mail fraud and money laundering charges stemming from his operation of the now-defunct Anglo-American Insurance Co. of Louisiana.

The 20-count indictment charges that Mr. Miro siphoned Anglo-American premiums out of the United States for his personal benefit, knowing that the insurer was insolvent.

Mr. Miro tried to conceal the insurer's

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Antitrust suit reinstated

Appellate court orders trial on boycott charges

By JUDY GREENWALD

SAN FRANCISCO—The reinstatement of massive insurance antitrust litigation could ultimately cost both the defendants and the 19 state plaintiffs millions of dollars in legal costs.

In a ruling that dealt a staggering defeat to the insurance industry, a three-judge panel of the 9th U.S. Circuit Court of Appeals June 18 unanimously overturned U.S. District Court Judge William Schwarzer's 1989 summary judgment dismissal of the suit against 31 insurance industry defendants.

The strongly worded decision by presiding Judge John T. Noonan Jr. ripped into Judge Schwarzer's reasoning on several points.

Insurance industry defendants now are considering their next step.

Their options include seeking a rehearing before an 11-member panel of the 9th Circuit or immediately asking the U.S. Supreme Court to review the case.

However, there is no guarantee that either the 9th Circuit or the Supreme Court will review the case.

A third option is to immediately embark on the time-consuming—and expensive—process of discovery on the trial court level.

Attorneys say a settlement, while always a possibility, apparently is not being actively discussed.

Insurance industry defendants named in a similar antitrust suit filed in state court in Texas, however, settled that litigation (see story, page 87).

For purposes of the initial stages of the litigation, both Judge Schwarzer's and Judge Noonan's rulings were based on the assumption that the factual allegations made by the states against the industry defendants are true.

The states, however, still have to prove these allegations if and when the case proceeds to a trial. The discovery process leading up a trial could take years.

If the case does go to trial, it would not be handled by Judge Schwarzer, who is now director of the Federal Judicial Center in Washington, the research and education arm of the judiciary. Judge Vaughn Walker in San Francisco has been assigned to the case.

In their original lawsuits filed in March 1988, the attorneys general

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Photo by Drake Sorey

The appellate decision ripped into Judge Schwarzer's earlier ruling.

AP/Wide World Photos

Thick ashes are spewed from the crater of Mount Pinatubo.

Little coverage exists for Filipino volcanic eruption

By REYNALDO A. de DIOS and ADRIENNE C. LOCKE

MANILA, Philippines—The volcanic eruption of Mount Pinatubo in the Philippines could cost as much as $110 million in damages, according to local press reports.

A government agency, however, estimates the damages at $40 million.

Whatever the total damage, very little is expected to be covered by insurance because Filipinos generally do not pay the additional premium for coverage for volcanic eruption under property and automobile insurance policies.

U.S. companies, which generally are covered for volcanic losses under all-risk insurance policies written outside of the country, are not expected to have losses because their operations in the

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Ruling may jeopardize UR in health care plans

By MICHAEL SCHACHNER

PHILADELPHIA—Benefit managers and other benefit experts hope a federal appellate court will overturn a ruling that health plans that penalize members for failing to have medical procedures precertified violate public policy and the Employee Retirement Income Security Act.

Employers' ability to design health plans with managed care features could be severely jeopardized if the April 19 U.S. District Court ruling—largely unnoticed until now—is upheld.

In a case involving Bethlehem Steel Corp., Judge William W. Caldwell maintained that penalizing plan members who fail to obtain precertification for treatment that is later found to be medically necessary violates public policy because the penalties are arbitrary and capricious. Such penalties also violate the fiduciary duties that ERISA imposes on plan administrators, he ruled.

Bethlehem Steel argues that the precertification requirement is not arbitrary and was adopted to reduce the chance of employees receiving unnecessary medical care.

The Bethlehem, Pa.-based company's appeal is now pending before the 3rd U.S. Circuit Court of Appeals in Philadelphia. A date for arguments has not been set.

Judge Caldwell's ruling is important because it could permit employees and retirees to challenge an array of managed care arrangements that include penalties for failure to comply. Precertification and utilization review programs and point-of-service health

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Employers' costs far outstrip premiums paid: Study

COBRA costs on the rise

By JERRY GEISEL

WASHINGTON—The cost to employers of providing COBRA health care benefits to former employees and their dependents continues an upward trend, far outpacing COBRA premiums paid, according to a new survey.

Fifty percent of companies surveyed said that during the first six months of 1990 they paid at least $1.90 in claims for every $1 in premiums they collected from COBRA beneficiaries.

In 1989, half of the surveyed companies said they paid at least $1.67 in claims for every dollar in COBRA premiums. And, in 1988, half of the companies said they paid at least $1.83 in claims.

"What employers take in premiums in no way actually comes near to their actual claims experience. COBRA is indeed a very costly benefit for employers," said Sharon Canner, assistant vp at the National Assn. of Manufacturers, a Washington, D.C.-based business trade group.

NAM sponsored the survey, which was conducted by TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc. of New York.

The survey also found that the cost of administering COBRA is much higher than the charge employers can pass on to employees.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, employers with 20 or more employees are required to extend group health care coverage to for-

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NEWSPAPER

Update

Miro indicted on fraud charges

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true condition from Louisiana examiners by transferring $1.5 million of Anglo-American's money to a London bank and then having it transferred back as an infusion of new capital, the indictment alleges.

The June 7 indictment also charges that he concealed $25,000 in payments to "an elected public official for the state of Louisiana" to obtain an insurance license for Anglo-American. No official is identified, but documents introduced in a 1989 congressional hearing showed that 25 Anglo-American employees bought $1,000 cashiers' checks payable to the re-election campaign of Sherman Bernard, who was then state insurance commissioner, the same day Mr. Miro arranged for a $25,062.50 cash withdrawal from an Anglo-American affiliate's bank account (*BI*, April 10, 1989).

Mr. Miro's current whereabouts are unknown, but prosecutors will seek his arrest and extradition if he is in a foreign country, according to the U.S. Attorney's office. He faces 115 years in prison and $5.25 million in fines if convicted on all the charges.

Anglo-American was declared insolvent by $19 million and ordered liquidated in 1989. Mr. Miro's activities as an Anglo-American principal and as a managing general agent for the failed Transit Casualty Co. were detailed in a 1990 House Oversight & Investigations Subcommittee report (*BI*, Feb. 26, 1990).

Eastern says retiree deal intact

MIAMI—An agreement between bankrupt Eastern Airlines and 14,000 retirees to extend health care benefits may be unraveling, retirees claim.

Under that deal, the airline would, beginning July 1, pay $170 monthly per retiree to extend health care benefits until Dec. 30. Retirees would contribute $75 per month (*BI*, May 27).

Retirees claimed last week that Eastern was backing out of the deal.

But Alan Gibson, vp-employee relations for Eastern, said it " is going forward with the plan. We were simply trying to clarify terms."

Retiree attorney William G. Bell said, "If (Eastern) doesn't stick to the agreement we will file for contempt."

The agreement was designed as a temporary solution until retirees litigate their standing in Eastern's bankruptcy case. Eastern claims it cannot afford retiree health care benefits (*BI*, May 6).

BC/BS urges coverage of tests

CHICAGO—Blue Cross & Blue Shield Assn. of Chicago is urging all of its 73 member plans to cover a battery of screening tests to detect a range of diseases at an earlier stage.

The BC/BS Assn. recommends its plans incorporate clinical screening guidelines issued by the American College of Physicians into some health insurance policies for an additional premium.

The ACP issued screening guidelines for breast, colon, cervical and lung cancer; heart disease; hypertension; diabetes; thyroid disease; and osteoporosis. Among other things, the guidelines recommend coverage of annual mammograms, after age 50, pap smears for cervical cancer once every three years and cholesterol tests at least once in early adulthood and at intervals of every five years thereafter for men and women.

Adding the screening tests to benefit packages will increase individual monthly premiums by about $3 and family premiums by about $7.50, said Bernard Tresnowski, president of the BC/BS Assn.

The ACP and the BC/BS Assn. say savings from early detection and treatment will outweigh those higher premiums.

Most other major health insurers, including Prudential Insurance Co. of America and Metropolitan Life Insurance Co., already cover preventive services for an additional premium. Some BC/BS plans also already offer coverage for preventive services.

Health proposal criticized

WASHINGTON—Universal health care legislation introduced earlier this month by Senate Democratic leaders would "waste" more than $1 trillion during the 1990s compared with a single-payer Canadian-style program, a consumer group charges.

Public Citizen Health Research Group said the Democratic proposal, S. 1227—which would establish a new publicly funded plan for the uninsured while requiring employers to offer health care coverage or face a payroll tax—would be wasteful because it would leave intact the existing health insurance bureaucracy.

Drawing on a General Accounting Office study, Public Citizen said the proposal would forgo more than $1 trillion in administrative savings from 1991 to 2000 that could be achieved through a Canadian-type program. The GAO estimated a Canadian-style program could save $67 billion in administrative costs during the first year (*BI*, June 10).

Public Citizen Health Research Group is an arm of Public Citizen, the consumer group founded by Ralph Nader that last fall published a report that questioned the solvency of five large property/casualty insurers in an economic downturn. The group later conceded it should not have made the allegations against two of the insurers, while insurers and others questioned the validity of the entire study (*BI*, Oct. 29, 1990; Oct. 22, 1990).

Keene to appeal Texas awards

DALLAS—Keene Corp. will appeal a $5.2 million jury award to three men with asbestos-related diseases and the family of another man who died after prolonged exposure to the substance.

A Texas District Court jury earlier this month awarded the family of Martin Mason of Pascagoula, Miss., $4.4 million and three Alabama men were awarded $650,000, $115,000 and $65,000.

Mr. Mason and the others handled insulation products containing asbestos while working at Baldwin-Ehret-Hill Inc., a Valley Forge, Pa.-based company bought in 1968 by New York-based Keene.

Ned Stewart of Atchley, Russell, Waldrop & Hlavinka in Texarkana, Texas, who represents Keene, said all the awards will be appealed to the Court of Civil Appeals in Dallas because they are unjustified.

The Alabama plaintiffs filed suit in Texas because the statute of

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Tougher annuity rules for pensions pursued

By JERRY GEISEL

WASHINGTON—In the wake of the collapse of Executive Life Insurance Co., two federal agencies are considering whether to strengthen standards employers must follow when they purchase annuities to replace workers' and retirees' pension benefits.

In separate notices published last week in the Federal Register, the Labor Department's Pension and Welfare Benefits Administration and the Pension Benefit Guaranty Corp. said they would seek public comment on whether tougher rules are needed.

"Additional regulatory requirements regarding annuity provider selection in terminating plans may be needed to ensure that participants receive financially sound annuity contracts," the PBGC said.

Currently, the only clearly defined standard for employers that buy annuities to replace pension benefits is that the insurer be licensed in at least one state.

The possibility of new federal rules on annuity insurers, which could restrict the availability of annuities and drive up their cost, was one of several Executive Life-related developments last week.

Other developments include:

• PBGC Executive Director James B. Lockhart said the agency is preparing a final rule requiring an employer terminating a pension plan to inform plan participants of the name of the annuity insurer as well as the fact that annuities are not insured by the PBGC.

Prodded by Sen. Howard Metzenbaum, D-Ohio, at a Senate Labor Subcommittee hearing, Mr. Lockhart said the agency also would investigate whether the new notification rules could be issued on an "emergency" basis to expedite their publication.

However, Mr. Lockhart also testified that requiring the PBGC to insure pension annuities underwritten by insurers would be "folly" and could lead to a disaster on the magnitude of the savings and loan association debacle.

"It would be folly for the federal government to take on a new huge type of risk without the ability to control its losses. With the regulation of insurance companies at the state level, a federal guarantee

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Lloyd's loses tax relief bid

Market still seeking tax-deductible catastrophe reserves

By GAVIN SOUTER

LONDON—Lloyd's of London's bid to save its members 50 million pounds ($85.5 million) by offsetting underwriting losses against profits over a three-year period received a severe setback last week when a government minister virtually rejected the proposal.

A House of Commons committee Tuesday threw out an amendment to the finance bill now pending in Parliament that would have extended the tax loss carryback—which is to be granted to British companies—to also include Lloyd's members.

The proposed amendment flung Lloyd's into the center of the political arena and provoked strong protests from members of Parliament.

However, Lloyd's has not abandoned its quest to strengthen the financial position of its members and now is seeking ministerial-level talks with the British government over a "number of possibilities," said Andrew Duguid, head of market services for Lloyd's.

For instance, Lloyd's hopes to persuade the Inland Revenue—the British equivalent of the U.S. Internal Revenue Service—to allow it to establish tax-deductible catastrophe reserves that, like those already set up by continental European insurance companies, would cushion the effect of large unforeseen losses.

Lloyd's began lobbying the government concerning the tax-loss carryback proposals in April, shortly after it was announced that companies would be granted the tax break.

Discussion of the proposal came to a head last week when Ian Taylor, a backbench Conservative member of parliament who is not a member of Lloyd's, tabled an amendment to the current finance

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NAIC defends accreditation from congressional critics

By MEG FLETCHER

INDIANAPOLIS—Criticism of NAIC state insurance regulators' new program of accrediting insurance departments leveled during congressional hearings on insurer solvency is an unfair swipe at the state regulatory system, regulators charge.

State regulators staunchly defended the accreditation program and the entire system of state insurance regulation during the National Assn. of Insurance Commissioners' summer meeting in Indianapolis earlier this month.

The NAIC also adopted a formal resolution stating it could not support federal legislation that would allow some banks to sell insurance unless state insurance regulators' role over such sales is clarified.

NAIC President and North Carolina Insurance Commissioner James E. Long defended the NAIC's accreditation program in the wake of criticism of the program during a House Subcommittee on Oversight and Investigations hearing last month (*BI*, May 27).

Richard L. Fogel, assistant comptroller general of general government programs for the U.S. General Accounting Office, said at the hearing: "We do not believe that state adoption of NAIC's current standards will achieve a consistent and effective system of solvency regulation. The underlying standards for accreditation are often undemanding and, in some cases, inadequate."

Mr. Long said in a press conference at the NAIC meeting that the hearing before the subcommittee of the House Committee on Energy and Commerce, chaired by Rep. John Dingell, D-Mich., "was not an objective fact-finding hearing."

"It was a stage for the denigra-

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Inside

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✓ Rising costs and concerns about chemical dependency underscore the need for a comprehensive program, say Dr. Richard Kunnes and Barbara Lambert of U.S. Behavioral Health in Perspectives. **PAGE 51**

✓ The soft commercial property/casualty insurance market is starting to stabilize, according to a new survey of risk managers. **PAGE 77**

✓ AXA Midi Assurances S.A., the rapidly expanding French insurer, may be close to acquiring its coveted U.S. foothold. **PAGE 79**

✓ E.C. members' state export credit insurers are rejecting a proposal to establish a reinsurance pool for export credit and political risk insurance covering trade with Eastern European countries. **PAGE 79**

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Spotlight report

Health insurance market

Premium increases show no signs of slowing at midyear

By CHRISTINE WOOLSEY

Group health insurance premium increases are not cooling off for employers renewing their programs this summer.

Premium increases for traditional group health indemnity plans are expected to remain at 20% to 25%, though some may reach 30%. Employers that add managed care components—particularly preferred provider networks—to their indemnity plans can expect premiums increases in the high teens or low 20s.

And, most health maintenance organizations expect to increase premiums 10% to 15% at mid-year.

Self-insured employers expect that their health care costs are increasing between 15% and 20% on an annual basis. However, insurers and consultants say that self-insured employers' cost increases depend heavily on the level of managed care designed into their plans.

These anticipated cost increases mirror those that employers faced in January (*BI*, Dec. 17, 1990).

"The trend is basically holding. We're seeing small fluctuations with renewals, but it's not rising or falling per se," said Rick Johnson, managing director in the Chicago office of William M. Mercer Inc.

"We're not seeing a lot of catastrophic renewals or as wide a range of renewals compared to last year," said Penny Zicker, senior consultant at Noble Lowndes (USA) of East Orange, N.J., referring to the range of rate increases.

"Health care costs are still heading up, but the curve might be less pronounced than it has been," said Tom Grass, national practice leader of group flexible benefits at The Wyatt Co. in San Diego.

According to the Labor Department's Bureau of Labor Statistics, the Consumer Price Index's medical care component rose at an annualized rate of 8.4% for the six months ending in April. The overall CPI rose 2.9% during that same period.

For all of 1990, the CPI's medical care component rose 9.6%, compared with a general inflation rate of 6.1%. In 1989, the medical care component rose 8.5%, compared to a general inflation rate of 4.6%.

Still, trend lines used to forecast health insurance cost increases—which are based in part on the CPI—range from 20% to 25% in 1991, up slightly from 20% to 24% last year.

Factors pushing up medical costs include the pressures of cost shifting from Medicaid and Medicare programs, advances in medical technology, the aging of the workforce and consumer demand.

Noble Lowndes projects an average 1991 trend factor of 24%, based on reports from 15 group health insurers. The consultant projects that rates for traditional indemnity plans will increase between 24% and 32% at midyear, compared with 20% to 25% for managed care plans.

The biggest reason behind the rising health costs continues to be medical inflation, driven by a 35% increase in the cost of hospital outpatient services in 1990 and through the first four months of 1991, explained Bill Gibson, senior health care consultant at Noble Lowndes.

However, Mr. Gibson pointed out that medical inflation has subsided slightly since 1989 (see chart). Medical inflation now accounts for 9.5% of the 24% trend factor, down from 10.4% in 1989.

But "although the mix of the components has changed, the trend factor is still hovering at the same high level," Mr. Gibson explained. "Some factors have gone down, but others have gone up, so the train is still rolling along."

Health care costs have risen more than 300% in the last decade and they "continue an unrelenting spiral upward," he said. "The cost of corporate health care has risen from less than 5% of payroll in 1980 to more than 14% of payroll in 1990."

Most group health insurers and consultants agree that insurance rates generally have caught up with medical inflation but that other components of trend lines continue to drive up premiums.

"We played catch up through most of 1989 and the beginning of 1990, but we're pretty much keeping even now" with medical inflation, said Joe Maginnis, vp of group underwriting at Prudential Insurance Co. of America in Newark, N.J.

"Insurers have caught up at this point, and they are really keeping pace with health care cost inflation" in developing their rates, agreed Ms. Zicker.

But, inflation is still a problem.

"Health care inflation isn't under control yet, and most of the programs we've seen that manage care do not address the aggregate cost of the system," said Bill Lane, vp and group actuary for Mutual of Omaha Insurance Co. of Omaha, Neb.

Meanwhile, the costs of technological advances and of increased utilization are the fastest rising components of medical inflation, said Noble Lowndes' Mr. Gibson. The costs for technological advances are projected to increase 15% in 1991, and the cost of increased utilization of health care services and technology is projected to increase nearly 18%.

But, he adds, the rate of the cost increase is projected to decrease by 13% in 1991 for so-called social shifts—including the cost of treating people with acquired immune deficiency syndrome, mandated benefits, psychiatric care, substance abuse programs and the aging population.

AIDS continues to be a factor in rising

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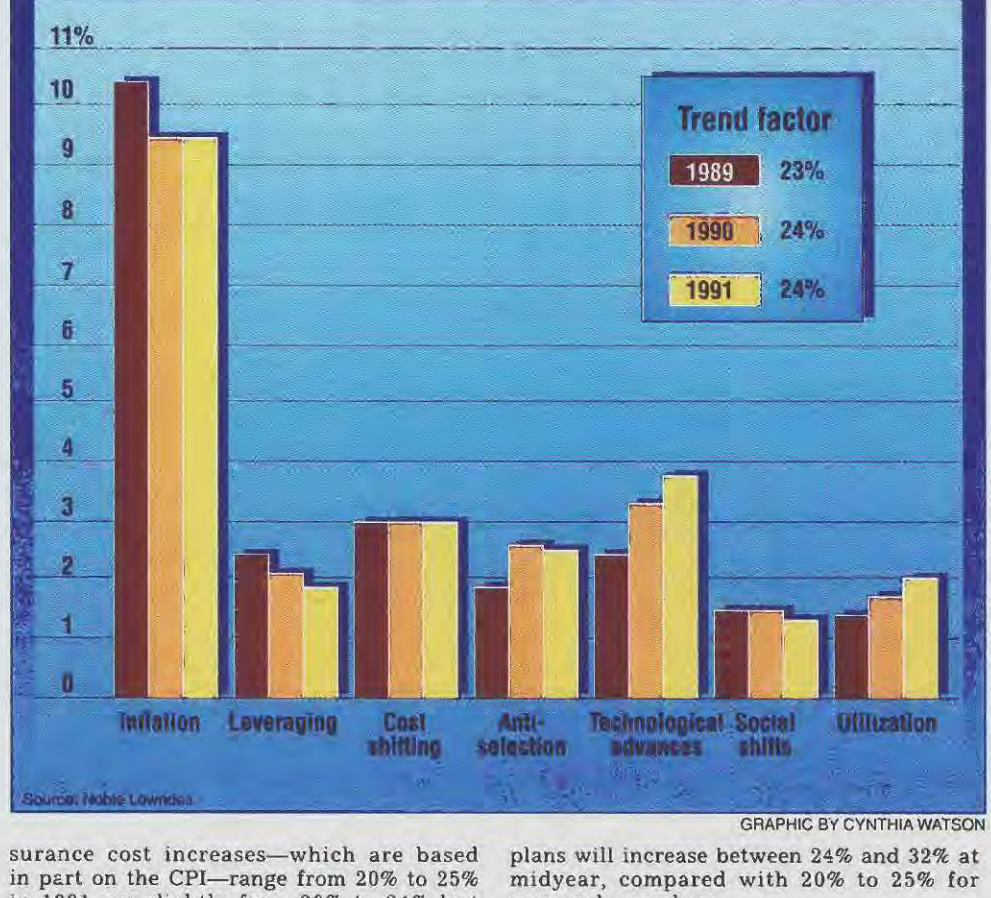
Why are health benefit costs rising?

While inflation is moderating slightly, other functions, like technological advances and utilization, continue to push health care cost trend lines above the 20% mark.



GRAPHIC BY CYNTHIA WATSON

Managing mental health costs

A comprehensive approach is regarded as most effective for treatment and cost control

By JOANNE WOJCIK

Finding a solution to the problem of skyrocketing mental health and substance abuse treatment costs is proving maddening for many employers.

They are faced with a plethora of products—like employee assistance programs, mental health preferred provider organizations and psychiatric utilization review—that promise to control costs.

However, none of these products, if used alone, will prove very effective in managing employers' mental health and substance abuse expenditures, experts say.

Rather, they advocate a fully integrated managed care approach to mental health care.

A comprehensive managed mental health care program should include coverage for both inpatient and outpatient treatment, utilization management, an EAP serving as a gatekeeper and some kind of preferred provider network, said Robin B. Weiner, a managing consultant in the Los Angeles office of A. Foster Higgins & Co. Inc.

"The basic plan design should acknowledge mental health and substance abuse as distinct elements with their own unique set of controls" by establishing separate copayments and coverage limits, said Ms. Weiner.

The ideal managed mental health care program should provide employees with easy access to care through a gatekeeper who is skilled not only in directing treatment, but also in managing costs, explained Jack Mahoney, a consultant with Hewitt Associates in Rowayton, Conn.

Employees should be able to access the managed care system through a toll-free phone number or a worksite EAP, suggests David J. McDonnell, president and chief executive officer of Preferred Health Care, a managed mental health care firm in Wilton, Conn.

Other components of managed mental health care include utilization review, admission precertificaton, concurrent review—all of the sundry elements of medical case management—mental health care experts say.

A quality assurance program also is essential to an effective managed mental health care program, according to Kristin Kopinski, a consultant with Alexander Consulting Group's Health Strategies Group in San Francisco.

Services that should be covered under a managed mental health care plan include: crisis intervention; counseling on family problems; stress; life crises like death or divorce; chemical dependency rehabilitation; and treatment of serious psychological conditions like depression and schizophrenia, experts believe.

A comprehensive managed mental health care program also should provide mental health and substance abuse education to employees and training to supervisors, said John Bunker, a consultant with The Wyatt Co. in Washington, D.C.

Some programs also should be able to provide performance guarantees, he said, either through a fully at-risk or risk-sharing contract.

A managed mental health care program also should have the capability to adjudicate and pay claims, said Eugene D. Hill, president and chief executive officer of U.S. Behavioral Health, a subsidiary of Travelers Corp. in Emeryville, Calif.

"A good managed mental health care program should do more than just identify problems. It also should continue to be involved in the case by monitoring care," said Mr. Hill.

> *'A good managed mental health care program should do more than just identify problems. It also should continue to be involved in the case by monitoring care.'*
> ***— Eugene D. Hill***

Robert Belchick, director of marketing for California Psychological Health Plan in Los Angeles, agreed. "It's not good case management if someone is being treated more than once for the same condition," he said, referring to employees who are recirculated through substance abuse treatment programs after they "fall off the wagon."

"Monitoring should continue almost indefinitely," Mr. Belchick said.

The need for managing mental health care expenses is greater than ever, experts say.

Indeed, the cost of providing mental health and substance abuse benefits rose 18% to $244 per employee on average in 1989 from $207 per employee in 1988, according to Foster Higgins' 1989 Mental Health and Substance Abuse survey (*BI*, Feb. 19, 1990).

This follows a 27% surge in the cost of mental health and substance abuse benefits between 1987 and 1988, the survey noted.

And, among employers with more than 5,000 employees, mental health and substance abuse costs shot up 47% to $297 per employee on average from $202 the previous year, the survey showed.

Large employers' mental health and substance abuse costs comprised 10.8% of their total health care plan costs in 1989, up from 8.7% in 1988, the Foster Higgins survey pointed out.

Part of the reason mental health and substance abuse costs are greater for large employers is that more small employers have insured health care plans, which have been more aggressive in managing mental health claims. In addition, larger employers are more likely to offer EAPs, which tend to increase

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Health renewals

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medical costs, according to Wyatt's Mr. Grass.

New research into the disease and longer life spans for AIDS patients are fueling national health care cost trends, he said.

However, Mr. Gibson said AIDS is having less of an effect than in previous years "primarily due to the fact that insurers are relying on actual AIDS experience as opposed to early catastrophic projections."

Early predictions put the medical bill for each case at about $200,000.

"We're seeing significant bills for AIDS, but they are in the $50,000 to $60,000 range," Mr. Gibson said.

Health care providers themselves are major contributors to rising health care cost trends, asserts Mr. Grass. "The medical professional doesn't play by strict supply and demand laws."

Because of the competition among health care providers in some locations, they often supply more services than are needed based on the community's size, Mr. Grass explained.

"It's not uncommon for a small community to have two hospitals that can perform heart transplants —even though it's not necessary that both hospitals have this capability," he said.

Also driving up costs is that fact that administrative expenses associated with managed care and flexible benefit programs are higher than they have been in the past, said Mr. Johnson. Benefit plan administration costs previously totaled about 6% to 10% of overall plan costs. "Now administrative costs are closer to 20%," he said.

Unbundling and upcoding of medical procedures also drive up costs, Mr. Johnson pointed out.

'It's not uncommon for a small community to have two hospitals that can perform heart transplants—even though it's not necessary that both hospitals have this capability,' Wyatt's Tom Grass explains.

All these factors are responsible for keeping aloft premium increases for traditional indemnity and managed care plans.

"For our insured business, we're seeing trend increases of 19% to 21%, and the premium increases we ask will follow those," said William Caulfield, senior vp for John Hancock Mutual Life Insurance Co. in Boston.

But, he said, "where we have had the opportunity to put in our own managed care—which for us means Cost Care—we're seeing increases as much as 10% less."

Hancock acquired Huntington, Beach, Calif.-based Cost Care Inc. last June (*BI*, June 11, 1990). The company provides cost containment services, including utilization review and case management, to Hancock policyholders.

Philadelphia-based CIGNA Corp.'s trend factor increased to 23% from 22% for mid-year renewals, said Joe Fitzgerald, senior vp of finance and chief financial officer.

"Unfortunately, I don't really see anything at this point that will mitigate the indemnity trend of 20% plus," Mr. Fitzgerald said. "That is the reason why more and more employers will go to managed care sooner or later."

Annualized increases for indemnity and managed care plans are 15% to 25% for most customers of Aetna Health Plans, said Charles T. Bell, senior vp-marketing for the Aetna Life & Casualty Co. unit in Hartford, Conn.

The renewal rate Phoebe Home Inc. is being quoted for its indemnity plan are in line with the rates quoted by most major group health insurers.

The Allentown, Pa.-based home for the aged is expecting a 25% to 30% increase in its rate when it renews its Blue Cross/Blue Shield plan in November, said John Herbster, director of human resources.

The nursing home employs 440 full- and part-time employees. About 11% of its annual operating budget—$1.4 million—now goes toward health care.

"We are looking at some alternatives" to help manage costs, Mr. Herbster said.

For example, the company is considering carving out doctor visits, surgeons' services and related physician services and entering into a PPO agreement with a regional medical center in the Allentown area.

However, some employers are finding deals.

ARA Magazine & Book Division Inc. in Los Angeles renewed its major medical plan, underwritten by Chicago-based CNA Financial Corp., at the same rate as last year.

But "this year is an aberration," conceded Bruce Lacey, vp of finance and administration.

He noted, though, that ARA's indemnity plan premiums over the last five years have increased 12% to 15% annually, which is below average for indemnity plans.

During that period the company did not significantly change the design of its health plan, but it has raised deductibles and established stiffer penalties for not complying with utilization review requirements, he said.

Insurers say indemnity plan cost increases depend on the level of a plan's built-in cost controls.

Travelers Corp. intends to raise premiums about 23% to 26% for indemnity plans with no cost controls, said Paul Glover, senior vp of managed care and employee benefit operations for the Hartford, Conn.-based insurer.

Rates for plans with utilization review or some other cost controls will increase 21% to 22%, he said. And increases for plans with PPOs will average between 16% and 19%, he said.

"Our PPO trend assumptions and rate increases are coming in at about 18% on average," said James Galasso, vp and actuary in the group life and health department of New York-based Metropolitan Life Insurance Co.

However, "while we're seeing a meaningful slowdown of costs when we implement a PPO, when it comes to trending it's not much different than indemnity plans," said Norman Bruce, senior vp at Pro America Network Inc., a Fort Worth, Texas, PPO.

Overall, HMO plan cost increases are averaging five to 10 points below indemnity plan increases, HMO executives say.

"The cost trend for heavily managed plans is 15% or lower," said William McGuire, president and chief executive officer of United HealthCare Corp. in Minnetonka, Minn. Increases throughout United HealthCare's HMO network are averaging between 11% and 16%, he said.

The average increase for U.S. Healthcare Inc. members will be 14%, said Costas Nicholaides, executive vp and chief financial officer.

The Blue Bell, Pa.-based HMO, which is the fifth-largest general service HMO in the nation based on 1.1 million members as of June 1990 (*BI*, December 1990), already has filed for an 8% premium increase in New

Continued on page 6

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Health renewals

Continued from page 4
York and a 7% increase in Pennsylvania, he said.

Some single-digit increases are expected at Blue Cross & Blue Shield Assn., which operates the second-largest network of HMOs in the nation—encompassing 4.8 million members.

"Our estimate for HMOs—and it probably applies to point-of-service plans as well—is most increases will fall between 9% and 14%," said Richard A. Maturi, executive director of managed care programs for the BC/BS Assn. of Chicago.

Point-of-service plans allow a covered life to obtain care from non-HMO providers for reduced benefits and higher costs.

Mr. Maturi said the Blues' HMO rate increases are getting lower because "the changes put in place have worked to dampen the medical expense trend, and the losses of the late '80s have been made up."

Members of the Group Health Cooperative of Puget Sound, a Seattle-based HMO, will face 14% premium hikes on average, said Peter Brumleve, group vp-marketing. "Compared to a year ago, that's a couple of points lower, and we see a continuing down trend."

Fountain Valley, Calif.-based FHP Inc. is "trying to be as conservative as possible" with midyear HMO renewals, said Guy Gullino, vp of sales. Mr. Gullino expects that rate hikes will range from single digits to the low teens.

Not all companies will be so fortunate.

For example, at Fort Wayne, Ind.-based Zollner Corp., which offers its 890 employees a choice between a traditional indemnity plan and an HMO, HMO premiums will increase about 20% while its indemnity plan rate will remain stable, said Tom Abbott, director of human resources.

Zollner has a minimum premium indemnity plan arrangement with Lincoln National Corp. of Fort Wayne, which also operates the HMO.

Community rating is partly to blame for the high HMO renewal rate, Mr. Abbott said. He noted that he is working with Lincoln National to convert Zollner's HMO rating to experience rating.

Lincoln National would not comment on the increase.

Consultants point out that HMO pricing often is driven by different factors in different markets.

For example, "if there is a pricing war in a particular area, HMOs will cut prices rather than base prices on actual experience," explained Tom Billet, a principal with A. Foster Higgins & Co. Inc. of New York.

Two California-based HMOs contacted by *Business Insurance* are experiencing a modest upswing in medical costs that will be reflected in their mid-year renewals.

"Costs are starting to head up again compared to six months ago," said Dave Helwig, senior vp and chief actuary of Blue Cross of California in Woodland Hills, Calif. Those increased costs in part are due to increased inpatient hospital claims, he said.

Premiums for BC of California HMOs will increase between 12% and 15%, while PPO members' premiums will increase 17% to 19%, Mr. Helwig said.

The Kaiser Permanente Medical Care Program is still "playing catch up with health care cost inflation," said Dick Anderson, vp of medical economics and statistics for the Oakland, Calif.-based HMO. Kaiser HMO members' premiums will increase 15% at midyear, he said.

"We are trying to adjust to what was an extraordinary period of three years of premium increases that weren't really enough to provide for our capital needs," Mr. Anderson said.

Kaiser's membership grew by 615,00 in 1989 and 275,000 in 1990, following several years of low rates, Mr. Anderson explained. Now Kaiser is raising premiums to beef up its capital reserves.

Meanwhile, self-insured employers can expect the same level of increases as insured indemnity plans, consultants say.

Insurance companies with administrative-services-only contracts that Noble Lowndes surveyed "have assured us that the same trends are being used (by self-insurers) as for insured plans," said Ms. Zicker.

The benefit-financing mechanism "has less to do with trend than the type of benefit plan design," she said. Self-funded plans with managed care components will experience lower increases than self-funded traditional indemnity plans, she said.

Though more employers are turning to managed care, experts predict that most insured employers will continue to see double-digit increases in health care coverage costs throughout the decade.

However, increases in the 1990s are not expected to reach the size of those experienced in the mid- to late '80s because insurers and HMOs better understand the underwriting cycle, they said.

"In the last cycle, we had a market that was over-optimistic" about savings resulting from using HMOs and hospital inpatient cost controls, Mr. Maturi of the BC/BS Assn. said. "People got caught in the whipsaw of increasing utilization of outpatient services."

But, "if we don't see a lot of volatility in the market and can hold to managed care trends and lessons," rate increases should taper off, he said.

Employers will continue to embrace managed care as their primary strategy for controlling rising health care costs, Mr. Billet predicted.

He also said employers will find it easier to implement managed care plans as insurer-sponsored networks and independent networks expand their territories so that employees in all areas of the country can be covered.

"Employers are looking at managed care not solely as an offensive strategy but as a defensive strategy," observed Ken Sperling, a consultant in the Rowayton, Conn., office of Hewitt Associates.

If an employer does not embrace managed care, its indemnity plan will increasingly experience cost shifting because so many other employers will have turned to managed care, he said.

However, some insurers feel they are unfairly blamed for not better controlling health care costs.

Employers "seem to buy into the concept of a good, solid primary care network," said Al Wagner, vp and director of group managed health care at Mutual of Omaha. "Then, about the time you tell them that they cannot have 40% or 50% of the doctors in the community in the network," they change their minds because they are afraid to limit their employees' choice of physicians, he said.

However, others point out that some employers that would like to implement managed care networks are unable to do so because of where their employees are located.

"A phenomenon a number of companies are realizing is that if they have gone to rural locations to bring down operating and salary costs, they don't have the competitive environment necessary to negotiate (health care) discounts," CIGNA's Mr. Fitzgerald said.

Consultants and insurers say there are other options available to help employers control rising

Continued on page 10

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Opinions

Managed care at risk

GROUP HEALTH CARE plan provisions that financially penalize employees for failure to comply with utilization review procedures are in danger if a trial court ruling is upheld.

A U.S. District Court judge in Philadelphia ruled earlier this year that imposing penalties on group health plan members who fail to obtain precertification when the treatment is later found to be medically necessary violates public policy because the penalties are arbitrary and capricious. Such penalties also violate the fiduciary duties imposed by the Employee Retirement Income Security Act, the judge held (see story, page 1).

The defendant in the case, Bethlehem Steel Corp., penalized employees 30% of otherwise recoverable benefits for failure to obtain precertification of medical procedures.

Bethlehem Steel, which is appealing the ruling to the 3rd U.S. Circuit Court of Appeals in Philadelphia, argues that the precertification requirement is not arbitrary and was adopted to reduce the chance of employees receiving unnecessary medical care.

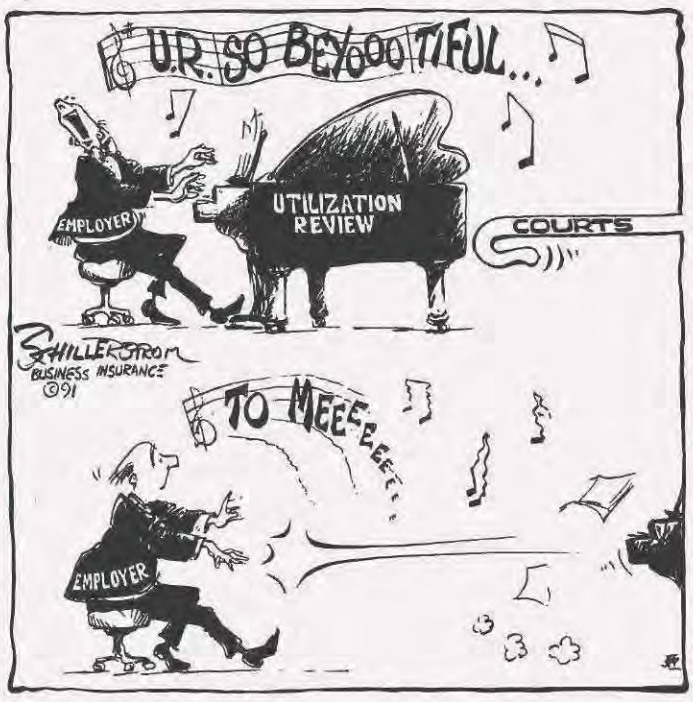
This is only one trial court ruling. But if it is upheld, the decision could invite litigation nationwide by employees denied full coverage of health care claims because they failed to comply with precertification requirements or other cost containment provisions contained in health care plans.

One benefit plan expert suggests that instead of imposing a percentage reduction in benefit recoveries for failure to comply, employers could deny all coverage to employees who fail to comply with utilization review procedures. We're not sure even that provision would have been upheld by this judge, who based his ruling in part on state insurance law.

What the judge did not comment on—and, we suspect, failed to consider—is that a procedure later deemed medically necessary may not have been the only effective treatment.

The judge reasoned that if under state insurance law a property/casualty insurer cannot deny coverage for a claim on the grounds of late notice unless the insurer was somehow prejudiced by the late notice, the group health care plan cannot reduce coverage for a medical claim deemed later to be medically necessary. It's an interesting, but counterproductive, analogy.

What the judge failed to comment on in his ruling—and, we suspect, failed to consider—is that a procedure can be deemed medically necessary after the fact, but may not have been the only effective treatment for the illness. Perhaps in this case the necessity of the treatment was so apparent that the judge could not imagine other cases in which other



patients could have obtained less costly methods of treatment than what was ultimately given.

If the courts decide to remove penalties for failure to comply with utilization review requirements, it will be more difficult for employers to convince employees to seek precertification for medical procedures. And, that will certainly be to the detriment of employees covered by the plan.

Employees who don't seek precertification will lose the opportunity to consider alternative methods of treatment for their illnesses. The employee could well prefer the alternative—for example, if it avoided surgery—if he or she were informed that it existed.

Furthermore, the fewer employees that participate in precertification of treatment and other managed care plan techniques, the less effective will be the so-called sentinel effect of these plan provisions. Doctors who have no one looking over their shoulders often are less concerned with the cost of medical care than those in contact with utilization reviewers.

And, for all employees, if the effectiveness of managed care techniques is hobbled, precious group health plan dollars will certainly be misspent on unnecessary, or unnecessarily expensive, medical care. That will leave fewer dollars available for necessary care.

Employers will not continue to pay unlimited increases in the cost of group health care plans. The corporate owners—be they individuals or shareholders—will not tolerate it.

If the courts eliminate the penalties in group health care plans for failure to comply with utilization review procedures, ultimately employees will be saddled with paying more for their health care plans.

We trust that numerous employer groups and utilization review firms will join in fighting this ruling. They must.

Letters

Congratulations from the 'hot potato' lawyer

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

To the editor: It was with sincere pleasure that I read the articles awarding Arnold L. Davenport the Risk Manager of the Year Award (*BI*, April 29).

Having had the opportunity to work with Arnie on a few matters as outside counsel for Marriott Corp., I have truly learned the meaning of an "open-door" policy.

He could write the book on it.

Even more interesting was reading "Hot Potato Suit Steams Davenport," since I was the counsel who defended the case. It by far was one of the more absurd product liability claims ever.

Our best to Arnie Davenport and all of the other winners for the superb job they're doing.

Walter A. McClatchy Jr.
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SUBSTANCE ABUSE IN THE WORKPLACE— THE VOICE OF EXPERIENCE.

Part of an ongoing series of conversations between Argonaut Insurance Company, our clients and their brokers, dealing with issues important to their business. The intent is to keep the lines of communication open. We invite your participation.

THE PARTICIPANTS: **MARK A. MARIANI,** *Owner and President of Mariani Packing Company, a leading processor and distributor of dried fruits.* **BOB APPLEBY,** *Woodruff Sawyer & Co., Mariani Packing Company's broker.* **STEVE LA SHIER,** *Senior VP Safety Management, Argonaut Insurance Company.* **JOE SILVA,** *Executive Safety Management Consultant, Argonaut Insurance Company.*

MODERATOR First of all, how many employees do you have?

MM: About 225. Approximately 40 are salaried and the balance hourly.

MODERATOR And how many facilities do you have?

MM: We have three full time facilities, primarily processing plants. San Jose is the final packaging facility.

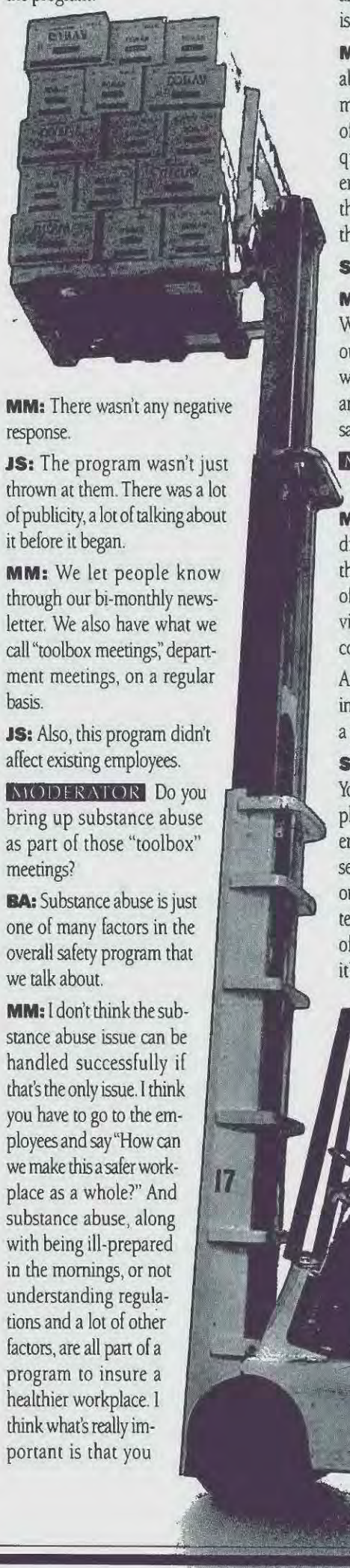
MODERATOR You've had a substance abuse program in place for about 18 months. Tell us about it.

MM: Our program is very simple. Every new employee is to be tested. Part of the program is the knowledge that if someone wants to work here, they will be tested. Upon the completion of those tests they either will or will not be eligible to work here.

MODERATOR What motivated the program? Did you have an internal problem, or was it just the realization that substance abuse is a growing problem in general?

MM: We didn't have a problem. I think there was an awareness at the management level within the company that we can't put our heads in the sand and think that we're not affected by drugs in the workplace. The other issue was that we found it was the newly hired employees that were being hurt on the job. They would come on for ten days, two weeks, then get hurt and go on workers' comp or disability. Pre-testing was one component of an overall effort to identify and correct the causes of injuries in the workplace.

MODERATOR What kind of reaction did you get from the employees when you told them you were going to initiate the program?



MM: There wasn't any negative response.

JS: The program wasn't just thrown at them. There was a lot of publicity, a lot of talking about it before it began.

MM: We let people know through our bi-monthly newsletter. We also have what we call "toolbox meetings," department meetings, on a regular basis.

JS: Also, this program didn't affect existing employees.

MODERATOR Do you bring up substance abuse as part of those "toolbox" meetings?

BA: Substance abuse is just one of many factors in the overall safety program that we talk about.

MM: I don't think the substance abuse issue can be handled successfully if that's the only issue. I think you have to go to the employees and say "How can we make this a safer workplace as a whole?" And substance abuse, along with being ill-prepared in the mornings, or not understanding regulations and a lot of other factors, are all part of a program to insure a healthier workplace. I think what's really important is that you have to deal with the well-being of the workplace as a whole.

SL: That's exactly how you should approach it. The successful substance abuse programs are the ones that have dealt with it just as you have—as a safety and health issue.

MM: I think it's interesting that while an abuse program has to be orchestrated by management, it also has to have the support of employees. We just finished tabulating a questionnaire we passed out among our employees. One of the questions was how they felt about drug testing. Over 98.6% of them said "We want drug testing."

SL: 98.6%. That's an impressive figure.

MM: We don't feel we're here to be the police. We're here to provide a safe environment for our working community. We're 225 people who spend nearly ½ of our lives together, and we'd better work as a community for the safety and well-being of all of us.

MODERATOR Why did you put out the questionnaire?

MM: We wanted to ask them "Do you think drugs should be in our workplace? Do you think our equipment operators and drivers of our vehicles should be drug tested to provide a safer work environment for all the community members?"

And 98.6% said yes, we want testing. I intend to take that response and implement a program for random drug testing.

SL: What you're doing now is not random. You're talking about a specific class of employees—equipment operators, forklift drivers—people that have the capability of doing serious damage to your plant, to themselves or other employees. Courts have upheld that testing an entire class of employees, because of their job function, is legal. Especially if it's demonstrated that their job is safety related. And if you structure your program properly, you'll find that as long as you test every single person in that class, you won't be labeled discriminatory. Now, I always recommend that customers pass their programs through a labor attorney.

JS: They're testing a specific group for safety related reasons.

SL: Right. That's not random. You're specifically testing all the workers in a clearly defined group. What you're doing is called "periodic and intermittent" or "routine" testing of that job class.

MM: I was ahead of myself when I said random. I should have said that we are classifying 'safety-sensitive job descriptions' and that we will be having unscheduled testing of workers in those classifications. Again, the process as we see it is first having the mandate by our community, developing the criteria, and rewriting our policy handbook. Then we'll have everyone tested in those classifications. And we'll tell them that if they're going to continue to be a forklift driver for us, we'll be routinely testing them.

98.6% of our employees said "Yes, we want drug testing."

JS: If I could interject something here; the questionnaire that Mark is talking about addressed much more than just substance abuse. It covered a wide variety of issues. Substance abuse is not being singled out, it's being incorporated into the overall management concerns.

BA: What Joe's saying is important. If other companies are going to follow our example, I think it's very important that they look at substance abuse as a *component* of any safety program and not make it the only issue.

Continued next week

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

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Health renewals

Continued from page 6
health care costs.

For example, many employers are looking to better manage their mental health and substance abuse benefits to squeeze additional savings from their health care plans (see stories beginning on page 3).

The trend for mental health and substance abuse benefits is higher than the trend for regular medical benefits, Prudential's Mr. Maginnis explained. As a result, "employers are carving out mental health and substance abuse benefits and managing them separately through an organization that is hired to exclusively manage those benefits."

"Micro-managing care or carving out particular coverages like mental health and prescription drugs does work toward bringing down the total expense bubble as opposed to splitting it through cost sharing," said Barry Schilmeister, a consultant with TPF&C, the benefit consulting arm of Towers, Perrin, Forster & Crosby Inc. of New York. And, "if a company isn't ready for managed care, this is a great place to start out," he said.

Mail-order drug programs that focus on maintenance medications can produce significant savings, particularly for employers with an older workforce or a large retiree population, Mr. Schilmeister said. Elderly employees and retirees often consume a large amount of maintenance medication for health problems like heart disease or diabetes. "Even though maintenance drugs may only account for one-fourth of your prescriptions, they can add up to 70% of your prescription costs," he said.

In addition, more employers are investigating employee assistance programs. "Employers are looking at ways to put a filter in front of an episode," Aetna's Mr. Bell noted.

Employee education and wellness programs also help control annual increases, experts say.

"There will be more faith in wellness programs—particularly for companies with low turnover," predicted John Hickey, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

Other consultants point out that many employers are leery of implementing wellness programs because they are unsure that the benefits will outweigh the costs.

Some observers say employees should be made more responsible for the health care they consume.

Employers must build "more incentives into plans for insureds to do the right thing," said Dick Neil, senior vp at The Principal Financial Group in Des Moines, Iowa.

Some of Principal's clients are building in per-event deductibles rather than per-plan-year deductibles to encourage employees to be more conservative in the use of health care benefits, he said. ■

Substance abuse best treated by tailoring amount of inpatient care

By SARA J. HARTY

Treating employees with a substance abuse problem no longer means an automatic 28-day stay in a costly—and perhaps inappropriate—inpatient facility.

That's good news for the employer footing the bill, as well as for employees trying to beat an addiction, experts say.

Traditionally, the model treatment for substance abuse included an automatic 28-day inpatient stay, explained John Bunker, a consultant in Washington, D.C., with The Wyatt Co. Clinicians, however, "would argue that many people do not need to be in that environment for that period of time," he said.

Using different levels of care suited to individual needs is now considered more appropriate, said Mr. Bunker.

Some substance abusers do require acute inpatient care, he said. But many can be successfully treated when hospitalized only from 9 a.m. to 5 p.m. daily, or in outpatient settings that can range in structure and intensity.

For years different levels of care have been used to treat substance abuse, said Mary Ellen Weber, a consultant with the managed care program at the Blue Cross & Blue Shield Assn. in Chicago.

What has changed is that insurers will now reimburse for those other levels, she said.

Outpatient care is much cheaper than inpatient treatment of substance abuse, pointed out Dr. Richard Kunnes, chief operating officer at U.S. Behavioral Health, a Travelers Corp. unit in Emeryville, Calif.

"The patient needs the greatest range of options or you end up with second-rate care, which also ends up costing more," said Dr. Kunnes.

"There's too much debate about whether inpatient or outpatient is better. The focus should be on getting what's right for the employee," said Dan Kidd, a regional vp at Comprehensive Care Corp. and administrator of CareUnit Hospital in Cincinnati.

He compares choosing inpatient or outpatient care to choosing between a hospital or doctor's office. "We do need both" for comprehensive substance abuse treatment, Mr. Kidd said.

A standardized set of clinical criteria is available that spells out "very meticulously what level of care the patient can best be served at," said Steven L. Ruohomaki, director of clinical services at Parkside Medical Services Corp. in Park Ridge, Ill.

Those criteria are advocated by the National Assn. of Addiction Treatment Providers. They assess the individual medically, psychologically and socially and measure the potential for relapse as well as the amount of resistance to treatment, Mr. Ruohomaki said.

Outpatient services, for instance, are appropriate for people who have some degree of motivation for treatment and whose medical condition does not require hospitalization, he explained.

Inpatient services, on the other hand, are useful for patients who require 24-hour supervision, he said.

Patients with psychiatric complications that impede general life responsibilities may be better off with inpatient care, as would those who strongly deny having a problem or those who strongly resist treatment, Mr. Ruohomaki noted.

Even those who need inpatient treatment of substance abuse rarely need a full 28 days, he said.

Continued on page 12

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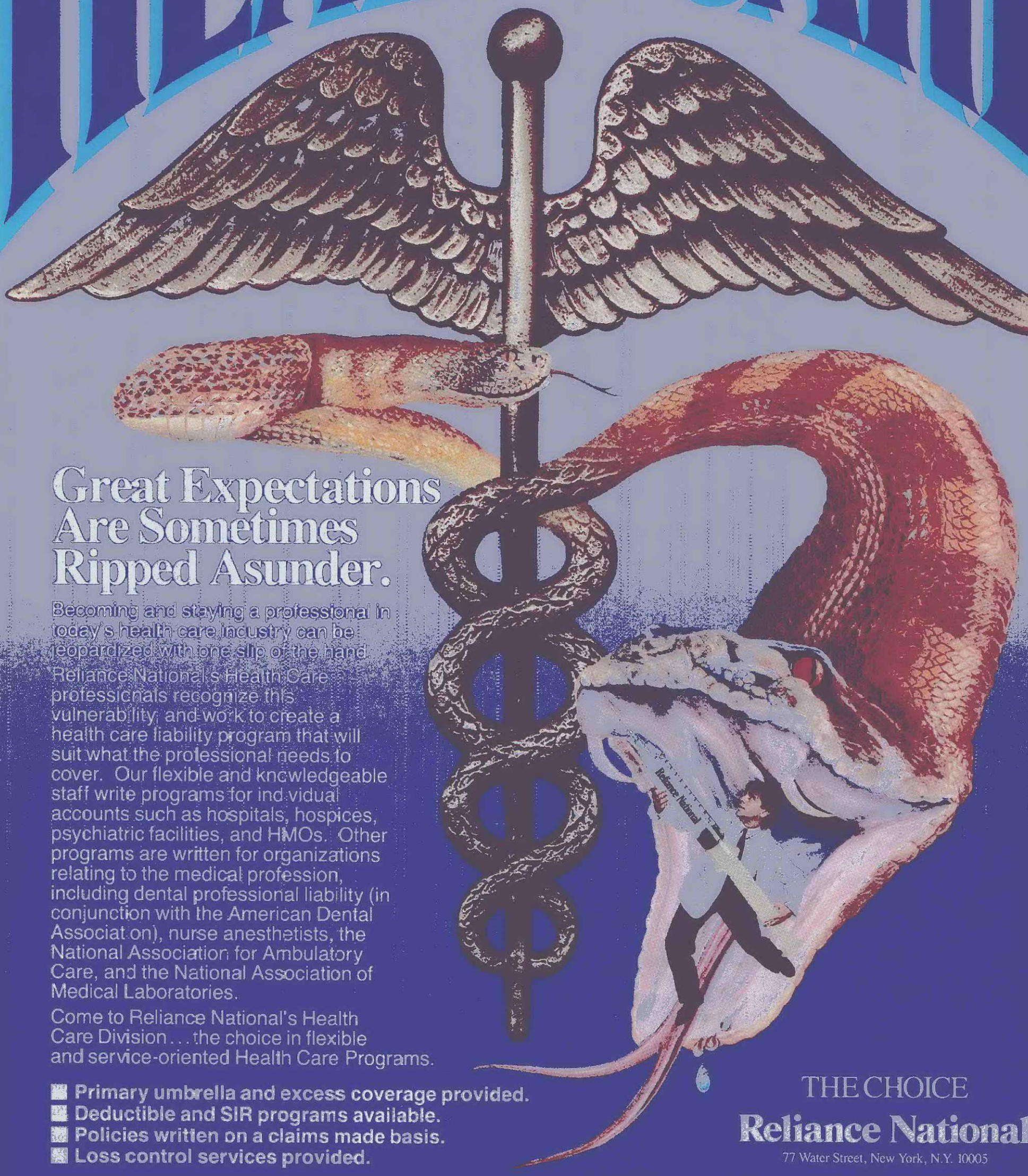

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Substance abuse

Continued from page 10

Likewise, it is not uncommon to recommend that a patient receiving outpatient care be moved to an inpatient level, he added.

It is important that patients' living environments be at least somewhat supportive of their efforts to recover, Mr. Ruohomaki said.

The day-to-day stresses of daily living are among the many causes of substance abuse, pointed out Dr. Kunnes of U.S. Behavioral Health. An artificial setting—like inpatient care—does not teach the patient the needed coping skills for daily living, he said.

In addition to matching treatment levels to the illness, easy access to the mental health care system is critical, Dr. Kunnes said. "That's cost-effective," he said, noting that making access easier can lead an employee to seek treatment earlier.

Early treatment of substance abuse helps avoid workers compensation claims, gets the employee back to work as early as possible and avoids more serious medical and surgical problems of the liver, pancreas and gastrointestinal destruction, Dr. Kunnes said.

Employee assistance programs can help to identify substance abuse at an earlier stage, he said.

Since an EAP "provides services that are not specifically drug-related," employees may turn there first for advice on problems that are in fact caused by substance abuse, Dr. Kunnes pointed out.

An EAP "must be able to deal with the full spectrum of problems of living," agreed Deborah Lewis, assistant vp and national employee outreach program practice coordinator with Alexander & Alexander Consulting Group Inc. in Westport, Conn.

For instance, an employee who is spending large amounts of money on drugs may seek help from his or her employer's EAP for ensuing financial problems. This increases the chances of the employee eventually getting help for the real problem, she explained.

The acronym EAP can also be thought of as "Easy Access Program," Ms. Lewis suggested.

However, some employers are needlessly wary of the cost, experts say.

"There is no such thing as an employer too small to afford an EAP," said Dr. Ronald Geraty, president of Assured Health Systems Inc. in Burlington, Mass.

Small employers should consider forming small employer consortiums that could be served by one EAP, he said.

The Corporation Against Drug Abuse, a Washington, D.C., coalition of businesses, health organizations and universities, recently founded just such a group, said Susan Berger, president of the group's small employer consortium.

CADA provides legal and human resource volunteers to answer questions that Washington, D.C.-area employers may have about drug problems in the workplace, Ms. Berger said.

The small employer coalition was formed after CADA members realized that employees working at small businesses make up a significant percentage of the workforce, and could use a program to address their problems, she said.

Member businesses will use their joint purchasing power to pay for the EAPs, creating better access for their employees, Ms. Berger explained.

Trying to save money, some employers have made the mistake of reducing or entirely getting rid of substance abuse treatment benefits, noted Suzanne Gelber, a health care consultant at TPF&C in New York. ■

Training required to spot addicts

By SARA J. HARTY

Training supervisors should be a top priority of employers that want their substance abuse program to succeed.

Supervisors need training to recognize the warning signs of drug addiction. Also, they must learn how to handle difficult situations: confronting impaired employees, referring them for treatment and setting up effective return-to-work plans.

It is very important that employers be willing to send their supervisors for some initial training, said Larry Finder, consultant for business services at the Parkside Lodge, Parkside Medical Services Corp.'s treatment facility in Mundelein, Ill.

The supervisor should be the first person to notice a problem but, without proper training, he or she will be reluctant to approach the employee, warned Ken Estes, director of communications with the Laguna Hills, Calif.-based National Assn. of Addiction Treatment Providers.

An addicted employee may deny his or her condition, but "there is denial on the part of the supervisor as well," Mr. Estes said. The result is that the supervisor does nothing and the problem gets worse, he said.

Signs of a potential substance abuse problem, expert say, include:

- Changes in personality and relationships.

A worker may be less able to work as part of a team and become more secretive and isolated, Parkside's Mr. Finder said.

- Declining work performance.

A formerly productive worker may begin to appear lazy, said Suzanne Gelber, a health care consultant in New York for TPF&C, the consulting arm of Towers, Perrin, Forster & Crosby Inc.

- Absenteeism, particularly on Mondays or Fridays.

Mr. Finder also warned of "on-the-job" absenteeism, which occurs when employees are missing during work hours because they are using or dealing drugs.

For example, an alcoholic may spend a lot of time in the bathroom or in the parking lot, said Ms. Gelber.

- Unexplained theft, especially if it is concentrated in one area.
- Unexplained accidents.

A train wreck caused by a drunken engineer is the classic example, Ms. Gelber said.

- A sudden increase in workers compensation claims.
- Sudden bursts of hostility and abusiveness.
- Violence of any kind in the workplace, including fights or the use of weapons.

"It sounds crazy, but it happens," said Ms. Gelber.

After warning signs have been noted, the employer should not put off taking appropriate action, Mr. Finder said.

However, the action that employers typically take in these situations is "very different from what needs to be done," he cautioned. The employee doesn't need time off at this point, which is a common response, he said.

The key is making the employee feel the consequences of his actions, rather than helping him to

Continued on next page

Are All Workers Compensation Provider Bill Audits The Same?

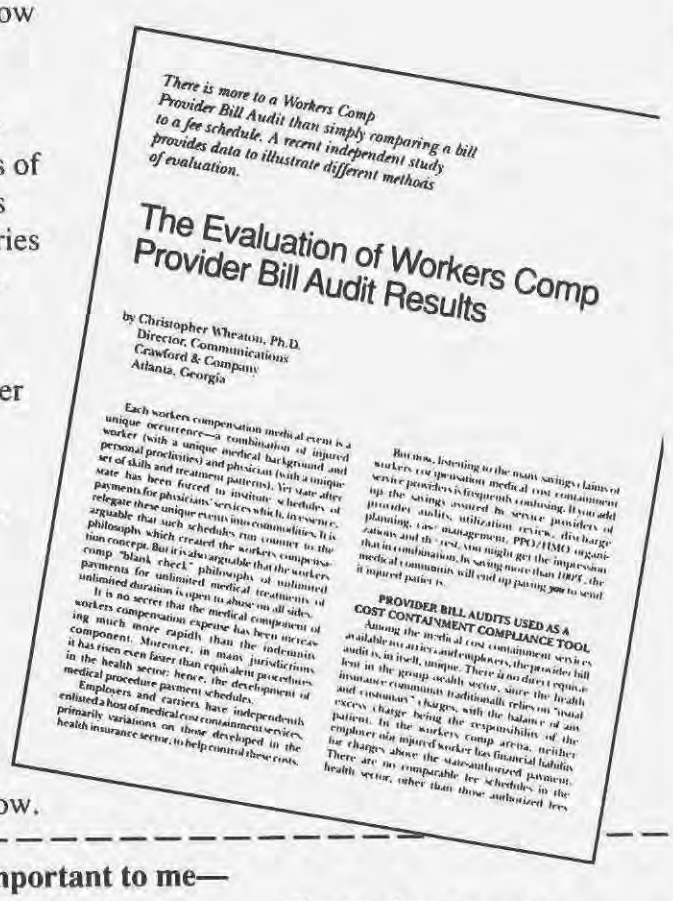
A Newly Released Study Says "No"

An independent research firm recently sent photocopies of the same 156 medical bills to 5 different vendors of fee schedule provider bill audits. Each vendor's performance was tracked and compiled in a side-by-side comparison that's yielded some surprising results.

These results are the basis of an important new report that's now available free of charge from Crawford & Company.

Among its findings, the report reveals that provider bill audits are not a "commodity service"—the quality and effectiveness of these audits varies dramatically depending on which vendor is reviewing the bills. The report backs up this finding with a series of charts that compare vendor performance in areas such as...

- TOTAL REDUCTIONS—On the same bills, one vendor found reductions of just $5,206.24 while another found over twice that, producing savings of $13,837.74.
- NET PERCENT SAVED—These numbers varied greatly, from a low of 14.4% to a high of 34.8%.
- RETURN ON INVESTMENT—Returns ranged from as little as $3.50 for every dollar spent to the study's best return—$9.70 to $1.



There is more to a Workers Comp Provider Bill Audit than simply comparing a bill to a fee schedule. A recent independent study provides data to illustrate different methods of evaluation.

The Evaluation of Workers Comp Provider Bill Audit Results

by Christopher Wheaton, Ph.D.
Director, Communications
Crawford & Company
Atlanta, Georgia

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Continued from previous page
manage the pain, he said.

Mr. Finder advised that supervisors or employers should:

- "Take copious detailed, performance-oriented notes" when an employee substance abuse problem develops.

Diagnosing the cause is not an employer's responsibility, he said, but documenting the consequences is.

- Discuss the documented performance problems with the employee in a non-judgmental fashion.

"The attitude should be one of 'We don't know what the problem is but there is a serious problem,' " Mr. Finder said.

It is important for the employer to restrict its involvement to work-related issues and to refer the employee to someone qualified to handle the personal issues, he added.

Employees' reactions to being confronted will vary, according to Mr. Finder.

Once confronted, an employee may become angry and storm out of the meeting, or he may acquiesce and say, "I know I have a problem and I need to get some help," Mr. Finder said.

"Poor performance at work is often an indicator that they want help," he said.

"Part of the disease is denial and there is often a conflict within the employee," he explained.

But, if the employee will not accept a referral for substance abuse counseling then the groundwork is set for disciplinary action, Mr. Finder said.

"Employers who say, 'Get treatment or lose your job' " are helping their employees, agreed James P. Carmany, president and chief executive officer of Comprehensive Care Corp. of St. Louis. The firm provides behavioral treatment through its subsidiary, CareUnit Inc.

Experts agree that the sooner an addict seeks help, the better the chances of recovery.

Employers, of course, also stand to gain from early substance abuse treatment.

They can avoid the workers compensation claims, lost productivity and serious medical complications that can result from an untreated alcohol or drug problem, explained Dr. Richard Kunnes, chief operating officer at U.S. Behavioral Health, a Travelers Corp. unit in Emeryville, Calif., that runs chemical dependency and managed mental health care programs.

"Unfortunately, sometimes these things do go on for years," which is unhealthy for everyone, Mr. Finder said.

Addiction is "a matter of perspective," he explained.

For employers, when attendance and performance suffer it's just the beginning of the problem. But for the employee, these problems indicate that all "major life areas have been so completely affected that they can't stop the consequences from hitting the workplace," explained Mr. Finder.

Diagnosing the cause of a worker's substance abuse problem is not an employer's responsibility, says Larry Finder of Parkside Medical Services Corp. But documenting the consequences is.

Addiction affects all areas of an individual's life and the "job or work site is always the last place affected," he said.

After treatment has begun and the employee has returned to work —if a leave was necessary—there are more steps an employer can take to help the worker maintain recovery, Mr. Finder said.

"The support of the employer is one of the most significant issues in maintaining sobriety and recovery," he said.

Simply making the return possible as soon appropriate can be helpful, said Dan Kidd, a regional vp at Comprehensive Care Corp. and administrator of CareUnit Hospital in Cincinnati.

"Work provides a structured setting," he said. "Patients who are not busy tend to get in trouble," he said.

And, returning to work can help relieve financial pressures, he added.

A return-to-work contract may be the easiest way to spell out expectations to an employee. It sets out very specific performance standards for the employee's return to the workplace, explained John Bunker, a consultant with The Wyatt Co. office in Washington, D.C.

The contract will also spell out requirements for after-care programs the employee is expected to participate in and possibly set guidelines for periodic drug testing, he said.

A contract can help give focus to an employee who may not have the ideal level of personal commitment, Mr. Finder commented.

Besides setting out expectations and consequences, there are other ways that employers can show their support.

At the workplace, the atmosphere needs to be positive and free from heckling from other employees, according to Mr. Kidd.

And, by providing unpaid time off, employers can make after-care sessions easier to attend, added Mr. Kidd. ■

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Mental health

Continued from page 3
utilization of mental health care benefits, according to the survey.

The largest contributor to employers' mental health care tab is inpatient treatment, pointed out Joan Pearson, a consultant in the Seattle office of TPF&C, the benefits consulting arm of Towers, Perrin, Forster & Crosby Inc. Inpatient care accounts for 70% of employers' total mental health care costs, she said. In comparison, only 35% of employers' medical costs are for inpatient care.

In addition to the direct costs of providing mental health and substance abuse benefits, those conditions also produce indirect costs for employers, like increased medical claims, use of long-and short-term disability benefits, lost productivity and increased absenteeism, experts say.

In fact, mental health care experts estimate that indirect costs may double or even triple the total costs associated with mental health and substance abuse, said Foster Higgins' Ms. Weiner.

For example, statistics from the National Institute on Alcohol and Alcoholism indicate that 40% of all work fatalities are caused by alcoholism and substance abuse and that employees using drugs and alcohol function at only 50% of capacity at work.

In addition, accident rates are four times greater for substance abusers than for non-drug or alcohol users, and substance abusers also use five times more health and workers compensation benefits, according to Ms. Weiner.

Alcoholism alone costs the nation an estimated $85.8 billion each year in lost productivity, absenteeism, illness, premature death, road accidents, crime and law enforcement, according to the Alcohol, Drug Abuse and Mental Health Administration in Washington, D.C.

Statistics from the National Institute on Alcohol and Alcoholism indicate that 40% of all work fatalities are caused by alcoholism and substance abuse and that employees using drugs and alcohol function at only 50% of capacity at work.

Implementing an aggressive managed care approach to mental health care has produced significant cost savings for many employers.

McDonnell Douglas Corp.'s EAP-driven managed mental health care program, for example, produced a 2.65-to-1 return on its investment in 1989, a 3.48-to-1 return in 1988 and a 2.89-to-1 return in 1987, according to a study conducted by the Alexander Consulting Group.

It is estimated that St. Louis-based McDonnell Douglas will save $2.1 million in employee medical claims, $3 million in dependent medical claims and more than $900,000 through reduced absenteeism, decreased turnover and replacement labor costs over the nest four years, according to the study.

Fullerton, Calif.-based Hunt-Wesson Inc. shaved $250,000 off its mental health care budget by restructuring benefits and contracting with Managed Health Network Inc., a mental health HMO based in Los Angeles.

While expanding treatment for outpatient care, the company set up a sliding benefit scale that gradually reduces reimbursements as the number of visits increases to "wean" employees from providers.

And, under its capitated fee contract with MHN, Hunt Wesson's risk is finite.

Before implementing the managed mental health care program, Hunt Wesson found that mental health and chemical dependency claim costs generated by its Southern California employees—which represent about 15% of total health care costs—increased by 36% between 1988 and 1989, said Joe Deacon, director of benefits and special compensation.

The state of Ohio is expected to save between $4.4 million and $6.5 million in 1991 under its contract with Biodyne Corp., a managed mental health care firm based in South San Francisco, Calif.

The state's mental health and substance abuse claims costs had been rising at an annual clip of 20% to 30%, but the Biodyne contract limits those increases to 5% per year, much like the risk-sharing contract that Allied-Signal Corp. entered into with CIGNA Corp. for its point-of-service managed health care plan (*BI*, Feb. 22, 1988).

For employers that are looking to adopt a managed mental health approach, there are several models to consider, according to Dr. Michael A. Freeman, president of the Institute for Behavioral Healthcare, a think tank in San Francisco. They include:

- The EAP-driven model, which is managed by an EAP, makes assessments and evaluations, refers employees to a provider network it has created and provides follow-up counseling.
- The carve-out model, which is managed by an external vendor that, depending on the contract structure, either provides services on an administrative-services-only basis or assumes 100% of the risk, much like a health maintenance organization.
- An altered benefit design that creates incentives for more efficient mental health care utilization.
- Mental health case management, which is provided by existing medical providers for an additional per-capita fee.

In addition, employers can manage mental health care costs by contracting with a specialty preferred provider organization, suggested Suzanne Gelber, a consultant in TPF&C's New York office.

An effective provider network should provide a full array of services and include a full assortment of providers, including clinical psychologists, psychiatric nurses, psychologists, master's degree-level social workers, and licensed alcohol and substance abuse treatment counselors, according to Deborah Hirschfelder, vp-corporate account services for Personal Performance Consultants Inc., a managed mental health care firm based in St. Louis.

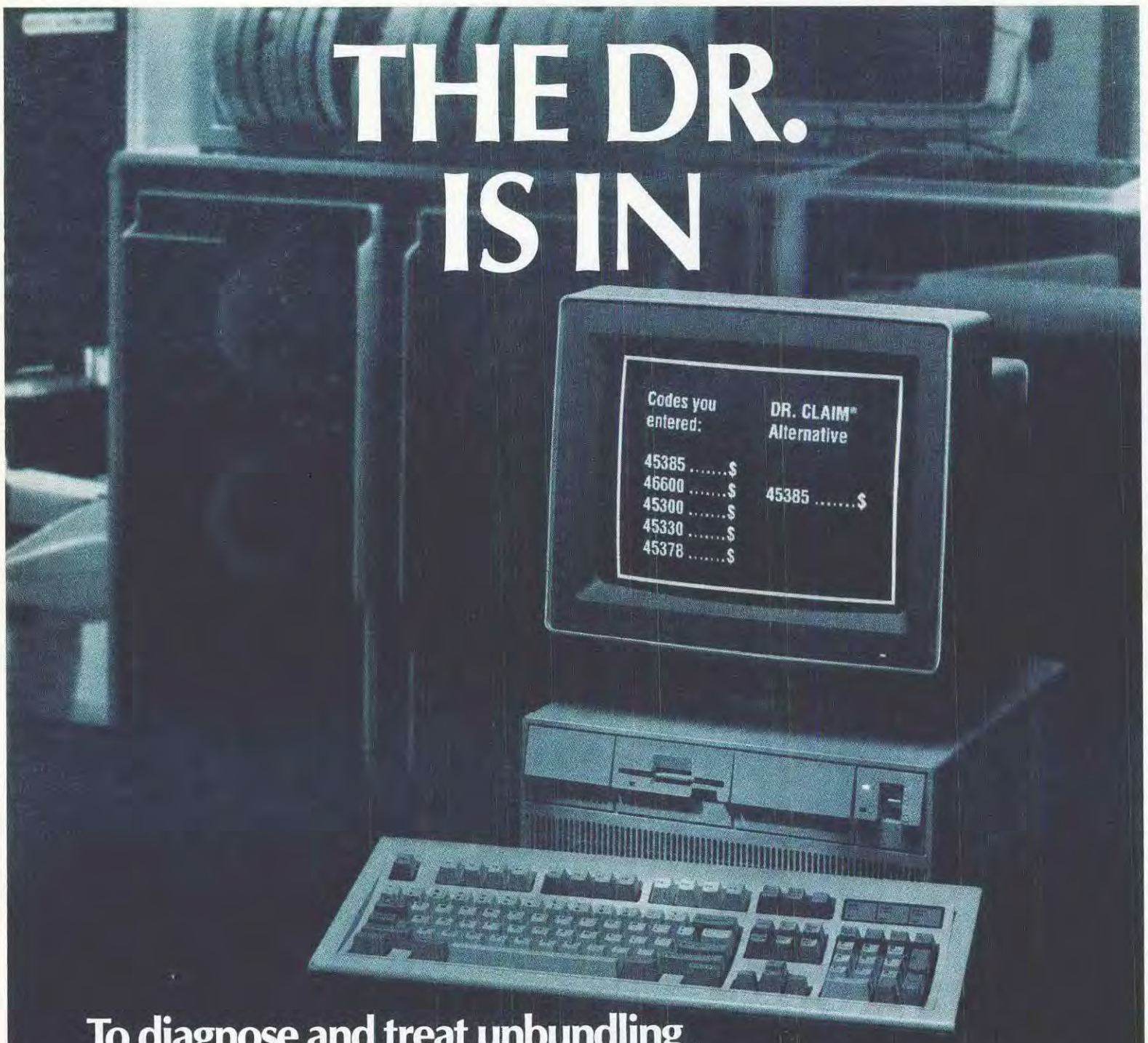
In addition, a wide variety of facilities should be included in the PPO, such as free-standing substance abuse treatment centers, residential treatment centers and hospitals, she said.

The provider that is selected to oversee the managed mental health care network should be fully credentialed with the ability to conduct sophisticated diagnostics, according to Lois Drapin, senior consultant with the National Psychiatric Alliance based in Philadelphia.

The NPA negotiates contracts with Fortune 500 companies, utilization review firms, insurers and brokers on behalf of mental health care providers.

The managed mental health care

Continued on page 18



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STRAIGHT TALK

We asked Jack Williams, the new CEO of Avesis—an ancillary managed-care benefits company formerly known as National Benefit Services—to comment on issues affecting the health care industry.

Q: Health benefit costs are going through the roof! What can be done?

A: A lot of companies will tell you, "Sure, we'll help you control costs." But very few of them can actually do it. We can. We do it by offering managed care in the area of ancillary benefits—vision, dental, hearing, pharmaceutical. For instance, if you're using another third-party pharmaceutical card program and you're *really* interested in managed care, Avesis will definitely save you money.

Q: Okay, but what about the end user?

A: Employees are getting frustrated at the way their benefit costs keep going up. Any company that can offer ancillary benefits at a lower price will offset some of that dissatisfaction. That's what we do. Our limited access PPOs have lower upfront administration fees, and reduced back-end claim costs. The bottom line is *decreased benefit costs*—and everyone comes out ahead!

Q: Is that a new idea?

A: No. We started it back in 1978! But a lot of things have changed in the marketplace—and so have we. Our new name, Avesis, is reflective of these changes.

Q: What can we expect from the new Avesis in this changing marketplace?

A: Our company is more market driven and customer sensitive. Our people are more accessible, more responsive to what customers want. And we've developed products and services for the changing environment...for example, the "graying of America."

Q: What does this demographic shift mean?

A: It means a growing need for ancillary benefits! For instance, just over 70% of the working population and 100% of persons reaching retirement age need some form of corrective vision. But fewer than 20% have vision benefits. Obviously, there's a shortfall. And if you can go to the marketplace with this benefit—at a modest cost—you've got a winner. Guaranteed!

Q: So Avesis is built around serving this need for affordable ancillary benefits?

A: Exactly. There are other companies which offer the individual components—vision, pharmacy, dental, hearing. But nobody does it all under one roof the way we do. Avesis is the only company in the U.S. that offers all these benefits on a nationwide managed care basis.

Q: And that's more convenient for your customers...

A: Precisely. You could get the individual components in different places, but Avesis offers them all...and they can be accessed with just one card! It's one-stop shopping. What people want is convenience, a quality product and a high level of service at an affordable price. And that's exactly what we offer.

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Spotlight report

'Carve-out' savings may not come cheap

By JOANNE WOJCIK

Separating mental health care from the rest of a benefit program can produce substantial savings for employers.

But there are drawbacks. Experts caution that such "carve-outs" can be more costly to administer and can severely restrict communication between providers when an employee is suffering from both a physical and psychological disorder.

Because mental health care is "an animal of a different color," it requires special handling by experts in the field, said Don McKean, national director of sales for Human Affairs International Inc., an Aetna Life & Casualty Co. unit in Salt Lake City.

Carve-outs can produce significant savings because they usually are managed by firms that specialize in mental health care treatment, said Stuart Ghertner, president and chief executive officer of one such specialist, Behavior Healthcare Options Inc. The Las Vegas firm is a subsidiary of Sierra Health Services, a Nevada HMO.

In addition, a carve-out allows a self-funded employer offering more than one plan to standardize its mental health care benefit design, he said.

Carve-outs also can reduce the adverse selection that occurs when employees who need mental health care opt for an indemnity plan over a health maintenance organization, according to Robin B. Weiner, managing consultant with A. Foster Higgins & Co. Inc. in Los Angeles.

HMOs usually have more restrictive mental health benefits than indemnity plans do, she pointed out.

Better data is another benefit for employers that carve out mental health benefits, according to John Brady, president of Psychology Systems in Milpitas, Calif. These employers "can delineate what's being spent" on mental health and substance abuse treatment, he said.

And the benefits of carve-outs are not necessarily limited to employers.

Workers who use managed mental health care programs usually make smaller copayments and seek help earlier, pointed out Ron Moreland, president and chief executive officer of Managed Health Network Inc., a mental health care HMO based in Los Angeles.

Employees often retain some freedom to choose providers. Like point-of-service HMOs, managed mental health care programs usually permit employees to use non-network providers, albeit at a reduced reimbursement rate, Mr. Moreland explained.

Carve-outs also can preserve mental health care benefits that are threatened by employer cost-cutting, according to Dr. Kenneth Kessler, chairman of American PsychManagement Co., a managed mental health care firm based in Rosslyn, Va.

"Many employers are cutting benefits to cut costs," but some well-run mental health care program can save enough to let employers expand other benefits, Dr. Kessler suggested.

Carve-outs, though, are not without disadvantages, experts warn.

They can be more expensive to administer and will require more coordination among health care providers, said Human Affairs' Mr. McKean.

For example, liver treatments for recovering alcoholics should be discussed with both the counselor and the physician, he said.

Mental health care benefits "should be integrated with the medical program because a lot of psychological conditions have medical consequences and vice versa," agreed Dr. Michael A. Freeman, president of the Institute for Behavioral Healthcare, a think tank in San Francisco.

For example, psychological counseling for depression could reduce the length of time an employee would have to spend in the hospital for a mastectomy, he said.

Integrating mental health treatment and medical treatment also can help "to make a diagnosis if an employee's other physical problems are known," said Jack Mahoney, a consultant with Hewitt Associates in Rowayton, Conn.

Carving out mental health benefits from the indemnity plan will not produce any cost savings by itself, according to Ms. Weiner of Foster Higgins.

For example, any reduced premium negotiated with HMOs usually is minimal, she said.

Carve-outs also are less successful for small employers with fully insured benefits because insurers or vendors are unlikely to cover a 250-person group that has experienced large mental health claims, according to Ms. Weiner. ■

Mental health

Continued from page 16

provider should have a sophisticated patient and payment tracking system to provide documentation of services rendered and reimbursed, she added.

The provider also should produce frequent utilization reports and analyze treatment patterns annually, said Preferred Health Care's Mr. McDonnell.

There also should be strong incentives for employees to use the network mental health care services, said Deborah Sheperis, vp-sales at Personal Performance Consultants.

"A 10% differential is not enough to force employees to use the program, especially in a highly paid white-collar environment," she said.

Ultimately, a managed mental health care program should achieve several objectives, according to Bryan Lawton, vp and director of the employee assistance services department at Wells Fargo & Co. in San Francisco.

Wells Fargo has had an internal EAP since 1986 and began contracting with American PsychManagement this year to manage its mental health care benefits.

Mr. Lawton says an effective managed mental health care program should:

- Support those who need early access to mental health care.
- Avoid cost-shifting to the medical plan.
- Ensure that treatment is provided only when necessary, to avoid abuse by employees seeking personal growth through psychoanalysis.
- Provide a high quality of care.
- Contain, if not reduce, costs.
- Use individual case management to provide richer benefits to those who need more intense care than the core package provides.
- Make employees more healthy and productive. ■

Group benefits services
can't always be programmed.

Not all firms need managed mental care

By JOANNE WOJCIK

Employers should decide whether they really need a managed mental health care plan before they invest the time and money to establish a plan, consultants advise.

Many times, simple plan design changes—like encouraging the use of outpatient treatment over inpatient care—may be all that is needed.

But if an employer finds it definitely needs a more comprehensive program to rein in mental health costs, it should proceed carefully and not expect results overnight.

"A lot of companies think they need managed mental health care, but they don't," said Joan Pearson, a consultant in the Seattle office of TPF&C, the benefits consulting arm of Towers, Perrin, Forster & Crosby Inc.

"Some employers think that if the second-largest expense item is mental health, they need a managed mental health care program. But the mental health piece may stick out because of worker demographics," said Jack Mahoney, a consultant in Hewitt Associates' Rowayton, Conn., office.

Before deciding whether to implement a managed mental health care plan, employers should conduct an audit of their mental health care claims.

To determine whether those costs are excessive, employers should compare them with relevant national norms by industry, employee population and by benefit design, advises Suzanne Gelber, a consultant in TPF&C's New York office.

Many firms feel they need managed mental health care, but they don't, says Ms. Pearson.

For example, "while five or six years ago it was considered high to have 7.5% of paid claims go to mental health care, today it's double that," said Dr. Kenneth Kessler, chairman of American PsychManagement Co. in Rosslyn, Va.

Employers also should look at medical claims that may be "masking" psychological problems, suggests Robert Belchick, director of marketing for California Psychological Health Plan in Los Angeles.

Many common physical maladies like ulcers, colitis, migraine headaches and muscle and back spasms are often linked to psychological or emotional problems.

"It has long been assumed that anxiety and stress turn up in physical ailments," said Ron Moreland, president and chief executive officer of Managed Health Network Inc. in Los Angeles.

In addition, many liver disorders can be traced to substance abuse, according to Mr. Belchick.

Employers also should audit their utilization review firm to make sure it is equipped to make judgment calls on mental health care and chemical dependency cases, according to Ms. Pearson.

Perhaps a provider audit also should be conducted to make sure the provider is prescribing the most appropriate treatment, according to Mr. Mahoney.

"Maybe managing the provider is needed" rather than a total restructuring of benefits, he said.

However, once an employer has determined that it definitely needs a managed mental health care program based on its past claims experience, it should then examine its current benefit structure to determine if it is steering employees into more expensive inpatient treatment by providing limited outpatient benefits.

For example, a plan that pays 80% of inpatient substance abuse treatment costs but has a $1,000 annual cap on similar outpatient treatment encourages employees to be institutionalized.

"Make sure employees aren't being financially penalized for seeking outpatient treatment," which typically is less expensive, said Ms. Pearson.

In many cases, "the plan design drives the patient right into the hospital, which is more expensive," said Mr. Moreland. However, "the least restrictive care setting often is best for the patient."

The next step in the process is to develop a plan for implementing a managed mental health care plan that takes into account the monetary, human, technical and space resources needed, how outside consultants should be used, what benefit structure should be employed and how providers will be held accountable, according to John Bunker, a consultant with The Wyatt Co. in Washington, D.C.

The plan also should take into account the employer's goals and objectives, he said.

For example, "is the goal to improve health, employee relations and productivity or to manage costs?" Mr. Bunker asked.

Employers also should decide whether to integrate the managed mental health care plan with its medical plan, said Kristin Kopinski, a consultant in Alexander Consulting Group's Health Strategies Group in San Francisco.

Most experts advocate separate, or "carved out" mental health care benefits (see story, page 18).

Employers also should consider various managed mental health care models before deciding the most appropriate to adopt, advises TPF&C's Ms. Gelber. For example, individual case management for catastrophic cases billed on an hourly basis may be more cost-effective than a comprehensive program that bills on a per capita basis, she explained.

"There's no point shooting a mosquito with a rifle," she quipped.

Next, employers should decide whether all or a part of their workforce will be covered by the plan, according to Ms. Gelber.

Only then can the employer send out a request for proposal soliciting vendors, she noted.

For example, if the entire workforce of a multistate population is to be covered by the plan, a provider with interstate capabilities should be selected, Ms. Gelber said.

During the vendor selection process, employers should negotiate price and performance standards, she advised.

In addition, employers should decide whether to maintain their current employee assistance plan or scrap it and purchase one from

Continued on next page

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Managed plans

Continued from previous page

the managed mental health care vendor.

"This is a big problem for many employers because many EAPs are selected and operated locally," TPF&C's Ms. Pearson pointed out. In addition, "many local offices may feel very strongly about their relationships with their EAP" and find a national EAP less personal, she said.

However, Joe Deacon, director of benefits and special compensation at Hunt-Wesson Inc. in Fullerton, Calif., feels that the EAP and the managed mental health care program "need to be married."

Meanwhile, prior to and throughout implementation of managed mental health care, employers should launch an extensive employee communications and education program to encourage employees and their dependents to take advantage of the program, Alexander Consulting's Ms. Kopinski said.

And, at the end of each year, the plan should be reviewed to determine how well the vendor met the employer's goals and to make any changes that may be necessary, she added.

But the program evaluation should not be limited to outcome measurements; it also should study the quality of care administered, Mr. Bunker advised.

If everything is going according to plan, employers should see a shift from inpatient to outpatient care, especially if the inpatient benefits were generous, according to Ms. Kopinski. In addition, group medical benefit use should decrease as more employees seek treatment in the more appropriate venue, predicts Jim Kent, executive vp and chief operating officer of Mental Health Programs Corp. in Tampa, Fla. ■

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EAP is part of managed mental care plan

By JOANNE WOJCIK

Employers who think an employee assistance program is managed mental health care should think again.

An EAP is just one component of an effective managed mental health care program, experts contend.

In addition, such a program usually acts as an employee advocate, while a managed mental health care program aims to obtain the best treatment at the lowest cost, the experts point out.

"When you buy a car, you don't just buy the tires for the car," but that's what employers who purchase EAPs without managed mental health care are doing, said Peter J. Stillman, a consultant with A. Foster Higgins & Co. Inc. in Los Angeles.

"An EAP is to managed mental health care what a primary care physician is to a medical/surgical program," said Dr. Michael A. Freeman, president of the Institute for Behavioral Healthcare, a nonprofit think tank in San Francisco.

"An EAP provides entry-level care, or the most elementary kind of care," according to John Brady, president of Psychology Systems in Milpitas, Calif.

In contrast, "the managed behavioral health concept is a whole system, it's much more involved," he said. Many employers erroneously believe that an EAP will have the same effect as managed mental health care, he added.

In many managed mental health care programs, the EAP serves as a "gateway" or "gatekeeper," according to Ron Moreland, president and chief executive officer of Managed Health Network Inc. in Los Angeles.

Robert Belchick, director of marketing for California Psychological Health Plan in Los Angeles, agreed: "An EAP is the door into the managed mental health care program, but it's not the whole program."

EAPs, for example, may provide three to five initial counseling visits that can focus on anything from job stress to financial counseling. But the program is not equipped to provide ongoing treat-

Continued on page 23

EAPs

Continued from page 20

ment for serious psychological disorders, he said.

In addition, many "EAPs are run by recovering alcoholics who are not qualified to make referrals for other psychological problems," Mr. Belchick said.

Often EAP counselors, for example, will encourage alcoholic employees to enter expensive, 28-day inpatient treatment programs because that is the program that worked for them, he said.

However, in many cases, outpatient treatment may be more appropriate, according to Mr. Belchick (see related story, page 10).

"An EAP is exactly what it stands for: An employee assistance program," Mr. Belchick concluded.

Few EAPs have the clinical psychiatrists needed to make immediate diagnoses in times of crisis, according to Joan Pearson, a consultant in the Seattle office of TPF&C, the benefits consulting arm of Towers, Perrin, Forster & Crosby Inc.

Rather, she said, they are equipped to "handle less severe problems," like helping parents communicate with reticent teen-agers.

EAPs first emerged in the 1940s as "occupational alcoholism programs" started mostly by large companies. The concept was expanded in the early 1960s to provide assistance for other problems—like marriage, family and financial difficulties —that can affect job performance.

"EAPs are oriented around maintaining the health and the productivity of employees," explained Dr. Roger Taylor, national leader of health care for The Wyatt Co. in Washington, D.C.

Indeed, according to the definition provided by the Employee Assistance Professionals Assn. in Arlington, Va., "An employee assistance program is a comprehensive worksite-based program designed to assist in the early identification and resolution of productivity problems associated with employees who are impaired or likely to be impaired by behavioral problems.

"These include, but are not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress or other behavioral problems which may adversely affect employee job performance."

In contrast, the goal of a managed mental health care program is to refer employees to the most appropriate treatment in a cost-effective manner.

Like managed medical care, managed mental health care includes utilization review, admission precertification, concurrent review, quality improvement, discharge planning and other elements of case management (see story, page 3).

The missions of the two programs are very different, according to Suzanne Gelber, a consultant in TPF&C's New York office.

While EAPs serve as patient advocates, managed mental health care providers are responsible to employers, she explained.

"EAPs have a critical role to play," said Dr. Kenneth Kessler, chairman of American PsychManagement Co. in Rosslyn, Va.

For example, EAPs do case finding—generating cases by interviewing employees after conducting a workplace seminar to see if they suffer from the problem that was discussed, Dr. Kessler explained.

"But once a person enters the managed mental health care system, the EAP's job is over," he said.

EAPs "are primarily in the referral business," said Jim Kent, executive vp and chief operating officer of Mental Health Programs Corp. in Tampa, Fla., and president of the American Assn. of Preferred Provider Organizations. "They have never been in the business of managing a benefit plan," he said.

Eugene D. Hill, president and chief executive officer of U.S. Behavioral Health in Emeryville, Calif., agreed.

EAPs are not equipped to provide ongoing treatment for serious psychological disorders, says Mr. Belchik. Many EAPs 'are run by recovering alcoholics who are not qualified to make referrals for other psychological problems,' he adds.

An EAP can be a vehicle for providing inexpensive and confidential assessment and referral to employees, but it does not follow a case the way a mental health care case manager would, according to Mr. Hill.

EAPs also are less efficient than managed mental health care plans in diagnosing problems because they often need three to five visits to make an assessment, evaluation and referral, according to Mr. Kent.

"A real managed mental health care plan will expedite the evaluation and referral process," he said.

In order to make sure their employees are receiving the most appropriate assessments and referrals, employers should select EAPs with a high percentage of practicing clinicians, suggests Robin B. Weiner, a managing consultant in Foster Higgins' Los Angeles office.

Her colleague, Mr. Stillman, agrees: "It's a touchy-feely business and employers have to be careful about the vendor they select." ■

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Spotlight report

Employee assistance plan trends

Changing demographics call for new counseling services

By DEBORAH SHALOWITZ

As notions of the "traditional" worker rapidly become dated, so do notions of the traditional employee assistance plan.

Originally created primarily to counsel workers with drug and drinking problems, EAPs are broadening their horizons considerably. More EAPs are now offering services like child care and elder care referrals; AIDS education and counseling; cultural adjustment counseling; and financial or career counseling.

Changing workforce demographics have forced the programs to expand, experts say.

"The issues that EAPs are being asked to deal with are changing," said Martha Sherwood, a senior consultant with The Wyatt Co. in New York.

"EAPs are looking at a much broader range of employee issues," observed Patricia Wiley, a managing consultant with A. Foster Higgins & Co. Inc.

Programs' "horizons have widened and will continue to widen," agreed Jack Mahoney, a consultant with Hewitt Associates in Rowayton, Conn.

Experts cite several reasons why.

Since the 1970s, there is a greater sensitivity to and acceptance of people seeking counseling, Ms. Sherwood noted. Counseling "for well people" is now accepted, and counseling itself has been popularized, she said.

Also, people are working longer hours, so they "don't have the luxury of having private time for counseling outside the organization," she added.

"In the old days, the extended family was there," observed Jesse Bernstein, president of Employee Assistance Associates Inc., an Ann Arbor, Mich.-based EAP.

"Now, people are isolated," he said, and in areas like child care and child rearing, "EAPs almost fulfill the role of the extended family."

One indicator of the role of the workplace comes from employee orientations, said Don Phillips, president of the Center for Occupational Programs for Employees Inc., an EAP based in Washington, D.C. Asked to name the five institutions that "socialize and nurture us from cradle to grave," workers almost invariably list family, school, church, community and work.

But most also say that family and community are becoming less important in their lives, and church had been descending but is making a comeback, he said. The assessment of the importance of school is split.

Only work is invariably regarded as becoming more powerful in everyday life, Mr. Phillips noted. "The employer is being asked to assume more and more responsibilities as people can't get their needs met elsewhere."

"Productivity is dependent on a person's mental as well as physical health," Mr. Bernstein said. "That's causing (employers) to be more concerned with people's frame of mind and mood."

Ironically, one of the leading causes of mental problems is balancing family and work responsibilities. Based on client requests, those dual responsibilities are actually the "predominant problem" in the minds of employees, said Miriam Fretthold, vp of professional practice for Personal Performance Consultants Inc., a St. Louis-based EAP.

"Strikingly, the issue that we're dealing with the most is work and family—the balancing act," she said.

An increasing number of her clients are providing child and elder care counseling and referral services, she said. "It is not that these issues are new. It's that more people are experiencing them."

Also growing in importance for EAPs is "family management," said Mr. Bernstein. Counselors, for instance, now can be called on to help parents adopting foreign-born children with issues such as maternity leave and how to relate to a culturally different child, he said.

Child care and family management, though, are not necessarily new areas for employers.

'Productivity is dependent on a person's mental as well as physical health,' says Jesse Bernstein of Employee Assistance Associates Inc. 'That's causing (employers) to be more concerned with people's frame of mind and mood.'

"We have always dealt with everything," said Mr. Bernstein. "Even if we focused on alcohol and substance abuse," when someone walked in the door, he or she could come in with any sort of problem.

Hewitt's Mr. Mahoney pointed out that "in some cases, an EAP counselor may actually visit child care sites." And as the U.S. population ages, programs "have become very involved in counseling people with older or dependent parents," he added.

Ms. Fretthold agreed, adding that sometimes Personal Performance Consultants is called upon to help employees deal with issues such as how three or even four generations can live together successfully.

With more older people remaining healthy and active, the company has had to adapt its offerings. It now counsels people on leisure activities for older people, Ms. Fretthold said.

Another employee assistance growth area is AIDS-related services.

Most often, experts said, EAPs are called on to educate employees about acquired immune deficiency

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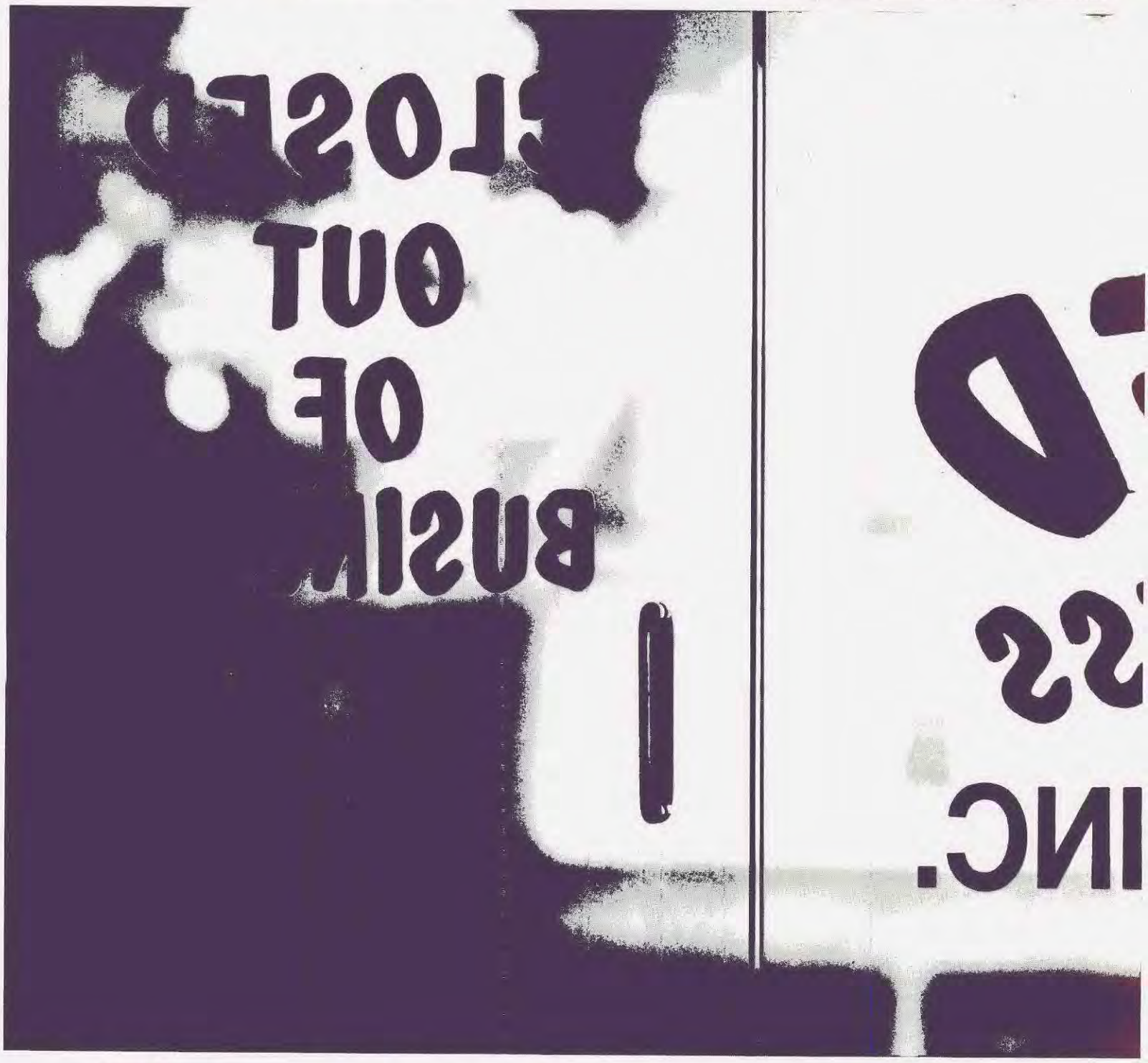

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syndrome and to counsel those stricken with the disease or related health problems.

Most counseling provided by Personal Performance Consultants is short-term, Ms. Fretthold said. But not for AIDS patients. Ongoing support from a counselor can be vital for them, she said. Personal Performance Consultants also provides companies with AIDS education and organizes family and peer support groups.

Educational programs can be short and informal—or lengthy and comprehensive.

At the University of Minnesota in Minneapolis, for example, the employee assistance program conducted a 13-month AIDS education program that its director, David Johnson, called quite comprehensive.

The program, which ran from April 1989 through May 1990, reached 4,000 of the 7,000 non-faculty staff employed by the university.

Some 225 two-and-a-half-hour seminars were held for groups of 30 people, he said. Department supervisors received additional AIDS education.

Funded by a $25,000 allowance from the university, the program was run by a half-time coordinator, Mr. Johnson said. The coordinator trained 13 volunteers—all university staffers—to help lead the seminars.

The coordinator and Mr. Johnson also created an AIDS risk and reference brochure that included the main points of the seminar and information on university, community and national AIDS-related resources. The brochure includes right to privacy information about the services.

Although the official program is over, the university continues to offer employees AIDS counseling and counseling on related issues such as disability insurance, Mr. Johnson noted.

Still another growth area is cultural adjustment counseling to workers both in the United States and abroad.

"An employer that wants a socialized, stabilized workforce needs to address cultural and ethnic differences" among its workforce, said Richard Bickerton, information officer for the Employee Assistance Professionals Assn., an EAP counselors' trade group in Arlington, Va.

Counselors can help employees work side-by-side with others who may not share the same language or lifestyle, he explained.

Mr. Bernstein noted that as companies become more international, EAPs need to develop resources in different countries.

"Americans abroad represent a whole special area of EAPs that is just beginning to be responded to and needs a lot more attention," said Wyatt's Ms. Sherwood. Language barriers are only part of the problem. Americans living abroad can face problems like finding schools and adapting to local customs, she noted.

And, American companies are going to have to deal with local workers who have problems such as alcoholism, Ms. Sherwood noted. For now, though, "the employee assistance movement. . .is just in its infancy stage in terms of a movement that is accepted in other cultures."

Increasingly, EAPs also are helping workers with financial and career counseling. Foster Higgins' Ms. Wiley said that employees often seek counseling on how to budget properly and understand credit.

She advised employers to make sure that they refer workers to financial counselors that do not have a product to sell.

Ms. Fretthold of Performance Consultants said counselors are also finding more need for help with early retirement. Not only do workers need career direction if they are retiring earlier than they had planned, but family members need support and direction on how to adjust to the retired worker's new schedule, she added. ■

Association formed for in-house directors of EAPs

By AMY KATZ

FALLS CHURCH, Va.—Help is on the way for thousands of corporate officials who oversee employee assistance programs.

Formed in May, the Employee Assistance Coordinators Organization aims to assist coordinators in defining their jobs, networking with other coordinators and improving their status within their organizations.

The Falls Church-Va.-based organization will provide a network of information and resources for EAP coordinators, said Irene Ansher, the group's executive director.

EACO was formed to address the distinct needs of in-house coordinators who serve as liaisons between employees and EAP counselors. A separate trade organization —the Employee Assistance Professionals Assn. of Arlington, Va.—is geared toward the counselors in an EAP.

"There are lots of resources to support counselors at that end of the business but little, if any, on our side," said Lisabeth English, manager of welfare plan administration for Kellogg Co. in Battle Creek, Mich. Ms. English is one of 15 members of the EACO Advisory board.

The group will 'give coordinators access to intelligence and experience,' says Rick Wall.

"This organization is focusing on folks like us that manage the EAPs," she said. It will explore how to effectively refer employees in need of assistance and what legal guidelines exist in this field, she added.

"We must come up with clear-cut parameters of what EAP coordinators are physically capable of doing since the job can be 24 hours a day, seven days a week," said another advisory board member, Deborah Munley, manager of management development and counseling services at Giant Food Inc. in Washington, D.C.

The organization plans to set up guidelines of what an EAP coordinator's job should be, Ms. Munley said.

Membership is open to full- or part-time EAP coordinators who assist businesses in contracting with third-parties; directors/managers of in-house EAP referral programs; and those who are now setting up such programs. So far, 500 people have joined the organization.

One thing the group will do is let members network with other coordinators. It will "give coordinators access to intelligence and experience from people who just do coordination," explained Rick Wall, coordinator of EAPs at Fairfax, Va.-based Mobil Corp. and an advisory board member.

Helping coordinators attain greater clout within their companies is another goal. "The role

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EAP coordinators

Continued from previous page

of the coordinator is relatively new, and it really doesn't enjoy any professional status or understanding," explained Ms. Munley.

"We want to make sure other people within the organization appreciate what the EAP coordinator is doing," according to Ms. Ansher.

EACO members will receive a coordinator's handbook with EAP information, coordinator job descriptions and tools for oversight, in addition to a quarterly newsletter.

Ms. Ansher says the newsletter will keep up with industry trends, such as the rising need for alcoholism-related programs.

Additionally, the organization has also been negotiating for membership discounts on conferences, publications, software and audits of EAP providers.

Coordinators, their companies and the providers have all been quite receptive to the organization, according to Ms. Ansher. "At first I was concerned (that providers) would be threatened, but the more informed the coordinators are, the less the EAP has to teach that person."

The association plans to address specific problems facing coordinators, like responsibility for time-consuming duties like staff training, according to Ms. Ansher.

Coordinators may spend anywhere from 5% to 100% of their job time on EAPs, she says.

"Their job tends not to be fully devoted to EAP," Ms. Ansher explained. "And they do this without training, without a support system, in the 60th hour of a 40-hour work week."

Lack of communication within a company or agency can also make the coordinator's job more difficult. Without contact with departments like employee benefits, programs may be inefficient or duplicated, she said.

Confidentiality rules present other problems. "There are a lot of legal restrictions that prevent me from knowing exactly what's going on," Ms. English says.

Those rules lead to accountability problems, often leaving the coordinator in the difficult position of being asked to sign a blank check, not knowing what services have been rendered, said Ms. Munley.

"You have to build in audits or some feedback mechanism or you can find yourself writing a check and not getting a return on your investment," she said.

"There is no (governing) body to do any kind of oversight to make sure the EAP coordinator knows what (the provider) is doing," Ms. Ansher said.

Understanding and interpreting information they receive from various EAPs is also a skill that many coordinators lack, she said.

"With sophistication, guidance and education, we can teach folks how to read (counselor) reports and how to use them," Ms. Ansher commented.

Membership in EACO is open to corporations, individuals, educators and students. A charter membership is $165 and is limited to applications postmarked on or before Aug. 31.

Corporate memberships are $225 for one representative and $165 for each additional representative. Individual memberships are $195, educator memberships are $175 and student memberships are $65. The annual renewal fee for membership is $110. A coordinator's handbook with software costs $135.

The organization is also seeking funding for research into coordinating EAPs.

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For more information, write to the Employee Assistance Coordinators Organization at 7700 Leesburg Pike, Suite 400, Falls Church, Va. 22043; or call 703-883-1156.

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Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.
Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.
Staff: 35; 32 clinical staff members (includes 26 subcontractors), including six CEAP, 14 MSW, seven CAC, one MD, one RN, four Ph.D. designations.
Reporting: Annually.
Service area: Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont.
Clients: 38; 26% with 1-100 employees, 55% with 101-1,000, 16% with 1,001-5,000, 3% with 5,001 or more. Lives covered at year-end 1990: 27,000 employees and 63,000 dependents.
1990 gross revenues: $450,000; 100% from EAP services.
Principal officers: Frank J. Hannon, president; Miles Theeman, executive vp; Daniel B. Coffey, treasurer.
Contact: Miles Theeman.

Aging & the Workplace

53 W. Jackson Blvd., Suite 1632, Chicago, Ill. 60604; 312-922-5890; fax: 312-922-4365

Parent company: Metropolitan Chicago Coalition on Aging.
Not for profit.
Assessment/treatment: Phone assessment and referrals for employed elder caregivers.
Educational/general services: Frequent employee education. Occasional supervisor training, workplace problem identification.
Counseling sites: All worksites, phone counseling.
Utilization Review: Consultation and referral.
Staff: Four, including two MSW.
On-site: social workers.
Reporting: Quarterly.
Service area: Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, Livingston, McHenry, Will counties in Illinois.
Contact: Christi Lennox, program director.

Archbold Employee Assistance Services

414 Park Ave., Thomasville, Ga. 31792; 912-228-6171

Parent company: John D. Archbold Memorial Hospital.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns. Occasional suicide, adolescent treatment.
Health promotion services: Frequent alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutri

Continued on page 28

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DUN & BRADSTREET 150TH ANNIVERSARY

Erisco

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Continued from page 26

tion/weight control, stress management.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Three; two clinical staff members, including one Ph.D.

On-site: one psychologist, one marriage/family/child counselor.

Contracted: one psychiatrist.

Facilities: One.

Reporting: Quarterly.

Service area: Decatur, Grady, Mitchell, Seminole, Thomas counties in Georgia.

Clients: 10; 40% with one to 100 employees, 50% with 101 to 1,000, 10% with 1,001 to 5,000. Lives covered at year-end 1990: 224 employees and 49 dependents.

1990 gross revenues: $12,705; 100% from EAP services.

Principal officers: Ann Lucas, director; Paul Peary, counselor.

Contact: Paul Peary.

B

BEMW Inc. Counseling & Training Associates

7984 D Old Georgetown Road, Bethesda, Md. 20814; 301-657-8922; fax: 301-657-8924

Year founded: 1976.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse. Occasional suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, effective parenting, assertiveness and communication. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Counseling sites: EAP/mental health care facilities, selected worksites.

Staff: 12; six clinical staff members, including four CEAP, four MSW, two NCC designations.

Facilities: Five.

Reporting: Monthly, quarterly.

Specialties: Government, real estate management.

Service area: District of Columbia, Maryland, Virginia; nationwide capability.

Clients: Six; 15% with 101 to 1,000 employees, 85% with 1,001 to 5,000. Lives covered at year-end 1990: 19,400.

1990 gross revenues: $280,000; 83% from EAP services, 17% from other services.

Principal officers: Irene N. Mendelson, president.

C

Counseling & Readjustment Services

1804 Hampton St., Columbia, S.C. 29201; 803-765-0700

Year founded: 1982.
For profit.

Assessment/treatment: Frequent stress, suicide, work and personal trauma. Occasional occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment.

Health promotion services: Frequent post-trauma services. Occasional stress management.

Educational/general services: Frequent employee education, supervisor training, psychiatric workers compensation review.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites.

Staff: Eight; five clinical staff members, including four MSW and one Ph.D. designations.

Reporting: On request.

Service area: Nationwide.

Clients: 20; 10% with one to 100 employees, 30% with 101 to 1,000, 40% with 1,001 to 5,000, 20% with 5,001 or more. Lives covered at year-end 1990: 15,000.

Principal officers: Lawrence H. Bergmann and Timothy Barnett Queen, partners.

Contact: Lawrence H. Bergmann.

D

DCC/The Dependent Care Connection Inc.

P.O. Box 2783, Westport, Conn. 06880; 203-226-2680; fax: 203-226-2852

Year founded: 1984.
For profit.

Assessment/treatment: Frequent family/marital problems, child care referrals, elder care referrals.

Health promotion services: Frequent child care, elder care.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Case management.

Counseling sites: Clients' headquarters, selected worksites, phone counseling.

Staff: 15; 12 clinical staff members, including one MSW.

On-site: 12 marriage/family/child counselors.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 5% with one to 100 employees, 20% with 101 to 1,000, 50% with 1,001 to 5,000, 25% with 5,001 or more. Lives covered at year-end 1990: 60,000 employees and 300,000 dependents.

1990 gross revenues: $1 million; 100% from EAP services.

Principal officers: John Place, president; Jeff Burki and Peter Burki, executive vps; Norma Savarino, vp.

Contact: John Place.

Directions

2221 S. 17th St., Suite 406, Lincoln, Neb. 68502; 402-473-5998 or 800-742-7845

Year founded: 1981.
Parent company: Lincoln General Hospital.
Not for profit.

Assessment/treatment: Stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Counseling sites: EAP/mental health care facilities.

Staff: Three; two clinical staff members, including two CAC designations.

On-site: marriage/family/child counselors.

Reporting: Monthly.

Service area: Nebraska.

Clients: 80% with one to 100 employees, 20% with 101 to 1,000.

1990 gross revenues: $60,000.

Contact: Mike Reynolds, director.

Dor & Associates Inc.

430 First Ave. N., Suite 216, Minneapolis, Minn. 55401; 612-332-4805

Year founded: 1978.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns. Occasional adolescent treatment.

Health promotion services: Smoking cessation, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Continued on next page

Lincoln National Life Insurance Company. Lincoln National Administrative Services Corporation, Affiliates of Lincoln National Corporation.

Guide to EAP, managed mental care listings

The first annual *Business Insurance* directory of employee assistance programs (see page 26) and managed mental health care providers (see page 39) lists organizations that provide these services directly to employers on a stand-alone basis.

Business Insurance defines an employee assistance program as an organization of counselors who counsel employees on a variety of issues and can also refer employees for specialist treatments. Managed mental health care providers offer EAP as well as actual mental health care services under a contract with the employer (see story, page 20).

The listings begin with the company name and address, followed by the **year founded**, **parent company** (if any) and whether the organization is for profit or not for profit.

Services available are listed under three categories—**assessment and treatment**, **health promotion** and **educational/general services**—indicating whether they are offered frequently or occasionally.

Utilization review services are listed next, followed by the **sites** of counseling and treatment.

Information on **staff** includes the number of total staff members, then full-time contracted clinicians. Professional designations and memberships held by staff members is also listed. How many staff members are on-site or contracted is noted next.

Number of participating **facilities** includes hospitals, treatment centers and halfway houses. How often utilization data is reported to employers is given under **reporting**, followed by any business or industry **specialties**.

The geographic **service area** is next, followed by total number of employer **clients** served at year-end 1990 and then total number of lives covered at year-end 1990.

When reported by the organization, 1990 **gross revenues** are included. **Principal officers** and a **contact person** for those seeking more information complete the listings.

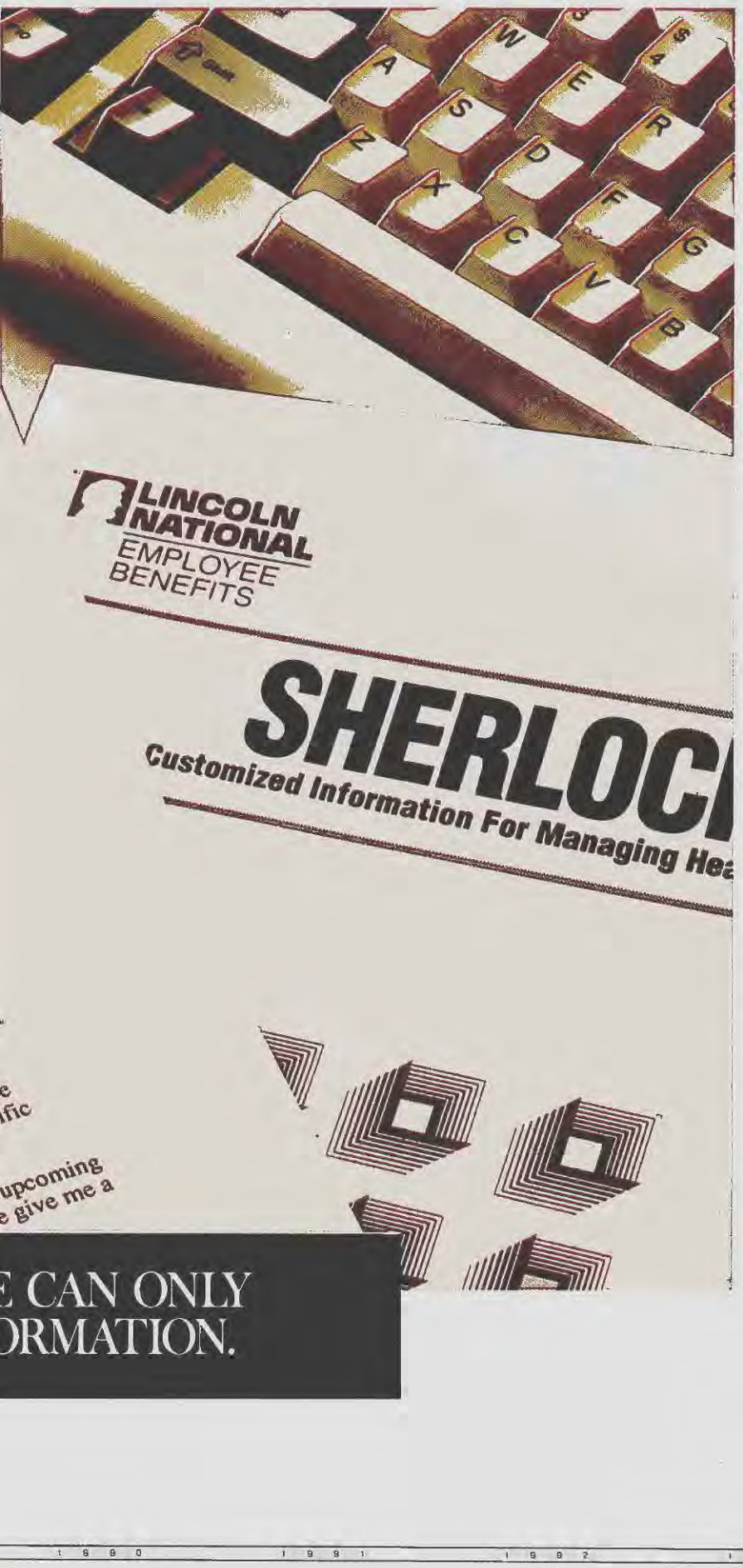
If you wish to locate a company by state, refer to the geographic index on page 73.

There is no charge to be included in the directory. Information reported is based on each company's responses to a *BI* questionnaire. Although every effort is made to publish complete and accurate listings, *BI* is unable to verify all information.

If you wish to receive a questionnaire for next year's directory, write Karen Armaganian, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590.

Following are the full professional designations for those abbreviated under the staff heading:

ACSW is Accredited Social Worker; **CAC** is Certified Alcohol Counselor; **CADC** is Certified Alcohol and Drug Counselor; **CCDC** is Certified Chemical Dependency Counselor; **CEAP** is Certified Employee Assistance Program Counselor; **CSW** is Certified Social Worker; **DMIN** is Doctor of Ministry; **DO** is Doctor of Osteopathy; **LCSW** is Licensed Clinical Social Worker; **LPC** is Licensed Professional Counselor; **MFCC** is Marriage Family Child Counselor; **MFT** is Marriage and Family Therapist; **MSW** is Master's in Social Work; **NCC** is National Certification Commission.



Managed care is the phrase you hear a lot around insurance circles these days. But without real management, managed care is just a phrase.

There's one health benefits company, however, that has a special capability to help you cost-effectively manage care.

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As part of the nation's 7th largest insurance holding company, we're committed to leadership in managed health care. A commitment we've demonstrated by developing management information capabilities like StatLinc, specially designed for statistical analysis of claims experience. Sherlock, which provides customized managed care reporting. EZ-Inquiry, a program that lets you access company health care information on your own personal computer.

And we're working on new capabilities that will provide even greater advances in managing and integrating health care information.

If all of this sounds a bit high-tech, there's a simpler way to look at it. It's just a smart way to manage care.

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Continued from previous page

Counseling sites: EAP/mental health care facilities.

Staff: 24; 16 clinical staff members, including five CEAP, four MSW, two Ph.D., three CCDP designations.

On-site: psychologists, social workers, marriage/family/child counselors.

Service area: Minnesota.

Clients: 80; 5% with one to 100 employees, 60% with 101 to 1,000, 20% with 1,001 to 5,000, 15% with 5,001 or more. Lives covered at year-end 1990: 1,900.

Principal officers: Janet Deming.

E

EAP, Service of Mount Auburn Hospital

55 Wheeler St., Cambridge, Mass. 02138; 617-661-0090 or 800-888-5105; fax: 617-499-5584

Year founded: 1981.

Parent company: Mount Auburn Hospital Foundation.

Not for profit.

Assessment/treatment: Stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, parenting skills.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, communication skills, assertiveness, management training.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Five; four clinical staff members, including one CEAP, four MSW, two CAC designations.

On-site: four social workers, one marriage/family/child counselor.

Contracted: one psychiatrist, two psychologists, six social workers.

Reporting: Monthly, annually.

Specialties: Companies that must comply with drug-free work place act and anti-drug regulations.

Service area: Middlesex, Suffolk, Norfolk and Lowell counties in Massachusetts; Nashua County, N.H.

Clients: 35; 9% with 1 to 100 employees, 85% with 101 to 1,000, 6% with 1,001 to 5,000. Lives covered at year-end 1990: 6,000.

1990 gross revenues: $180,000; 100% from EAP services.

Principal officers: Frank Lynch, president; Mark Tolosky, executive vp; Lucy Farmer, vp-planning/development; Katherine Whidden, vp-human resources; Tim O'Neil, vp-nursing administration.

Contact: Nancy Zare, director.

Education & Training Programs Inc.

7 Waterside Crossing, Suite 204, Windsor, Conn. 06095; 203-285-8585; fax: 203-285-8240

Year founded: 1974.

Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns. Occasional legal problems, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, single parenting, elder care. Occasional nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.

Utilization review services: Case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities.

Staff: 10; 392 clinical staff members, including 71 CEAP, 86 MSW, 59 CAC, 4 MD, 8 RN, 39 Ph.D., 59 ACSW designations.

On-site: two psychologists, three social workers, one marriage/family/child counselor, one alcohol/drug counselor.

Contracted: eight psychiatrists, 39 psychologists, 117 marriage/family/child counselors, four physicians, 118 social workers.

Continued on next page

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Reporting: Quarterly, on request.
Service area: Nationwide.
Clients: 39; 5% with one to 100 employees, 46% with 101 to 1,000, 36% with 1,001 to 5,000, 13% with 5,001 or more. Lives covered at year-end 1990: 73,000 employees and 110,000 dependents.
1990 gross revenues: $2.6 million; 60% from EAP services, 40% from management consulting and professional services.
Principal officers: Dr. David J. Powell, president/chief executive officer; Paul F. Crotty, senior vp; Steve Szuchy, vp-administration; Debra J. Barnicle, director-employee assistance programs; Dr. Mark Braunsdorf, clinical director.
Contact: Jeff L. Lefkovich, director-communications/business development.

Employee Assistance Network

14 E. Jackson, 15th Floor, Chicago, Ill. 60604; 312-663-5600

Year founded: 1857.
Parent company: United Charities.
Not for profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns. Occasional suicide, adolescent treatment.
Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional trauma debriefing.
Utilization review services: Precertification of inpatient/outpatient treatment.
Counseling sites: EAP/mental health care facilities, selected worksites.
Staff: Nine; five clinical staff members, including six MSW, five CAC, one SCAC designations.
On-site: social workers.
Contracted: psychiatrists, psychologists.
Reporting: Quarterly.
Service area: Cook County, Ill.
Clients: 50; 25% with one to 100 employees, 70% with 101 to 1,000, 5% with 1,001 to 5,000. Lives covered at year-end 1990: 25,000.
1990 gross revenues: $300,000; 85% from EAP services, 15% from managed mental health care services.
Principal officers: A. Gerald Erickson, president; Francis Moynihan, senior vp; Frances Corwin, vp; Ivy Spataro, regional manager; Alan Wertheimer, director.
Contact: Ivy Spataro.

Employee Assistance Program

1000 Hastings, Traverse City, Mich. 49684; 616-947-8387; fax: 616-947-3522

Year founded: 1972.
Not for profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional suicide, legal problems, financial concerns.
Health promotion services: Stress management, alcohol awareness, drug/chemical awareness, management issues, conflict management. Occasional AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.
Utilization review services: Precertification of outpatient treatment, case management.
Counseling sites: EAP/mental health care facilities, phone counseling.
Staff: Six; five clinical staff members, including one CEAP, three MSW, four CAC, one Ph.D. designations.
On-site: five social workers, one marriage/family/child counselor.
Contracted: one psychiatrist, one physician.
Reporting: Quarterly.
Service area: Michigan.
Clients: 40; 65% with one to 100 employees, 28% with 101 to 1,000, 7% with 1,001 to 5,000.
1990 gross revenues: $50,000; 100% from EAP services.
Contact: Tom Shea.

Employee Assistance Program Consultants Inc.

3330 Fiechtner Drive, Suite 104, Fargo, N.D. 58103; 701-235-4440; fax: 701-235-0306

Year founded: 1979.
For profit.
Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment. Occasional occupational problems, suicide, legal problems.
Health promotion services: Frequent stress management. Occasional alcohol awareness, drug/chemical awareness, AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.
Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.
Staff: Seven; four clinical staff members, including two CEAP, one MSW, four CAC designations.
On-site: social workers, marriage/family/child counselors, addiction counselors.
Contracted: psychologists, social workers, marriage/family/child counselors.
Reporting: Quarterly, annually.
Service area: Minnesota, North Dakota.
Clients: 80; 55% with one to 100 employees, 40% with 101 to 1,000, 5% with 1,001 to 5,000. Lives covered at year-end 1990: 19,000 employees and 46,000 dependents.
1990 gross revenues: 100% from EAP services.
Principal officers: Bill Kippley, president; Kathy Marcil, vp-clinical services; Larry Johnson, vp-sales/marketing.
Contact: Larry Johnson.

Employee Counseling Associates Inc.

612 Pasteur Drive, Suite 207, Greensboro, N.C. 27403; 919-854-1760

Year founded: 1985.
For profit.
Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, drug/chemical abuse. Occasional occupational problems, suicide, financial concerns, adolescent treatment.
Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, AIDS awareness.
Educational/general services: Frequent employee education, supervisor training. Occasional drug-free workplace regulatory adherence, workplace problem identification.
Utilization review services: Precertification of inpatient/outpatient treatment, case management.
Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.
Staff: Five; four clinical staff members, including one CEAP, one CAC, one RN, one AAMFT, three NCC designations.
On-site: three marriage/family/child counselors, one substance abuse counselor.
Contracted: one psychologist.
Reporting: Monthly, quarterly.
Service area: Alamance, Forsyth, Guilford, Rockingham counties in North Carolina.
Clients: 28; 7% with one to 100 employees, 72% with 101 to 1,000, 21% with 1,001 to 5,000. Lives covered at year-end 1990: 10,000 employees.
Gross revenues: 100% from EAP services.
Principal officers: Nelson B. Hodgkins, president; Merle D. Walker, secretary; Barbara M. Callahan, associate/clinical director; George H. Batten, assistant secretary.
Contact: Barbara M. Callahan.

F

Family Alternatives/ Employee Assistance Services

3230 Lake Worth Road, Lake Worth, Fla. 33461; 407-967-8025

Year founded: 1980.

Continued on page 33

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Continued from page 30

For profit.

Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns. Occasional occupational problems, suicide, adolescent treatment, critical incident debriefing, work center team-building.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Five; two clinical staff members, including two CEAP, three CAC, one Ph.D. designations.

On-site: one psychologist.

Reporting: Quarterly, annually.

Service area: Florida.

Clients: Eight; 50% with one to 100 employees, 25% with 101 to 1,000, 25% with 1,001 to 5,000. Lives covered at year-end 1990: 4,000 employees and 6,000 dependents.

1990 gross revenues: 100% from EAP services.

Principal officers: Billie H. Wilson, president; Jerry A. Wilson, vp.

Contact: Jerry A. Wilson.

Family Service Assn. of Greater Lawrence

430 N. Canal St., Lawrence, Mass. 01840; 508-683-9505

Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, family and mental health issues. Occasional smoking cessation, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 16; 11 clinical staff members, including one MD, one RN designations.

On-site: one psychiatrist, one psychologist, seven social workers, one physician.

Reporting: Quarterly, on request.

Service area: Essex County, Mass. and nationally through Family Service network.

Principal officers: Kay Frishman, executive director; John Zielin, assistant director; Leonard DeBenedictis, EAP director.

Contact: Leonard DeBenedictis or Kay Frishman.

H

Harting Associates Inc.

8 Executive Drive, Suite 160-D, Fairview Heights, Ill. 62208; 618-632-3145; fax: 618-632-3169

Year founded: 1979.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns. Occasional suicide, legal problems.

Health promotion services: Frequent drug/chemical awareness. Occasional stress management, alcohol awareness.

Educational/general services: Occasional employee education, supervisor training, drug-free workplace regulatory adherence.

Counseling sites: EAP/mental health care facilities, phone counseling.

Staff: Three; two clinical staff members, including CEAP, MSW designations.

On-site: social workers.

Contracted: psychiatrists, social workers.

Service area: St. Louis; St. Clair, Ill.; Madison and Monroe counties in Illinois.

Clients: 15. Lives covered at year-end 1990: 3,000 employees.

1990 gross revenues: $160,000; 25% from EAP services, 75% other.

Principal officers: James J. Harting, president.

HealthLine Employee Assistance Programs

3005 W. Martin Luther King Jr. Blvd., Tampa, Fla. 33607; 813-870-4840; fax: 813-870-4692

Year founded: 1985.

Parent company: St. Joseph's Ancillary Services Inc.

Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional suicide, legal problems, financial concerns.

Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Five; four clinical staff members, including one CEAP designation.

On-site: one psychologist.

Contracted: one psychiatrist, one psychologist.

Specialties: Hospitals, utilities, defense.

Service area: Florida.

Clients: 16,000; 2.5% with one to 100 employees, 17.5% with 101 to 1,000, 80% with 1,001 to 5,000. Lives covered at year-end 1990: 15,623.

Principal officers: Sister Marie Celeste, president; Isaac Mallah, chief operating officer; Gary Chaulk, chief financial officer; John Biebel, vp; Mike Mauldin, controller.

L

Michael Legot, EAP Consultant

P.O. Box 590863, San Francisco, Calif. 94159; 415-751-5762

Year founded: 1984.

For profit.

Assessment/treatment: Stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical

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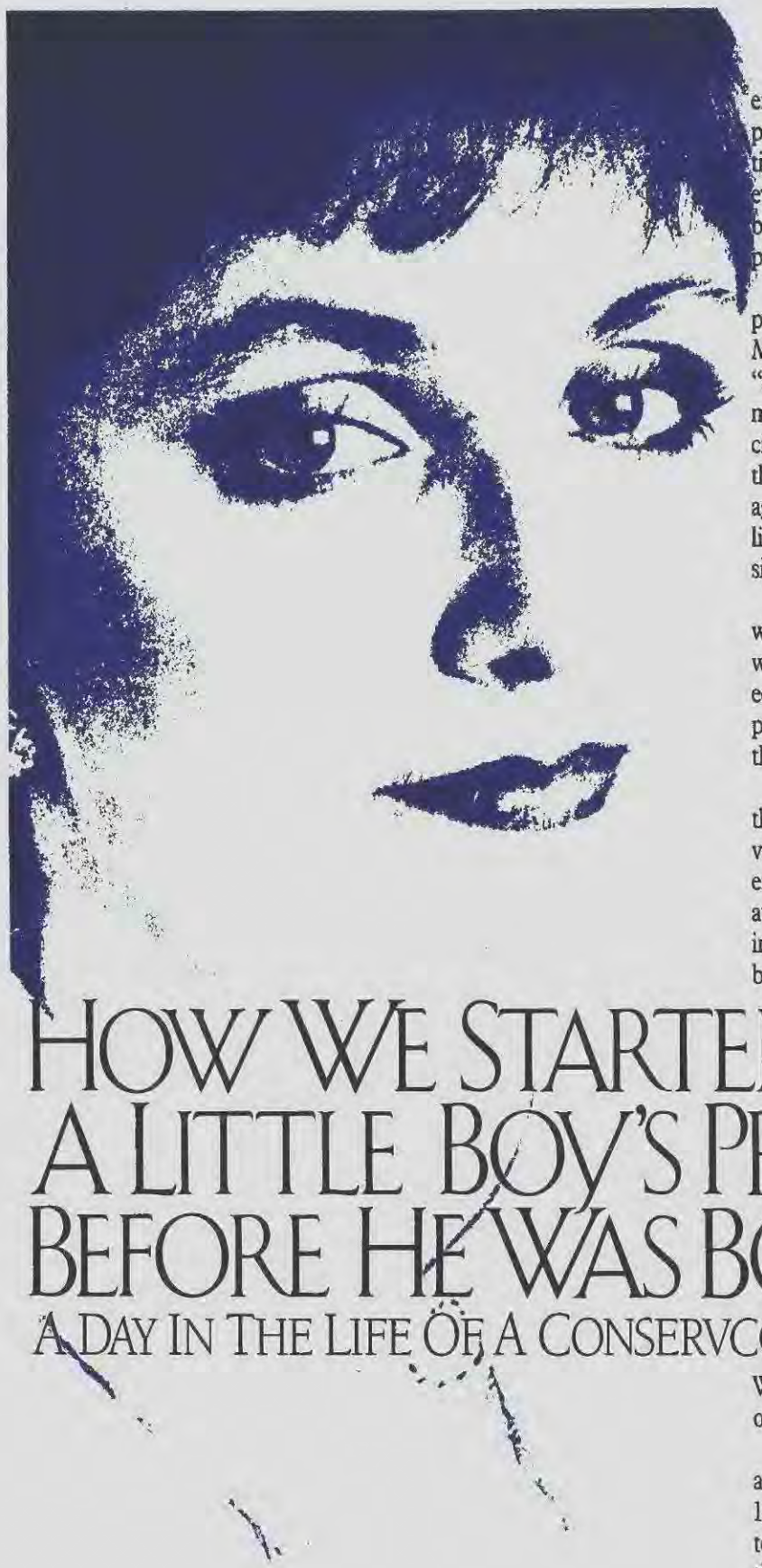

MIDWEST U.S. – It was difficult enough to realize her unborn child had a heart problem. But when this young mother's contractions began just 24 weeks into her pregnancy, every day brought the added fear of premature birth. That's when Conservco came into the picture.

"The patient's benefit plan did not provide payment on home uterine monitoring," said Medical Case Manager Mary Crowe-Richards, "something we felt was of great value to both mother and child. Working with one of our physician advisors, we came up with a strong case for the home monitoring program and obtained an agreement to cover the cost. This not only made life easier for the patient's family, but resulted in significant savings."

Mary's involvement with the case continued when the child was born prematurely at 33 weeks. "We arranged for the appropriate home equipment and negotiated the best possible prices. Basically, we took care of the details so that the mother could take care of her child."

Another problem came up months later when the assigned PPO hospital was undergoing renovations and could not provide the baby with an emergency cardiac catheterization. Mary negotiated the PPO rate at another hospital. Almost immediately following the procedure, the little boy's condition improved dramatically.

HOW WE STARTED SOLVING A LITTLE BOY'S PROBLEMS BEFORE HE WAS BORN.

A DAY IN THE LIFE OF A CONSERVCO R.N., #5 IN A SERIES.

What's more, the savings on this case amounted to over $12,000.

For the full story on medical case management and other cost-saving ideas from Conservco, call 1-800-525-5590. The way we see it, the best time to start solving big medical cost problems is when they're little.

MARY CROWE-RICHARDS, R.N.
Medical Case Manager

CONSERVCO

WORKING TOGETHER, EVERYONE BENEFITS.
Integrated Medical/Disability Management

Continued from previous page
awareness, AIDS awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Staff: Two; two clinical staff members, including one Ph.D.

On-site: psychologists, marriage/family/child counselors.

Facilities: Four.

Reporting: On request.

Specialties: Service-oriented industries.

Service area: Northern California.

Clients: Three; 100% with 101 to 1,000 employees.

1990 gross revenues: 10% from EAP services, 90% from consulting.

Principal officers: Michael Legot, Suzanne Lerner.

Contact: Michael Legot.

Lincoln Employee Assistance Program Inc.

201 N. Eighth St., Lincoln, Neb. 68508; 402-476-0186

Year founded: 1974.
Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, critical incident stress debriefing.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, balancing home and work, elder care. Occasional AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, outplacement/company transition services. Occasional psychiatric disability review.

Utilization review services: Precertification of inpatient/outpatient treatment, case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

phone counseling.

Staff: 10; eight clinical staff members, including three CEAP, one CAC designations.

On-site: eight marriage/family/child counselors.

Reporting: Monthly.

Specialties: Small- to mid-sized businesses.

Service area: Nebraska.

Clients: 60; 48% with one to 100 employees, 42% with 101 to 1,000, 10% with 1,001 to 5,000. Lives covered at year-end 1990: 23,385 employees and 58,000 dependents.

1990 gross revenues: $386,000; 96% from EAP services, 4% from interest income.

Principal officers: Brian Baxter, president; Gerry Dimon, vp; Nancy Hicks, secretary/treasurer; John Sullivan and Art Sharp, directors.

Contact: Kristine Brennan, executive director.

Longview Associates Inc.

287 State St., Springfield, Mass. 01105; 413-785-4200; fax: 413-785-4215

Year founded: 1978.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, critical incident response.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 30; 27 clinical staff members, including 10 CEAP, six MSW, six CAC, two RN, one Ph.D. designations.

On-site: psychologists, social workers, physicians.

Reporting: Quarterly.

Service area: Northeast United States.

Clients: 10% with one to 100 employees, 40% with 101 to 1,000, 40% with 1,001 to 5,000, 10% with 5,001 or more. Lives covered at year-end 1990: 25,000 employees and 75,000 dependents.

1990 gross revenues: $1 million; 100% from EAP services.

Principal officers: Robert E. O'Connor, chairman; Jerry S. Clausen, president.

Longview Associates Inc.

360 Mamaroneck Ave., White Plains, N.Y. 10605; 914-946-0525; fax: 914-683-0037

Year founded: 1972.
Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment, elder care. Occasional suicide, legal problems, financial concerns.

Health promotion services: Stress management, alcohol awareness, drug/chemical awareness, parenting, financial.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review.

Utilization review services: Case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Nine; seven clinical staff members, including four CEAP, one MSW, five CAC.

Reporting: Annually, semi-annually.

Specialties: Non-profit organizations.

Service area: Nationwide.

Clients: 2% with one to 100 employees, 95% with 101 to 1,000, 1% with 1,001 to 5,000, 2% with 5,001 or more. Lives covered at year-end 1990: 280,000 employees.

Principal officers: Marcia E. Nagle, president; T.J. Elliott, vp.

M

Mansfield Associates Inc.

234 East St. S., Suffield, Conn. 06078; 413-731-6057

Year founded: 1987.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse. Occasional suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness. Occasional stress management, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Five; three clinical staff members, including one CEAP, one Ph.D. designations.

Contracted: one psychologist, two marriage/family/child counselors.

Reporting: Quarterly.

Service area: Western Massachussetts, northern Connecticut.

Clients: Three; 25% with one to 100 employees, 75% with 101 to 1,000.

1990 gross revenues: 90% from EAP services, 10% from private clients.

Principal officers: Barbara Mansfield, president; James W. Barber, treasurer.

Contact: Barbara Mansfield.

MedCenter One Employee Assistance Program

300 N. Seventh St., Bismarck, N.D. 58501; 701-224-6765

Parent company: MedCenter One.
Not for profit.

Assessment/treatment: Frequent family/marital problems. Occasional stress, occupational problems, problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness.

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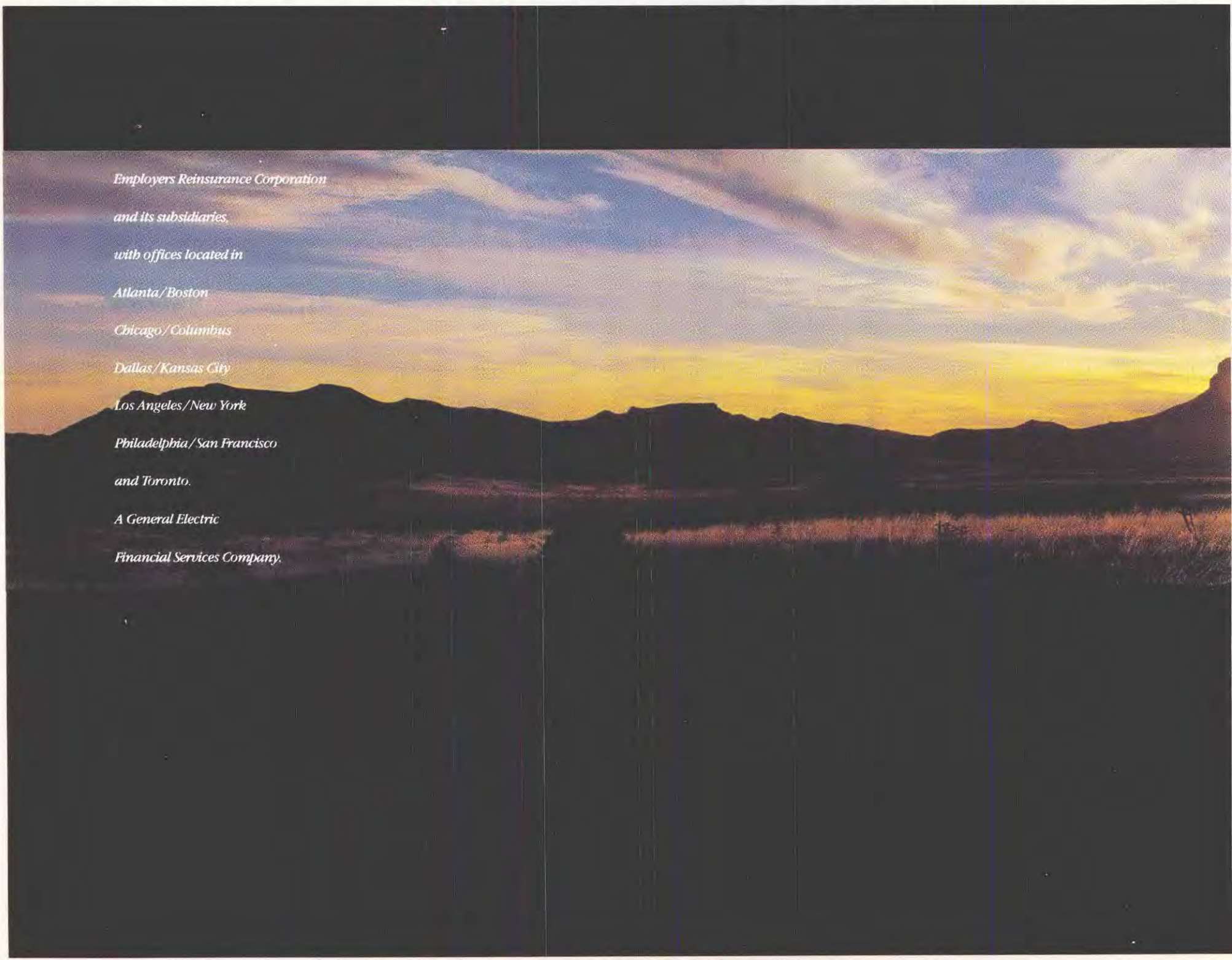

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Educational/general services: Frequent employee education, supervisor training. Occasional workplace problem identification.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Seven; four clinical staff members, including four MSW designations.

On-site: four social workers.

Contracted: 13 psychologists, 20 social workers, 13 addiction counselors.

Reporting: Quarterly.

Service area: North Dakota, South Dakota, Montana, Wyoming.

Contact: Lowell Flemmer, director.

Michiana Employee Assistance Program

818 E. Jefferson Blvd., South Bend, Ind. 46617; 219-287-1879

Year founded: 1974.

Parent company: NCA-DD, Michiana-The Alcoholism Council.

Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, co-dependency. Occasional suicide, adolescent treatment, eldercare.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Four, including one CEAP designation.

Reporting: Quarterly.

Service area: Elkhart, LaPorte, Marshall, St. Joseph, Starke counties in Indiana; Cass, St. Joseph, Van Buren counties in Michigan.

Clients: 310; 20% with one to 100 employees, 67% with 101 to 1,000, 13% with 1,001 to 5,000. Lives covered at year-end 1990: 322 employees and 28 dependents.

1990 gross revenues: $94,200; 100% from EAP services.

Principal officers: Jack Gordon, president; Father Michael Heppen, first vp; Chris Davey, second vp; John Voor, secretary; Pete Schueth, treasurer.

Michael Mitroff

38950 Blacow Road, Suite D, Fremont, Calif. 94536; 415-794-4500

Year founded: 1980.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment. Occasional suicide.

Health promotion services: Frequent physical fitness/exercise, stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Two; two clinical staff members, including two CEAP, one MSW, one Ph.D. designations.

On-site: one social worker, one marriage/family/child counselor.

Contracted: psychiatrists, psychologists, physicians.

Reporting: On request.

Service area: California.

Clients: Three; 50% with one to 100 employees, 50% with 101 to 1,000. Lives covered at year-end 1990: 400 employees and 600 dependents.

Contact: Michael Mitroff.

N

New Choices Inc.

1111 S. Las Vegas Blvd., Suite 233, Las Vegas, Nev. 89104; 702-383-9777

Year founded: 1986.

For profit.

Assessment/treatment: Frequent stress, alcohol abuse, drug/chemical abuse. Occasional occupational problems, family/marital problems, suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation.

Educational/general services: Frequent employee education, supervisor training. Occasional drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, selected worksites.

Staff: Two; two clinical staff members, including CEAP, CAC, MFT designations.

Contracted: one marriage/family/child counselor.

Reporting: Monthly, quarterly.

Service area: Clark County, Nevada.

Clients: 20; 80% with 1 to 100 employees, 20% with 101 to 1,000. Lives covered at year-end 1990: 600 employees and 200 dependents.

Principal officers: Megan Henderson, president; Bob Henderson, executive director.

Contact: Bob Henderson.

Northeast Georgia Employee Assistance Program

3724 Atlanta Highway, Unit 2, Athens, Ga. 30606; 404-549-6658

Year founded: 1981.

For profit.

Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, drug/chemical abuse. Occasional occupational problems, suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Six; four clinical staff members, including one CEAP, one MSW, two CAC designations.

Reporting: Quarterly.

Service area: Georgia.

Clients: 35; 34% with one to 100 employees, 60% with 101 to 1,000, 6% with 1,001 to 5,000. Lives covered at year-end 1990: 12,000 employees.

1990 gross revenues: $105,000; 100% from EAP services.

Principal officers: Jim Bremner, chairman; Russ Settles, vice chairman; Marsha Rosenthal, secretary; Priscilla Fraser, treasurer; James Alford, board member.

Contact: Marsha Rosenthal, executive director.

O

Open-Door Services Inc.

1603 Orrington Ave., Suite 1157, Evanston, Ill. 60201; 708-328-5455; fax: 708-866-6360

Year founded: 1982.

For profit.

Assessment/treatment: Stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, grief, post-traumatic stress, war-related issues.

Health promotion services: Smoking cessation, physical fitness/exercise, stress management, alcohol awareness, drug/chemical awareness, AIDS aware-

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Risk doesn't come with the territory. It is the territory.

In an unforgiving atmosphere, every move has indelible consequences.

At ERC, the moves are bold, decisive and swift. Most importantly, the moves are informed.

There are no sure things. Only surefootedness.

Employers Reinsurance
5200 Metcalf, Overland Park, Kansas 66201

Continued from previous page
ness, working families.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Counseling sites: EAP/mental health care facilities.

Staff: Six; five clinical staff members, including three CEAP, five MSW designations.

On-site: psychiatrists, psychologists, social workers, marriage/family/child counselors, physicians.

Contracted: psychiatrists, psychologists, social workers, marriage/family/child counselors, physicians.

Reporting: Quarterly.

Service area: Cook, DuPage, Lake, Kane counties in Illinois.

Clients: 20; 20% with one to 100 employees, 50% with 101 to 1,000, 25% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 14,500 employees.

1990 gross revenues: $220,000; 95% from EAP services, 5% from training and publishing.

Principal officers: Sewell F. Gelberd, David J. O'Brien.

Contact: Sewell F. Gelberd.

P

PAS-Personnel Assistance Services

4158 Lindell Blvd., St. Louis, Mo. 63108; 314-533-5331 or 800-356-0845; fax: 314-652-8351

Year founded: 1982.

Parent company: Magdala Foundation.

Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, critical incident stress, social climate of workplace.

Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, case management, data-base provider evaluation.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 17; nine clinical staff members, including one CEAP, 10 MSW, four CAC, one Ph.D., four LPC designations.

On-site: nine social workers, five marriage/family/child counselors.

Contracted: one psychologist, one social worker.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 65; 49% with one to 100 employees, 43% with 101 to 1,000, 8% with 1,001 to 5,000. Lives covered at year-end 1990: 25,000 employees and 37,500 dependents.

1990 gross revenues: 100% from EAP services.

Principal officers: David Meyer, executive director; Susan Skinner, director-operations; Linda Mueller, operations coordinator; C. Lee Richards, training coordinator; Marcus Piper, senior case manager.

Contact: Susan Skinner.

PHR Group Inc.

P.O. Box 23945, Tampa, Fla. 33623; 813-931-0007

Year founded: 1979.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse. Occasional suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent smoking cessation, stress management, alcohol awareness, drug/chemical awareness. Occasional physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric workers compensation review.

Utilization review services: Case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 14, including two RN designations.

On-site: marriage/family/child counselors.

Reporting: On request.

Service area: Florida.

Principal officers: Thomas Aderhold, president.

Pathways EAP

674 Prospect Ave., Hartford, Conn. 06105; 203-233-6228

Year founded: 1978.

For profit.

Assessment/treatment: Frequent stress, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns. Occasional occupational problems, legal problems, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Five; one clinical staff member, including two Ph.D. designations.

On-site: two psychologists, one marriage/family/child counselor, one drug and alcohol rehabilitation counselor.

Contracted: psychiatrists, social workers, marriage/family/child counselors, physicians.

Reporting: Annually, semi-annually.

Service area: Nationwide.

Clients: 14; 7% with one to 100 employees, 93% with 101 to 1,000. Lives covered at year-end 1990: 4,500 employees and 6,750 dependents.

1990 gross revenues: $91,000; 100% from EAP services.

Principal officers: Allan L. Schiffer, president.

Contact: Loretta M. Vasso, director-marketing & services.

Personal Assistance Services of San Diego

2525 Camino Del Rio South, Suite 159, San Diego, Calif. 92108; 619-275-2320

Year founded: 1978.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment. Occasional suicide, general emotional problems.

Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness, medical issues.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment.

Counseling sites: EAP/mental health care facilities, selected worksites.

Continued on page 38

How Well Are You Controlling Your Benefits Costs?

If you're like most companies, your employee benefits costs are continuing to soar.

Corroon & Black can bring those costs under control. We've proven that over and over again in our work with companies throughout the U.S. and overseas, including many Fortune 500 companies.

Corroon & Black is the United States half of Willis Corroon plc, the world's fourth largest broker. Together, we're developing leading-edge risk management and benefits programs for the 1990s.

We do business in over 100 U.S. cities, and with our growing network of C&B Consulting Group offices, we deliver a level of expertise, combined with personal service, that would be tough for any broker to match.

Take This Simple Test:

To see if your company is getting the most effective help in coping with rising benefits costs, take a moment to answer these 7 questions.

Yes ❑ **No** ❑ We have a current evaluation of our company's present and projected benefits costs.

Yes ❑ **No** ❑ We have a working program in place to manage health and medical claims.

Yes ❑ **No** ❑ Our benefit and compensation plans are subject to the same sort of budget review as all corporate capital and operating budgets.

Yes ❑ **No** ❑ Our benefits broker/consultant keeps us abreast of state and federal regulatory changes, with timely advice and recommendations.

Yes ❑ **No** ❑ Our broker periodically evaluates world insurance markets to identify the best possible coverages.

Yes ❑ **No** ❑ Self-insured benefits programs have been thoroughly evaluated.

Yes ❑ **No** ❑ Our benefit programs are designed to fit with our long-term corporate strategy.

If you would like to discuss your employee benefits in more detail, call us. We can help by reviewing your costs and discussing any aspect of your benefits program. Call Tom Ucko at (800) 242-2495.

CORROON & BLACK
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Continued from page 36

Staff: Five; two clinical staff members, including two CEAP, one LCSW designations.

Contracted: one social worker, two marriage/family/child counselors.

Reporting: Quarterly, annually.

Service area: San Diego and Riverside counties in California.

Clients: 65; 40% with one to 100 employees, 55% with 101 to 1,000, 5% with 1,001 to 5,000. Lives covered at year-end 1990: 7,500 employees and 11,250 dependents.

Principal officers: Duane Rogers, president/chief executive officer; Siegrid Wensink, administrative services manager.

Contact: Duane Rogers.

Pius XII Corporate Services

372 Fullerton Ave., Newburgh, N.Y. 12550; 800-962-7487; fax: 914-562-0813

Year founded: 1985.
Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence, psychiatric disability review.

Counseling sites: EAP/mental health care facilities.

Staff: 10; nine clinical staff members, including one CEAP, three MSW, one CAC designations.

On-site: social workers, marriage/family/child counselors.

Contracted: psychiatrists, psychologists.

Reporting: Quarterly.

Service area: Northeastern United States.

Clients: 33; 5% with one to 100 employees, 80% with 101 to 1,000, 15% with 1,001 to 5,000. Lives covered at year-end 1990: 15,000 employees.

Principal officers: Frederick E. Noll, director.

The Prime Employee Assistance Program Inc.

214 N. Charles St., Baltimore, Md. 21201; 301-547-6650

Year founded: 1979.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Nine; six clinical staff members, including three CEAP, three MSW, one CAC, one RN, one Ph.D. designations.

On-site: social workers, marriage/family/child counselors.

Contracted: psychiatrists, psychologists, physicians.

Facilities: 350.

Reporting: Quarterly.

Service area: Maryland, Delaware, Pennsylvania, Virginia, West Virginia.

Clients: 60; 20% with one to 100 employees, 65% with 101 to 1,000, 10% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 25,000 employees and 50,000 dependents.

1990 gross revenues: $600,000; 100% from EAP services.

Principal officers: James J. Murphy, president/secretary; Albert J. Bautz, vp/treasurer.

Contact: Albert J. Bautz.

Professional Employee Assistance Consulting

15315 Magnolia Blvd., Suite 300, Sherman Oaks, Calif. 91403; 818-905-9313

Year founded: 1986.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment. Occasional legal problems, traumatic incident.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness, AIDS awareness, retirement planning. Occasional smoking cessation, nutrition/weight control, stress management.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Three; two clinical staff members, including one CEAP designation.

On-site: psychologists, marriage/family/child counselors, certified AIDS counselor & trainer.

Contracted: psychiatrists, social workers, physicians.

Facilities: 12 to 14.

Reporting: Annually, on request.

Specialties: Oil and beverage industries, attorneys, municipalities.

Service area: Los Angeles, Kern counties in California.

Clients: Six; 50% with one to 100 employees, 16% with 101 to 1,000, 34% with 1,001 to 5,000. Lives covered at year-end 1990: 6,500 employees.

1990 gross revenues: $90,000; 80% from EAP services, 20% from managed mental health care services.

Principal officers: Nancy A. Petenbrink, sole proprietor.

R

RADAR EAP Inc.

645 Farmington Ave., Hartford, Conn. 06105; 203-523-9273

Year founded: 1979.
Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns, management consultation. Occasional suicide, legal problems, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, eating disorders. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Seven; 30 clinical staff members, including three CAC, two MD, one RN, one Ph.D. designations.

On-site: two social workers, four marriage/family/child counselors.

Contracted: two psychiatrists, five psychologists, 16 social workers, six marriage/family/child counselors, one physician.

Facilities: Four.

Reporting: Quarterly, annually.

Service area: California, Colorado, Connecticut, Florida, Idaho, Massachusetts, Michigan, Missouri, New Jersey, Pennsylvania, Rhode Island, Texas, Canada.

Clients: 20; 30% with one to 100 employees, 60% with 101 to 1,000, 10% with 1,001 to 5,000.

1990 gross revenues: $110,000; 100% from EAP services.

Principal officers: Jane Gunn, chairperson; Jean Jones, secretary, Noreen McGill, treasurer, Marlene Dube, executive director.

Contact: Karen Reckmeyer, Marlene Dube.

Rehagen & Associates

707 N. East St., Bloomington, Ill. 61701; 309-827-4884

Year founded: 1986.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns, sexual abuse, eating disorders. Occasional suicide, legal problems, adolescent treatment.

Health promotion services: Frequent smoking cessation, nutrition/weight control, stress management, al-

Continued on next page

The reason you need Managed R_x to control prescription drug costs is spelled out right here.

Right here, on the label of every prescription drug container, are the most important elements of the prescription drug delivery system—the pharmacy, the patient and the drug.

If you want to control the cost and improve the quality and safety of your prescription drug benefit plan, each of these elements must be managed effectively.

That's the fundamental principle behind managed care today.

PCS has the nation's first and only fully integrated system for managing the entire prescription drug care benefit—the PCS *Managed* R_x℠ system.

Managed R_x offers you the

Continued from previous page
cohol awareness, drug/chemical awareness. Occasional physical fitness/exercise, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence, psychiatric disability review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, phone counseling.

Staff: Four; three clinical staff members, including one CEAP, two CAC, one Ph.D. designations.

On-site: two psychologists, two marriage/family/child counselors, two pastoral counselors.

Contracted: one psychiatrist.

Facilities: One.

Reporting: Quarterly.

Service area: McLean, Dewitt, Mason, Levingston, Sangamore, Tazwell, Champaign counties in Illinois.

Clients: Nine; 33% with one to 100 employees, 67% with 101 to 1,000. Lives covered at year-end 1990: 1,200 employees and 1,800 dependents.

1990 gross revenues: $90,000.

Principal officers: Gerald A. Rehagen, Marirose Rehagen, Judith Schnaitten.

Resource EAP Inc.

1046 Riverside Ave., Jacksonville, Fla. 32204; 904-634-1700; fax: 904-634-8803

Year founded: 1982.
For profit.

Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment. Occasional occupational problems, suicide, legal problems.

Health promotion services: Frequent smoking cessation, stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness.

Educational/general services: Frequent employee education, supervisor training.

Counseling sites: EAP/mental health care facilities.

Staff: 11; seven clinical staff members, including five CEAP, seven MSW designations.

Reporting: Quarterly.

Service area: Connecticut, Florida, Georgia, New Jersey, South Carolina.

Clients: 20% with one to 100 employees, 70% with 101 to 1,000, 10% with 1,001 to 5,000.

Principal officers: Robert J. Appleby, president; James Griffis, vp-operations.

Contact: Karen Whitworth.

S

St. Luke's Roosevelt Hospital Center Employee Assistance Program

428 W. 59th St., New York, N.Y. 10019; 212-523-7200

Year founded: 1986.
Parent company: St. Lukes Roosevelt Hospital Center.
Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, gambling, eating disorders, grief, AIDS, housing problems, immigration problems.

Health promotion services: Frequent stress management. Occasional smoking cessation, nutrition/weight control, alcohol awareness, drug/chemical awareness, AIDS awareness, sleep disorders.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Case management.

Counseling sites: EAP/mental health care facilities, phone counseling.

Staff: Six; four clinical staff members, including one CEAP, four MSW designations.

Contracted: psychiatrists, psychologists, social workers, physicians.

Reporting: Semi-annually, on request.

Specialties: Small corporations.

Service area: New York.

Clients: Lives covered at year-end 1990: 9,500 employees.

1990 gross revenues: $75,000; 100% from EAP services.

Principal officers: Ronnie Sue Jaffe, director-EAPs.

Straussner Associates

124 W. 79th St., New York, N.Y. 10024; 212-787-0357

For profit.

Assessment/treatment: Family/marital problems, alcohol abuse, adolescent treatment, child assessment, parenting problems, women's issues.

Educational/general services: Employee education.

Counseling sites: EAP/mental health care facilities.

Staff: Two; two clinical staff members, including one CEAP, one MSW, one Ph.D. designations.

Reporting: As requested.

Specialties: Small to mid-sized companies.

Service area: New York City.

Principal officers: Dr. Lala Straussner, Dr. Joel Straussner.

Contact: Dr. Lala Straussner, 212-787-0357 or 212-998-5947.

Listing of managed mental health care vendors

A

The Allen Group

2965 W. SR434, Suite 100, Longwood, Fla. 32779; 407-788-8822; fax: 407-862-1477

Year founded: 1980.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment. Occasional suicide, legal problems.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, communication skills. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Nine; five clinical staff members, including one CEAP, one Ph.D. designations.

Reporting: Quarterly.

Service area: Nationwide.

Principal officers: Dr. J.D. Allen, president; Linda Allen, vp-administration; Barbara Elkes, vp-services.

Contact: Linda Allen.

Allied Assistance Services

4500 Massachusetts Ave. N.W., District of Columbia 20016-5690; 202-457-1111; fax: 202-885-8605

Year founded: 1986.
Parent company: ACCA Inc.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns. Occasional suicide, legal problems, adolescent treatment.

Health promotion services: Frequent smoking cessation, physical fitness/exercise, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review.

Utilization review services: Pre-

Continued on next page

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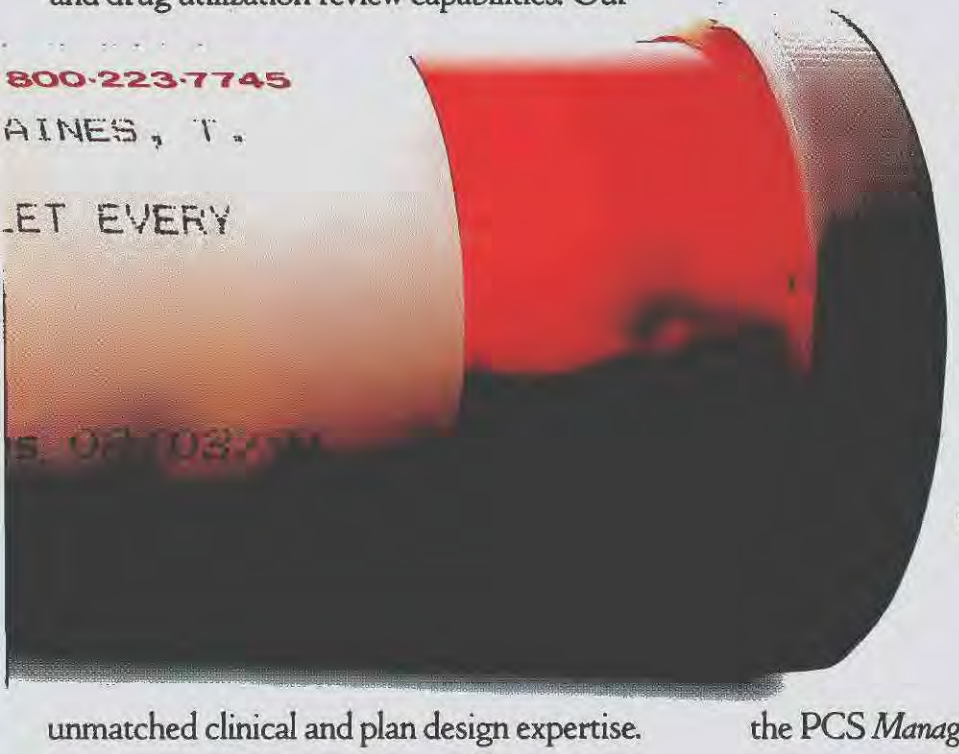

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By Managing Prescription Drug Care.℠

Continued from previous page
certification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 10; three clinical staff members, including four CEAP, four MSW, seven CAC, one MD, two Ph.D. designations.

Contracted: one psychiatrist, one psychologist, four social workers, two marriage/family/child counselors, one physician.

Reporting: On request.

Service area: District of Columbia, Maryland, Virginia; nationwide capability.

Clients: Five; 80% with 101 to 1,000 employees, 20% with 1,001 to 5,000. Lives covered at year-end 1990: 3,000 employees and 6,000 dependents.

1990 gross revenues: $100,000; 40% from EAP services, 60% from other services.

Principal officers: Alpha Brown, president; Gaudalupe Pacheco, treasurer; Deidre Saunders, secretary.

Contact: Alpha Brown.

American PsychManagement Inc.

1560 Wilson Blvd., Suite 1000, Arlington, Va. 22209; 703-528-2255; fax: 703-528-0623

Year founded: 1983.
Parent company: Value Health Inc.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, after-care monitoring.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 310; 92 clinical staff members, including five CEAP, 14 MSW, three CAC, six MD, 51 RN, 11 Ph.D designations.

Contracted: 1,847 psychiatrists, 1,220 psychologists, 4,864 social workers and 1,340 marriage/family/child counselors.

Facilities: 1,147.
Reporting: Quarterly.

Specialties: Computer, oil and financial services sectors.

Service area: Nationwide.

Clients: 184; 10% with 101 to 1,000 employees, 82% with 1,001 to 5,000, 13% with 5,001 or more. Lives covered at year-end 1990: 1.2 million employees and 1.9 million dependents.

1990 gross revenues: $18.6 million; 2% from EAP services, 98% from managed mental health care services.

Principal officers: Steve Linehan, chief executive officer; John Hill, chief operating officer; Ric Helfrich, chief financial officer; Tina Blasi, vp-network operations; Dan Patterson, medical director.

K.H. Antia, Ph.D. & Associates/Magi Human Resources Center

17730-B S. Oak Park Ave., Tinley Center, Tinley Park, Ill. 60477; 708-460-6060

For profit.

Assessment/treatment: Frequent stress, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment, incest victims. Occasional occupational problems.

Health promotion services: Frequent smoking cessation, weight control, stress management, alcohol awareness, drug/chemical awareness, disability/pain evaluation.

Educational/general services: Frequent supervisor training, workplace problem identification, psychiatric disability review, psychiatric workers compensation review. Occasional employee education, drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: Clients' headquarters, EAP/mental health care facilities, phone counseling.

Staff: Two clinical staff members, including one MSW, one Ph.D. designations.

Facilities: Six.

Reporting: On request.

Service area: Cook, DuPage, Grundy, Will counties in Illinois.

Principal officers: Dr. Kersey H. Antia, D.K. Antia, Ana K. Antia.

Contact: Dr. Kersey H. Antia, 8318 W. 138th Place, Orland Park, Ill. 60462.

B

Behavioral Health Access of Blue Cross of California

21555 Oxnard St., Woodland Hills, Calif. 91367; 818-712-6559; fax: 818-703-2848

Year founded: 1989.
Parent company: Blue Cross of California.
Not for profit.

Assessment/treatment: Frequent stress, alcohol abuse, drug/chemical abuse, adolescent treatment. Assessment/treatment of occupational problems, family/marital problems, suicide, legal problems, financial concerns by contractual arrangement only.

Health promotion services: Stress management, alcohol awareness, drug/chemical awareness by contractual arrangement only.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review by contractual arrangement only.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, phone counseling. Clients' headquarters, selected worksites by contractual arrangement only.

Staff: 11; five clinical staff members, including eight MSW, six MD, three Ph.D. designations.

On-site: one psychiatrist, three psychologists, eight social workers, one physician.

Contracted: 106 psychiatrists, 253 psychologists, 147 social workers, 110 marriage/family/child counselors.

Facilities: 104.

Reporting: Quarterly.

Service area: California.

Clients: 15; 20% with one to 100 employees, 20% with 101 to 1,000, 53% with 1,001 to 5,000, 7% with 5,001 or more. Lives covered at year-end 1990: 29,000 employees and 45,000 dependents.

1990 gross revenues: $4 million; 100% from managed mental health care services.

Principal officers: Leonard D. Schaeffer, chairman; H.W. Marston, Ron Williams, Mark Weinberg and Marvin Rich, executive vps.

Contact: Neal Andrews, director.

Behavioral Healthcare Options

2801 S. Valley View Blvd., Suite 8, Las Vegas, Nev. 89104; 800-873-2246; fax: 702-364-0843

Year founded: 1991.
Parent company: Sierra Health Services.
For profit.

Assessment/treatment: Frequent family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment, crisis, psychiatric and psychological services. Occasional stress, occupational problems.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness. Occasional smoking cessation, nutrition/weight control, stress management, AIDS awareness, health education-family awareness.

Educational/general services: Frequent employee education, psychiatric disability review. Occasional supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, phone counseling.

Staff: 30; 15 clinical staff members, including seven MSW, one CAC, two MD, one RN, one Ph.D. designations.

On-site: one psychiatrist, one psychologist, seven social workers.

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Continued from page 40
Contracted: one psychiatrist.
Facilities: 40.
Reporting: Quarterly.
Specialties: HMOs, insurance companies, self-insured, fee for service.
Service area: Arizona, Colorado, Nevada, New Mexico.
Clients: Lives covered in 1991: 200,000.
1990 gross revenues: 100% from managed mental health care services.
Principal officers: Stuart Ghertner, chief executive officer/president; Susan Prest, vp-utilization management; Michael Adams, vp-clinic operations.

Jenesys

1776 St. James Place, Houston, Texas 77056; 713-871-0821

Year founded: 1978.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, adolescent treatment. Occasional financial concerns.
Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, pre-natal counseling, trauma prevention. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.
Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, phone counseling.
Staff: 85; 418 clinical staff members, including three CEAP, 120 MSW/CSW, 15 CAC, 71 MD, eight RN, 107 Ph.D., 78 LPC, 22 MFCC designations.
Reporting: Monthly, quarterly.
Service area: Arkansas, California, Colorado, Florida, Georgia, Illinois, Louisiana, New Jersey, New Mexico, New York, Oklahoma, Pennsylvania, Texas.
Clients: 61; 18% with one to 100 employees, 51% with 101 to 1,000, 16% with 1,001 to 5,000, 15% with 5,001 or more.
1990 gross revenues: $8.8 million; 6.7% from EAP services, 76.2% from managed mental health care services, 17.1% from fee for service and medical director fees.
Principal officers: Dr. Thomas A. Blocher, chairman; Dr. James F. Considine, president/chief executive officer; Joseph V. Smith, executive vp; Dorothy Windham O'Shea, vp; Shirley Haeckel, controller/treasurer.

Bethesda Provider Network & EAP

4400 E. Iliff Ave., Denver, Colo. 80222; 303-759-6357

Year founded: 1910.
Parent company: Bethesda Psychealth System.
Not for profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional legal problems, financial concerns.
Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.
Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.
Staff: 15; 12 clinical staff members, including one CEAP, four MSW, one CAC, one MD, one RN designations.
On-site: four social workers, three marriage/family/child counselors.
Contracted: one psychiatrist, three marriage/family/child counselors.
Facilities: Five.
Reporting: Monthly, quarterly.
Specialties: Hospitals, educational institutions, small employers, manufacturing, financial institutions.
Service area: Colorado.
Clients: 100; 35% with one to 100 employees, 35% with 101 to 1,000, 30% with 1,001 to 5,000. Lives covered at year-end 1990: 30,000 employees and 20,000 dependents.
1990 gross revenues: $700,000; 60% from EAP services, 40% from managed mental health care services.
Principal officers: Patricia A. Hagan, director-contracting and managed care; Beth Brown, program director-employee assistance; Dr. Neil Weiner, medical director.
Contact: Beth Brown (EAP services) 3801 E. Florida Ave., Denver, Colo. 80210, 303-691-2374 or Patricia A. Hagan (managed mental health services).

Birmingham Psychiatry

3490 Independence Drive, Birmingham, Ala. 35209; 205-879-7953; fax: 205-870-7987

Year founded: 1974.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, financial concerns, adolescent treatment. Occasional legal problems, drug/chemical abuse.
Health promotion services: Frequent smoking cessation, nutrition/weight control, stress management. Occasional physical fitness/exercise, alcohol awareness, drug/chemical awareness, AIDS awareness.
Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.
Counseling sites: Clients' headquarters, selected worksites.
Staff: 12, including CEAP, MSW, CAC, MD, RN, Ph.D., two LPC designations.
On-site: eight psychiatrists, 12 psychologists, two social workers, one marriage/family/child counselor.
Contracted: Four psychiatrists, eight psychologists.
Facilities: Seven.
Reporting: Monthly.
Service area: Alabama.
Clients: Lives covered at year-end 1990: 40,000 employees and 50,000 dependents.
1990 gross revenues: $2.2 million; 10% from EAP services, 90% from managed mental health care services.
Principal officers: Dr. H.E. Logue, president; Dr. James M. Lee, vp; L.E. Shehi Jr., medical director.
Contact: Richard D. Robins, 205-868-4221.

Bradman Therapy Centers

7951 S.W. Sixth St., Suite 100, Plantation, Ill. 33324; 305-474-8727; fax: 305-474-1351

Year founded: 1986.
Parent company: Unipsych Corp.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent
Continued on next page

WESTERN U.S. – What happens when a neurologist and orthopedist are treating the same patient and can't agree on a method of treatment?

That's the situation Conservco Medical Case Manager Laura Avedesian encountered when she opened the case of a 64-year-old woman who broke her right ankle. Three days later, the woman suffered a stroke that affected her left side, totally incapacitating her.

"There seemed to be a lack of communication between the two attending doctors," noted Laura. "The orthopedist didn't plan to begin treatment until he received authorization from the neurologist. At the same time, the neurologist was waiting for the orthopedist to make the first move."

Laura consulted a Conservco physician advisor who initiated a peer-to-peer review. Once the lines of communication were open, the doctors agreed upon a method of treatment. As a result, the woman was able to return home from the hospital two weeks earlier than expected.

Laura's actions and the intervention of one of our physician advisors not only helped bring a woman home to her family ahead of schedule, but also helped save thousands of dollars in unnecessary hospital costs.

While this case was unusual, the fact that Conservco's Medical Case Management program saved thousands of employee benefit dollars is not. It's something we do for our clients on a daily basis and something we can do for you.

To get the full story on medical case management and other common sense ideas, call Conservco at 1-800-525-5590. Because the need to manage rising medical costs is one idea we all can agree on.

HOW WE HELPED A STROKE VICTIM SUFFERING FROM A BREAKDOWN IN COMMUNICATION.

A DAY IN THE LIFE OF A CONSERVCO R.N., #6 IN A SERIES.

LAURA AVEDESIAN, R.N.
Medical Case Manager

CONSERVCO
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Integrated Medical/Disability Management

Continued from previous page
treatment. Occasional legal problems, financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification, psychiatric disability review, psychiatric workers compensation review. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 100; 70 clinical staff members, including 18 MSW, two CAC, 20 MD, 30 Ph.D. designations.

On-site: two psychiatrists, three psychologists, one social worker, one marriage/family/child counselor.

Contracted: 18 psychiatrists, 27 psychologists, 17 social workers, two marriage/family/child counselors, one physician.

Facilities: 32.

Reporting: Quarterly.

Specialties: Self-insured employers.

Service area: Florida, nationwide availability with 90- to 120-day notice.

Clients: 17; 30% with 101 to 1,000 employees, 40% with 1,001 to 5,000, 20% with 5,001 or more. Lives covered at year-end 1990: 100,000.

1990 gross revenues: 2% from EAP services, 90% from managed mental health care services, 8% from consulting.

Principal officers: Dr. Leo Bradman, chairman; Ronald Harshman, president/chief executive officer; Dr. Ernest Cohen, psychiatric director; Laurel Patterson, administrator; Dr. David Storrs, computer and MIS director.

Contact: Dr. Leo Bradman.

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Burke-Taylor Associates

P.O. Box 12692, Research Triangle Park, N.C. 27709; 919-941-5512

Year founded: 1981.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 38; 30 clinical staff members, including 22 CEAP, five MSW, eight CAC, two RN designations.

Reporting: Quarterly.

Service area: Alabama, Georgia, North Carolina, South Carolina.

Clients: 10% with one to 100 employees, 65% with 101 to 1,000, 20% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 103,000 employees.

1990 gross revenues: $2 million; 95% from EAP services, 5% from managed mental health care services.

Principal officers: John J. Burke, president; Chuck Taylor, vp-operations.

Contact: John J. Burke.

C

CMG Health

25 Crossroads Drive, Owings Mills, Md. 21117; 301-581-5000; fax: 301-581-5007

Year founded: 1986.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, retrospective review, discharge planning.

Counseling sites: All worksites, EAP/mental health care facilities, selected worksites and phone counseling available.

Staff: 95; 755 clinical staff members, including two CEAP, 11 MSW, one CAC, 11 MD, 10 RN, seven Ph.D., one D.O., four LCSW designations.

Contracted: 134 psychiatrists, 183 psychologists, 307 social workers.

Facilities: 18.

Reporting: Varies by product line and as requested.

Specialties: HMOs, PPOs, insurance companies.

Service area: 20 states and the District of Columbia.

Clients: One, with 5,001 or more employees. Lives covered at year-end 1990: 250,000 employees and 350,000 dependents.

1990 gross revenues: 5% from EAP services, 95% from managed mental health care services.

Principal officers: Alan Shusterman, president; Dr. Ronald Cunn, vp-medical affairs; Dr. Douglass Kay, vp-quality assurance; Lisa Shusterman, vp-clinical affairs; Diana Woltereck, vp-operations; Henry Boyd, vp-finance; Wayne Feest, vp-sales/marketing.

Contact: Tracy Witek, public relations specialist.

California Psychological Health Plan

5750 Wilshire Blvd., Suite 490, Los Angeles, Calif. 90036; 213-965-4870 ext. 217; fax: 213-937-9688

Not for profit.

Assessment/treatment: Stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, alternative lifestyle issues.

Health promotion services: Smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: Clients' headquarters, selected worksites, phone counseling.

Staff: 22, including two CEAP, one MSW, one MD, one RN, two Ph.D. designations.

On-site: two psychologists, one social worker.

Contracted: three psychiatrists, 17 psychologists.

Reporting: Quarterly.

Specialties: Schools, municipalities.

Service area: California.

Clients: 5% with one to 100 employees, 65% with 101 to 1,000, 25% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 93,000 employees and 140,000 dependents.

1990 gross revenues: $6.9 million; 10% from EAP services, 90% from managed mental health care services.

Principal officers: Dr. James Holt, chairman; Robert L. Belichick, director-marketing; Dr. Michael Jospe, director-professional services; Julia Cyburt, controller.

Contact: Robert L. Belichick.

Continued on page 46

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Continued from page 44

CIGNA Mental Health Inc.

11095 Viking Drive, Suite 350, Eden Prairie, Minn. 55344; 612-943-9500; fax: 612-943-9579

Year founded: 1974.
Parent company: CIGNA Corp.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional legal problems, financial concerns.
Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.
Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.
Staff: 850; 408 clinical staff members, including 122 MSW, 81 CAC, 85 MD, 45 RN, 120 Ph.D. designations.
On-site: 85 psychiatrists, 120 psychologists, 122 social workers and marriage/family/child counselors.
Contracted: 1,420 psychiatrists, 1,320 psychologists, 1,477 social workers and marriage/family/child counselors, 80 physicians.
Facilities: 1,907.
Reporting: Quarterly.
Service area: Nationwide except Idaho and Wyoming.
Clients: 250; 26% with one to 100 employees, 51% with 101 to 1,000, 13% with 1,001 to 5,000, 10% with 5,001 or more. Lives covered at year-end 1990: 1 million employees.
1990 gross revenues: $80.8 million; 12% from EAP services, 88% from managed mental health care services.
Principal officers: Travis Wills, president; Mark Johnson, vp-operations, West region; Randy Cox, vp-operations, East region; Joe Strahan, vp-operations, national service center; Julian Cohen, vp-operation support.
Contact: Mary Ellen F. Hamel, CIGNA Employee Benefits Cos., 900 Cottage Grove Road, Bloomfield, Conn. 06152; 203-726-5805.

Community Care Network

8911 Balboa Ave., San Diego, Calif. 92123; 800-247-2898; fax: 619-278-5955

Year founded: 1984.
Parent company: San Diego Health Care Alliance.
Not for profit.
Assessment/treatment: Frequent family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment, behavioral health conditions. Occasional stress, occupational problems, legal problems, financial concerns, adolescent treatment.
Utilization review services: Precertification of inpatient treatment, precertification of outpatient treatment, concurrent review, case management, assessment/referral.
Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.
Staff: 323, including MSWs, RNs, Ph.D.s, MFCCs.
Contracted: 380 psychiatrists, 203 psychologists, 212 social workers, 124 marriage/family/child counselors, 11,120 physicians.
Facilities: 328.
Reporting: Quarterly.
Service area: California.
Clients: 499. Lives covered at year-end 1990: 622,978.
Principal officers: George Murphy, chief executive officer; Robert Colasanto, president; Sandra Foote, vp-provider affairs; Nancy Plaxico, vp-purchaser affairs; Douglas Reeves, vp-information systems.
Contact: Armando Jackson, marketing manager-Western region.

ComPsych Employee Assistance Programs Inc.

515 N. State St., Suite 2310, Chicago, Ill. 60610; 312-332-4081 or 800-272-7255; fax: 312-419-6140

Year founded: 1981.
For profit.
Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, psychological issues. Occasional occupational problems, suicide, adolescent treatment.
Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, life management classes. Occasional smoking cessation, nutrition/weight control.
Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, management customized training seminars. Occasional psychiatric disability review, psychiatric workers compensation review.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, follow-up management.
Counseling sites: All worksites, EAP/mental health care facilities, selected worksites, phone counseling.
Staff: 30; 21 clinical staff members, including three CEAP, five MSW, two CAC, three MD, one RN, five Ph.D. designations.
On-site: three psychiatrists, five psychologists, five social workers, nine marriage/family/child counselors.
Contracted: 10 psychiatrists, 1,000 psychologists, 40 social workers, 1,000 marriage/family/child counselors.
Reporting: Quarterly, varies by contract.
Service area: North America and Puerto Rico.
Clients: 137; 19% with one to 100 employees, 45% with 101 to 1,000, 29% with 1,001 to 5,000, 7% with 5,001 or more. Lives covered at year-end 1990: 220,000 employees and 330,000 dependents.
Principal officers: Dr. Richard A. Chaifetz, president; Michael B. Garfield, vp-corporate services; Jill Stephan, comptroller.
Contact: Michael B. Garfield.

CONCERN: Counseling & EAP Services

8030 Montgomery Road, Suite 200, Cincinnati, Ohio 45236; 513-891-1627; fax: 513-891-0673

Year founded: 1984.
Parent company: Bethesda Healthcare Inc.
Not for profit.
Assessment/treatment: Frequent stress, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional occupational problems, legal problems, financial concerns.
Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence. Occasional workplace problem identification, psychiatric disability review.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, claims review and authorization.
Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.
Staff: 64; 50 clinical staff members, including 20 CEAP, 20 MSW, three CAC, two MD, one RN, three Ph.D., 24 LPC designations.
Reporting: Quarterly.
Specialties: Sales and marketing staffs.
Service area: Nationwide.
Clients: 130; 19% with one to 100 employees, 66% with 101 to 1,000, 11% with 1,001 to 5,000, 4% with 5,001 or more. Lives covered at year-end 1990: 100,000 employees and 150,000 dependents.
1990 gross revenues: 75% from EAP services, 25% from managed mental health care services.
Principal officers: Daniel E. Ansel, director-Behavioral Health Systems; Mark Self, manager-CONCERN Counseling Services; Mary Monfiles, national program director; Pat Minzner, managed care director.
Contact: Mitch Fillhaber, director-business development and sales, 513-891-1622.

Corporate Counseling Associates Inc.

475 Park Ave. S., New York, N.Y. 10016; 212-686-6827; fax: 212-686-6511

Year founded: 1985.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol

Continued on next page

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Continued from previous page
abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, dependent care, psychological problems.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, eldercare, parenting.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 16; 12 clinical staff members, including six CEAP, 11 MSW, six CAC, two Ph.D. designations.

On-site: two psychologists, 10 social workers.

Contracted: three psychiatrists.

Reporting: Quarterly.

Specialties: Communications, retail, public service authorities.

Service area: Nationwide.

Clients: 25; 44% with 101 to 1,000 employees, 44% with 1,001 to 5,000, 12% with 5,001 or more. Lives covered at year-end 1990: 70,000 employees and 175,000 dependents.

Principal officers: Robert Levy and Eugene Cooper, principals; Georgia Critsimilios, director-marketing.

Contact: Georgia Critsimilios.

Creative Care Management

1440 Hicks Road, Rolling Meadows, Ill. 60008; 708-894-7113; fax: 708-590-5908

Year founded: 1981.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, child care, elder care.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, psychiatric disability review. Occasional drug-free workplace regulatory adherence, workplace problem identification, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites.

Staff: 13; five clinical staff members, including four CEAP, eight MSW, four CAC, one MD, two Ph.D. designations.

On-site: one psychologist, seven social workers.

Contracted: one psychiatrist, one psychologist, 40 social workers.

Reporting: Semi-annually, annually.

Service area: 16 states.

Clients: 32; 10% with one to 100 employees, 20% with 101 to 1,000, 30% with 1,001 to 5,000, 40% with 5,001 or more. Lives covered at year-end 1990: 60,000 employees and 140,000 dependents.

1990 gross revenues: 40% from EAP services, 30% from managed mental health care services, 30% from consulting.

Principal officers: Fred Vojtsek, president; Paul Maiden, vp-national business development; Rick Kronberg, vp-clinical operations; Allen Showalter, psychiatrist; Eric Ostrov, psychologist.

Contact: Fred Vojtsek.

E

EAP Associates

2775 Cottage Way, Suite 18, Sacramento, Calif. 95825; 916-972-0703

Year founded: 1980.

Parent company: Breining Institute.

For profit.

Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, drug/chemical abuse. Occasional occupational problems, suicide, financial concerns.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, stress management.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 12; six clinical staff members, including one CEAP, six CAC, one LLD designations.

Contracted: two psychiatrists, two psychologists, two social workers, three marriage/family/child counselors, two physicians, five CADCs.

Facilities: Six.

Reporting: Quarterly.

Service area: Sacramento, Yolo, El Dorado, Placer, Colusa, San Joaquin, Amador counties in California.

Clients: 10; 30% with one to 100 employees, 60% with 101 to 1,000, 10% with 5,001 or more.

Principal officers: Bernard Breining.

EAP Systems

51 N. 12th St., Kansas City, Kan. 66102; 800-624-5544; fax: 913-281-8494

Year founded: 1978.

Parent company: Bethany Medical Center.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 13; 350 contracted clinical staff members, including two CEAP, two MSW, one MD, two Ph.D., six LPC designations.

Reporting: Quarterly.

Service area: Nationwide and Canada.

Clients: 75; 3% with one to 100 employees, 71% with 101 to 1,000, 14% with 1,001 to 5,000, 12% with 5,001 or more. Lives covered at year-end 1990: 100,000 employees and 131,000 dependents.

Principal officers: Richard H. Ready, director.

Employee Advisory Resource

8100 34th Ave. S., P.O. Box 0-HQW 03P, Minneapolis, Minn. 55440-4700; 612-853-3206; fax: 612-853-5599

Parent company: Control Data Corp.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, price control, fee negotiation/bill review.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

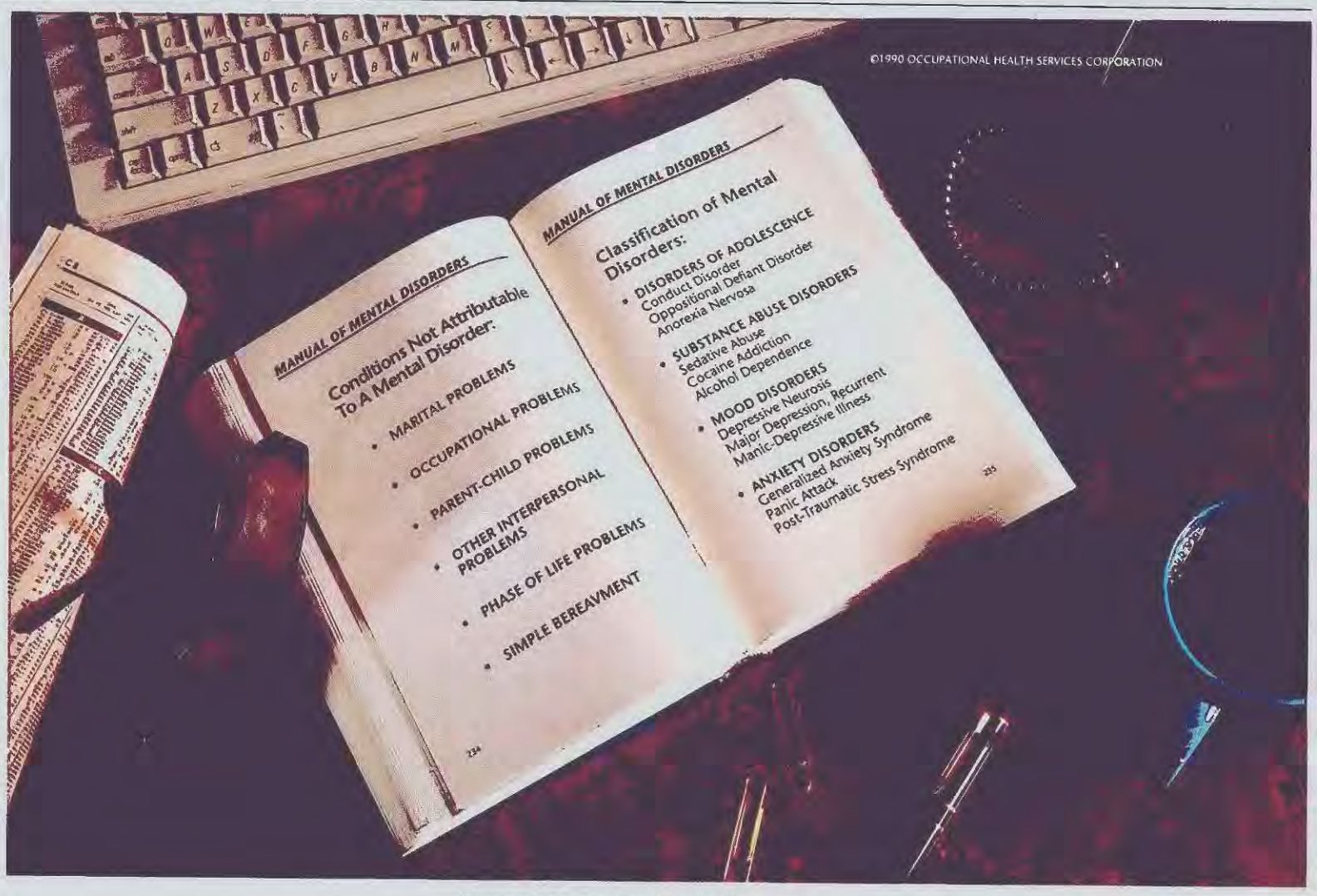
Staff: 94; 17 clinical staff members, including one CEAP, 10 MSW, two Ph.D., three CCDP, one DMIN designations.

On-site: 10 psychologists, 12 social workers.

Contracted: 110 psychologists, 29 social workers.

Reporting: Quarterly.

Continued on page 56



To treat or not to treat, isn't the question.

The problems on the left page affect most of your work force at one time or another.

Untreated, they lead to higher medical and psychiatric benefit costs, increased absenteeism, and diminished productivity. Yet, they do not meet the reimbursement guidelines under your health benefit plan.

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The diagnoses on the right page may only affect a small percentage of your employees.

Treatment, however, will eat up a tremendous amount of your medical benefit dollars. Without specialized managed mental health care services, your employees and dependents are subject to unnecessary hospitalizations, ill-conceived treatment plans, and overly lengthy stays that often characterize psychiatric and chemical dependency treatment.

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OHS. Occupational Health Services Corporation. 125 East Sir Francis Drake Blvd., Larkspur, CA 94939. Fax: 415/925-9728. Phone: 800/327-7526.

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American International Companies

MEDICAL COST CONTAINMENT REPORT

ACCOUNT NO. 9999999	POLICY NO. 999999999	ACCOUNT NAME ABC CORPORATION	POLICY PERIOD 1/1/90-12/31/90	PAYMENT PERIOD 9/1/90-12/31/90	REPORT DATE 9/15/90	PAGE 1

REPORTING DIVISION 100 ALL DIVISIONS
REPORTING LOCATION 011 ALL LOCATIONS

OFF	CASE	CLAIMANT NAME	STATE	NUMBER BILLS	ORIGINAL AMOUNT	AMOUNT PAID	S	PBA	E	R HBR	V	I PRO	C	E OTHERS	S	GROSS SAVINGS
001	123451	S. HURCHALLA	PA	2	1,230.00	984.93		0.00		245.07		0.00		0.00		245.07
001	123452	G. KOSTURA	OH	1	225.00	183.49		0.00		0.00		0.00		41.51		41.51
001	123453	W. DOE	FL	6	2,251.38	1,751.74		258.30		0.00		31.01		10.50		479.84
001	123454	J. GREENE	TX	1	100.00	62.19		26.02		0.00		221.25		0.00		37.80
001	123455	K. MURRAY	GA	5	15,203.48	11,709.38		369.68		0.00		11.77		0.00		3,484.10
001	123456	J. HARRINGTON	NH	2	6,081.38	4,687.74		0.00		0.00		3,115.67		0.00		1,393.64
001	123457	A. HAYES	PA	10	3,040.69	2,343.87		0.00		73.93		1,245.78		147.86		696.82
001	123458	D. PSZONEK	FL	3	9,122.07	7,031.61		221.79		0.00		622.89		0.00		2,090.46
001	123459	C. FINN	GA	1	1,520.33	1,171.93		0.00		36.96		1,808.60		60.07		348.40
TOTALS FOR LOCATION 011 ALL LOCATIONS				22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTALS FOR DIVISION 100 ALL DIVISIONS				22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65

PBA: PROVIDER BILL AUDIT PPO: PREFERRED PROVIDER ORGANIZATION HBR: HOSPITAL BILL REVIEW OTHERS: OTHER TYPES OF SAVINGS

American International Companies

MEDICAL COST CONTAINMENT SUMMARY

ACCOUNT NO. 9999999	ACCOUNT NAME ABC CORPORATION	PAYMENT PERIOD 9/1/90-12/31/90	REPORT DATE 9/15/90	PAGE 1

	NUMBER BILLS	ORIGINAL AMOUNT	AMOUNT PAID	S	PBA	E	R HBR	V	I PRO	C	E OTHERS	S	GROSS SAVINGS
TOTAL FOR POLICY PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTAL FOR ACCOUNT PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTAL FOR POLICY PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTAL FOR ACCOUNT PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTAL FOR POLICY PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTAL FOR ACCOUNT PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTAL FOR POLICY PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTAL FOR ACCOUNT PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65
TOTAL FOR POLICY PERIOD ABC CORPORATION	22	38,844.53	30,026.88		876.05		355.96		7,367.21		218.43		8,817.65

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A little strategic planning at the outset, we've found, can speed things up further down the road.

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Ranking from Business Insurance, "Agent/Broker Profiles," June 18, 1990.

Chemical dependency

Utilization is up, but many plans' approach to care still incomplete

By Dr. Richard Kunnes and Barbara Lambert

MOST CHEMICAL DEPENDENCY programs implemented in worksites across the county have played to mixed reviews and discomfiting controversy. At the same time, destigmatization of the dependency problem has played a major role in increasing utilization of chemical dependency services.

For example, nationwide publicity generated by published biographies of Betty Ford and Kitty Dukakis have created a virtual bipartisan coalition for fixed-day, inpatient chemical dependency treatment programs. Further, intensive and advertising—particularly by expensive, inpatient-based 28-day programs—have upped utilization to a significant level, while failing to demonstrate little in the way of proven efficacy or quality, let alone success.

One negative common point among these programs, including some of the best, is a lack of comprehensiveness. While one can make the argument that "doing something is better than doing nothing," what currently is being done is not nearly enough. Consequently, many programs are

Publicity generated by biographies of Betty Ford and Kitty Dukakis have created a virtual bipartisan coalition for fixed-day, inpatient chemical dependency treatment programs.

ineffective and ultimately discouraging, leaving us to face the problem of managing the unmanageable.

In an attempt to confront the issue of comprehensiveness, we simplistically have divided the chemical dependency "continuum of care model" into four major components:

- Prevention.
- Assessment.
- Treatment.
- After-care.

We reviewed programs around the country and analyzed our own experiences with major employer groups. It became clear that even where there were elements of comprehensiveness—like having two or three of the above components—non-integration nevertheless make the continuum less than comprehensive and, consequently, less than effective. Programs weak in any of the four critical areas cited above created deficiencies in the whole approach and minimized the program's effectiveness. In fact, it appears as if the most important component is "integrated comprehensiveness," where particular attention needs to be given to what are often the two weakest links in many programs: prevention and after-care.

Failure to achieve a high level of integration and comprehensiveness clearly hurts programs. Integrated components, on the other hand, promote quality and cost control synergy for employer and employee. While maximizing the potential for reducing dependency, these integrated components increase opportunities for successful treatment outcomes, reduce relapses and help maintain a valuable, productive workforce.

Rising costs and concerns about chemical dependency have created the need for comprehensive workplace programs. About 10% of employees use drugs in the workplace. The combined cost of psychiatric and chemical dependency care is going to increase by an astonishing 41% in 1991, according to a recent report by A. Foster Higgins & Co. Inc. Yet, only 5% to 10% of the chemically dependent receive treatment.

Increasing safety and security concerns, short- and long-term disability costs, workers compensation, medical and surgical claims can often be traced back to chemical dependency disorders. Additionally, other work performance concerns—like lost productivity, inventory "shrinkage," absenteeism and turnover—are connected with patterns of abuse.

To address this wide range of related chemical dependency problems and to manage the unmanageable, "integrated comprehensiveness" emerges as the most important missing component. Employers need to send a clear message to employees, develop and implement effective policies, provide education and assistance, and design chemical dependency managed care benefits. Additionally, it is important to provide quality care, produce cost-effective outcomes, reduce inappropriate utilization of health care services and keep people productive on the job.

With the implementation of a continuum of care model, this challenge becomes an achievable reality:

✔ Prevention.

Establishing a drug-free culture and philosophy can create a corporate ambiance supportive of drug avoidance. It also encourages quicker approaches to assessment, destigmatizes the problem and assists in breaking through denial barriers. And denial is often the key symptom of chemical dependency established to "protect" the problem and prevent detection and treatment.

Within each continuum component are many interactive sub-components. For example, within "establishing a drug-free corporate culture" are such features as:

- Creative, compassionate and effective policies and procedures that deliver a clear message, while establishing earlier return-to-work/stay-at-work goals.
- Giving easy access to confidential services and encouraging self-referral.
- In-house training and education programs for supervisors, employees and family members. These are essential to increasing awareness while decreasing dependency and preventing problems from occurring and escalating.

Such programs effectively destigmatize the problem, bring it "out of the closet," and lessen the need for care.

This abbreviated laundry list indicates the interactive and enhancing potential among these components and sub-components. Employers also need to be creative or at least to try to look at old issues from a somewhat fresher perspective. For example, comprehensive prevention approaches commonly consist of some form of testing—most often pre-employment testing or "for cause" testing. However, other forms of testing may be more effective. Three possible examples are: non-random testing, risk rating and function testing.

While random testing is a much-discussed and often-debated issue with limited employee acceptance, little, if anything, has been written or attempted in the area of *non-random* testing. Non-random testing would have the advantage of catching those truly unable to confront their drug usage, since employees would have pre-notification of such testing.

Risk rating is another relatively novel approach to group health benefit design in the chemical dependency area. There are many ways to implement risk rating. Under one scenario, the employee who voluntarily agrees to testing and tests negative also pays lower out-of-pocket costs for all group health benefits.

Function testing could replace most mass, direct drug screenings. That is, as a matter of policy, employees would be expected to routinely perform specific functions—typing, for example—on a timely and accurate basis. Those who routinely cannot or do not pass function testing may become subject to drug testing.

A final comment on prevention and the importance of comprehensiveness: We think it is essential to include alcohol in any chemical dependency program. While many companies do an excellent job of establishing an anti-drug atmosphere, they have little to say about alcohol. Yet, alcohol may quickly become "the drug of choice" once the company takes a strong stand to eliminate other drugs.

One common point among programs is a lack of comprehensiveness. Many such programs are ineffective and ultimately discouraging, leaving us to manage the unmanageable.

✔ Assessment.

Very easy access to the earliest possible problem assessment is critical to successful prevention and treatment. Assessment must be available 24 hours a day, seven days a week. It must be provided by caring professionals who are very sensitive to the difficulty of the caller and the often urgent nature of the call.

Assessment should be performed through a national 800 number by and for the prospective patient of any representative of the prospective payer. Often, programs insist that the person with the problem must call on his or her own behalf. While there are clinically sound arguments for this approach, it is not always realistic. Access to care should not be limited or restricted, but rather made available through a variety of access points. Flexibility, not rigidity, is the appropriate approach of easy, early access to care.

It is critical that the benefit design complements the desired outcome. Such consistency further supports the fully integrated, continuum of care model. That is, coverage for chemical dependency must be generous enough and comprehensive enough to encourage people to immediately seek the most appropriate care. This is most often achieved by having readily available free EAP services that encourage seeking assistance and create a positive experience from the point of initial contact with the program.

Additionally, benefit design should include chemical dependency outpatient coverage at the same level as inpatient coverage. Traditionally, outpatient coverage is reimbursed at 40% to 60%, while the more expensive inpatient coverage is in the 80% to 100% range.

Such disparities encourage expensive inpatient care that doesn't necessarily increase quality or cost-effectiveness. Unnecessary inpatient care can also greatly disrupt patients' personal and professional lives, while creating an unrealistic model of what life without dependency will be like—removing them from real-world stresses and strains.

Benefit designs that pay for and encourage prospective case management will most likely insure that proper assessment precedes treatment and is not something to be circumvented by or provided for only in hospital emergency rooms. Prospective case management in this context becomes an asset, an

Continued on next page

Chemical dependency

Continued from previous page
important step in the assessment process that occurs before any treatment except, of course, in the case of true medical emergencies. Such an approach emphasizes individualized needs and treatment design, matching symptoms with services, and vice versa.

Treatment.

Critical to successful treatment is a specialized, highly skilled and dedicated preferred provider network. That is, all maximally reimbursed chemical dependency services must be network-based and monitored and managed by chemical dependency specialists. Use of a pre-selected, continuously evaluated specialist network assures better quality and more cost control. Managed, network-based chemical dependency care also assures easy access for patients.

Chemical dependency networks should not be evaluated by the size of their directory, but rather by the seriousness of their quality oversight functions of a wide range of treatment modalities. Network monitoring should include on-line quality assurance systems. Such on-line quality assurance systems allow for continuous ratings of provider performance along a number of well-defined parameters, not the least of which is, "does the patient measurably improve?" The networks in turn must be available on a national basis in all major metropolitan areas in order to offer consistent service and benefits on a national basis, particularly for large national employers and unions.

Further, network composition must be comprehensive. That is, the fullest range of services and professionals must be available to match symptoms with services and vice versa. Of particular note is the need for intermediate intensity programs—partial hospitalization, day treatment and night treatment types of programs—specifically designed for chemical dependency cases. Such service synergy will cut claim costs and increase clinical quality while providing the most appropriate and applicable care.

Benefit design must be generous enough to encourage outpatient care, while being balanced and sophisticated enough to avoid diagnosis "gaming" of the system, or creating preferences for chemical dependency vs. psychiatric diagnoses (or vice versa) or medical/surgery vs. chemical dependency/psychiatric diagnoses.

With the proper blend of benefit designs and carefully selected networks, claim and quality guarantees can be offered to corporate customers. Such guarantees can contractually offer limits on chemical dependency claim expense significantly below current levels of utilization, irrespective of inflation, even while enriching chemical dependency treatment benefits. Performance guarantees can be tied to overall medical/surgical claim dollars, to absentee rates, to recidivism rates and to other work performance criteria.

It is essential to actively involve family members, union representatives, supervisors and employees themselves in ongoing after-care efforts.

Further, because of the presence of a comprehensive chemical dependency network, chemical dependency disability and chemical dependency workers compensation impairments can be evaluated in the same network. This will save significant chemical dependency workers compensation and disability claim dollars.

A key chemical dependency quality feature is systematic satisfaction and grievance instruments, accessible to patient, provider and management. For example, this might include a strong member service component, along with both internal and external review boards to assess critical or controversial cases.

After-care.

Even programs that can be considered to be comprehensive in prevention, assessment and treatment efforts, all too often fall frightfully short in the area of after-care. This could account, in part, for the high rates of recidivism that still exists in the chemical dependency field.

First, specific staff and programs must be dedicated solely to chemical dependency after-care. Additionally, worksite commitment to after-care must be visible; employees must be integrated back into the workplace and placed in ongoing support groups. Visible success stories often convey the most powerful message of all, encouraging others to seek assistance for themselves.

It is essential to actively involve family members, union representatives, supervisors and employees themselves in ongoing after-care efforts. Also critical is offering a wide range of support, education, information, and resources.

Integrated, comprehensive, network-based, managed programs, coupled with pro-active prevention and affirmative after-care programs, are a needed to combat chemical dependency. This can be done cost-effectively without sacrificing quality care. Indeed, quality can be enhanced.

Success can be measured though continuing abstinence, lowered per employee health care costs, reduced worksite accidents and inpatient hospital days, along with decreased and less expensive workers compensation and disability claims and decreased workplace crime.

Harder to measure, but equally important, success factors include healthier workers, improved work relationships, increased motivation and productivity, and a reduced demand for drugs.

It is safe to say there is a great deal more that can be done to manage chemical dependency problems. Failure to do more than is currently being done has lead to the "mixed reviews" received by most chemical dependency programs around the country. Integrated comprehensiveness is a key component to changing this. ■

Richard Kunnes, M.D., is chief operating officer and Barbara Lambert is director of training, education and consultation at U.S. Behavioral Health in Emeryville, Calif., a unit of Travelers Corp.

Mr. Kunnes

Ms. Lambert

Managed mental health care

Growth in industry can cause new problems for employers

By Leo H. Bradman

A BENEFITS CONSULTANT recently called me to ask for my assistance in evaluating the approximately 40 responses that he received when he released a request for proposal for a managed mental health care contract. This did not surprise me as there has been explosive growth in this specialized industry. Historically, it represents an opposite and equal reaction to the tremendous growth of for-profit provider systems that occurred a number of years ago.

Until recently, the overriding issue has simply been to cut costs. I'll focus on how costs are being reduced and what possible future costs are being increased. A small but growing number of legal cases show that employers *eventually* may have to pay the consequences of some of the current problems associated with managed mental health care.

One example of a significant problem is the fact that some incentive-driven providers have become adept at deciphering ways to exploit any system. They tend to overutilize benefits in the usual manner when there are little or no management controls. However, the same providers may underutilize or misutilize benefits when this will bring them added "managed care" referrals. Indeed, it is not uncommon to find some of the most aggressive utilizers of the past now heavily marketing themselves in managed care environments.

Some of the most important factors that should be considered in selecting a managed mental health care company are cited below, with some caveats.

- **Ownership.** Since everyone is getting into the managed mental health care arena, one should ask who owns or operates the company and what hidden agendas there may be.

Managed mental health care companies are now being owned and operated by venture capital firms, insurance companies, hospitals, employee assistance program companies, case management firms, groups of providers, health maintenance organizations and others. Issues of vested interest and conflict of interests should be fully examined.

- **References.** A balanced reference sheet is essential. An effective company should receive high marks from different and sometime competing sectors, including benefit consultants, insurers, claims administrators, employers, hospitals, medical directors, local professionals, unions and other groups. The best company to select is one that respects the needs of all parties without undue bias toward any single interest. A confident vendor also will provide references from contracts that have been terminated or not renewed and specify the reasons they were discontinued.

Some incentive-driven providers have become adept at deciphering ways to exploit any system.

- **Providers.** It's essential to have an adequate number of providers (clinicians and facilities) that are properly dispersed geographically. These providers should all be licensed, insured and properly credentialed. They should be required to directly render services, not just supervise lesser credentialed or unlicensed clinicians.

Beware of companies that boast extremely large provider lists. Very often, these lists are compiled through mail-in applications, and most of the providers listed are rarely, if ever, used. I recommend companies that have a sufficient number of closely monitored and reputable private-sector providers.

- **Utilization.** The company should provide ample data about past performance and expected future performance. In particular, care should be taken in selecting a company that ensures proper utilization patterns without risking either overutilization or underutilization of benefits. It is not

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PAY NOW OR PAY LATER

...the cost cutting gamble.

Cutting benefits for treatment of drug and alcohol abuse is not a cost effective solution to controlling rising health care costs. In fact, paying less in the short term could result in paying more later.

Cookie cutter formulas that arbitrarily reduce treatment or restrict coverage to outpatient services may not be cost effective in the long term.

Your health care benefits plan should include coverage for a full range of treatment services – using your monies more wisely by making certain that your employee or their dependents receive the treatment services most appropriate to their needs.

The high cost of inappropriate treatment.

Providing the wrong type or intensity of treatment can be costly. When substance abuse is inappropriately treated, the employee and family members will continue to experience the physical and emotional turmoil that results from these problems. Providing inadequate care, or treatment that is not needed, translates directly into increased health care costs.

THE PARKSIDE PERSPECTIVE ON HEALTH CARE BENEFITS FOR SUBSTANCE ABUSE.

The facts are clear. Cutting or severely limiting health care benefits for substance abuse treatment is a cost-cutting gamble that will backfire. It will ultimately result in higher, not lower, long term health care costs – not to mention continuing problems in the workplace including increased absenteeism, decreased productivity and the impaired morale of other workers.

Treatment works and we can prove it.

Parkside treatment outcome studies clearly demonstrate that when patients are matched to the level of care appropriate to the intensity of their illness – treatment works. When treatment works, there is a reduction in other health care services for the employee and dependents.

The Parkside Difference.

When you choose Parkside as your health care benefits partner, you will find that we deliver on our promises. We are committed to providing the highest quality treatment in the most cost effective setting. Operating through a national network of facilities and programs – we offer a broad range of services across all levels of care.

With more than 30 years experience in substance abuse treatment, we know the best way to assure successful outcome. The best way to deliver treatment worth paying for – treatment that works.

Learn more about treatment solutions.

For a Free copy of Cost Effective Solutions For Drug & Alcohol Abuse In The Workplace and our most recent Treatment Outcome Study, please call (708) 698-4744, or write to our Vice President of Research and Program Evaluation at Parkside Medical Services Corporation, 205 West Touhy Avenue, Park Ridge, IL 60068-5881.

PARKSIDE
MEDICAL SERVICES CORPORATION

The nation's leading non-profit behavioral health care provider.

Evaluation criteria

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uncommon for companies to artificially drive utilization patterns in preconceived directions.

For example, a company that owned partial hospitalization facilities had an unexpectedly high rate of utilization for this type of service. Another company had an extremely low rate of hospitalizations but, upon closer scrutiny, it was found that patients were being "dumped" into publicly funded crisis centers and, therefore, not appearing in the reported data.

- **Criteria.** Companies should have well-developed and properly executed sets of criteria on which they base coverage and denial decisions. Managed mental health care companies often cut costs by inappropriately denying necessary services over the telephone or by mail, frequently citing mysterious "proprietary" criteria.

Criteria must be clinically sound, easily available and clearly communicated. Those who enforce criteria should have face-to-face contact with the patient, whenever possible, and have equal or similar credentials as the providers they are supposed to manage.

- **Grievance procedures.** The company should have a clear set of policies and procedures with respect to handling grievances. The organization should have a multidisciplinary committee, including lay representation, that objectively review any problems or difficulties that may arise. Patients or their families should have easy access to grievance processes.
- **Rates.** It is not uncommon to find large differences in rates among companies. This is based on the fact that they deliver different services. Although all marketing efforts equally emphasize "quality" and "cost effectiveness," there are differences in what happens on the front lines of service.

A company should specify clearly what rates consist of and what they account for. Administrative fees should be analyzed separately. Inpatient and outpatient service costs should be differentiated.

The greater the number of parties involved in any managed mental health care contract, the higher the expected costs.

Psychiatric vs. substance abuse costs should be clarified. And, there should be some type of refund mechanism whereby an employer can be credited if utilization falls below expected levels. This point does not negate the fact that a small reserve fund should always be allowed to handle unexpected losses in the future.

- **Lawsuit history.** A reputable company should be willing to discuss any pending lawsuits, complaints to insurance commissioners, regulatory problems and other such issues in an open manner.

Sometimes, it may be necessary to independently check a managed care organization's history. For example, some companies have changed names and key personnel after problems have occurred.

While employers routinely have legal counsel that review their contracts with managed care firms, it should be noted that exposure often comes from problems between managed care companies and their contracted providers. Some firms operate without *any* contracts with providers.

- **Financial strength.** The company should provide proof of financial resources. When necessary, stop-loss or excess liability coverage should be required. The company should demonstrate stability with respect to assuming full-risk or risk-sharing contracts.
- **Disintermediation.** I have seen that the greater number of parties involved in any contract, the higher the expected costs.

The extent of bureaucracy, intermediaries and profit levels in the managed care arrangement should be examined. Questions concerning duplication of services and excess management (i.e., non-clinical) personnel should be addressed.

The more direct that a contract can be between the consumer and the provider of services, the less expensive the contract will tend to be. The vast majority of the funds in any contract should be used to pay for delivery of clinical services.

- **Eclecticism.** Effective companies should provide a comprehensive range of services in the most appropriate, least restrictive and most cost-effective manner for each individual patient. I would beware of those companies that use the managed care banner to funnel patients into some favorite treatment program or facility.

I believe that all of the above are important factors to consider. While no single company may satisfy all requirements, the selected company should receive good marks in most categories.

Also, I believe that an objective request for proposal and bidding process should always be employed, preferably with the assistance of a truly independent, specialized consultant.

Employers must become much more sophisticated in how they allow their mental health and substance abuse benefit costs to be managed. Most managed mental health care companies are just a few years old, yet many already are grossing millions of dollars in revenues, often with little of it going to pay for direct clinical services. If employers do not become more astute at selecting and evaluating mental health vendors, the only people who will gain from current cost-containment trends will be the malpractice attorneys. ■

Leo H. Bradman is chairman of Bradman Therapy Centers, based in Plantation, Fla. Mr. Bradman, who is a licensed clinical psychologist, is completing a book on managed mental health care.

EAPs need integrated managed care

By Dr. Ronald Geraty

AT A TIME WHEN a national recession is eroding profits and increasing stress in the workforce, maintaining peak performance is vital to the survival of business. But soaring behavioral health care costs—now estimated at a staggering $17 billion to $20 billion annually—threaten business and industry's continued ability to sustain the mentally healthy and drug-free workforce that is key to profitability.

Nearly 70% of the Fortune 500 companies have responded to chemical dependency and mental health problems in the workplace by implementing employee assistance programs, which have been very successful in getting troubled employees into treatment. EAPs, however, have done little in the way of controlling costs. In response, increasing numbers of employers are layering managed care systems on top of their EAPs. But while managed care succeeds in stemming the cost of care, it often does so at the expense of effective treatment of the individual.

Employers are crying out for new solutions. Achieving the best of both worlds is an ideal that is crucial to business right now—and it is attainable, through a well-planned integration of cost-sensitive EAPs and progressive managed care strategies. However, integration must be more than simply adding on a typical EAP "product" to managed care, or vice versa. Both parts of the equation need to be enhanced by the perspective of the other. The EAP can no longer be blind to the cost implications of its recommendations. And managed care can no longer focus solely on the bottom line.

This, combined with concern among clinicians and employees, is causing many employers to look for a "friendlier," more effective way to manage the costs of care. Today's larger and more sophisticated employers are demanding that their EAPs and managed care systems find a way to work together so that employees receive the care they need to regain their productivity, at an affordable cost.

Some EAP companies are responding by adding on managed care services, and some managed care firms are adding on EAPs. However, this strategy only perpetuates the problem. Though supplied by one vendor, the EAP and managed care components often continue to operate on the basis of their very different approaches to working with employers, the professional community and employees. Treatment for the individual and cost containment are once again cast into conflict.

In striking contrast, a truly integrated program is unified in its approach, with managers and clinicians speaking the same language and working together toward common goals. Managed care principles are at work from the outset of the EAP's contact with the employee population through supervisor and staff training, consultation on personal problems, and face-to-face assessment and referral. And because the EAP's involvement with an employee or family member usually begins before treatment options have been considered, the EAP is in a position to steer the patient toward the most cost-effective treatment option, thereby meeting the goals of both the EAP and managed care.

The benefits of integration to employers are immediate and numerous:

- It discourages counterproductive competition between vendors (EAP and managed care) and within the company (human resources and benefits).
- It encourages a single policy implemented ideally through one vendor.
- It is less expensive than two separate contracts with two overheads.
- It encourages use of cost-effective alternatives to hospitalization by setting expectations up front.
- It eliminates potential provider bias toward his or her range of treatment options and skills, because integration relies on face-to-face assessments of the employee rather than telephonic reviews of the provider's assessment.
- Employee relations improve. Integration eliminates conflicting messages about what treatment is needed or is best. The process is usually simpler for employees, with one telephone number for help and no need for additional pre-certification. The EAP staff is often viewed as an ombudsman assisting the employee through the maze of benefits, access and provider selection.
- There is a workplace linkage that results in more visibility and increased productivity.

The integration of managed care systems and EAPs may very well revolutionize mental health care and benefits in this country—and none too soon. Without creative new solutions, our nation's mental health care system will be at risk.

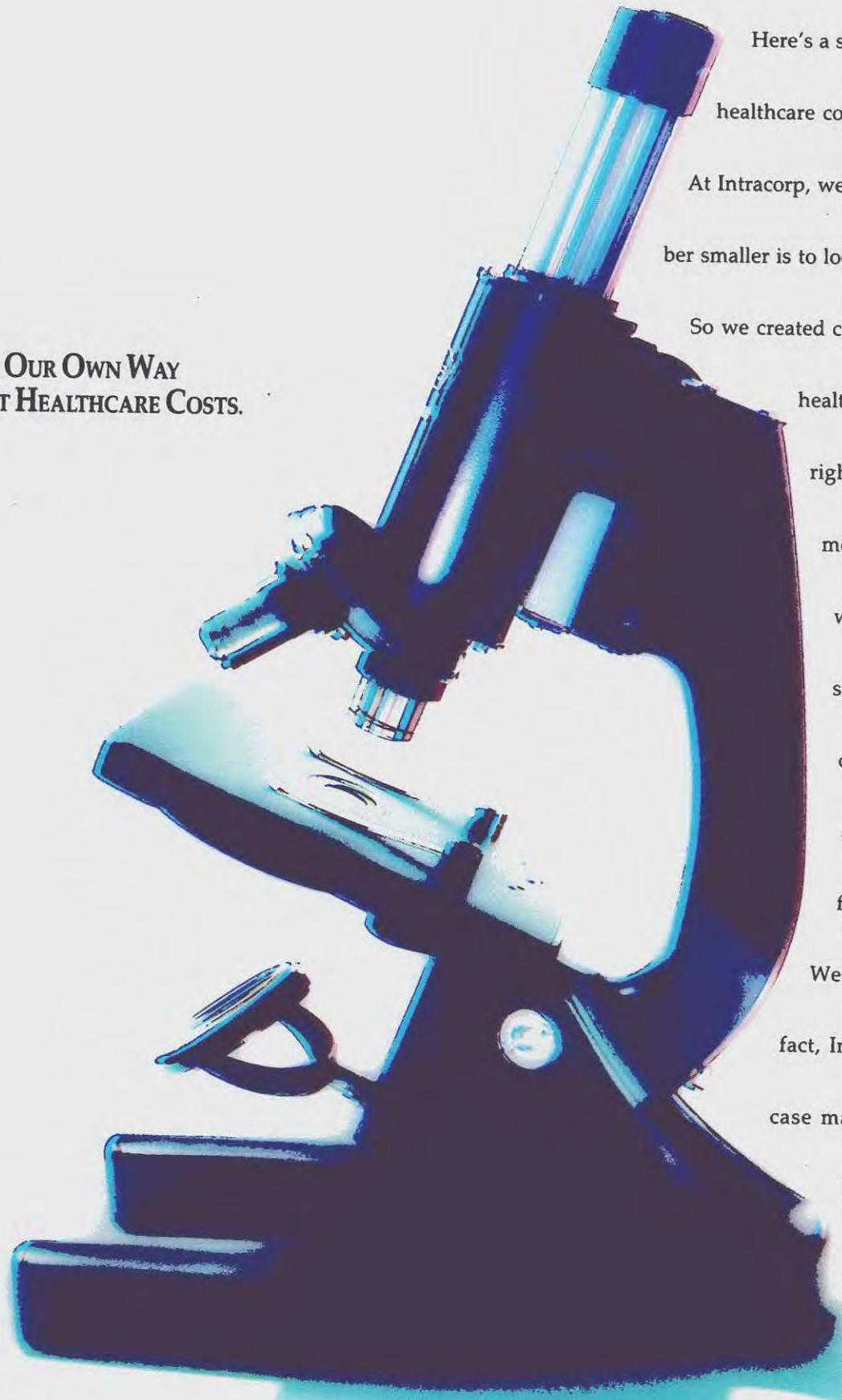
At a time when employees are struggling with recession-driven worries about job security, child and elder care pressures, or the challenge of adjusting to life back home after serving in the Persian Gulf, the need for effective approaches to mental health and substance abuse problems in the workplace is greater than ever.

Stresses in today's workforce are sapping the ability of employees to perform productively and lead fulfilling lives. Our collective commitment to maintaining a mentally healthy workforce must begin with developing new, effective approaches to mental health benefits.

Otherwise, we will find ourselves simply being unable to provide them. ■

Ronald Geraty, M.D., is president and co-founder of Assured Health Systems Inc. in Burlington, Mass.

We Have Our Own Way Of Looking At Healthcare Costs.



Here's a sobering thought: by the end of next year, healthcare costs are expected to climb to $620 billion. At Intracorp, we believe the only way to make that number smaller is to look at healthcare costs closer. A lot closer.

So we created cost control measures at every step of the healthcare cycle, from the onset of an illness, right through to its resolution. We closely monitor hospital admissions to determine whether hospitalization and length of stay are appropriate. We offer the same critical assessment of outpatient cases and provide reviews of treatment plans for mental health and substance abuse.

We pay special attention to serious cases. In fact, Intracorp pioneered the concept of total case management for catastrophic illnesses.

Lastly, we painstakingly scrutinize healthcare bills looking for inaccurate charges or inappropriate treatments. If you'd like us to take a closer look at your healthcare costs, write Intracorp, Dept. I3, 1205 Westlakes Drive, Suite 300, Berwyn, PA 19312. After all, the closer we look, the better you'll look.

INTRACORP

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Service area: Nationwide, Canada, Mexico, Puerto Rico.

Clients: 30% with one to 100 employees, 40% with 101 to 1,000, 20% with 1,001 to 5,000, 10% with 5,001 or more. Lives covered at year-end 1990: 350,000 employees and 650,000 dependents.

Principal officers: Larry Perlman, chief executive officer.

Contact: Tim Glaros, marketing manager, 612-853-4193.

Employee Assistance Associates Inc.

1580 Eisenhower Place, Ann Arbor, Mich. 48108; 313-973-0606; fax: 313-973-1513

Year founded: 1981.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment. Occasional suicide.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 40; 28 clinical staff members, including nine CEAP, 23 MSW, one MD designations.

Reporting: On request.

Service area: Southeast Michigan, northern Ohio.

Clients: 102; 33% with one to 100 employees, 48% with 101 to 1,000, 15% with 1,001 to 5,000, 4% with 5,001 or more. Lives covered at year-end 1990: 88,853 employees and 257,673 dependents.

1990 gross revenues: 100% from EAP services.

Principal officers: Jesse Bernstein, president.

Contact: Joan L. Nowak.

Employee Assistance Center

161 Ottawa Ave., Suite 301, Grand Rapids, Mich. 49503; 616-458-8540

Year founded: 1978.
Parent company: Project Rehab.
Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, adolescent treatment. Occasional financial concerns.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness. Occasional smoking cessation, stress management, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, phone counseling, affiliate network.

Staff: 13; seven clinical staff members, including two CEAP, five MSW designations.

On-site: one psychologist, five social workers.

Contracted: one psychiatrist, one physician.

Facilities: Six.
Reporting: Quarterly.
Specialties: HMOs.
Service area: Western Michigan.
Clients: Lives covered at year-end 1990: 100,000.

Principal officers: Owen McKenzie, director; Rick Sanders, director-managed care.

Contact: Rick Sanders.

Employee Assistance Programs Inc.

410 17th St., Suite 2000, Denver, Colo. 80202; 303-892-7903; fax: 303-892-8920

Year founded: 1978.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional legal problems, financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, preferred provider network.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 29; 23 clinical staff members, including nine CEAP, 18 MSW, two CAC, one MD, one RN, two Ph.D. designations.

On-site: one psychologist, 18 social workers, two marriage/family/child counselors.

Contracted: one psychiatrist, one psychologist.

Facilities: Nine.
Reporting: Quarterly.
Service area: Colorado.

Clients: 54; 2% with one to 100 employees, 53% with 101 to 1,000, 40% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 30,000 employees and 30,000 dependents.

1990 gross revenues: $1.4 million; 80% from EAP services, 20% from managed mental health care services.

Principal officers: Jodi Collins, president; Lauren Behmer and Kathleen Steven, vps; Rick Polster, CIO.

Contact: Jodie Collins, Rick Polster.

Employee Assistance Service Inc.

7918 Jones Branch Drive Suite 230, McLean, Va. 22102; 703-448-8608; fax: 703-448-8674

Year founded: 1984.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, mental health. Occasional suicide.

Health promotion services: Frequent smoking cessation, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, safety. Occasional physical fitness/exercise, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review. Occasional psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 340; 318 clinical staff members, including 64 CEAP, 136 MSW/LCSW, 53 CAC, 42 MD, 18 Ph.D., 17 MFFT designations.

On-site: Two psychiatrists, three psychologists, six social workers, three physicians.

Contracted: 24 psychiatrists, 12 psychologists, 125 social workers, 75 marriage/family/child counselors, 10 physicians.

Facilities: 450.
Reporting: Monthly.
Specialties: Municipalities, trucking, regional consortiums.
Service area: Nationwide.

Clients: 110; 25% with one to 100 employees, 45% with 101 to 1,000, 25% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 50,000 employees and 50,000 dependents.

Principal officers: Gail E. Gibson, president.

Employee Counseling Programs-Corporate Health Systems

120 W. 57th St., New York, N.Y. 10019; 212-245-8178 or 800-354-3544

Year founded: 1980.
Parent company: Jewish Board of Family and Children's Services.
Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/

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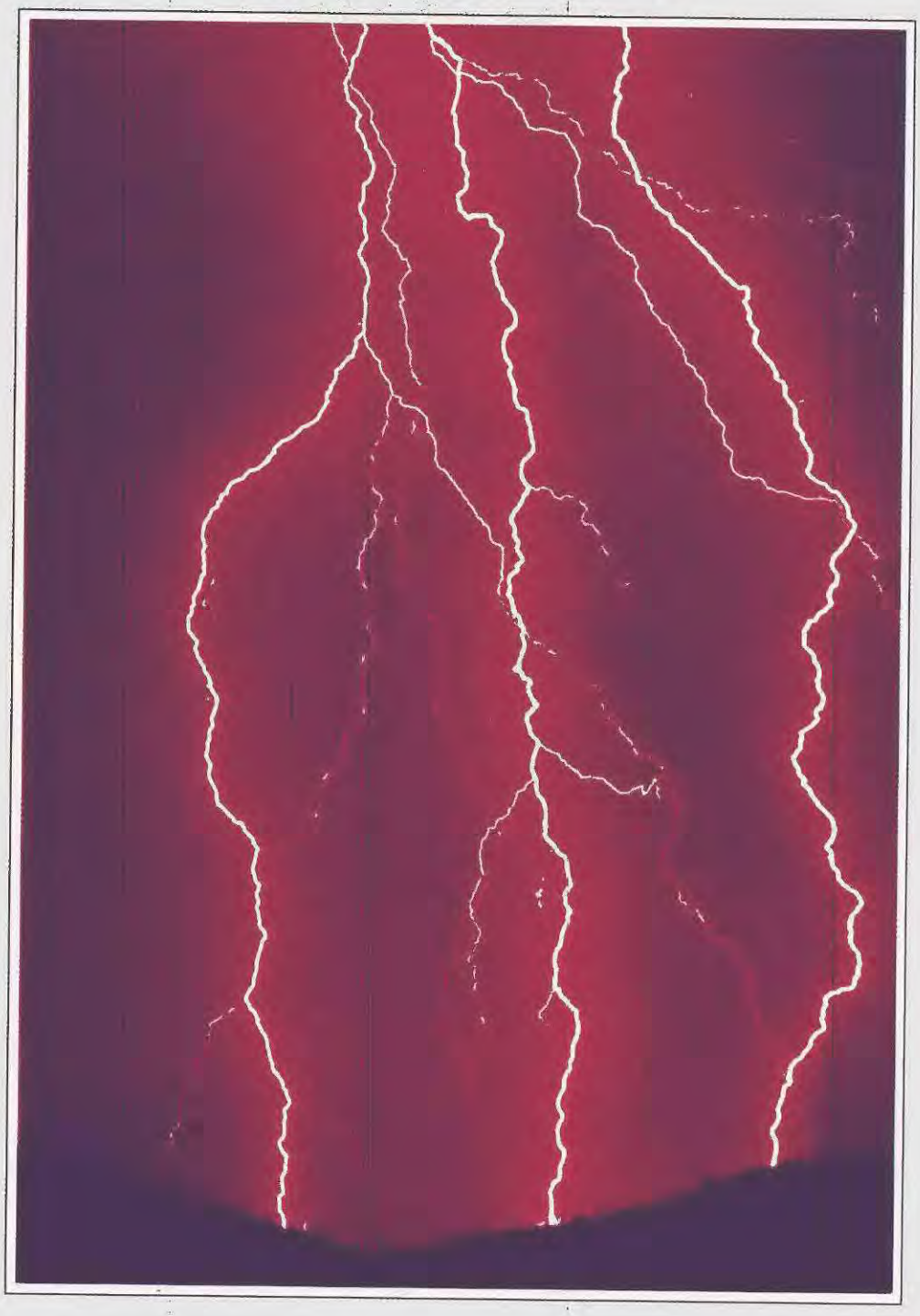
DON'T CONFUSE ACTIVITY



The Lockwood Companies

Continued from previous page
chemical abuse, adolescent treatment. Occasional suicide, legal problems, financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 16; 13 clinical staff members, including one MSW, two MD, one Ph.D., nine CSW designations.

Contracted: 144 psychiatrists, 210 psychologists, 405 social workers.

Facilities: 40.

Reporting: Quarterly.

Service area: 20 states in Eastern and Southern United States.

Clients: 40; 18% with one to 100 employees, 23% with 101 to 1,000, 45% with 1,001 to 5,000, 15% with 5,001 or more. Lives covered at year-end 1990: 150,000.

1990 gross revenues: $1 million; 30% from EAP services, 70% from managed mental health care services.

Contact: Joyce Zinbarg.

Employee Counseling Service

4455 Duncan, St. Louis, Mo. 63110; 314-533-3800 or 800-633-9672; fax: 314-371-6510

Year founded: 1979.

Parent company: Provident Counseling Inc.

Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review. Occasional psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities.

Staff: 150; 85 clinical staff members, including three CEAP, 60 MSW, 15 CAC, three MD, three RN, 15 Ph.D. designations.

On-site: 15 psychologists, 65 social workers, five marriage/family/child counselors.

Contracted: Three psychiatrists.

Facilities: 10.

Reporting: Monthly, quarterly.

Service area: Nationwide.

Clients: 36; 6% with one to 100 employees, 69% with 101 to 1,000, 22% with 1,001 to 5,000, 3% with 5,001 or more.

1990 gross revenues: 90% from EAP services, 10% from managed mental health care services.

Principal officers: Kathleen Buescher, president/chief executive officer; Janice Olson, chief operating officer; Dennis Knighton, chief financial officer; Philip B. Crause, executive vp-employee counseling service.

Contact: Philip B. Crause.

Employee Health Plus

1661 Garden Highway, Sacramento, Calif. 95833; 916-929-1365

Year founded: 1990.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment. Occasional legal problems.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Three; three clinical staff members, including three CEAP, one MSW designations.

On-site: one social worker, two marriage/family/child counselors.

Contracted: 10 psychiatrists, 20 psychologists, 30 social workers, 50 marriage/family/child counselors, five physicians.

Reporting: Monthly, quarterly, annually.

Service area: Nationwide.

Clients: Five; 80% with one to 100 employees, 20% with 1,001 to 5,000. Lives covered at year-end 1990: 6,500 employees and 13,000 dependents.

1990 gross revenues: $200,000; 75% from EAP services, 25% from managed mental health care services.

Principal officers: Nancy S. Bailey, Lisa Destro, Lorraine M. Gordon.

F

FHC Options

240 Corporate Blvd., Norfolk, Va. 23502; 804-459-5200; fax: 804-459-5217

Year founded: 1986.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 132; 49 clinical staff members, including three CEAP, 13 MSW, four MD, nine RN, four Ph.D. designations.

Facilities: 76.

Reporting: Monthly, quarterly, annually.

Service area: California, Florida, Maryland, Pennsylvania, Tennessee, Virginia, Wisconsin.

Clients: 17; 41% with 101 to 1,000 employees, 23% with 1,001 to 5,000, 36% with 5,001 or more. Lives covered at year-end 1990: 240,000 employees and 220,000 dependents.

1990 gross revenues: $34.8 million; 2% from EAP services, 98% from managed mental health care services.

Principal officers: Jeffrey L. McWaters, president/chief executive officer; Denna L. Ferrante, chief financial officer.

Contact: Steven Kee, marketing.

Family Service of Milwaukee

1110 N. Old World Third St., Milwaukee, Wis. 53203; 414-342-4559; fax: 414-276-0464

Year founded: 1882.

Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment, day-care/elder care concerns. Occasional legal problems.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, conflict resolution. Occasional psychiatric disability review, psychiatric workers compensation review.

Continued on next page

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Continued from previous page

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: Clients' headquarters, EAP/mental health care facilities, phone counseling.

Staff: Eight; four clinical staff members, including four CEAP, two MSW, two CAC, one MD designations.

On-site: psychologists, social workers, marriage/family/child counselors.

Contracted: psychiatrists, psychologists, social workers, marriage/family/child counselors.

Facilities: 11.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 19,000; 5% with one to 100 employees, 80% with 101 to 1,000, 10% with 1,001 to 5,000, 5% with 5,001 or more.

1990 gross revenues: $400,000; 80% from EAP services, 20% from daycare and elder care resource and referral services.

Principal officers: Susan Halling, vp; Criss Bricker, manager-managed care; Cheryl Lipscomb and Roger Schneider, account executives.

Contact: Susan Halling, 414-276-0153.

Florida Psychiatric Management Inc.

1276 Minnesota Ave., Winter Park, Fla. 32789; 407-647-1781; fax: 407-647-0668

Year founded: 1978.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional suicide, legal problems, financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence. Occasional workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, claims audit.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 23, including two CEAP, two MSW, three MD, three RN designations.

Contracted: 19 psychiatrists, 26 psychologists, eight social workers, 40 marriage/family/child counselors.

Facilities: 10.

Reporting: Quarterly, annually.

Service area: Florida.

Clients: Five; 100% with 5,001 or more employees. Lives covered at year-end 1990: 210,000.

Principal officers: Dr. Martin Lazoritz, president; Dr. Robert W. Pollack, medical director; Dr. Bruce G. Henry, assistant medical director; I. Paul Mandelkern, vp-administration; David M. Cunningham, vp-operations.

Contact: I. Paul Mandelkern.

G

Kathleen Greer Associates

161 Worcester Road, Framingham, Mass. 01701; 508-879-2093

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns. Occasional adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, lunchtime seminar series. Occasional AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence.

Counseling sites: All worksites, selected worksites, phone counseling.

Staff: Eight; three clinical staff members, including two CEAP, four MSW, one Ph.D., one LCSW designations.

On-site: one psychologist, four social workers.

Reporting: Quarterly.

Specialties: High tech, biotech.

Service area: Northeastern United States.

Clients: 12; 10% with one to 100 employees, 70% with 101 to 1,000, 20% with 1,001 to 5,000. Lives covered at year-end 1990: 8,000 employees.

1990 gross revenues: $189,000; 60% from EAP services, 10% from managed mental health care services, 30% from training.

Principal officers: Kathleen Greer, president.

H

Hazelden Services Inc.

1400 Park Ave., Minneapolis, Minn. 55404-1597; 612-349-4200; fax: 612-339-5195

Year founded: 1979.

Parent company: Hazelden Foundation.

Not for profit.

Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment, emotional/mental health.

Continued on page 60

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Continued from page 58
Occasional occupational problems, suicide, legal problems, financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation, drug-free workplace compliance training.

Educational/general services: Frequent employee education, supervisor training, employee chemical dependence identification. Occasional drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, retrospective review.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 70; 33 clinical staff members, including four CEAP, 25 MSW, six CAC, two Ph.D. designations.

On-site: six psychologists, four social workers.

Contracted: 30 psychiatrists, 10 psychologists, 4,425 social workers, 4,525 marriage/family/child counselors, 10 physicians.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 141; 25% with one to 100 employees, 48% with 101 to 1,000, 19% with 1,001 to 5,000, 8% with 5,001 or more. Lives covered at year-end 1990: 565,488 employees.

1990 gross revenues: $4 million; 84% from EAP services, 16% from managed mental health care services.

Principal officers: Peter White, chairman; Jerry Spicer, president; Patricia Owen, vp.

Contact: Mary Gjerdingen.

Health Risk Management Inc.

8000 W. 78th St., Minneapolis, Minn. 55439; 612-829-3500; fax: 612-829-3578

Year founded: 1977.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment. Occasional suicide.

Health promotion services: Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review, general patient information.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

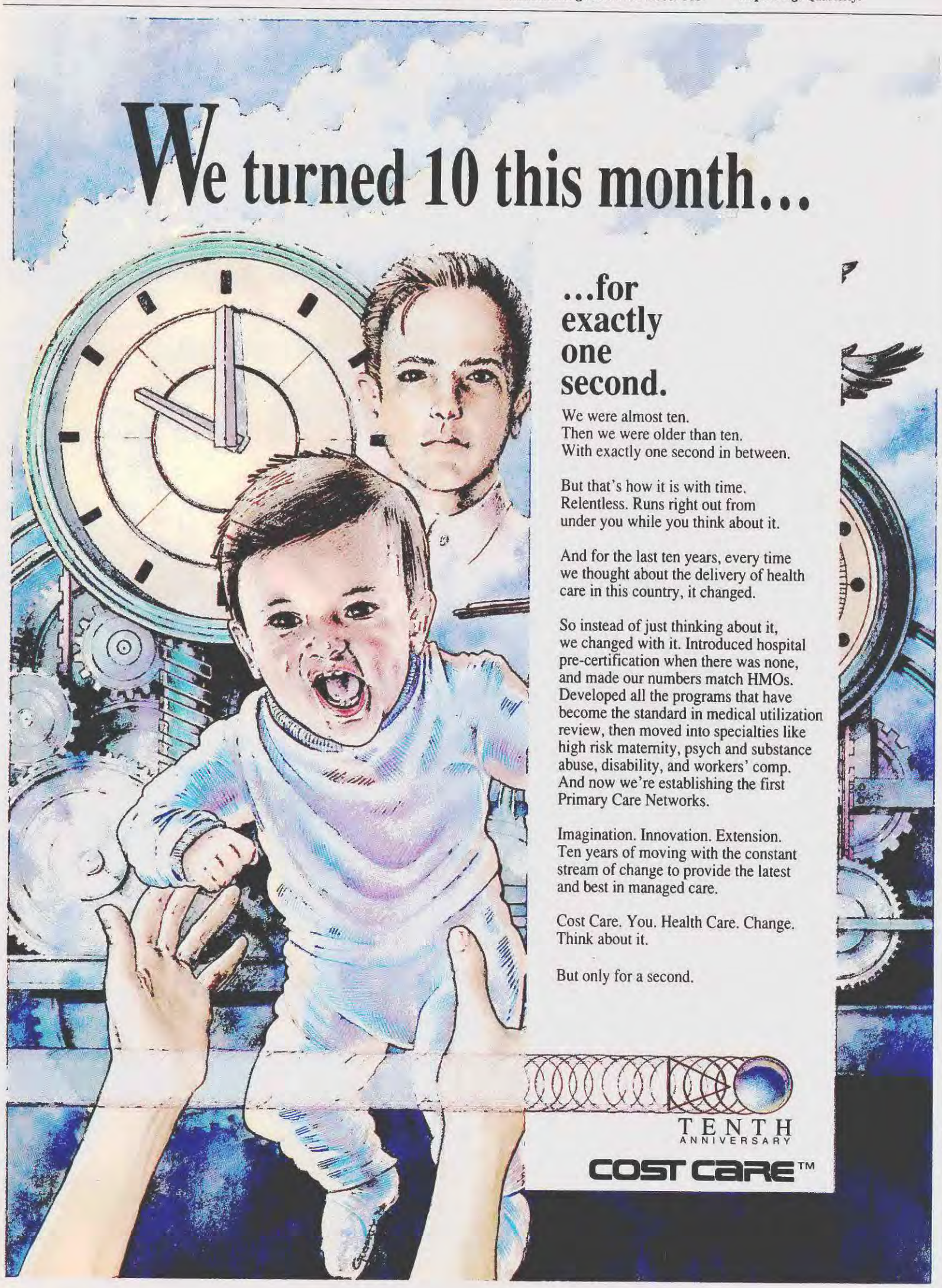
Counseling sites: EAP/mental health care facilities, phone counseling.

Staff: 272; 90 clinical staff members, including 55 MSW, six CAC, six MD, 83 RN, 124 Ph.D. designations.

On-site: 72 psychologists, three social workers, six physicians, four addictionists.

Contracted: two psychiatrists, 20 psychologists, 25 physicians, one addictionist.

Reporting: Quarterly.



Health & Human Resource Center

7798 Starling Drive, San Diego, Calif. 92123; 619-571-1698; fax: 619-569-5164

Year founded: 1979.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment. Occasional suicide.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness. Occasional smoking cessation, nutrition/weight control, stress management, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: Clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 17.

Service area: California.

Principal officers: Dr. Stephen H. Heidel, president; Dennis J. Senko, vp.

Contact: Dennis J. Senko.

Healthcare Resources

6974 Brockton Ave., Suite 203, Riverside, Calif. 92506; 714-683-8082; fax: 714-683-8099

Year founded: 1988.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional legal problems, financial concerns.

Health promotion services: Stress management, alcohol awareness, drug/chemical awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Five; two clinical staff members, including one CEAP, one MSW, one CAC, one MD.

Contracted: two psychiatrists, one psychologist, two social workers, five marriage/family/child counselors.

Facilities: Five.

Reporting: Monthly.

Service area: Southern California.

Clients: Four; 25% with 101 to 1,000 employees, 50% with 1,001 to 5,000, 25% with 5,001 or more. Lives covered at year-end 1990: 3,500 employees and 5,000 dependents.

1990 gross revenues: $150,000; 5% from EAP services, 75% from managed mental health care services, 20% from management consulting.

Principal officers: Brad Rafuse, Steve Wildish.

The Holman Group

6900 Owensmouth, Canoga Park, Calif. 91303; 818-704-1444; fax: 818-593-2529

Year founded: 1979.
For profit.

Assessment/treatment: Stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Stress management, alcohol awareness, drug/chemical awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification,

Continued on page 62

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psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, acute care hospitals, resident facilities, halfway houses, adolescent ranches.

Staff: 85; including two MSW, one CAC, two MD, two Ph.D. designations.

On-site: one psychiatrist, three psychologists, three social workers, six marriage/family/child counselors.

Contracted: 52 psychiatrists, 315 psychologists, 320 social workers, 550 marriage/family/child counselors.

Reporting: Monthly, quarterly, annually.

Specialties: Labor organizations, government agencies.

Service area: Nationwide.

Contact: Dan Girling, vp-marketing/sales.

Human Affairs of Alaska

4300 B St., Suite 606, Anchorage, Alaska 99503; 907-562-2812

Assessment/treatment: Stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 17 clinical staff members, including one CEAP, 10 MSW, one CAC.

On site: psychiatrists.

Contracted: one psychiatrist.

Reporting: Quarterly, biannually, annually.

Service area: Alaska, Hawaii.

Clients: 220; 95% with one to 100 employees, 4% with 101 to 1,000, 1% with 1,001 to 5,000. Lives covered at year-end 1990: 33,000 employees and 49,500 dependents.

Principal officers: Darryl Logan, area director-HAA; Jim Plack, chief operating officer-HAI; Jay Youell, vp-western region-HAI.

Human Affairs International

5801 S. Fashion Blvd., Salt Lake City, Utah 84107; 801-268-0553; fax: 801-268-9716

Year founded: 1973.

Parent company: Aetna Life & Casualty Co.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, crisis intervention, critical stress debriefing.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, managing change. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, on-site case management, claim coordination.

Counseling sites: Clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 1,100; 825 clinical staff members, including 724 CEAP, MSW, and CAC designations; six MD, 15 RN, 80 Ph.D. designations.

On-site: 850 psychiatrists, 1,465 psychologists, 1,059 social workers, 63 marriage/family/child counselors, 156 physicians.

Facilities: 896.

Reporting: Monthly to semi-annually.

Service area: Nationwide.

Clients: 690; 17.4% with one to 100 employees, 47.3% with 101 to 1,000, 27.3% with 1,001 to 5,000, 8% with 5,001 or more. Lives covered at year-end 1990: 4.4 million employees and 6.6 million dependents.

Principal officers: Jim Plack, chief operating officer; Dave Levine, vp-marketing/account management; Dave Harrington, vp-North; Mike Aleander, vp-South; Jay Youell, vp-West; Dr. Lafe Myers, vp-clinical operations.

Contact: Janice Daff, marketing/sales.

Hurst Associates

21 Custom House St., Boston, Mass. 02110; 617-737-8600; fax: 617-737-8601

Year founded: 1978.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, critical incident debriefing. Occasional suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regula-

Continued on next page

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tory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 14; eight clinical staff members, including three CEAP, four MSW, four Ph.D. designations.

On-site: four psychologists, four social workers.

Contracted: two psychiatrists, one physician.

Reporting: Quarterly.

Service area: Massachusetts, Rhode Island, New Hampshire, Maine, California.

Clients: 60; 15% with one to 100 employees, 30% with 101 to 1,000, 40% with 1,001 to 5,000, 15% with 5,001 or more. Lives covered at year-end 1990: 92,000 employees and 100,000 dependents.

1990 gross revenues: 80% from EAP services, 10% from managed mental health care services, 10% from behavioral risk analysis.

Principal officers: Michael W. Hurst, president; William A. Roiter, executive vp.

Contact: William A. Roiter.

I

Institute for Human Resources

5601 Smetana Drive, P.O. Box 1459, Minneapolis, Minn. 55440; 612-936-1200; fax: 612-936-4959

Year founded: 1982.

Parent company: United HealthCare.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment. Occasional suicide.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, full MH/CD carve out.

Counseling sites: Clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 68; 41 clinical staff members, including five CEAP, 16 MSW, 20 CAC, six Ph.D. designations.

On-site: three psychiatrists, 10 psychologists, 18 social workers, 13 mental health counselors.

Contracted: 10 psychiatrists, 304 psychologists, 369 social workers, 35 marriage/family/child counselors, 79 mental health counselors.

Reporting: Quarterly.

Service area: Nationwide and Canada.

Clients: 215; 18% with one to 100 employees, 61% with 101 to 1,000, 18% with 1,001 to 5,000, 3% with 5,001 or more. Lives covered at year-end 1990: 246,110.

1990 gross revenues: $3.9 million; 100% from EAP services.

Principal officers: Edward Bergmark, chief executive officer; Steve Eichler, president; Phil Dell, director-sales/marketing; Jude Miller, director-operations; Cliff Goldberg, senior vp; Jan Salinas, vp-operations.

Contact: Phil Dell, 612-936-4984; or Anne Griffin, marketing director, 1700 Rockville Pike, Suite 500, Rockville, Md. 20852, 800-331-7519.

Iowa Managed Health Care Inc.

2750 First Ave., Cedar Rapids, Iowa 52402; 319-363-8705; fax: 319-363-8728

Year founded: 1990.

For profit.

Assessment/treatment: Drug/chemical abuse, pscyhiatric disorders.

Health promotion services: Stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, selected worksites.

Staff: Six; three clinical staff members, including two MSW, one M.D. designations.

On-site: one psychiatrist, two social workers.

Contracted: 12 psychiatrists, 18 psychologists, 20 social workers.

Facilities: Six.

Reporting: Monthly.

Service area: Iowa, Florida.

Clients: 100% with 5,001 or more employees.

Contact: Phil Dorothy, executive director.

J

The Jernberg Corp.

390 Main St., Worcester, Mass. 01608; 508-754-1770; fax: 508-753-0902

Year founded: 1978.

For profit.

Assessment/treatment: Frequent stress, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, case management.

Counseling sites: EAP/mental health care facilities, phone counseling.

Staff: 33; including 20 CEAP, five MSW, 10 CAC designations.

Facilities: 5,702.

Service area: Nationwide, Canada, Caribbean.

Clients: 1,206; 25% with one to 100 employees, 55% with 101 to 1,000, 15% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 92,000 employees and 294,400 dependents.

1990 gross revenues: $1.7 million; 90% from EAP services, 10% from managed mental health care services.

Principal officers: W.R. Jernberg, president; S.E. Mann, vp.

L

Lampton & Associates

Nolan Building, 2100 Gardiner Lane, Louisville, Ky. 40205; 502-459-7799

Year founded: 1986.

For profit.

Assessment/treatment: Stress, occupational problems, family/marital

Continued on next page

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problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Stress management, drug/chemical awareness.

Educational/general services: Supervisor training, workplace problem identification.

Utilization review services: Precertification of inpatient treatment, case management.

Counseling sites: All worksites, EAP/mental health care facilities, phone counseling.

Staff: Four; three clinical staff members, including one CEAP, four MSW.

On-site: four social workers, two marriage/family/child counselors.

Contracted: psychiatrists, psychologists, physicians.

Facilities: Two.

Reporting: Monthly, quarterly.

Specialties: Professional organizations.

Service area: Seven counties in the Louisville, Ky., area; Clarksville, Jefferson counties in southern Indiana.

Clients: 20% with one to 100 employees, 10% with 101 to 1,000, 70% with 1,001 to 5,000. Lives covered at year-end 1990: 2,500 employees and 1,700 dependents.

1990 gross revenues: $75,000; 90% from EAP services, 10% from managed mental health care services.

Principal officers: T. Patrick Lampton, president/owner.

LifeCare Management Systems Inc.

51 Upper Montclair Plaza, Montclair, N.J. 07043; 201-744-9040; fax: 201-744-2829

Year founded: 1988.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment, panic disorders. Occasional suicide, legal problems, eating disorders.

Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness.

Educational/general services: Occasional employee education, supervisor training, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Eight; four clinical staff members, including four Ph.D. designations.

On-site: four psychiatrists.

Contracted: 29 psychiatrists, 128 psychologists, 43 social workers, 14 marriage/family/child counselors.

Facilities: 14.

Reporting: Monthly.

Service area: New Jersey, surrounding areas of New York and Pennsylvania.

Clients: 33.3% with 101 to 1,000 employees, 66.7% with 5,001 or more. Lives covered at year-end 1990: 20,000 employees and 40,000 dependents.

Principal officers: Nicholas P. Armenti, president; Bruce Nils Miller, director-operations; Carmen J. Armenti, vp-finance.

Contact: Nicholas P. Armenti.

M

MCC Cos. Inc.

11095 Viking Drive, Suite 350, Eden Prairie, Minn. 55344; 612-943-9500; fax: 612-943-9659

Year founded: 1972.
Parent company: CIGNA Corp.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness, disaster intervention.

Educational/general services: Frequent employee education, supervisor training, psychiatric disability review. Occasional drug-free workplace regulatory adherence, workplace problem identification, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 1002.

On-site: 84 psychiatrists, 35 psychologists, 110 social workers, 52 substance abuse counselors, 35 psychiatric nurses, 30 EAP counselors.

Contracted: 1,505 psychiatrists, 1,856 psychologists, 3,118 social workers, 44 substance abuse counselors, 164 psychiatric nurses, 420 EAP counselors.

Reporting: Quarterly.

Service area: Nationwide, Canada, United Kingdom.

Clients: 155; 25% with one to 100 employees, 57% with 101 to 1,000, 12% with 1,001 to 5,000, 6% with 5,001 or more. Lives covered at year-end 1990: 245,840 employees.

1990 gross revenues: $80.8 million; 8% from EAP services, 92% from managed mental health care services.

Principal officers: Travers H. Wills, president; Joseph D. Strahan and Dr. John C. Barlett, vps; Gail B. Marcus, treasurer; David C. Copp, secretary.

Contact: Jim Higgins, vp-marketing/sales.

Managed Health Network Inc.

5100 W. Goldleaf Circle, Suite 300, Los Angeles, Calif. 90056; 213-299-0999; fax: 213-290-1274

Year founded: 1987.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, eldercare, change in the workplace, gambling, juggling marriage and kids, crime victims. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review. Occasional psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, retroactive reviews.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 280; 87 clinical staff members, including 38 MSW, one CAC, one MD, six RN, six Ph.D., eight LCSW designations.

On-site: one psychiatrist, seven psychologists, 40 social workers, 21 marriage/family/child counselors.

Contracted: 612 psychiatrists, 1,745 psychologists, 1,213 social workers.

Facilities: 380.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 328; 11% with one to 100 employees, 55% with 101 to 1,000, 25% with 1,001 to 5,000, 9% with 5,001 or more. Lives covered at year-end 1990: 580,000 employees and 1.1 million dependents.

1990 gross revenues: $30.3 million; 34% from EAP services, 66% from managed mental health care services.

Principal officers: Ronald W. Moreland, president/chief executive officer; Dr. H.G. Whittington, vp/medical director; Gary S. Velasquez, chief financial officer; Ann McClanathan, vp-clinical operations; Tom Boyajy, vp/general manager-Eastern region.

Contact: Carolyn Suminski; Jack Dolan, 90 John St., 21st Floor, New York, N.Y. 10038, 212-972-5200; Bill Nickelsen, 1 Daniel Burnham Court, Suite 300 C, San Francisco, Calif. 94109, 415-776-0252.

Management & Behavior Consultants

Leominster Hospital Medical Building, Leominster, Mass. 01453; 508-840-2776 or 4 Muzzey St., Lexington, Mass. 02173, 617-862-3219

Year founded: 1982.
For profit.

Assessment/treatment: Frequent stress, family/marital problems, alcohol

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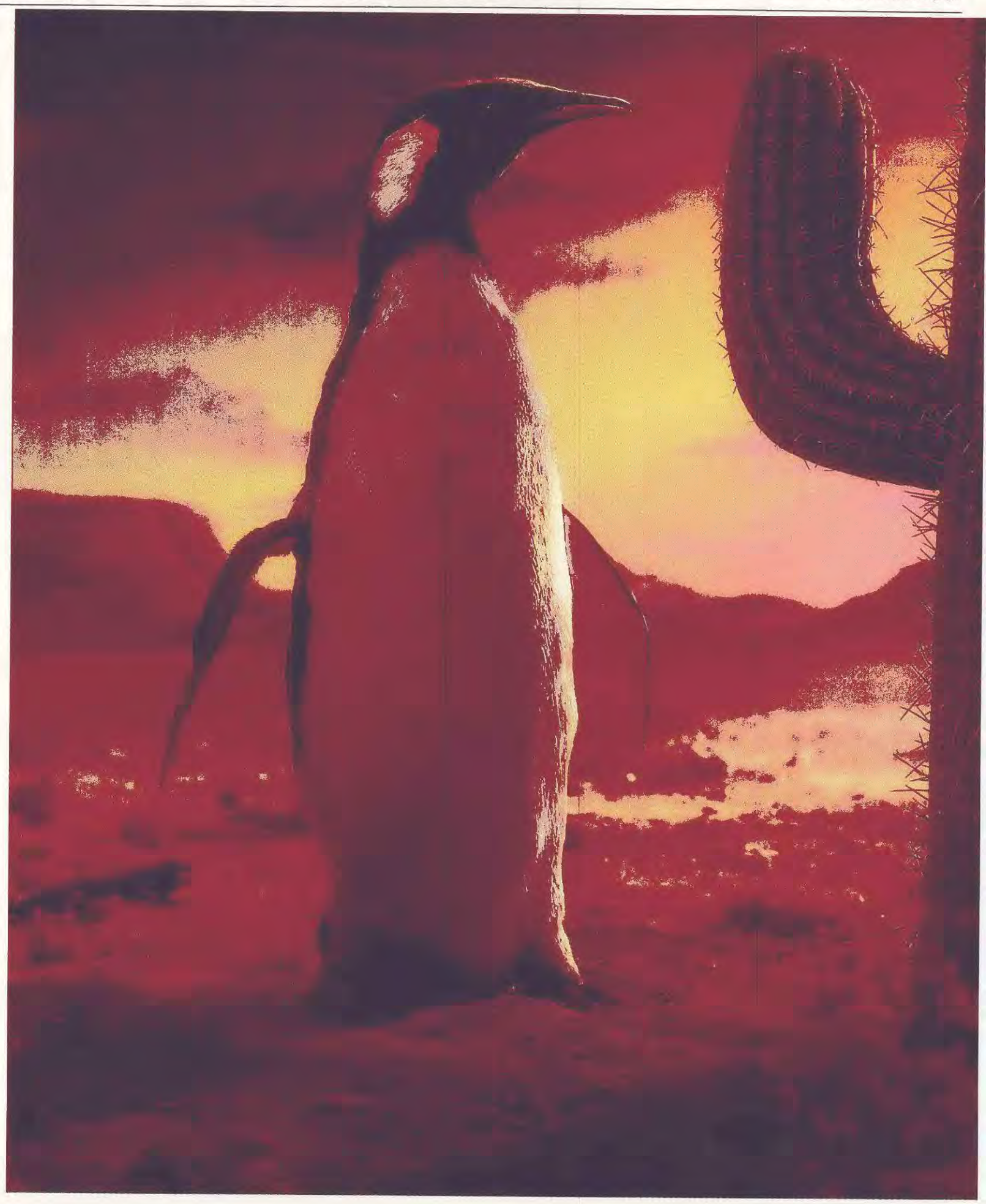

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abuse, drug/chemical abuse. Occasional occupational problems, suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence, psychiatric disability review.

Utilization review services: Precertification of outpatient treatment, case management.

Counseling sites: EAP/mental health care facilities, selected worksites.

Staff: One clinical staff member who holds CEAP, Ph.D. designations.

On-site: one psychologist.

Reporting: Quarterly.

Specialties: Plastic industry, service industry.

Service area: Massachusetts.

Clients: 2,000; 20% with one to 100 employees, 80% with 101 to 1,000. Lives covered at year-end 1990: 160.

Principal officer: J. Robert Kagey.

Maschhoff Barr & Associates

P.O. Box 8148, Tacoma, Wash. 98408; 800-441-3119; fax: 206-472-5563

Year founded: 1979.

Parent company: Pierce County Medical, a Blue Shield Plan.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, trauma debriefing.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Case management.

Counseling sites: EAP/mental health care facilities.

Staff: 38; 1,200 clinical staff members.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 314; 43% with one to 100 employees, 43% with 101 to 1,000, 12% with 1,001 to 5,000, 2% with 5,001 or more. Lives covered at year-end 1990: 153,965 employees and 396,516 dependents.

Principal officers: Thomas Maschhoff, president; William C. Barr, vp.

Contact: Deborah Banta, director-marketing.

Dr. Jim Mastrich & Associates

128 Main St., Kingston, N.J. 08528; 609-921-3665

Year founded: 1986.

For profit.

Assessment/treatment: Frequent family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment, adult children of alcoholics. Occasional stress, occupational problems, suicide, legal problems, financial concerns.

Health promotion services: Frequent physical fitness/exercise, stress management, alcohol awareness. Occasional smoking cessation, nutrition/weight control, drug/chemical awareness, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review.

Counseling sites: All worksites, EAP/mental health care facilities.

Staff: Four; including two MSW, two CAC, two Ph.D. designations.

On-site: two psychologists, two social workers.

Contracted: two psychiatrists.

Facilities: Three.

Reporting: Quarterly.

Service area: New Jersey.

Clients: Four; 100% with 101 to 1,000 employees. Lives covered at year-end 1990: 375 employees and 600 dependents.

Contact: Dr. Jim Mastrich.

Medical Business Management Inc.

3490 Independence Drive, Birmingham, Ala. 35209; 205-871-7814; fax: 205-870-7987

Year founded: 1990.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment, depression, parenting, eating disorders, panic pain management. Occasional legal problems.

Health promotion services: Frequent smoking cessation, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness. Occasional physical fitness/exercise, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification, psychiatric disability review, psychiatric workers compensation review. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 10; 41 clinical staff members, including one CEAP, three MSW, three CAC, 18 MD, three RN, 26 Ph.D., four LPC designations.

On-site: Seven psychiatrists, 13 psychologists, three social workers.

Contracted: 18 psychiatrists, 26 psychologists, three social workers, five marriage/family/child counselors, one physician.

Facilities: 14.

Reporting: Bimonthly and as requested.

Service area: Alabama.

Clients: 32; 20% with one to 100 employees, 75% with 101 to 1,000, 5% with 1,001 to 5,000. Lives covered at year-end 1990: 7,500 employees and dependents.

Principal officers: Allen S. Blackwell, president/chief executive officer; Dr. H. Edward Logue, medical director; Lita A. Clark, director-community relations; Richard D. Robins, vp-managed mental healthcare; Carolyn S. Ellis, director-provider relations.

Contact: Lita A. Clark.

Mental Health Programs Corp.

2203 N. Lois Ave., Suite 1100, Tampa, Fla. 33607; 813-876-5036; fax: 813-872-8666

Year founded: 1986.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment, pain management. Occasional legal problems, financial concerns.

Health promotion services: Frequent smoking cessation, physical fitness/exercise, stress management, alcohol awareness, drug/chemical awareness, sexual dysfunction. Occasional nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, psychiatric workers compensation review.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 18; 4,800 clinical staff members, including one CEAP, one MSW, one CAC, two MD, three RN, one Ph.D. designations.

On-site: two psychiatrists, one psychologist, one social worker, four marriage/family/child counselors, two physicians.

Contracted: 720 psychiatrists, 720 psychologists, 960 social workers, 2,400 marriage/family/child counselors, 720 physicians.

Facilities: 450.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 40. Lives covered at year-end 1990: 1.2 million.

1990 gross revenues: 25% from EAP services, 75% from managed mental health care services.

Principal officers: Dr. Walter E. Afield, chief executive officer/medical director; Jim Kent, executive vp/chief operating officer.

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Motanky & Associates, Member Alliance of EAP Services

5440 N. Cumberland, Chicago, Ill. 60656; 312-693-0139; fax: 312-714-8225

Year founded: 1987.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, legal problems, financial concerns, gambling, eating disorders. Occasional suicide, drug/chemical abuse, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification, workplace problem identification. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, phone counseling.

Staff: Four; two clinical staff members, including one CEAP, one CAC, one Ph.D. designations.

Contracted: one psychiatrist, 60 psychologists, 50 social workers.

Reporting: Monthly, quarterly.

Service area: Nationwide, London, Puerto Rico.

Clients: 12; 8% with one to 100 employees, 59% with 101 to 1,000, 25% with 1,001 to 5,000, 8% with 5,001 or more. Lives covered at year-end 1990: 10,000 employees and 25,000 dependents.

1990 gross revenues: $250,000; 90% from EAP services, 10% from managed mental health care services.

Principal officers: Guy U. Motanky, president.

Mustard Seed Inc.

Neshaminy Plaza One, Suite 102, Street Road & Bristol Pike, Bensalem, Pa. 19020; 215-638-2273

Year founded: 1985.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional legal problems, financial concerns.

Health promotion services: Frequent stress management, alcohol awareness and drug/chemical awareness programs. Occasional AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient, precertification of outpatient treatment, concurrent review, case management and retrospective review.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 25; 15 clinical staff members, including three CEAP, three MSW, two CAC, one RN, two Ph.D. designations.

On-site: one psychologist, two marriage/family/child counselors, two physicians.

Contracted: two psychiatrists, two psychologists, two physicians.

Facilities: 75.

Reporting: Monthly.

Service area: Philadelphia, Bucks, Delaware and Montgomery counties in Pennsylvania; Perth Amboy, Woodbury, N.J.; Houston; Albany, Poughkeepsie, N.Y.; Wilmington, Newark, Del.

Clients: 7,200; 50% with one to 100 employees, 50% with 1,001 to 5,000. Lives covered at year-end 1990 include: 5,168 employees and 13,954 dependents.

1990 gross revenues: $2 million; 20% from EAP services, 50% from managed mental health care services, 30% from other.

Principal officers: Francis X. Selgrath, president; Frank Heinze, secretary; Robert J. Fluehr, assistant treasurer; William D. Freeman, trustee.

Contact: Francis X. Selgrath.

N

Charles Nechtem Associates Inc.

121 W. 27th St., Suite 702, New York, N.Y. 10001; 212-989-5589

Year founded: 1978.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review, accident disability, workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, psychiatric and medical disability review.

Counseling sites: All worksites, phone counseling.

Staff: 90; 2,800 clinical staff members, including three CEAP, 28 MSW, six CAC, two MD, four RN, 25 Ph.D. designations.

On-site: two psychiatrists, 25 psychologists, 28 social workers, 14 marriage/family/child counselors.

Contracted: 50 psychiatrists, 1,000 psychologists, 1,000 social workers, 800 marriage/family/child counselors.

Facilities: 48.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 20% with 101 to 1,000 employees, 30% with 1,001 to 5,000, 50% with 5,001 or more. Lives covered at year-end 1990: 175,000 employees and 400,000 dependents.

Principal officers: Charles Nechtem, president; Beverly Pitts, senior v; Tom Lombardi, director-marketing/training.

Contact: Tom Lombardi.

National Resource Consultants Inc.

2835 Camino Del Rio S., Suite 300, San Diego, Calif. 92108; 619-291-0330; fax: 619-692-4305

Year founded: 1984.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness. Occasional smoking cessation, nutrition/weight control, stress management, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 43; 25 clinical staff members, including seven CEAP, seven MSW, one CAC, one MD, four RN, three Ph.D., 15 MFCC, six LCSW designations.

On-site: six social workers, 15 marriage/family/child counselors, one physician.

Contracted: seven psychiatrists, 65 psychologists, 101 social workers, 159 marriage/family/child counselors, three physicians.

Reporting: Monthly, quarterly.

Service area: Nationwide.

Clients: 80; 27% with one to 100 employees, 30% with 101 to 1,000, 24% with 1,001 to 5,000, 19% with 5,001 or more. Lives covered at year-end 1990: 90,000 employees and 95,000 dependents.

Principal officers: Nicholas Krnich, president; Florenza Williams, chief executive officer.

Contact: Nicholas Krnich.

Newbridge Consultation

309 Madison St., Westbury, N.Y. 11590; 516-334-7028

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, psychological problems. Occasional suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, drug/chemical awareness, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, phone counseling.

Staff: 11; 10 clinical staff members, including four CEAP, 10 MSW, two CAC designations.

On-site: 10 social workers.

Service area: Nassau, Manhattan, Queens, Suffolk, N.Y.

Clients: 11; 40% with 101 to 1,000 employees, 60% with 1,001 to 5,000. Lives covered at year-end 1990: 19,000 employees and 30,000 dependents.

1990 gross revenues: $500,000; 95% from EAP services, 5% from managed mental health care services.

Principal officers: Lawrence Eisenberg, director; Ellen Eisenberg, clinical director.

Contact: Lawrence Eisenberg.

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O

Occupational Health Services Inc.

125 E. Sir Francis Drake Blvd., Suite 300, Larkspur, Calif. 94939-1860; 800-327-7526 or 415-461-8100; fax: 415-925-9728

Year founded: 1972.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, child and elder care consultation.
Health promotion services: Smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, hypertension.
Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, post-trauma stress, pre-employment psychological screening.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, claim review and adjudication, substance abuse after-care monitoring.
Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.
Staff: 220; 3,736 clinical staff members, including 10 CEAP, four MSW, three MD, three RN, four Ph.D. designations.
Contracted: 177 psychiatrists, 925 psychologists, 1,566 social workers, 822 marriage/family/child counselors.
Facilities: 406.
Reporting: Monthly, quarterly, annually.
Service area: Nationwide, Puerto Rico.
Clients: 400; 2% with one to 100 employees, 48% with 101 to 1,000, 40% with 1,001 to 5,000, 10% with 5,001 or more. Lives covered at year-end 1990: 837,521 employees and 1.4 million dependents.
1990 gross revenues: $11.6 million; 85% from EAP services, 15% from managed mental health care services.
Principal officers: Robert G. Temer, president; Juliann Zuhlke, vp-finance; Edith L. Jardine, vp-marketing & sales; Larry N. Gelb, vp-managed care division; Robert Reiser, vp-clinical services.
Contact: Edith L. Jardine.

Omni Health Systems Inc.

6 Union St., Natick, Mass. 01767; 508-655-9766; fax: 508-655-9922

Year founded: 1981.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment.
Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability consultation, psychiatric workers compensation review.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.
Counseling sites: All worksites, EAP/mental health care facilities, selected worksites, phone counseling.
Staff: 130; nine clinical staff members, including nine CEAP, 96 MSW, four CAC, 66 MD, three RN, 30 Ph.D., 102 LICSW designations.
On-site: five psychiatrists, three psychologists, 20 social workers.
Contracted: 61 psychiatrists, 54 psychologists, 178 social workers.
Facilities: 11.
Reporting: Monthly, quarterly.
Service area: 31 states, Canada, Puerto Rico.
Clients: 69; 11% with one to 100 employees, 46% with 101 to 1,000, 4% with 1,001 to 5,000, 2% with 5,001 or more. Lives covered at year-end 1990: 37,000 employees and 74,000 dependents.
Principal officers: Dr. Anthony Capobianco, president; Patricia Dzindolet, June Ameen, Renee McCard, vps.
Contact: June Ameen.

P

People Resources Inc.

10900 Manchester Road, St. Louis, Mo. 63122; 314-822-8210; fax: 314-822-4419

Year founded: 1983.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment, depression. Occasional suicide, legal problems.
Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, parenting. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.
Utilization review services: Pre-

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certification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 12; 66 clinical staff members.

Reporting: Quarterly.

Specialties: Unions, law firms.

Service area: Nationwide.

Principal officers: Janet Mug, president; Kent Newcome, director-operations; Tom Fox, vp-clinical services.

Contact: Kent Newcome.

Personal Performance Consultants

1400 S. Brentwood Blvd., Suite 400, St. Louis, Mo. 63144; 314-963-1700

Year founded: 1975.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment, mental illness. Occasional legal problems, financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, discharge planning, aftercare.

Counseling sites: All worksites, phone counseling.

Staff: Four CEAP, 196 MSW, eight CAC, one MD, two RN, five Ph.D., 77 ACSW, 49 LCSW designations.

Facilities: 2,160.

Service area: Nationwide, Canada, Puerto Rico, United Kingdom.

Clients: 600; 2% with one to 100 employees, 13% with 101 to 1,000, 60% with 1,001 to 5,000, 25% with 5,001 or more. Lives covered at year-end 1990: 1.4 million employees and 2.4 million dependents.

1990 gross revenues: $31 million; 80% from EAP services, 20% from managed mental health care services.

Principal officers: Richard Hellan, president; Carl Tisone, chief executive officer; Ronald L. Rummel, chief operating officer.

Contact: Ronald L. Rummel.

Perspectives Ltd.

111 N. Wabash Ave., Suite 1620, Chicago, Ill. 60602; 708-932-8008 or 800-456-6327; fax: 312-558-1570

Year founded: 1981.
For profit.

Assessment/treatment: Frequentstress, alcohol abuse, legal problems, drug/chemical abuse. Occasional occupational problems, family/marital problems, suicide, financial concerns, adolescent treatment.

Health promotion services: Frequent smoking cessation, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, organizational development. Occasional AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 25; 20 clinical staff members, including four CEAP, 18 MSW, 12 CAC designations.

On-site: two psychologists, 18 social workers.

Contracted: one psychiatrist, one psychologist.

Reporting: As requested.

Service area: Nationwide.

Clients: 50; 8% with one to 100 employees, 72% with 101 to 1,000, 16% with 1,001 to 5,000, 4% with 5,001 or more. Lives covered at year-end 1990: 51,000 employees and 65,500 dependents.

Principal officers: Bernard S. Dyme, president; Jeffrey N. Blaine, vp-finance/administration; Judith M. Bank, vp-clinic services; W. Leighton Clark, vp-EAPs.

Contact: Bernard S. Dyme, Terry Cahill.

Plan 21

4550 Post Oak Place Drive, Houston, Texas 77027-3106; 713-621-6500; fax: 713-621-6560

Year founded: 1984.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment, children, co-dependency. Occasional legal problems, financial concerns.

Health promotion services: Frequent nutrition/weight control, stress management, drug/chemical awareness, AIDS awareness. Occasional smoking cessation.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification, psychiatric disability review. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, specialty provider network.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 28; 20 clinical staff members, including two CEAP, 10 MSW, three CAC, three MD, three RN, four Ph.D. designations.

On-site: two psychiatrists, two psychologists, eight social workers, two psychiatric nurses.

Contracted: one psychiatrist, two psychologists, four social workers, one physician, one psychiatric nurse.

Facilities: 20.

Reporting: Quarterly.

Service area: Texas, Louisiana, Oklahoma.

Clients: 35; 15% with one to 100 employees, 35% with 101 to 1,000, 49% with 1,001 to 5,000, 10% with 5,001 or more. Lives covered at year-end 1990: 35,000 employees and 42,000 dependents.

Principal officers: Joseph F. Madonia, president; Don Foster, Stephen Luppino and Janet Zaozirny, vps.

Contact: George Moody.

Professional Psychology Services

1 Rittenhouse Square, Suite 401, Philadelphia, Pa. 19103; 215-567-1306

Year founded: 1980.
For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment, medical/psychotherapy, women's issues. Occasional financial concerns.

Health promotion services: Frequent nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, aging. Occasional smoking cessation, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification, executive consultation, management training and consultation. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 14; three clinical staff members, including one CEAP, three MSW, one CAC, one MD, seven Ph.D. designations.

On-site: one psychiatrist, five psychologists, three social workers, one marriage/family/child counselor.

Contracted: three psychologists, one social worker.

Reporting: On request.

Service area: New Jersey, Pennsylvania.

Contact: Dr. Marion Frank.

Prudential Insurance/Total Psychiatric Management

P.O. Box 27730, Houston, Texas 77227-7730; 800-334-6404; fax: 713-993-3971

Year founded: 1990.

Parent company: Prudential Insurance Co. of America.

For profit.

Services: Varies by contracted provider.

Utilization review services: Precertification of inpatient/outpatient

Continued on next page

GENERAL REHABILITATION SERVICES INC.
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Continued from previous page
treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, phone counseling.

Staff: Contracted psychiatrists, psychologists, social workers, marriage/family/child counselors, physicians.

Reporting: Quarterly.

Specialties: Large employers.

Service area: Nationwide.

Contact: Cliff Johnstone, marketing consultant, 24 Greenway Plaza, Suite 700, Houston, Texas 77046.

Psychology Systems Inc.

415 S. Main St., Milpitas, Calif. 95035; 408-263-8046; fax: 408-992-0664

Year founded: 1979.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, adolescent treatment, psychiatric problems, depression/anxiety disorders. Occasional financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, clinical review/authorization.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 1,900; 1,800 clinical staff members, including 100 CEAP, 400 MSW, 100 CAC, 150 MD, 20 RN, 500 Ph.D. designations.

On-site: one psychiatrist, three psychologists, three marriage/family/child counselors.

Contracted: 150 psychiatrists, 500 psychologists, 400 social workers, 530 marriage/family/child counselors.

Reporting: Quarterly.

Specialties: Public school systems, high-technology firms.

Service area: Nationwide.

Clients: 400; 5% with one to 100 employees, 66% with 101 to 1,000, 35% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 85,000 employees and 112,000 dependents.

1990 gross revenues: $4.5 million; 50% from EAP services, 30% from managed mental health care services, 20% from carved-out HMO mental health services.

Principal officers: John C. Brady II, president; Richard Falls, vp-marketing; James B. Wallace, vp-managed care; Howard Hilderbrand, treasurer.

Contact: Richard Falls.

R

REACH

332 Springfield Ave., P.O. Box 100, Summit, N.J. 07901; 908-277-7804; fax: 908-277-1334

Year founded: 1985.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment, compulsive gambling, general psychotherapy.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional physical fitness/exercise, nutrition/weight control, AIDS awareness, elder care.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 11; six clinical staff members, including two CEAP, nine MSW, two CAC designations.

On-site: six social workers.

Reporting: Monthly, quarterly, annually.

Service area: Nationwide.

Clients: 29; 17% with one to 100 employees, 59% with 101 to 1,000, 17% with 1,001 to 5,000, 7% with 5,001 or more. Lives covered at year-end 1990: 74,407 employees and 186,018 dependents.

Principal officers: Scott J. Pontier, director; Anthony Kearney, coordinator; Brian Burgener, account executive; Denise Adams, EAP coordinator.

Contact: Brian J. Burgener.

REAP of Milford Inc.

9 Seaview Ave., Milford, Conn. 06460; 203-874-3639; fax: 203-876-7285

Year founded: 1986.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse. Occasional suicide, legal problems, financial concerns, adolescent treatment.

Health promotion services: Physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, organizational change.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review.

Utilization review services: Case management, follow-up study evaluation.

Counseling sites: All worksites, EAP/mental health care facilities.

Staff: Four; three clinical staff members, including three CEAP, one MSW, one CAC, one Ph.D. designations.

Contracted: two psychologists.

Reporting: As requested.

Service area: Connecticut.

Clients: 11; 12% with one to 100 employees, 50% with 101 to 1,000, 8% with 1,001 to 5,000, 30% with 5,001 or more.

Principal officers: Jacqueline Harrigan, Alex Selgi, Daniel Harrigan, Brian Onofrio.

Contact: Jacqueline Harrigan.

S

St. Louis Area Employee Assistance Program

8764 Manchester Road, Suite 216, St. Louis, Mo. 63144; 314-968-8764; fax: 314-968-7394

Not for profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 10; six clinical staff members, including one CEAP, one MSW, three CAC, one RN, one Ph.D., three LPC designations.

On-site: one social worker, three LPCs.

Contracted: one psychologist, one physician.

Facilities: Four.

Reporting: As requested.

Service area: St. Louis, Mo., with affiliate providers in 18 states.

Clients: 115; 30% with one to 100 employees, 30% with 101 to 1,000, 30% with 1,001 to 5,000, 10% with 5,001 or more. Lives covered at year-end 1990: 30,000 employees.

1990 gross revenues: 100% from EAP services.

Principal officers: Tim Hobart, director; Ed Tasch, executive director; Sharon Diekemper, clinical coordinator.

Contact: Tim Hobart.

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Services to Industry

375 Cambridge, Palo Alto, Calif. 94306; 415-326-9890; fax: 415-326-1340

Year founded: 1983.
Parent company: Family Services Mid-Peninsula.
Not for profit.
Assessment/treatment: Stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.
Health promotion services: Stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, family/parenting issues.
Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification.
Utilization review services: Precertification of inpatient/outpatient treatment, case management.
Counseling sites: EAP/mental health care facilities, selected worksites.
Staff: Includes CEAP, MSW, CAC, Ph.D., LMFC designations.
On-site: psychologists, social workers, marriage/family/child counselors.
Contracted: psychiatrists, physicians.
Reporting: Quarterly.
Specialties: Computer software, medical, educational, theme parks.
Service area: Santa Clara and San Mateo counties in California.
Clients: 25; 80% with 101 to 1,000 employees, 20% with 1,001 to 5,000. Lives covered at year-end 1990: 20,000 employees and 45,000 dependents.
1990 gross revenues: $170,000; 60% from EAP services, 40% from managed mental health care services.
Principal officers: M.J. Myatt Loughran, director; Chester F. Villalba, executive director; Ron Taylor, business director.
Contact: M.J. Loughran.

Sobel & Raciti Associates

16 Boston Post Road, Wayland, Mass. 01778; 800-227-2195

Year founded: 1988.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse. Occasional financial concerns, adolescent treatment.
Health promotion services: Frequent smoking cessation, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, parenting. Occasional AIDS awareness.
Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review.
Utilization review services: Precertification of inpatient/outpatient-treatment, concurrent review, case management.
Counseling sites: All worksites, clients' headquarters, selected worksites, phone counseling.
Staff: Seven; five clinical staff members, including one CAC, four Ph.D. designations.
On-site: four psychologists, one social worker.
Contracted: five psychiatrists.
Facilities: Six.
Reporting: Quarterly, annually.
Specialties: Small, self-funded high-technology companies.
Service area: Connecticut, Massachussetts, New York, New Jersey, Rhode Island.
Clients: 91% with 101 to 1,000 employees, 9% with 1,001 to 5,000. Lives covered at year-end 1990: 10,000 employees.
1990 gross revenues: 60% from EAP services, 30% from managed mental health care services, 10% from individual coaching, counseling of executives.
Principal officers: Harry J. Sobel, president; Michael A. Faciti, executive vp.
Contact: Harry J. Sobel.

SouthCare Medical Alliance PHP Inc.

3715 Northside Parkway 400, Suite 300, Atlanta, Ga. 30327; 404-231-9911; fax: 404-231-9416

Year founded: 1985.
Not for profit.
Assessment/treatment: Frequent stress, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional occupational problems, suicide, legal problems, financial concerns.
Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness. Occasional AIDS awareness.
Educational/general services: Frequent employee education, psychiatric disability review. Occasional supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.
Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.
Staff: Includes eight MSW, 18 MD, 16 Ph.D. designations.
Contracted: 18 psychiatrists, eight psychologists, six social workers.
Reporting: Monthly, quarterly, annually.
Service area: Atlanta.
Clients: 40% with one to 100 employees, 30% with 101 to 1,000, 20% with 1,001 to 5,000, 10% with 5,001 or more. Lives covered at year-end 1990: 114,065 employees and 262,870 dependents.
1990 gross revenues: $100 million; 8% from managed mental health care services, 92% from H&A PPO services.
Principal officers: Richard Hubbard, chairman; Larry L. Madlem, president/chief executive officer; Rebecca McQueen, vp-administration; Al Teets, vp-marketing; Dr. S. Angier Wills, director.
Contact: Larry L. Madlem, Cathy Sykes.

Southwest Health Providers

1301 W. 38th St., Suite 312, Austin, Texas 78705; 612-459-3185; fax: 612-459-8687

Year founded: 1986.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional suicide, financial concerns.
Health promotion services: Occasional alcohol awareness, drug/chemical awareness.
Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, psychiatric disability review, psychiatric workers compensation review available.
Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.
Counseling sites: EAP/mental health care facilities, phone counseling.
Staff: 13; five clinical staff members, including three MSW, six MD, one RN designations.
On-site: four psychiatrists, three social workers.
Contracted: 19 psychiatrists, 17 psychologists, 24 social workers.
Facilities: Seven.
Reporting: As requested.
Service area: Nationwide.
Clients: 100% with 5,001 or more employees. Lives covered at year-end 1990: 27,000.
1990 gross revenues: $1.9 million; 100% from managed mental health care services.
Principal officers: Dr. Stuart S. Nemir Jr., president; Dr. Robert L. Zapalac, vp; Dr. Tracy R. Gordy, treasurer; Dr. Theodore Dake Jr., secretary; Dr. James L. Boynton, shareholder.
Contact: Linda Mitchell, director-operations, 800-626-2152.

Square Lake Corp. & Affiliates

1750 S. Telegraph , Suite 200, Bloomfield Hills, Mich. 48302; 313-338-0382; fax: 313-338-3940

Year founded: 1989.
For profit.
Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment, psychological/emotional problems. Occasional legal problems, financial concerns.
Health promotion services: Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, support groups.
Educational/general services: Frequent employee education, supervisor training. Occasional drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers

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Continued from previous page
compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, crisis intervention, emergency assessment, referral coordination.

Counseling sites: All worksites, EAP/mental health care facilities, selected worksites, phone counseling, insurer facilities.

Staff: Includes one CEAP, 30 MSW/CSW, three CAC, four MD, two RN, six Ph.D. designations.

On-site: four psychiatrists, 56 psychologists, 32 social workers, one physician, seven alcohol/drug counselors.

Facilities: 205.

Reporting: Quarterly.

Service area: Michigan, Ohio.

Clients: Four; 100% with 101 to 1,000 employees. Lives covered at year-end 1990: 124,000 employees and 186,000 dependents.

1990 gross revenues: $1.8 million; 1% from EAP services, 59% from managed mental health care services, 40% from direct service provision, consultation and management services.

Principal officers: A. Diane Vincent, chief executive officer; Robert K. Graham, chief operating officer; Jane Abbot, chief financial officer; Brian K. Loque, vp-marketing; Nancy Grose, vp-operations; Melissa Klein, vp-human resources.

Contact: M. Diane Vincent, Brian Loque, Joanne Lindensmith.

StayWell Health Management Systems Inc.

1285 Corporate Center Drive, Suite 100, Eagan, Minn. 55121; 612-454-3577; fax: 612-454-4062

Year founded: 1978.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, legal problems, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Frequent smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, back care, safety.

Educational/general services: Frequent employee education, supervisor training, workplace problem identification. Occasional drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management, bill review, fee negotiation.

Counseling sites: All worksites, clients' headquarters, selected worksites, phone counseling.

Staff: 90; 70 clinical staff members, including 30 MSW designations.

On-site: psychologists, social workers.

Contracted: psychologists, social workers.

Facilities: 6,000.

Reporting: Quarterly.

Service area: Nationwide and Canada.

Clients: 109; 9% with one to 100 employees, 60% with 101 to 1,000, 26% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 100,000 employees.

Principal officers: G.L. (Bud) Anderson, president; John Tarbuck, vp-marketing; David Anderson, vp-operations.

Contact: John Tarbuck.

Robert Strutman & Associates Inc.

34 Lincoln St., Newton Highlands, Mass. 02161; 617-630-0300

Year founded: 1990.

For profit.

Assessment/treatment: Frequent alcohol abuse, drug/chemical abuse.

Health promotion services: Frequent alcohol awareness, drug/chemical awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: Phone counseling.

Staff: Eight; five clinical staff members, including one MSW, four CAC, two Ph.D., three CAS designations.

On-site: two psychologists.

Contracted: two psychologists, one social worker.

Reporting: As requested.

Service area: Nationwide.

Clients: Five; 40% with 101 to 1,000 employees, 40% with 1,001 to 5,000, 20% with 5,001 or more. Lives covered at year-end 1990: 7,500 employees.

1990 gross revenues: 5% from EAP services, 5% from managed mental health care services, 90% from comprehensive drug-free workplace programs.

Principal officers: Robert M. Stutman, president; Michael A. Golbe, vp.

Contact: Michael A. Golbe.

T

Take Control

401 W. Michigan, Milwaukee, Wis. 53203; 414-226-5373; fax: 414-226-5488

Year founded: 1985.

Parent company: Blue Cross/Blue Shield United of Wisconsin.

For profit.

Continued on next page

★ ★ **ANNOUNCING** ★ ★

The Council on Employee Benfits (CEB)
1991 Fall Conference
BENEFITS IN TRANSITION
October 2-4, 1991
The Westin Hotel, Chicago, IL.

Registration Contact:
C.S. Lazaroff, Secretary-Treasurer
c/o Goodyear Relief Association
1144 E. Market Street, Akron, Ohio 44316
(216) 796-4008

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REINSURANCE WITH ASSURANCE

Continued from previous page

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, depression, anxiety. Occasional legal problems, financial concerns, adolescent treatment.

Health promotion services: Frequent medical self-care, health risk assessment. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness.

Educational/general services: Occasional employee education, supervisor training, workplace problem identification, life-style based insurance premium program.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 40; 26 clinical staff members, including one MSW, three MD, 24 RN, two Ph.D. designations.

On-site: one psychologist, one social worker, two physicians, one exercise physiologist.

Contracted: 10 psychiatrists, one psychologist, 20 physicians.

Reporting: Annually.

Service area: Wisconsin.

Clients: 369; 53% with one to 100 employees, 42% with 101 to 1,000, 4% with 1,001 to 5,000, 1% with 5,001 or more. Lives covered at year-end 1990: 106,339 employees and 159,508 dependents.

Principal officers: Dr. Richard Christenson, chief executive officer/medical director; Barbara Tyler, director-professional analyst; Ken Savage, director-operations; Bruce Christiansen, assistant director-medical affairs; Brenda Northern, marketing manager.

TAO Inc.

1901 Market St., 32nd Floor, P.O. Box 15988, Philadelphia, Pa. 19103; 800-344-1255; fax: 215-241-4766

Year founded: 1985.

Parent company: Independence Blue Cross.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 414 clinical staff members, including 112 MSW, eight CAC, 77 MD, 22 RN, 118 Ph.D. designations.

On-site: 18 psychiatrists, 26 psychologists, nine social workers.

Contracted: 59 psychiatrists, 92 psychologists, 94 social workers.

Facilities: 137.

Reporting: Quarterly.

Service area: Nationwide.

Clients: Lives covered at year-end 1990: 330,000.

1990 gross revenues: $3.7 million; 2% from EAP services, 98% from managed mental health care services.

Principal officers: Dr. Anthony F. Panzetta, president/chief executive officer; Barry Davis, chief operating officer; Frank Erdlen, senior vp-planning and development; Dr. William Hetznecker, vp-clinical affairs; Donna E. DeHart, vp-marketing.

Contact: Eric Kramer, manager-sales and marketing.

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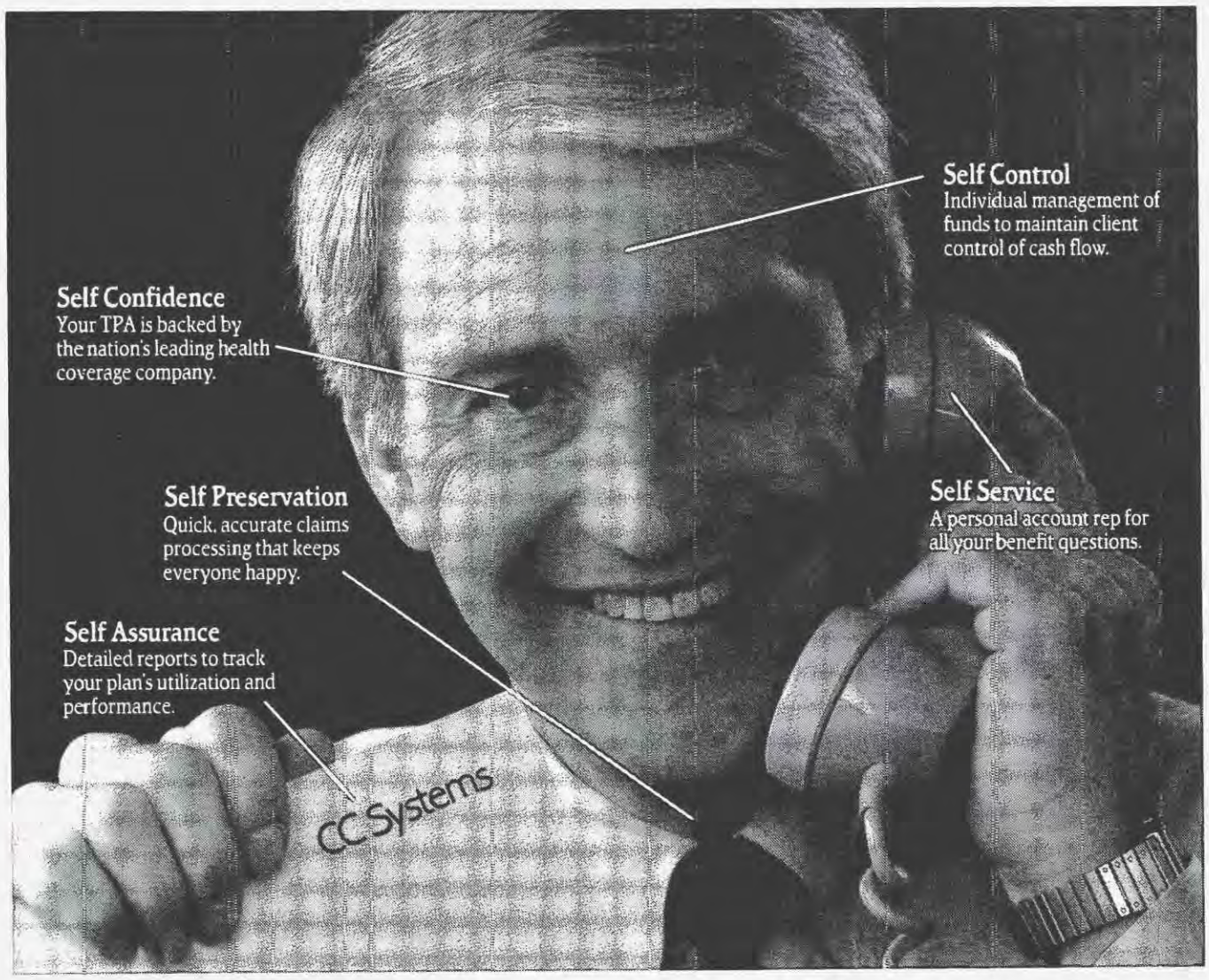

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U

United Behavioral Systems Inc.

3600 W. 80th St., Suite 210, Minneapolis, Minn. 55431; 800-433-0519; fax: 612-830-3122

Year founded: 1985.

Parent company: United HealthCare.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional suicide, legal problems, financial concerns.

Health promotion services: Occasional smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness.

Educational/general services: Occasional employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: 205; 90 clinical staff members, including 43 MSW, two MD, three RN, 28 Ph.D., 14 CCDC designations.

On-site: two psychiatrists, 28 psychologists, 43 social workers.

Contracted: 259 psychiatrists, 404 psychologists, 576 social workers.

Facilities: 124.

Reporting: Monthly, on request.

Service area: Cities of Atlanta; Chicago; Des Moines, Iowa; St. Louis; Omaha, Neb.; Oklahoma City and Tulsa, Okla.; Columbia, S.C.; Salt Lake City and Provo, Utah. States of Indiana, Kentucky, Minnesota, Oregon.

Clients: Nine; 10% with 1 to 100 employees, 80% with 101 to 1,000, 10% with 1,001 to 5,000.

Principal officers: Jack Newstrom, president/chief executive officer; John D. Tadich, vp-marketing and product development; Charles F. Sherman and Glenn Andis, operations directors; Deborah Trout, director-utilization review and network programs.

Contact: Jackie Heinen.

U.S. Behavioral Health

2000 Powell St., Suite 1180, Emeryville, Calif. 94608; 415-601-2200; fax: 415-547-2336

Year founded: 1979.

Parent company: Travelers Corp.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, suicide, alcohol abuse, drug/chemical abuse, adolescent treatment. Occasional legal problems, financial concerns.

Health promotion services: Frequent stress management, alcohol awareness, drug/chemical awareness, AIDS awareness. Occasional smoking cessation, physical fitness/exercise, nutrition/weight control.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification. Occasional psychiatric disability review.

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Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Includes MSW, MD, RN, Ph.D., MFCC designations.

Contracted: 1,800 psychiatrists, 3,900 psychologists, 2,750 social workers, 1,500 marriage/family/child counselors.

Facilities: 675.

Reporting: Quarterly.

Specialties: Union trusts, insurance companies, HMOs, government agencies, high-tech industries.

Service area: 29 states.

Clients: 5% with 1 to 100 employees, 25% with 101 to 1,000, 40% with 1,001 to 5,000, 30% with 5,001 or more. Lives covered at year-end 1990: 2 million employees and 2.1 million dependents.

1990 gross revenues: 15 to 20% from EAP services, 80 to 85% from managed mental health care services.

Principal officers: Eugene D. Hill, president/chief executive officer; Saul Feldman, chairman; Dr. Richard Kunnes, chief operating officer.

Contact: Thomas Carter, vp.

W

The Wellness Group Inc.

2525 Telegraph, Suite 304,
Bloomfield Hills, Mich. 48302;
313-338-1870; fax: 313-338-7391

Year founded: 1982.

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, parenting concerns. Occasional suicide, drug/chemical abuse, financial concerns, adolescent treatment.

Health promotion services: Smoking cessation, physical fitness/exercise, nutrition/weight control, stress management, alcohol awareness, drug/chemical awareness, AIDS awareness, back problems, carpal tunnel syndrome.

Educational/general services: Employee education, supervisor training, drug-free workplace regulatory adherence, workplace problem identification, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: EAP/mental health care facilities.

Staff: 15; five clinical staff members, including CEAP, CAC, MD, RN designations.

Contracted: psychiatrists, psychologists, social workers, marriage/family/child counselors, physicians.

Reporting: On request.

Service area: Florida, Michigan, Ohio, Texas.

Clients: 46; 10% with one to 100 employees, 70% with 101 to 1,000, 20% with 1,001 to 5,000. Lives covered at year-end 1990: 34,500 employees and 80,000 dependents.

1990 gross revenues: $425,000; 50% from EAP services, 20% from managed mental health care services, 30% from health promotion and related activities.

Principal officers: Delores C. Tripp, Dr. Lucius C. Tripp, Lucius Theus.

Y

Yost Inc.

Bentley-Settle Building, Sixth Floor,
120 Walton St., Syracuse, N.Y.
13202; 315-425-1716;
fax: 315-425-1808

For profit.

Assessment/treatment: Frequent stress, occupational problems, family/marital problems, alcohol abuse, drug/chemical abuse, financial concerns, adolescent treatment. Occasional suicide, legal problems.

Health promotion services: Frequent smoking cessation, stress management, alcohol awareness, drug/chemical awareness. Occasional physical fitness/exercise, nutrition/weight control, AIDS awareness.

Educational/general services: Frequent employee education, supervisor training, drug-free workplace regulatory adherence. Occasional workplace problem identification, psychiatric disability review, psychiatric workers compensation review.

Utilization review services: Precertification of inpatient/outpatient treatment, concurrent review, case management.

Counseling sites: All worksites, clients' headquarters, EAP/mental health care facilities, selected worksites, phone counseling.

Staff: Includes three CEAP, four MSW, four CAC designations.

On-site: two psychologists, four social workers.

Reporting: Quarterly.

Service area: Nationwide.

Clients: 75,000; 5% with one to 100 employees, 70% with 101 to 1,000, 20% with 1,001 to 5,000, 5% with 5,001 or more. Lives covered at year-end 1990: 75,000 employees and 135,000 dependents.

Principal officers: William H. Yost, president.

Contact: Robert Brown, 315-425-6481. ■

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EAPs, managed mental health plans listed by state

Nationwide

Employee Assistance Plans
- Counseling & Readjustment Services
- DCC/The Dependent Care Connection Inc.
- Education & Training Programs Inc.
- Longview Associates Inc.
- Pius XII Corporate Services (Northeast)
- Pathways EAP

Managed Mental Health Care Plans
- The Allen Group
- American PsychManagement Inc.
- CIGNA Mental Health Inc. (except Iowa and Wyoming)
- ComPsych Employee Assistance Programs Inc.
- CONCERN: Counseling & EAP Services
- Corporate Counseling Associates Inc.
- Employee Advisory Resource
- Employee Assistance Service Inc.
- Employee Counseling Service
- Employee Health Plus
- Kathleen Greer Associates (Northeast)
- Hazelden Services Inc.
- Health Risk Management Inc.
- The Holman Group
- Human Affairs International
- Institute for Human Resources
- The Jernberg Corp.
- Charles Nechtem Associates Inc.
- National Resource Consultants Inc.
- Occupational Health Services Inc.
- Omni Health Systems Inc.
- People Resources Inc.
- Personal Performance Consultants
- Perspectives Ltd.
- Prudential Insurance/Total Psychiatric Management
- Psychology Systems Inc.
- REACH
- Southwest Health Providers
- StayWell Health Management Systems Inc.
- Robert Strutman & Associates Inc.
- TAO Inc.
- Yost Inc.

Alabama

Managed Mental Health Care Plans
- Birmingham Psychiatry
- Burke-Taylor Associates

Alaska

Managed Mental Health Care Plans
- Human Affairs of Alaska

Arkansas

Managed Mental Health Care Plans
- Benesys

Arizona

Managed Mental Health Care Plans
- Behavioral Healthcare Options
- CMG Health

California

Employee Assistance Plans
- Michael Legot, EAP Consultant
- Michael Mitroff
- Personal Assistance Services of San Diego
- Professional Employee Assistance Consulting
- RADAR EAP Inc.

Managed Mental Health Care Plans
- Behavioral Health Access of Blue Cross of California
- Benesys
- California Psychological Health Plan
- Community Care Network
- Creative Care Management
- EAP Associates
- Health and Human Resource Center
- Healthcare Resources
- Hurst Associates
- Services to Industry

Colorado

Employee Assistance Plans
- RADAR EAP Inc.

Managed Mental Health Care Plans
- Behavioral Healthcare Options
- Benesys
- Bethesda Provider Network & EAP
- CMG Health
- Employee Assistance Programs Inc.

Connecticut

Employee Assistance Plans
- Affiliated Healthcare Systems Mansfield Assn. Inc.
- RADAR EAP Inc.
- Resource EAP Inc.

Managed Mental Health Care Plans
- Creative Care Management
- Employee Counseling Programs-Corporate Health Systems
- Mansfield Associates Inc.
- REAP of Milford Inc.
- Sobel & Raciti Associates

Delaware

Employee Assistance Plans
- The Prime Employee Assistance Program Inc.

Managed Mental Health Care Plans
- CMG Health
- Employee Counseling Programs-Corporate Health Systems

District of Columbia

Employee Assistance Plans
- BEMW Inc. Counseling & Training Associates

Managed Mental Health Care Plans
- Allied Assistance Services
- CMG Health
- Employee Counseling Programs-Corporate Health Systems

Florida

Employee Assistance Plans
- Family Alternatives/Employee Assistance Services
- HealthLine Employee Assistance Programs
- PHR Group Inc.
- RADAR EAP Inc.
- Resource EAP Inc.

Managed Mental Health Care Plans
- Benesys
- Bradman Therapy Centers
- Family Alternatives/Employee Assistance Services
- Iowa Managed Health Care Inc.
- The Wellness Group

Georgia

Employee Assistance Plans
- Archbold Employee Assistance Services
- Northeast Georgia Employee Assistance Program
- Resource EAP Inc.

Managed Mental Health Care Plans
- Benesys
- Burke-Taylor Associates
- Creative Care Management
- Employee Counseling Programs-Corporate Health Systems
- SouthCare Medical Alliance PHP Inc.
- United Behavioral Systems Inc.

Hawaii

Managed Mental Health Care **Plans**
- **Human Affairs of Alaska**

Idaho

Employee Assistance Plans
- RADAR EAP Inc.

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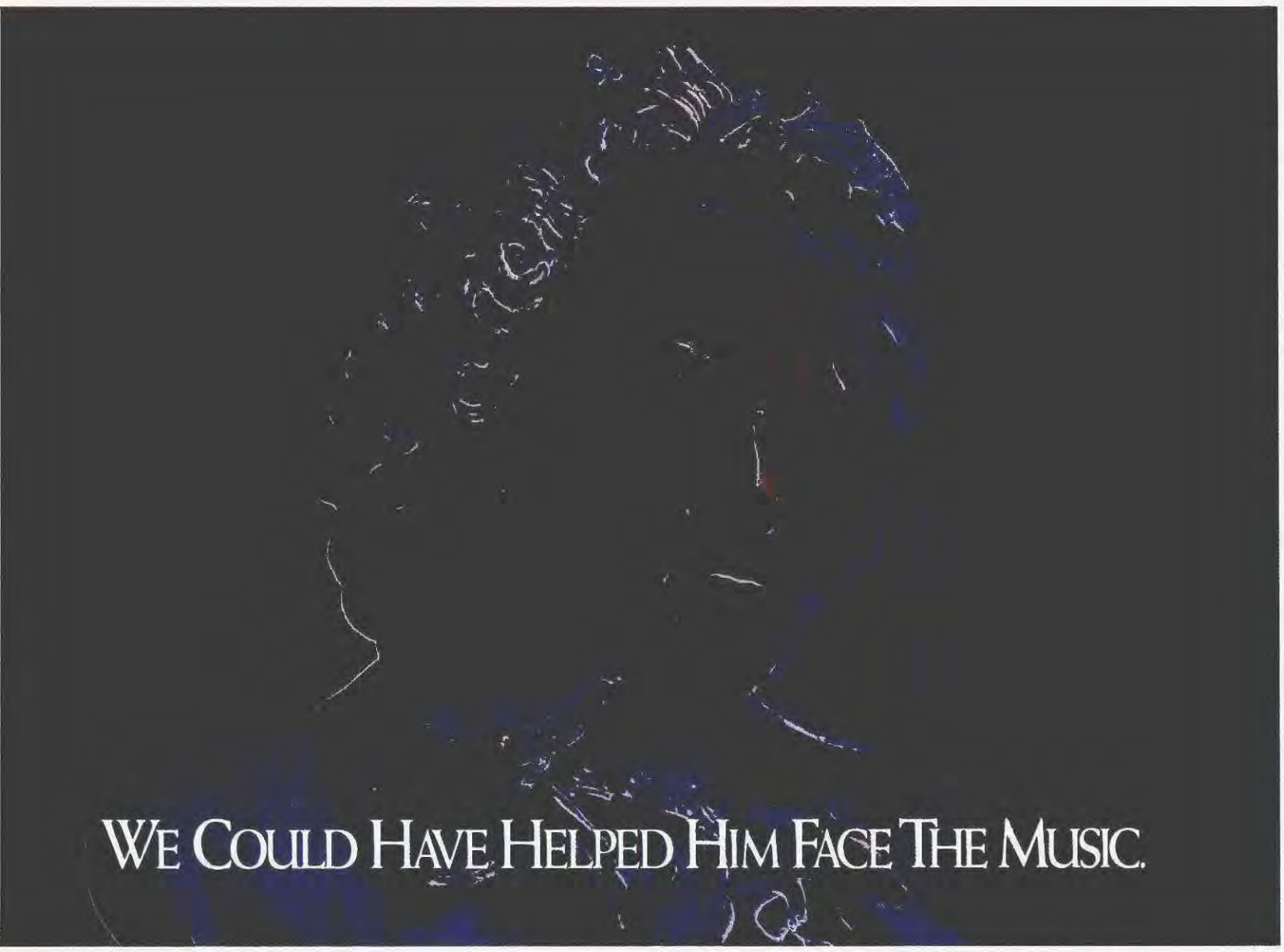

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Aging & the Workplace
Employee Assistance Network
Harting Associates Inc.
Open-Door Services Inc.
Personnel Assistance Services
Rehagen & Associates
Managed Mental Health Care Plans
K.H. Antia, Ph.D. & Associates/Magi Human Resources Center
Benesys
CMG Health
Creative Care Management
United Behavioral Systems Inc.

Indiana

Employee Assistance Plans
Michiana Employee Assistance Program
Managed Mental Health Care Plans
Michiana Employee Assistance Program
United Behavioral Systems Inc.

Iowa

Managed Mental Health Care Plans
CMG Health
Iowa Managed Health Care Inc.
Lampton & Associates
United Behavioral Systems Inc.

Kansas

Managed Mental Health Care Plans
CMG Health
Creative Care Management

Kentucky

Managed Mental Health Care Plans
Employee Counseling Programs-Corporate Health Systems
Lampton & Associates
United Behavioral Systems Inc.

Louisiana

Managed Mental Health Care Plans
Benesys
Plan 21

Maine

Employee Assistance Plans
Affiliated Healthcare Systems
Managed Mental Health Care Plans
Employee Counseling Programs-Corporate Health Systems
Hurst Associates

Maryland

Employee Assistance Plans
BEMW Inc. Counseling & Training Associates
The Prime Employee Assistance Program Inc.
Managed Mental Health Care Plans
Allied Assistance Services
CMG Health
Employee Counseling Programs-Corporate Health Systems

Massachusetts

Employee Assistance Plans
Affiliated Healthcare Systems
EAP, Service of Mount Auburn Hospital
Family Service Assn. of Greater Lawrence
Mansfield Assn. Inc.
RADAR EAP Inc.
Managed Mental Health Care Plans
Creative Care Management
Employee Counseling Programs-Corporate Health Systems
Family Service Assn. of Greater Lawrence
Hurst Associates
Mansfield Associates Inc.
Sobel & Raciti Associates

Michigan

Employee Assistance Plans
Employee Assistance Program
Michiana Employee Assistance Program
RADAR EAP Inc.
Managed Mental Health Care Plans
Creative Care Management
Employee Assistance Associates Inc.
Employee Assistance Center
Square Lake Corp. & Affiliates
The Wellness Group

Minnesota

Employee Assistance Plans
Dor & Associates Inc.
Employee Assistance Program Consultants Inc.
Managed Mental Health Care Plans
CMG Health
Creative Care Management
United Behavioral Systems Inc.

Missouri

Employee Assistance Plans
Harting Associates Inc.
Personnel Assistance Services
RADAR EAP Inc.
Managed Mental Health Care Plans
CMG Health
Creative Care Management
St. Louis Area Employee AssistanceProgram
United Behavioral Systems Inc.

Montana

Employee Assistance Plans
MedCenter One Employee Assistance Program

Nebraska

Employee Assistance Plans
Directions
Lincoln Employee Assistance Program Inc.
Managed Mental Health Care Plans
CMG Health
United Behavioral Systems Inc.

Nevada

Employee Assistance Plans
New Choices Inc.
Managed Mental Health Care Plans
Behavioral Healthcare Options

New Hampshire

Employee Assistance Plans
Affiliated Healthcare Systems
EAP, Service of Mount Auburn Hospital
Managed Mental Health Care Plans
Employee Counseling Programs-Corporate Health Systems
Hurst Associates

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CMG Health

Ohio

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The Wellness Group

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CMG Health

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Texas

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Benesys
Creative Care Management
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The Wellness Group

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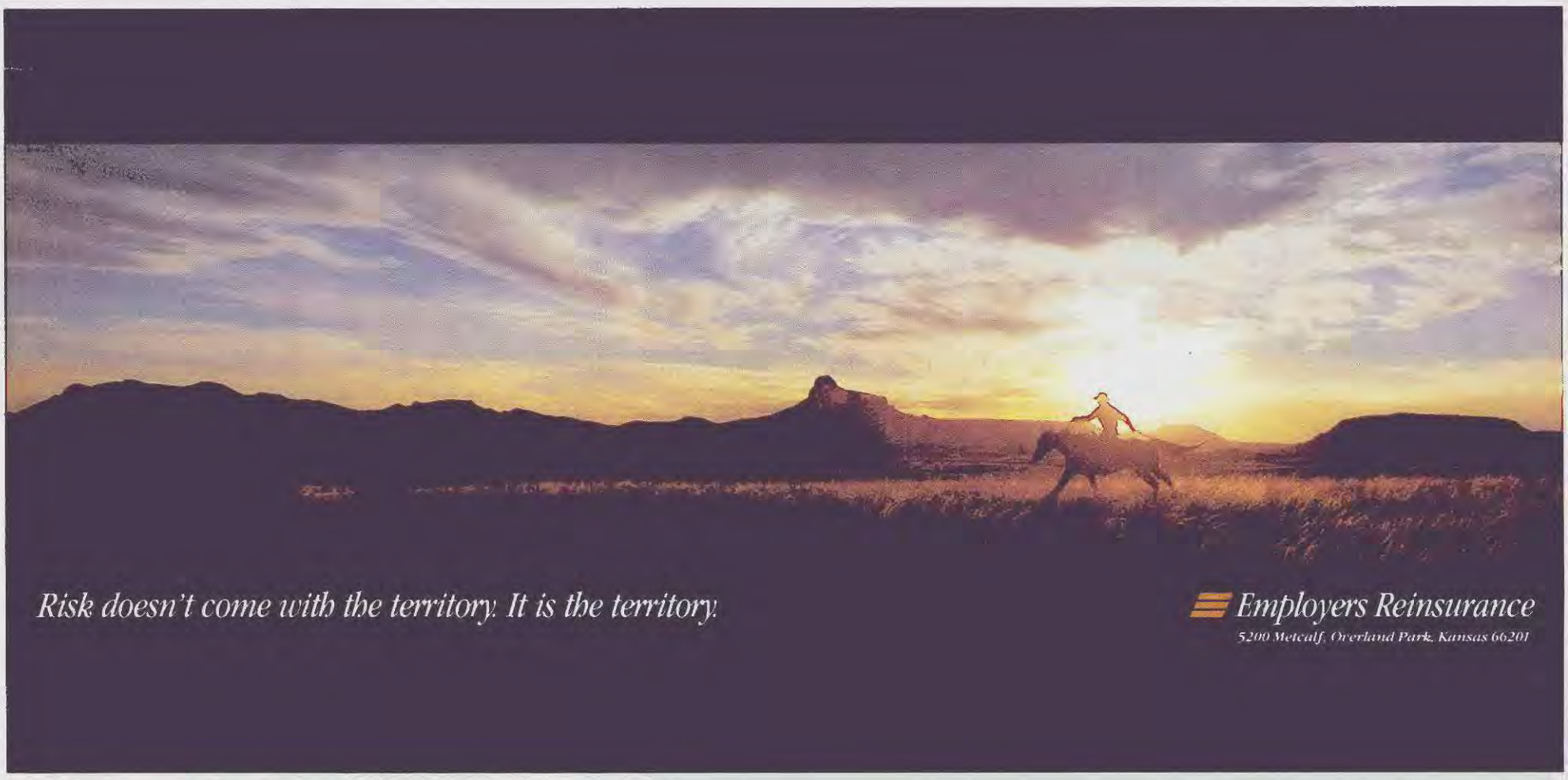

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Utah

Managed Mental Health Care Plans
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United Behavioral Systems Inc.

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Precertification

Continued from page 1

care networks could all be challenged.

While the Bethlehem Steel case involves a retiree medical plan, active workers also could allege that managed care techniques violate public policy should the ruling be upheld, benefit experts say.

"What's at stake is every employer's ability to design a plan that minimizes costs but still provides effective health care," said Mark Ugoretz, president of the ERISA Industry Committee in Washington, D.C., an employer lobbying group.

Sue Nelson, corporate insurance manager with Texas Instruments Inc. in Dallas, said she would be very concerned if the ruling is upheld.

"I have a real concern about leaving an open road for employees to challenge managed care. I'm glad the ruling is being appealed."

Employers should have the right to penalize employees that fail to comply with requirements that meet a plan's stated objectives, so long as employers are adequately warned of the penalty, Ms. Nelson maintained.

If Judge Caldwell's ruling is upheld and his "position becomes widely held, it will take the teeth away from the concept of precertification," predicted William J. Miner, an actuary with The Wyatt Co. in Chicago.

"Companies will be forced to come up with other incentives or disincentives to get their plan participants to comply with managed care features. This is definitely an onerous ruling for employers that puts them in an all-or-nothing situation as far as managed care is concerned," he said.

Bill Custer, director of research with the Employee Benefit Research Institute in Washington, D.C., agreed that if the ruling is upheld, employers could be forced to redesign plans to ensure that managed care elements are not arbitrary.

"If employers can't steer their employees through monetary incentives, then they'll have to choose other methods. They could make precertification mandatory and there would be no question as to whether a penalty was capricious," said Mr. Custer, suggesting that employers may be forced to deny all coverage if precertification is not obtained.

At the center of the case is Richard Nazay. In 1989, Bethlehem Steel partially denied hospitalization benefits for the 62-year-old retiree, who was covered under a self-insured plan for union retirees.

After 37 years at Bethlehem's Steelton, Pa., plant, Mr. Nazay retired in 1986. He suffered from a heart condition and, before being hospitalized in June 1989, he experienced shortness of breath. Two cardiologists then determined that he needed to be admitted to a hospital for treatment.

After eight days, Mr. Nazay was discharged. The hospital submitted a bill for $7,438 to Bethlehem Steel.

The Bethlehem Steel retiree health care plan pays 100% of most covered expenses. However, while the company's insurance board—which administers the plan—said the treatment was medically necessary, it deducted 30%, or $2,231, from Mr. Nazay's benefits because he failed to obtain precertification.

A provision added to the Bethlehem Steel plan for retirees and active employees in April 1984 requires all non-emergency hospital admissions to be precertified.

Employees and retirees who fail to obtain precertification for services that later are determined by the board to have been medically necessary are penalized 30% of covered expenses. Employees and retirees who do not obtain precertification for services later determined to have not been medically necessary receive no reimbursement.

After Bethlehem Steel refused to fully pay his claim, Mr. Nazay filed suit in August 1990 in Pennsylvania state court. The case was later transferred to federal court.

Mr. Nazay argued that imposing a 30% penalty for what the company conceded was medically necessary treatment was both arbitrary and capricious. He contended that the penalty was excessive and that it didn't advance the company's stated goal of reducing unnecessary medical care because the company insurance board had the authority to refuse to pay for any unnecessary treatment.

"The penalty in this case served no realistic purpose. It only avoided paying the full amount of a legitimate claim that the beneficiary is entitled to," said Robert Mulderig, an attorney in the Law Offices of Ron Turo in Carlisle, Pa., which represents Mr. Nazay.

Mr. Nazay's suit also claimed that by imposing a penalty Bethlehem Steel violated its fiduciary duties under the Employee Retirement Income Security Act.

Section 1104 of ERISA states that a "fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants."

Mr. Mulderig said, "We feel that the company cannot design a pension or health plan with so many pitfalls that it can virtually give the retiree nothing."

Judge Caldwell based his decision on Pennsylvania state insurance law and a 1989 ERISA ruling by the 3rd Circuit.

Neither Bethlehem Steel nor the plaintiff were able to cite any specific cases that considered whether precertification penalties violate public policy or ERISA.

Judge Caldwell relied mostly on insurance law in Pennsylvania, where courts have found in cases involving property/casualty insurance that an insurer must show prejudice before it can deny a claim because of late notice. He noted that "a rule requiring prejudice before benefits can be denied is consonant with ERISA's goal of providing coverage which the participant reasonably anticipates receiving."

"The defendants have not argued that plaintiff's treatment was not medically necessary or that charges were unreasonable. The only thing they can point to is the lack of precertification which, in the absence of any prejudice to the plan, is insufficient to deny coverage," he said.

"In short, a provision imposing a blanket 30% penalty is arbitrary and capricious and cannot be upheld under ERISA," he said.

In addition, Judge Caldwell referred to the 3rd Circuit ruling in a case involving "other insurance provisions" in a health care plan, which said that "employees enrolled in a benefit plan should not be deprived of compensation that they reasonably anticipate under the plan's purported coverage."

Neither officials of Bethlehem Steel nor its attorneys—Thorp, Reed & Armstrong of Pittsburgh—would comment on Judge Caldwell's ruling.

In its May 3 appeal to the 3rd Circuit, the company claims that Judge Caldwell erred in holding that ERISA's fiduciary standards apply to an employer including cost containment features in an employee health plan.

The appeal argues that the precertification requirement was not arbitrary or capricious as a matter of law and that Judge Caldwell erred in finding—without proof of actual harm to plan assets—that ERISA bars penalties against participants who do not obtain hospitalization precertification.

However, Richard Hinden, an attorney with Altheimer & Gray in Chicago, said the ruling "extends the traditional obligation of fiduciary duty in a way that common sense would suggest. If the plan is designed for the beneficiaries, it should be administered for them, too. But on the other hand, if the fiduciary is charged with the obligation of guarding the plan, it has to administer it according to the plan's language."

Mr. Hinden said he believes Bethlehem's insurance board breached its fiduciary duty in this case because it denied benefits that would otherwise have been paid except for a technical clause in the plan.

However, benefit experts, including Mr. Hinden noted that the ruling was a surprise because it breaks down some of the support for managed care techniques that employers have found under ERISA.

That law "has usually been viewed as protective of an employer's right to design a reasonable plan with cost containment features," said Mr. Hinden. "This case is interesting because it uses ERISA to favor a plaintiff and suggests that some chinks are appearing in ERISA's armor."

Mary Lynn Eubanks, a consultant with Hewitt Associates in Lincolnshire, Ill., called Judge Caldwell's ruling "bold" and "surprising."

"If this ruling is upheld, it creates federal common law. It's a surprising ruling because there had not been any indicative signs issued by any other court on this matter. Employers need to keep watch of the appeal. The whole principle of precertification is at question," she warned.

One attorney who specializes in employee benefits law said the judge mistakenly ruled that Bethlehem Steel's plan was not prejudiced by Mr. Nazay's failure to obtain precertification.

"Regardless of medical necessity, the ruling takes away an employer's right to discuss with physicians' alternative treatments. The loss the plan suffered was the opportunity to conduct concurrent review. After a person is discharged, it's too late," explained Michael Greenfield of Asher, Gutler & Greenfield in Chicago.

Mr. Ugoretz of the ERISA Industry Committee said the court simply failed to differentiate between fiduciary duty and an employer's right to design a medical plan that controls costs.

"This is a plan design issue and requiring precertification is clearly within the scope of the employer's authority. The court seems to have been looking for a way to award the plaintiff," he said.

Sharon Canner, assistant vp and director of employee benefits for the National Assn. of Manufacturers in Washington, D.C., said the ruling impedes employers' flexibility in designing cost-effective benefit plans.

"Employers need that flexibility to deal with the abundance of unnecessary care that is provided," she remarked.

While noting that an important part of managed care could be imperiled by a dispute over a $2,200 claim, benefit experts agreed that Bethlehem Steel was justified in litigating the claims dispute.

"Many insurance companies litigate all claims and have successfully used ERISA to fend off lawsuits arising from the denial of benefits," said Mr. Hinden of Altheimer & Gray. "But in this case, it may have backfired on Bethlehem Steel."

Mr. Hinden said that Bethlehem was probably trying to avoid setting a precedent by not allowing Mr. Nazay full reimbursement.

This is not the first time Bethlehem Steel has been sued by a retiree over medical benefits.

In 1984, when Bethlehem Steel overhauled its health care plan for active employees and retirees, a class of 7,500 non-union retirees sued in federal court in Buffalo, N.Y. They claimed the company never clearly reserved the right in plan documents to reduce retirees' coverage.

Under a settlement, the steelmaker agreed to freeze monthly premium payments by union retirees, while non-union retirees accepted a new medical plan with deductibles and coinsurance (*BI*, March 18, 1985).

•

Richard Nazay Sr. vs. L. Miller, Bethlehem Steel Corp. and Michael P. Dopera, U.S. District Court for the Middle District of Pennsylvania, 1:CV-90-1641.

Soft market beginning to stabilize: RIMS study

By STACY ADLER

NEW YORK—The soft commercial property/casualty insurance market is starting to stabilize, according to a new survey of risk managers.

Most lines of coverage were widely available and premiums changed only slightly during 1990, while limits and coverage conditions remained nearly the same, according to risk managers responding to the Risk & Insurance Management Society Inc.'s sixth annual "Insurance Availability Survey."

"In general, the 1990 insurance market was neither overly friendly, nor overly hostile to the insurance consumer," the survey authors contend. "Although still at hand, the soft market of the past three to four years lost much of its momentum during 1990 and appears to have stabilized."

The survey analyzed the responses of 1,233 RIMS members in the United States and Canada about coverage availability, cost, limits, retentions and coverage conditions for 11 lines of property and casualty insurance—including workers compensation—based on their most recent renewals. The responses were received by Feb. 15, 1991, so they measure the January renewals for most companies.

Most lines of coverage were still widely available in 1990, the survey said.

Primary general liability and property damage/business interruption coverages were the easiest lines to purchase in 1990: 87% of the risk managers reported property damage/business interruption was "easy to purchase" and 83% said primary general liability was "easy to purchase."

On the other hand, environmental impairment liability coverage was either difficult to purchase or unavailable in 1990, with 39% of the risk managers reporting "some difficulty" or "much difficulty" in obtaining this coverage, and 24% reporting this line was "unavailable."

Premiums remained stable during 1990, with a majority of the survey respondents reporting "no change," or fluctuations within 10% for each of the 11 surveyed lines.

Although not as "soft" as in recent years, premiums were down in 1990 for property damage/business interruption and umbrella/excess liability coverages, the survey found. Forty percent of risk managers saw property damage/business interruption premiums decline last year, while 47% reported lower umbrella/excess liability premiums. That compares, though, with 63% reporting decreased premiums for both lines in the 1989 survey (*BI*, April 30, 1990).

And, limits did not change significantly during the 1990 renewals for almost all lines of coverage, the survey found. In fact, three quarters of the risk managers—76%—saw no change in limits during their 1990 renewals.

Property damage/business interruption was again an exception, with 40% of the respondents reporting increased limits. The survey authors suggest higher property limits may be necessary because of inflation.

The majority—83%—of risk managers did not change their self-insured retention during the 1990 renewals.

"The movement of retentions is often closely aligned with that of limits," note the authors.

A vast majority of the respondents reported that coverage conditions remained the same or improved for all 11 lines. Improved conditions were particularly prevalent for property damage/business interruption coverage, where 35% of the respondents saw improvements, the survey found.

And, EIL coverage was the line most likely to have coverage restrictions, with 25% reporting conditions "somewhat" or "highly" restricted.

Despite the generally stable insurance market conditions, risk managers in 1990 continued to utilize alternative risk financing mechanisms.

The most popular alternative continued to be self-insurance, the survey authors reported, followed by single-parent captives, risk retention groups and risk purchasing groups.

The lines of coverage most likely to be self-insured, the survey found, were workers comp—reported by 36% of self-insurers—and general liability —25% of self-insurers.

Among companies using single-parent captives, the most popular risk covered—reported by 8%—was general liability, followed by 7% that cover product liability risks.

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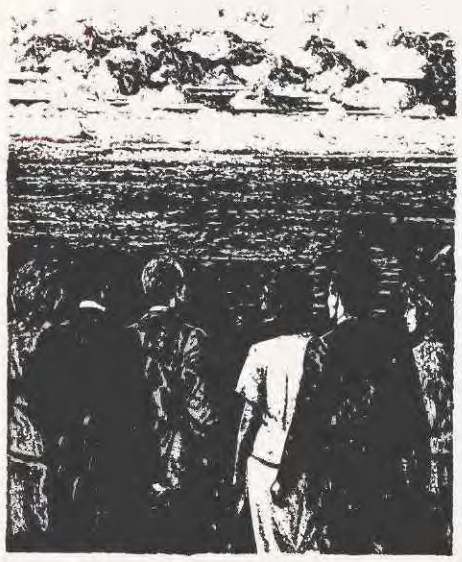

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INTERNATIONAL

European officials reject reinsurance pool plan

By MARIA KIELMAS

BRUSSELS, Belgium—The state export credit insurers of the European Community's largest members are rejecting an E.C. proposal to establish a reinsurance pool for export credit and political risk insurance written for trade with Eastern European countries.

Officials from the individual state agencies say their governments regard the E.C. proposal as out of touch with commercial reality and of no interest to each member state's strategic and commercial interests.

The reinsurance pool proposal "is over for now," said an official with France's state export credit insurance agency, Coface.

"We think the best result would be for the E.C. proposal to be withdrawn or at least to be radically altered," said an official with the United Kingdom's Export Credit Guarantee Department in London.

The reinsurance proposal was first presented to E.C. state export credit and political risk insurers last November, according to an official at the E.C.'s Brussels headquarters.

The reinsurance pool proposal 'is over for now,' says an export credit insurance agency official.

Details on how the reinsurance would be divided among member countries' state agencies still has to be worked out, the official said.

But, the proposal's aim was to allow all E.C. state agencies to participate in reinsuring up to 40% of medium- and long-term Eastern European export credit and political risk business. The ceding company would retain 60% of its own account.

"We proposed that 60% of the risk should stay with the insurer so that the ceding companies only accept reasonable risks," the E.C. official explained, noting that the pool would reinsure coverage that "is much more risky than other forms of insurance."

Only business involving trade with—or investment in—Czechoslovakia, Poland, Hungary, Romania, Bulgaria and Yugoslavia would be included in this proposal.

The Soviet Union was excluded because of its ongoing economic and political crisis. And, reinsurance of E.C. trade with Third World developing countries only could be considered realistically in two or three years, the E.C. official said.

The reinsurance pool proposal is part of an attempt to equalize the availability of state export credit and political risk insurance for exporters from the different E.C. countries, the E.C. official said.

"Some countries may insure 80% of a risk for a low premium, while others insure 90% for a higher premium. Exporters from different E.C. countries should have the same opportunities. This pool

Continued on page 81

Equitable, AXA may be close to agreement

By WILLIAM H. PITT

PARIS—AXA Midi Assurances S.A., the rapidly expanding French insurer, may be close to acquiring its coveted U.S. foothold.

More surprisingly, the foothold seems likely to come in the form of a 40% stake in the Equitable Life Assurance Society of the United States, the mutual life insurer that was rejected by AXA Chairman Claude Bebear earlier this year when it made overtures to AXA.

Both U.S. and European reports put AXA's total investment in Equitable at $1 billion, though neither company would confirm it. That total would be substantially below the $6 billion to $8 billion that AXA said it was willing to spend to acquire a U.S. insurer late last year.

New York regulators would have to approve any such deal, though last week only "informal discussions" were being held, said a spokesman for the New York Insurance Department. "For us to act, we'd have to receive a formal proposal from the companies."

Mr. Bebear

After rejecting Equitable's earlier proposal because it was being offered only a minority stake (*BI*, March 11), the French insurer has changed its thinking. A spokesman for Paris-based AXA says the insurer would be content with a 40% stake, provided that investment made AXA the largest Equitable shareholder.

"We do not want to be a passive shareholder," he said. "We want to be able to exploit synergies. To do that we don't need control—that would be putting it too strongly. But we need to be the single biggest shareholder."

New York-based Equitable, a large issuer of guaranteed investment contracts and one of the largest U.S. individual life insurers, plans to raise badly needed capital through a demutualization plan allowed by a 1988 New York law (*BI*, Dec. 17, 1990).

Even if the two companies reach an accord, regulators are not the only hurdle to clear. Equitable policyholders, who currently own the mutual insurer, would also have to approve, New York officials point out.

Regulators, though, may be the toughest sell.

The AXA spokesman downplayed the suggestion that the insurer's reputation with U.S. regulators was injured by its ill-fated attempt to win control of Farmers Group Inc. last year. AXA's $4.5 billion bid for Farmers collapsed along with Sir James Goldsmith's highly leveraged bid for Farmers' parent, B.A.T Industries P.L.C. (*BI*, May 21, 1990).

"People made a distinction between our insurance operation and Jimmy Goldsmith's bid," the spokesman said.

If AXA does take a stake in Equitable, it will acquire part of a business that has weathered some difficult times recently. Its 1990 real estate, mortgage and junk bond losses were estimated at $200 million. Net earnings before policyholder dividends plummeted to $1.1 million last year from $200.9 million in 1989. Its surplus fell $203.5 million to $1.1 billion at year-end 1990.

Equitable has had a particularly tough time with guaranteed investment contracts. Last year it set aside a special reserve of $86 million against future payouts on GICs. Earlier this year, Chairman Richard Jenrette called the contracts a "decade-old drag on profitability" but predicted that the problem "is essentially behind us."

Demutualization, said Mr. Jenrette, "will enhance our ability to take advantage of growth opportunities."

The demutualization process is certain to be drawn out. A company spokesman now puts the target date at mid-1992.

Earlier this month, an investment group that included New York-based American International Group Inc. discontinued negotiations with Equitable over a possible investment in the life insurer.

GAN leads insurance cover for fire at French oil depot

PARIS—French oil company Total Cie. Francaise des Petroles is still investigating the cause of a fire that sent a plume of black smoke into the sky above one of the company's oil depots in Paris on June 14.

Insurance Manager Regis de Villemeur said that the accident was more spectacular than costly, adding that he was unable to put a figure on the loss.

Mr. de Villemeur confirmed that coverage for the depot is led by the government-controlled Groupe des Assurances Nationales and reinsured through Total's offshore captive. The broker was Societe Generale de Courtage d' Assurances S.A., a unit of Alexander & Alexander Services Inc.

Mr. de Villemeur said last week that he could not say how the oil leak that caused the fire occurred. None of the oil in 12 huge tanks at the depot caught fire, he noted. The plume of smoke, which was visible for miles, was generated from oil burning in the pipes between the tanks.

Total has some public liability exposure from the fire, he acknowledged.

Three train cars belonging to the French railway Societe Nationale des Chemins de Fer were damaged by the flames.

And, about 2,500 people were reportedly evacuated from the vicinity of the depot while firefighters brought the blaze under control. Several firefighters were injured when a portable gas cylinder exploded.

Mr. de Villemeur said that the accident was not serious enough to produce a business interruption claim.

—By William Pitt

GLOBAL BRIEFS

Airline's insurance

SYDNEY, Australia—A new Australian airline has taken off with $756 million of aviation liability insurance and $75.6 million of hull insurance, among other coverages.

Brisbane-based Compass Airlines Pty. Ltd., a unit of Compass Holdings Ltd., sought high policy limits with low deductibles because it "could not afford any major losses in the early days," explained Andrew B. Grey, assistant to the chief executive and the officer in charge of insurance.

"Because we are a new company, we could not afford any disruption due to a lack of cover. Next year, when we have more flexibility, we will look at raising some of the deductible levels," Mr. Grey commented.

The airline, Australia's third domestic passenger airline, was launched after the federal government agreed to scrap its two-airline agreement as of Nov. 1, 1990. The agreement had prevented any new airlines from competing on major city routes against the government-owned Australian Airlines and Ansett Airlines, which is controlled by TNT Ltd. of Sydney.

Compass Airlines has three 360-passenger Airbus A300 aircraft operating now, and another two

Continued on next page

Premium hike needed, warns ABI head

By GAVIN SOUTER

LONDON—British insurers will raise commercial insurance premiums 20% this year to offset their past losses, warns the Assn. of British Insurers.

Massive losses occurred in 1990 in all areas of the non-life insurance market, and for every one pound taken in premiums, insurance companies paid or reserved 1.20 pounds in claims and expenses, said Joe Palmer, chairman of the ABI.

"The industry clearly cannot allow this deficit to continue. Our efforts to improve prevention against crime and other losses, and our drive to reduce our expenses are continuing, but we are suffering from an increasingly risk-ridden society," said Mr. Palmer. "Our customers must recognize that their present level of premiums is well below the true cost and that companies will be forced to charge significantly more."

LONDON

Worldwide underwriting losses for British insurers in 1990 totaled about 5 billion pounds ($9.65 billion at year-end 1990 exchange rate) and plunged the industry into a 1.48 billion pound trading deficit ($2.86 billion), Mr. Palmer said.

Fire and accident premiums for domestic and commercial business increased 6% in 1990, but underwriting losses jumped 22%, Mr. Palmer said.

"With massive storm and flood claims last year, subsidence payments up five-fold on a normal year, theft claims up over 34% and fire damage up 25%, all our customers must brace themselves for premium increases of three or four times the rate of inflation," he added.

Mr. Palmer acknowledged that tight competition among insurers will hold increases back somewhat, but he added that commercial insurance premiums still should rise by 20% this year.

Underwriting results from U.S. business produced a meager amount of comfort to British insurance companies, Mr. Palmer noted.

Premium income from U.S. business decreased by 14% in 1990, but this was due to the strength of sterling, he said. In dollar terms, premium income increased only slightly.

Personal lines, though, accounted for most of that premium increase and commercial business remained unprofitable, he added.

"Commercial business remains poor as competition has kept premium income increases to well below the level of claims inflation," Mr. Palmer reported.

Marine, aviation and transport business continued to run at a loss with increased provisions being made for major losses in previous years, he added.

Meanwhile, Ian Rushton, director and group chief executive of Royal Insurance P.L.C., has been elected chairman of the ABI for two years beginning July 1.

Underwriting agencies

Two Lloyd's of London underwriting agencies are being bought by their management.

R.H.M. Outhwaite (Underwriting Agencies) Ltd. and John Poland (Managing Agency) Ltd. will both change their names as well has their ownership.

Continued on page 82

INTERNATIONAL

GLOBAL BRIEFS

Continued from previous page
are on order from Toulouse, France-based Airbus Industrie S.A. One will join the Compass fleet this month and the other is expected in November, Mr. Grey said.

The airline maintains routes between Brisbane, Cairns, Sydney, Melbourne and Perth. It will add new destinations as new aircraft become available.

At a recent risk management conference in Sydney, Mr. Grey provided a rundown of the types and limits of coverage the start-up airline obtained before getting off the ground in December 1990.

Compass has insured its fleet, which is leased, for up to $100 million Australian ($75.6 million) for hull losses and $1 billion Australian ($756 million) for liability.

Mr. Grey said the deductible for the hull coverage was $1 million Australian ($756,000) for each aircraft and $10,000 Australian ($7,560) for each engine.

Deductible insurance was purchased from underwriters at Lloyd's of London, reducing the airline's hull loss deductible to $250,000 Australian ($189,000) per aircraft.

The hull and aviation liability coverage is led by the Melbourne-based Australian Aviation Underwriting Pool Pty. Ltd., which represents 20 underwriters and wrote 20% of the coverage.

Among other insurers on the risk are Lloyd's of London syndicates, which wrote 62.5% of the risk; New York-based Aviators International Insurance Group, an affiliate of The Navigators Group Inc., which wrote 10%; Aviation Office of America, a Short Hills, N.J.-based pool, which wrote 5%; and Polygon Insurance Co. Ltd., a Guernsey insurer owned by eight airlines—led by KLM Royal Dutch Airlines, Scandinavian Airline System and Swiss Air Transport Co. Ltd.—which wrote 5%.

In addition, the airline has $8.5 million Australian ($6.4 million) of engine breakdown insurance limits, with a $250,000 Australian deductible per engine. Lloyd's syndicates write 100% of the coverage.

The airline also has up to $100 million Australian ($75.6 million) of war and political risk coverage per aircraft with a $250 million Australian ($189 million) limit for ground risks, Mr. Grey said. Lloyd's syndicates wrote 65% of the coverage, Aviators International Insurance Group wrote 20%, Polygon wrote 5% and the Australian aviation pool wrote 7.5%. The remaining 2.5% was placed with overseas underwriters.

The airline also has $60 million Australian ($45.4 million) of property and industrial special risks coverage limits. The policy covers contractors liability for refurbishing work at its Brisbane headquarters, a branch office in Melbourne and five airport terminals with in limits. The deductible is $500 Australian ($378).

The lead underwriter, with 40% of the coverage, is Sydney-based AMP Fire & General Insurance Co. Ltd., a unit of the Australian Mutual Provident Society.

The other 60% of coverage is split evenly among Melbourne-based Royal Insurance Australia Ltd. of Melbourne, Switzerland General Insurance Co. Ltd. of Sydney and Suncorp Insurance & Finance of Brisbane.

The first layer of the airline's non-aviation general liability coverage, written by AMP Fire & General, provides the airline $10 million Australian ($7.6 million) of limits.

CIGNA Insurance Australia Ltd. underwrites the second $10 million Australian layer excess of $10 million Australian.

The deductible for the non-aviation general liability cover also is only $500 Australian.

—By Kate McIlwaine

Egyptian market

CAIRO, Egypt—Egyptian insurance authorities are studying various ways the country's domestic market may be opened up to foreign insurers.

"Up to now this has been an idea under consideration by the authorities," said Khary Salim, head of the Egyptian Insurance Authority and the country's insurance supervisor.

All aspects of the insurance sector are currently under review, Mr. Salim said. The government is considering allowing foreign insurers, reinsurers and brokers to operate in the market as well as allowing partial or total foreign ownership of Egyptian companies.

A government decision about the future of the insurance market can be expected "very soon," he said.

Under Egyptian law, foreign companies are not allowed to write insurance in the domestic market.

The prohibition applies to insurance arrangements for major risks—like oil industry risks—that consist of foreign companies working under a joint venture agreements with Egyptian companies.

However, this rule is waived in many so-called free zones—located in the port cities of Suez and Port Said, and certain restricted areas in Cairo and Alexandria—which are exempt from standard Egyptian taxation.

Two joint ventures by Egyptian and foreign insurers currently write business for industries located in the free zones.

One of the joint ventures is Egyptian American Insurance Co., owned by American International Underwriters Corp. of New York—a subsidiary of American International Group Inc.—and Al Chark Insurance Co. of Cairo.

The other venture is the Arab International Insurance Co. of Cairo, whose foreign partners include Willis Corroon P.L.C. of London and Tokio Marine & Fire Insurance Co. Ltd. of Tokyo.

Egypt's domestic market consists of six insurers and one reinsurer, Egyptian Reinsurance Co.

Last year, gross premium volume for the Egyptian market was 700 million Egyptian pounds ($215.4 million at current exchange rates).

The insurers are legally bound to cede a minimum of 30% of their premiums to Egypt Re, while the reinsurer retrocedes between 50% and 60% of its premium volume into the international market, Mr. Salim said.

Foreign brokers are not allowed into the market.

International insurers have welcomed the possibility of change.

Egypt's renewed relationship with countries like Saudi Arabia following the Persian Gulf War could give the local insurance market some hope for growth, said Bill Hazeldon, deputy international manager at Commercial Union Assurance Co. P.L.C. in London.

—By Maria Kielmas

Japanese insurance losses

TOKYO—In fiscal 1990/1991, Japan's largest non-life insurers suffered their first declines in profit—or actual losses—in eight years, largely from typhoon damage claims.

Claims paid out following Typhoon No. 19, which hit Japan last fall, were the largest ever for a single typhoon. The typhoon caused 3.6 billion yen ($25 million) in insured damages, according to German reinsurer Munich Reinsurance Co.

Returns on invested assets and premium income were both higher in the fiscal year ending March 31 for the Japanese non-life industry, the latter as a result of brisk consumer spending that led to more auto insurance contracts. The drop in net income, however, was caused by higher claims from both the typhoons and vehicle repair costs, which have risen due to labor shortages.

Aftertax insurance profits for five of the eight largest fire and marine insurance companies in Japan fell substantially, leaving one in the red. Aftertax profits were 3.6% to 12.1% below fiscal 1989/1990 levels.

At Mitsui Marine & Fire Insurance Co. of Tokyo, net earnings rose 9% in fiscal 1990/1991 to 487 billion yen ($3.46 billion), but after taxes, the company lost 14.4 billion yen ($99.4 million).

The other major companies reported profits, albeit lower ones.

At Tokio Marine & Fire Insurance Co. Ltd. of Tokyo, the nation's largest non-life insurer, net earnings rose 8.8% in fiscal 1990/1991 to 1 trillion yen ($7.1 billion). The firm is the first Japanese non-life insurer to hit the 1 trillion yen mark for earnings.

Despite that record, Tokio Marine & Fire's aftertax profits fell 8% to 37 billion yen ($262.7 million), its first drop in profits since 1982.

Sumitomo Marine & Fire Insurance Co. Ltd. of Tokyo saw net earnings rise 9% while aftertax profits fell 3% to 14 billion yen ($99.4 million).

Nippon Fire & Marine Insurance Co. Ltd. of Tokyo posted a 10% increase in net earnings to 360 billion yen ($2.56 billion) while aftertax profits fell 6% to 10 billion yen ($71.1 million).

And at Yasuda Fire & Marine Insurance Co. Ltd. of Tokyo, net earnings rose 6% to 724 billion yen ($5.14 billion) while aftertax profits fell 3% to nearly 16 billion yen ($106.6 million).

—By Judith Rawnsley

Motel 6 was losing sleep over its benefits program...

...until QicClaim/2® put their problems to rest.

Human resources personnel at Motel 6 were lodged in a health benefits administration nightmare.

"We found ourselves bogged down in paperwork and claims resolution...stuck between our insurance company and our employees," said Tom Higgins, vice president of human resources.

The QicClaim/2 advantage for Motel 6? "It works."

Then they woke up to the fact that they could serve their 6,000 covered employees better–and more economically–by self-insuring and self-administering their group health program.

So they talked to other human resources executives. They consulted software experts. They sent for information and they reviewed several products. Most software programs left them with reservations.

All but one–QicClaim/2 software from Resource Information Management Systems, Inc.(RIMS).

Higgins quickly discovered what he calls the major advantage of QicClaim/2: "It works."

Even the installation was easy. The program came in four small boxes and plugged right in to Motel 6's existing PC hardware.

When it came to actually paying claims, the motel chain didn't lose any sleep, either. That's when RIMS top training and support staff checked in.

"I could almost run the program just from watching the demonstration, so you know it's easy," Higgins said.

As for QicClaim/2's efficiency, Motel 6 expects a 15-month return on their investment.

Now, when Motel 6 employees have health claims questions, they call their co-workers. And that's a dream come true for staff and the human resources department alike.

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Reinsurance pool

Continued from page 79

would be an impetus to make the national systems more alike," he said.

He explained that export credit insurance systems in European countries have been in force since the 1920s and were developed independently. To ease Eastern Europe's transition to a market economy, the European Commission wanted to make the coverage available equally to E.C. exporters.

The pool would not require too much administration in Brussels, the E.C. official said. "It just needs a few people in the Commission to receive telexes and calculate premiums."

The proposal's future will be clearer by the beginning of September, but no final decision is expected before October, the official added.

However, E.C. members' state agencies are panning the idea.

"A reinsurance pool for east Europe is not a worthwhile idea," said an official from Hermes Kreditversicherungs A.G. in Hamburg, Germany, the private sector company that acts as an agent for the German government's export credit insurance programs.

"The general idea of reinsurance is to spread the risk, while an East Europe pool would mean a homogenous risk structure, which would not make sense," he said.

"For the time being, we do not think the idea is on the table anymore, but it is not totally out of sight," the Hermes official said.

"The E.C. proposal is not rejected for the moment, but postponed," he said.

He noted that Hermes insures a large proportion of Third World trade risks and that it would be more sympathetic to the idea of a reinsurance pool that includes developing countries.

The availability of this kind of coverage has been shrinking since the onset of the debt crisis.

"We are not that ready to compete with private insurers for commercial risks. We see ourselves as insurers of last resort," the Hermes official said.

"The general feeling is that cooperation in the E.C. should be improved with a view to 1993," he said.

For example, there is room for improving joint venture coverage for E.C. exporters of differing nationalities, like allowing a single state agency to cover the risks of both partners.

The views of the Italian Treasury department and its export credit insurance agency, Sezione Speciale per L'Assicurazione del Credito al'Esportazione in Rome, on the E.C.'s proposal are more forthright: "It's obscene," a SACE official said.

"The reason is that the commission proposes that if a transaction is channeled from a member country to this pool, then the commission also has the right to reject the 40% reinsurance. And, if they reject a risk, they say that we would not have the choice to take the whole risk for our own account," he said.

"Moreover, they suggested that the pool be divided amongst member governments through a quota system, with smaller countries taking the smallest share, say, 5%," the SACE official said.

But, he explained, a small economy like Greece's, for example, would not be competitive enough to take 5% of E.C. trade with Eastern Europe. If a country like Greece manages to acquire 1% of East European trade, it would be lucky, he said. But, under the reinsurance pool proposal, it would have to accept risk for more than its trade share.

Various proposals emerging from the European Commission are far from equalizing trade opportunities and actually distort them, he charged. The result is that the state agencies, instead of being able to build up competitive business systems, actually lose out in the international fight for business.

The SACE official suggested that the best course of action for E.C. members' state agencies would be to harmonize the different national insurance systems available to exporters. This would include the type of risks covered, the premiums charged, and the waiting period—the period of time between the maturity of the contract and when a claim is paid, he said.

"There is now a big effort being made by a study group to level these difference," the SACE official said.

"We need a unified system with unified procedures to be applied by the various agencies," he said. The logical outcome is for different agencies to treat the same people in the same way, he said. "Right now, we are treating the same people in a different way," the SACE official said.

The reaction of France's state agency, Coface, is similar. "We do not see any interest in the E.C. proposal for a reinsurance pool for East Europe because Coface, which acts on behalf of the French government, has decided to form its own policy for covering Eastern European risk," said the Coface spokesman.

"Such a mechanism does nothing for our sovereign interests and is a rather complicated system which would produce only a poor result," he said.

The Coface spokesman said the real question for the E.C. state agencies concerns cooperation among the different agencies and the harmonization of export credit and political risk insurance. "This is more important than the creation of a new body," he said.

The United Kingdom's ECGD does not like the reinsurance pool proposal "because it will not achieve its objective of increasing the flow of exports to Eastern Europe," the department official said.

"We also feel that we would be obliged to accept a share of risks from other insurers who were not as cautious in their underwriting practice as we may be," the official said.

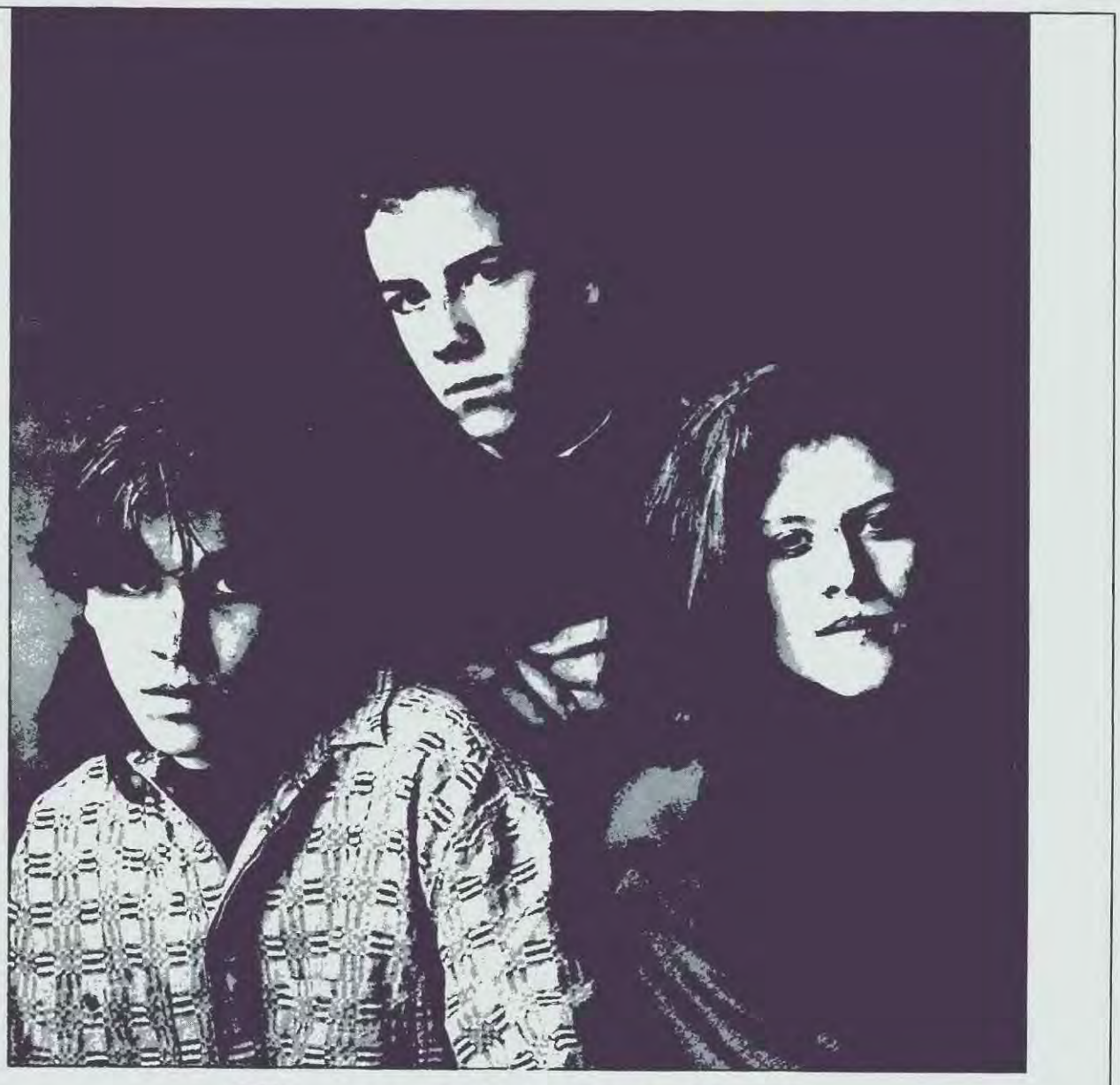
For example, the ECGD may find that trade with Czechoslovakia and Hungary is far more attractive than trade with Poland and Romania, he said.

He predicted that the reinsurance proposal would be buried by other requirements necessary to meet single-market requirements and that many working groups are considering some changes to established practice.

Already, there has been a considerable convergence of practice among E.C. state export credit and political risk insurance agencies on the underwriting of short-term business, whether by privatizing the state agency's short-term business, as in the case of the ECGD, or by the state taking a stake in private insurers, as happened in some European countries, he said.

"In order to meet the requirements of the single market, the differences between the private and state sector insurers should be reduced so that the state sector is not seen to have an unfair advantage in the market," the ECGD official said.

However, he noted that private sector insurers do not cover medium- and long-term risks, which the E.C. reinsurance pool is designed to cover. ■



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INTERNATIONAL

LONDON

Continued from page 79

The Outhwaite purchase is led by Chief Executive Edward Bloxham.

A group of 12 Outhwaite managers will buy rival agency Laurence Philipps (Agencies) Ltd., for an undisclosed sum. Laurence Philipps then will acquire from holding company R.H.M. Outhwaite Holdings Ltd. the ongoing business, but not the company or the name, of R.H.M. Outhwaite (Underwriting Agencies) Ltd.

The price is dependent upon future earnings and the money will not be distributed to the shareholders in the holding company until Outhwaite's pending litigation with members over the disastrous 1982 underwriting year is resolved.

Richard Outhwaite, active underwriter of syndicate 317/661, owns around 40% of the company.

The buy-out team is composed principally of managers at Outhwaite, including Mr. Outhwaite, but also includes members of Laurence Philipps' management, including Chairman Robert Hunt.

None of the managers will own more than 20% of the new underwriting agency, which will retain the Laurence Philipps name.

The purchase effectively will remove the Outhwaite company name from active underwriting at Lloyd's.

Mr. Bloxham played down the significance of the name change.

Outhwaite has long intended to spread ownership more widely, he said. "Also, there is a need in the Lloyd's market to achieve economies of scale, and we see this alliance as achieving that."

Massive asbestos losses on the still open 1982 year of syndicate 317/661 have plagued Outhwaite in recent years. However, apart from 1982, the syndicate has outperformed the rest of the market, and Mr. Outhwaite has a high reputation as an underwriter, Mr. Bloxham said.

"It was a very difficult decision to make about which name to choose, as Mr. Outhwaite has an excellent reputation, but Laurence Philipps is an older name," Mr. Bloxham said.

Laurence Philipps was established in 1935 and currently manages the affairs of 207 members representing about 100 million pounds ($161.2 million at current exchange rates) of capacity.

The company also manages marine syndicate 710, which has a capacity of 10 million pounds ($16.1 million).

Outhwaite manages marine syndicate 317/661 and non-marine syndicates 1047 and 1081, which have a total capacity of 80 million pounds ($129 million).

It also manages 150 members.

Outhwaite syndicates bucked the market on the 1988 underwriting year just closed, making a 9.7% profit on total written premiums of 75 million pounds ($144.8 million at appropriate exchange rate). However, it is "quite likely" that as the rest of the Lloyd's market, the syndicates will show a loss when their 1989 results are published next year, Mr. Bloxham said.

The John Poland buyout is headed by Chief Executive Trevor Bradley and Non-executive Chairman David Corsan.

The buyout team has set up a new firm, the Knightstone Group, consisting of two operating units—Knightstone Syndicate Management Ltd., which will manage eight syndicates and two service companies, and Knightstone Underwriting Ltd., which will be a members agent for John Poland's 400 members.

The syndicates have a total underwriting capacity of 190 million pounds ($306.3 million at current exchange rate).

Under Knightstone, the syndicates will concentrate on low-risk business, Mr. Bradley said.

"We will be writing mainly direct business, producing a relatively low-risk portfolio with a good spread of business providing consistent return. We will not generally write excess-of-loss or long-tail U.S. casualty business and we will not expand syndicates for the sake of producing income for the agency," he said.

John Poland actually manages 11 syndicates, but three—excess-of-loss syndicates 104 and 733 and marine syndicate 455—will be closed.

The syndicates under Knightstone management will be: motor syndicate 560; marine 711; non-marine 767; non-marine 1053; marine 108, which will be renamed 1188; non-marine 109, which will be renamed 1189; aviation 103; and non-marine 105, which will be renamed 1191. ■

Trial suspended in historic case against Lloyd's

By STACY SHAPIRO

LONDON—The historic trial of a lawsuit bought against the Corporation of Lloyd's by members of loss-riddled syndicates formerly managed by Oakeley Vaughan Underwriting Ltd. won't resume until next January—if at all.

The suspension follows last week's preliminary decision by Justice Gatehouse that both sides should first argue whether Lloyd's owed any duty of care to the Oakeley Vaughan members and whether Lloyd's is immune from liability under the 1982 Lloyd's Act if it did owe a duty of care.

Lloyd's and Oakeley Vaughan attorneys will present their arguments on these issues on July 1. Since British courts recess for the summer at the end of July, it is likely that the trial will not recommence until January at the earliest, said Justice Gatehouse.

However, if it is found that Lloyd's does not owe a duty of care to members, the case could be dismissed as early as July, the judge said.

Twelve other actions by Oakeley Vaughan members against the Corporation of Lloyd's hinge on whether Lloyd's owed a duty of care to the names, Justice Gatehouse noted.

While the misconduct alleged in the suit took place between 1980 and 1983, when the plaintiffs became members of the Oakeley Vaughan syndicates, the members did not file suit until August 1987. The trial date was first set for October 1990, but the plaintiffs in August asked for a postponement to make "very substantial amendments" to their points of claim, said Justice Gatehouse. The trial was rescheduled for April 22.

Then, on Feb. 1, the Oakeley Vaughan members switched law firms, hiring Michael Freeman & Co. in place of Elborne Mitchell.

"This has had a serious effect on the conduct of the case both before and during the trial," said Justice Gatehouse. Michael Freeman has taken over "very heavy documentation, which was apparently in disarray," he said. For example, an outline prepared for the trial, which is expected to last nine weeks, now runs 1,500 pages.

The plaintiffs also failed to make "proper discovery" before the trial began, the judge said.

Nevertheless, the trial—the first in memory involving a lawsuit against the Corporation of Lloyd's—began April 22. The 24 plaintiffs, who have incurred losses of more than 5 million pounds ($8.1 million), contend that if Lloyd's had told them of the results of its investigation into alleged improprieties at the Oakeley Vaughan syndicates, the members could have resigned and not incurred the heavy losses produced by the four Oakeley Vaughan syndicates (*BI*, April 29).

Another nine plaintiffs who are not represented by counsel will preliminary hearing on these points, wanting the judge to decide these matters after the trial is concluded.

However, Justice Gatehouse last week ruled in favor of Lloyd's and will listen to arguments on these issues from both sides beginning on July 1. He will then make a ruling on this matter soon afterward.

In part, Justice Gatehouse is allowing this preliminary point to be argued to save money. "In this case, the great bulk of the expense of preparation for trial has already been incurred, but there is now the considerable extra expense and delay involved in preparing to meet the new amendments as well as the costs of the full hearing, which will certainly extend over many more weeks," he said.

If it is found that Lloyd's does not owe a duty of care to the plaintiffs, "that is an end of the case and a vast amount of time and money would be saved," said Justice Gatehouse. "If the plaintiffs succeed, the trial will continue."

There is also a question of time, said the judge. Because of the new amendments by the plaintiffs, it wouldn't be fair to Lloyd's to continue the trial before July 8. Then there would be only 15 working days before the end of the current court session, said Justice Gatehouse. "In that period, the plaintiffs' case cannot conceivably be concluded. Mr. Lyndon-Stanford has not yet finished his opening," he noted.

Justice Gatehouse also noted that whatever verdict he renders likely will be appealed to the House of Lords, Britain's highest court. Lloyd's has also indicated that could take the case to the House of Lords.

Late last week, the plaintiffs were still debating whether to appeal the preliminary decision to the Court of Appeals. ■

If Lloyd's is found to owe no duty of care to the member plaintiffs, 'that is an end of the case and a vast amount of time and money would be saved,' says Justice Gatehouse. 'If the plaintiffs succeed, the trial will continue.'

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NAIC meeting

Continued from page 2

tion of state insurance regulation," Mr. Long said.

The accreditation program is "one of the things which we are most proud of, and we defend it because we know it is right and proper, and we are doing a fine job of it," Mr. Long said.

The NAIC announced at the meeting that Illinois and South Carolina have become the third and fourth states to adopt a minimum set of financial regulation standards necessary for accreditation. Florida and New York were accredited in December (*BI*, Dec. 10, 1990).

In addition, at least 25 states this year have adopted model legislation included in the standards, while at least 20 more states have considered related laws or regulations, according to the NAIC.

The lengthy hearing last month before the Dingell hearing was referred to several times at the NAIC meeting's opening session.

Mr. Dingell's name is one that causes state insurance commissioners "heartburn and a sense of frustration," said Indiana Insurance Commissioner John J. Dillon III.

Mr. Long added: "In spite of what our critics from some segments of the industry, from the federal government and from the media would have you believe, I'll match our 120-year track record against those who have the responsibility for commercial banks, savings and loans, the war on drugs, the plight of the homeless, inadequate access to health care, the quality of our environment, the quality of our food and water, telephone service and the delivery of the United States mail."

"The federal government is not user-friendly," observed South Carolina Insurance Commissioner John G. Richards in accepting the accreditation certificate for his department. "We are in the business of protecting real people and real lives."

Mr. Richards added that being from South Carolina makes him especially aware that the victor in any fight is not necessarily the one who fires the first shot, alluding to the fact that the South initiated hostilities in the Civil War.

However, NAIC Vp and Nebraska Insurance Commissioner William McCartney said that the spotlight federal authorities have aimed at state regulation has been "helpful" because it gives impetus to NAIC changes that enhance the effectiveness of state insurance regulation and may help clarify issues about regulatory system options.

He hopes that the outcome will not be a federal regulatory system, though a combination federal and state system may be worse than that, he said.

In other action at the meeting, the NAIC's Committee on the McCarran-Ferguson Act held a public hearing as part of its continuing inquiry into the role of advisory organizations that provide rating information to regulators and insurers.

The committee's aim was to examine the decision-making role of insurers and others that belong to —and finance—advisory organizations and not to stave off legislation in Congress that would overhaul the insurance industry's antitrust exemption under McCarran-Ferguson, regulators say.

However, the NAIC opposes legislation, H.R. 9, introduced by Judiciary Committee Chairman Jack Brooks, D-Texas, that would modify the McCarran antitrust exemption (*BI*, June 17).

Among those testifying at the NAIC committee's public hearing were J. Robert Hunter, president of the National Insurance Consumer Organization of Alexandria, Va., who thanked the NAIC for paying his travel expenses.

Mr. Hunter advocated that advisory organizations be independent of insurance company control—either by being privately owned or controlled by a state—and disseminate information primarily on historic loss and expense data.

However, representatives of several major advisory organizations, including the Insurance Services Office Inc. and the National Council on Compensation Insurance, emphasized that the organizations have recently restructured to insulate rate-related activities from insurer control and to increase consumer participation on their boards.

The NAIC also adopted a formal resolution stating that it could not support legislation, H.R. 1505 and S. 713, that as written would increase the integration of financial services by allowing some banks to sell insurance.

The one-page NAIC resolution, softened from an earlier version drafted by its Financial Services and Insurance Regulation Task Force, says regulators could support the the Financial Institutions Safety and Consumer Act of 1991 if it were changed to clarify the role of state insurance regulators.

The final version states that both bills "should be amended to clarify that nothing herein should be construed to pre-empt or erode the states' authority to regulate the business of insurance, including the right to examine records necessary to regulate all insurance-related activities and transactions between insurers and their affiliates."

In addition, "the use of confidential customer information by insurance companies should continue to be regulated by the state Unfair Trade Practices Act and the Insurer Privacy Acts," the resolution says.

The NAIC adopted the resolution because it is concerned with protecting the insurance-buying public. "The integration of financial services could raise additional questions as to the safety and soundness and solvency of insurance companies," the resolution said.

In addition, the resolution states that "individual commissioners may want to consider supporting state legislation to discourage coercive tying" of insurance sales to banking transaction. Insurance regulators may want to consider, for example, giving consumers a 30-day cooling-off period during which they could rescind an insurance contract with a bank.

The NAIC also considered several other issues at its meeting, including:

Risk-based capital

Separate working groups are continuing to develop formulas for risk-based capital requirements and promulgate appropriate schedules, instructions and models to implement them for both life/health and property/casualty insurers.

State insurance regulators believe that risk-based capital requirements for insurers are preferable to the generally prevailing system of minimum capital and surplus requirements as a means of enhancing the solvency of all insurers.

The working group concerned with life insurers is using as a starting point a complex formula previously used by New York insurance regulators, said Terence Lennon, working group chairman and assistant deputy superintendent and a chief examiner at the New York Insurance Department.

The working group is being aided by an advisory committee that has broken into seven subgroups to consider issues, including four different levels of contingency risks, formula testing and the impact of such requirements on small companies.

About 100 small companies responding to a recent survey had "a very favorable" reaction to the concept of a risk-based capital formula, but some were concerned about the expense of calculating the necessary data, said Paul Kolkman, advisory committee cochairman and vp-corporate actuary of IDS Life Insurance Co. of Minneapolis.

In addition, the working group dealing with property/casualty companies is continuing its research into a wide variety of topics related to developing the new requirements. These include: capital charges for reserve fluctuations, discount factors, the credibility of risk by line of business, applicability of requirements to affiliates, charges for reinsurance ceded, asset and liability matching, and unallocated loss adjustment expenses.

New model law language

The NAIC adopted new language for model laws on risk retention groups and broker-controlled insurers and a new model law on how reciprocals monitor the performance of their attorney-in-fact.

The NAIC also adopted some new insurer reporting requirements.

- An amendment to the NAIC

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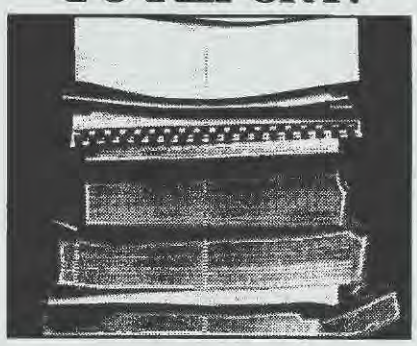

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NAIC activity

Continued from previous page
Model Risk Retention Act requires risk retention and risk purchasing groups to file annual statements with the NAIC.

The NAIC also modified the model registration forms for such groups.

- The model act on regulating producer-controlled property/casualty insurers was amended primarily in response to criticism by the National Assn. of Insurance Brokers, which had lobbied several state legislatures to either amend or defeat the NAIC's model law when it is considered by individual states.

The major changes include clarifying the concept of "control" by replacing the vague wording contained in the previously adopted model law with a more precise definition of control contained in the NAIC's model act regulating holding companies.

In addition, an insurance commissioner seeking damages from a broker would have to obtain them through a civil court proceeding instead of through an administrative action, which would allow an independent party to determine the outcome.

The amendments to the broker model act will be automatically incorporated into the financial regulatory standards that a state needs adopt to obtain NAIC accreditation.

Already accredited states then will have two years to adopt the changes.

However, any other amendments to existing accreditation models and other new models will have to first be approved by the NAIC's Committee on Financial Regulation and Accreditation before they are incorporated into the requirements, according to North Dakota Insurance Commissioner Earl Pomeroy, who chairs that NAIC committee.

- A model act was adopted that requires insurance reciprocals to establish a committee of subscribers to monitor the performance and operation of the attorney-in-fact and to make recommendations on the attorney's continued employment.
- Instructions an insurance company must follow in filling out its annual statement will be supplemented so its managers must discuss and analyze the insurer's operations.

The NAIC also adopted a new form that requires insurance companies to provide biographical information about key executives.

Issues under discussion

The NAIC plans to finalize amendments to the NAIC's Medicare Supplement Model Act and Regulation and obtain approval for them in a special voting session of commissioners by telephone on July 30.

In addition, the NAIC commissioners are continuing to discuss several topics including proposed model laws or amendments to model laws that regulate: licensing foreign insurers, providing immunity for receivers, curbing employee leasing abuses and allocating premium tax on multistate risks.

Other topics under consideration include two proposals to increase the ability of small employers to purchase group health insurance as well as the role of governmental self-insurance pools, which will be the subject of a hearing at the NAIC's fall meeting in Pittsburgh.

Underwriting cycle report

Market cycles and crises in insurance pricing and availability are phenomena largely outside of regulatory control, according to a report prepared primarily by several outside economists at the NAIC's request (*BI*, Sept. 25, 1989).

However, the most prudent actions state insurance regulators can take include strengthening insurance company solvency requirements and trying to curtail excessive underpricing in soft markets, the NAIC said. ■

Progress seen on fronting proposal

By MEG FLETCHER

INDIANAPOLIS—Insurance regulators are making slow but steady progress in drafting a model law that states could use to ban most fronting arrangements.

"The model is getting better in tiny little increments," said Paul Brown, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York.

"Progress is being made," agreed Vincent Laurenzano, chief of the New York Insurance Department's Property Companies Bureau and chairman of the National Assn. of Insurance Commissioners' working group that is drafting the model fronting law.

Nevertheless, RIMS and other participants in an industry advisory committee plan to continue negotiations with the NAIC to further refine the fronting proposal.

Insurance regulators favor a model fronting law to ensure the solvency of fronting insurers. But their proposal, first unveiled in December (*BI*, Dec. 10, 1990), came under immediate attack. Policyholders, insurers and brokers severely criticized the proposal because it would have banned nearly all fronting arrangements involving captive insurers.

In the wake of that criticism, the NAIC appointed the 17-member industry advisory committee to offer suggestions concerning the proposal and redrafted the proposal (*BI*, April 29; April 15; April 8).

The regulators' latest proposal includes more precise language in some areas, including how the fronting requirements apply to life and non-life insurers, and uses a definition of "controls" that is found in the NAIC's model holding company law.

One of the more significant changes made to the proposal establishes a threshold below which fronting arrangements would be permitted, although they would be subject to other provisions of the proposed model law. The new language allows an admitted insurer to cede business to an unlicensed reinsurer if the reserve liability for life business or the amount of non-life written premiums ceded to a single, unlicensed reinsurer does not exceed 1% of the licensed insurer's policyholder surplus in its previous year, and that all such reserve liabilities or written premiums do not exceed 5% of the insurer's policyholder surplus.

In addition, the current proposal now provides four exemptions to the proposed ban on most fronting arrangements:

- The first exemption is for fronted programs reinsured by a policyholder's captive, as long as the policyholder maintains net worth of at least $50 million and agrees to indemnify the fronting insurer for losses the captive is unable to cover.

RIMS feels the proposed $50 million requirement is "too high," Mr. Brown said. The trade group suggests a $5 million to $10 million net worth requirement, he said.

Mr. Brown said he plans to seek information about the number of captives operated by RIMS members that would be affected by such a provision.

In addition to the net worth requirement, this exemption also would require that the corporation indemnify the licensed fronting insurer for any losses resulting from the failure of the unlicensed assuming reinsurer to meet its obligations.

Alternatively, the reinsurance agreement could provide for a "surplus maintenance" agreement that would require the policyholder to maintain the assuming reinsurer's policyholder surplus at the greater of $10 million or one-third of its gross premiums written on all business in the past 12 months.

RIMS supports the idea of such an agreement but considers the amounts "too restrictive," Mr. Brown said. RIMS had proposed that the amounts be set at the lesser of $2 million or one-fourth of gross premiums, Mr. Brown said.

Furthermore, the exemption calls for annual caps on reserve liabilities for life insurers and direct written premiums for non-life business ceded to unlicensed reinsurers.

The proposed cap is 2% of the fronting insurer's policyholder surplus ceded to any single unlicensed reinsurer and 10% of the licensed insurer's surplus for business ceded to all unlicensed reinsurers, based on the insurer's previous year annual statement.

- The second exemption for fronted programs allows for intercompany reinsurance or pooling arrangements within the same insurance holding company system.
- The third exemption applies to other intercompany reinsurance pooling arrangements or "joint underwriting or joint reinsurance" subject to state regulation.
- The fourth exemption includes other fronting arrangements that are approved by the appropriate state insurance commissioner, or are approved by the commissioner of the state in which the licensed insurer is domiciled or any other state, as long as it is accredited by the NAIC.

The new draft fronting proposal also contains a provision that would require an unlicensed assuming reinsurer to provide acceptable security equal to 125% of the liabilities ceded under the reinsurance agreement.

RIMS had proposed a similar 115% provision as an option for exempting these programs but not as a requirement, Mr. Brown said.

The draft model law also would establish minimum contract provisions for agreements with non-admitted reinsurers as well as requirements for reporting and maintaining records.

The next drafting meeting is expected to be held sometime in July.

Mr. Laurenzano anticipates that the NAIC will adopt a model law to curb fronting during its winter meeting Dec. 8-12 in Houston. ■

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Sub-total	**24,591**
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TOTAL	**50,176**

* Source Business/Occupational breakdown of qualified circulation, November 26, 1990 issue, as submitted to BPA for December 1990 BPA Publisher's Statement.

U.S. regulators urged to make their case abroad

By MEG FLETCHER

INDIANAPOLIS, Ind.—Members of the National Assn. of Insurance Commissioners must continue explaining to foreign regulators how the U.S. regulatory system works, an international economic development official recommends.

That is the only way regulators can dispel the negative perceptions in some foreign countries that the United States' multistate regulatory system creates a trade barrier to international insurance business, according to Rinaldo Pecchioli, head of the Paris-based Financial Affairs Division of the Organization for Economic Cooperation and Development.

Many of the 24 countries belonging to the OECD think that U.S. insurance regulation may have "a very negative effect" on the ability of foreign insurers to operate in the United States, Mr. Pecchioli explained at the International Conference of Insurance Regulatory Officials that the NAIC sponsored in Indianapolis during its summer meeting June 9-13.

"If you don't have anything to hide, come along and answer questions," like an NAIC representative did at a recent OECD meeting, Mr. Pecchioli said.

"The OECD is a club, but it is not a closed club," he said. It is becoming more open to non-member entities like the NAIC as well as to non-member nations, he said.

Mr. Pecchioli's recommendation followed his presentation on international insurance issues to about 65 regulators and other representatives from about 35 countries.

Countering some foreign regulators' "significant" faulty impressions about how insurance regulation works in the United States is important, agreed Alaska Insurance Director David Walsh. Mr. Walsh, the vice chairman of the NAIC's International Insurance Relations Task Force, represented the NAIC at the OECD meeting last month in Europe.

"To them, we appear to have a Byzantine and even bizarre system of regulation that simply doesn't work," he noted in his written report of the OECD meeting to the NAIC task force.

However, Mr. Walsh says he is convinced that foreign regulators' views about the U.S. regulatory system can be corrected over time, especially if the NAIC presents members of the OECD "think tank" with practical market data showing the already significant penetration of foreign insurers in U.S. markets.

Mr. Walsh recommended continued NAIC presence at OECD meetings, although federal officials—and not the NAIC—technically represent the United States at these meetings.

Mr. Walsh also urged the NAIC to work closely with the U.S. Department of Commerce as part of "a long-term education and advocacy process" to raise the level of knowledge on how state regulation of insurance works and demonstrate to OECD member countries that the U.S. system is designed to protect consumers rather than to block trade.

However, the NAIC disagrees with a request from the OECD and the U.S. Department of Commerce that all 50 states submit to a special examination of their procedures.

Mr. Walsh said the examination process would be expensive and time consuming for states and of questionable value at this time, especially since the NAIC readily provides all information the OECD requests on both general and specific regulatory practices in the United States.

For its part, the OECD develops "codes" or operating guidelines to liberalize the flow of capital and services between member nations, although it does not seek to regulate "subnational elements" like states, Mr. Pecchioli said.

European countries—19 in all—dominate the OECD. The OECD, which was reorganized 30 years ago, was established under the Marshall Plan to help reconstruct Europe after World War II.

The other, non-European OECD members are the United States, Australia, Canada, Japan and New Zealand.

The OECD in the past few years has focused on liberalizing transactions involving banks and other financial institutions, moving toward a single worldwide market and participating in international insurance negotiations like the General Agreement on Tariffs and Trade, Mr. Pecchioli said.

He said this focus stems in part from changes in the international insurance market, including increasing interaction among financial institutions, integration of markets and more "functional ownership" linkages between insurance companies and other financial institutions.

Every insurance regulator worldwide will face "a major challenge" in the future because he will have to balance the structural and supervisory requirements of his regulatory system as well as the degree to which he wants to control transactions across national borders, Mr. Pecchioli said. ■

Disparate nations, common concerns

By MEG FLETCHER

INDIANAPOLIS—Regulators from around the world share several key concerns in their efforts to keep up with the globalization of insurance markets, a survey reports.

Staff training, deteriorating underwriting results and trading information with other regulators were all cited as top concerns in the survey, which included written responses from regulators in about 60 countries.

The survey is the second conducted in connection with the International Conference of Insurance Regulatory Officials, which was sponsored by the National Assn. of Insurance Commissioners during its summer meeting June 9-13 in Indianapolis.

About 40% of the regulators contacted responded. The information builds on data gathered last year and helps increase understanding among regulators, said Steven W. Butterworth, superintendent of insurance for the Guernsey Financial Services Commission in St. Peters Port, Guernsey.

Difficulty in training and retaining staff members was the most significant problem cited by many regulators, according to Mr. Butterworth.

For example, adequate formal training is a problem that regulators are now addressing, according to written comments from a representative from Ireland. That official, like some others, was identified in the survey only by the country he represented.

And with a massive economic restructuring underway throughout Eastern Europe, Hungary has "a lot of difficulties" in training and retaining staff, a regulator said. "The insurance market became larger suddenly, and we haven't got enough experts."

However, representatives from some countries—including Cyprus and the Philippines—said that they have established or have access to good training programs.

Retaining experienced staff members also is a problem in some nations.

"The private sector has attracted a number of our more experienced officials," a regulator from Ireland said.

"The private sector offers attractive salaries," explained a regulator from Belgium.

The survey also found that insurers' poor underwriting results—and the requirements for reporting those results—are a concern for

Continued on next page

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Global regulation

Continued from previous page

some regulators.

Regulators from both Belgium and Ireland blame the competitive nature of insurance markets in those countries for poor underwriting results of late.

Regulators in Nova Scotia noted that automobile insurance results are deteriorating, while officials in Trinidad report poor results from both automobile and property business. Results are poor in South Africa for non-life insurance lines, regulators there said.

And while underwriting results are "not bad" in Hungary, the inflation rate is very high, noted a Hungarian regulator.

Claims-related issues were also discussed at the meeting at which the survey was presented.

Guernsey's Mr. Butterworth said he was personally concerned about large punitive damage awards made by U.S. courts against foreign insurers. Such awards, he said, could discourage international insurance trade.

Another concern of regulators was the need to enhance communication among themselves.

A few regulators, though, pointed out that they must cope with local laws that make some information confidential.

A regulator from South Africa commented that he is concerned about the ability of fellow regulators to provide him with information about AIDS in Africa.

Part of the problem in Africa is the "lack of accurate statistical information," a representative from Ghana said.

"We would like to see specific guidelines under which such information can be provided," a regulator from Ireland said.

The survey also found that several regulators are concerned about the integration of insurers, banks and investment companies.

In British Columbia, there is "constant pressure" from insurers that want to expand into unrelated areas, a regulator reports.

Australia guards against such problems by requiring insurers to meet their solvency requirements on a stand-alone basis. But, "where the insurer is part of a wider financial services group, there are some concerns that difficulties in other parts of the group may put" the insurer at risk, an Australian regulator said.

Several jurisdictions—including Australia, Malaysia, Ontario and British Columbia—also say that insurer reporting is becoming more standardized.

In a separate presentation, Eva Ebli, the Hungarian insurance commissioner, said the insurance industry in her country is experiencing "a huge" surge in innovation in its transition to a competitive market from an oligopoly. However, insurers seeking to cope in the new marketplace still face problems including: a 35% to 40% inflation rate, difficulty in converting currency, lack of statistical data for calculating premiums and restrictions on foreign insurers. ■

COBRA

Continued from page 1

mer employees and employees' dependents following events like termination of employment, death, divorce or marital separation. Former employees can receive up to 18 months of coverage, while dependents, like a divorced spouse or an employee's widow, can receive coverage for up to 36 months.

Employers can charge beneficiaries a premium up to 102% of the group rate, of which the 2% is supposed to cover an employer's administrative cost in extending COBRA coverage.

The NAM survey is based on the responses of 135 employers: 81 with fewer than 2,000 employees and 54 with 2,000 or more employees.

The survey is one of the first to examine how much employers are spending to comply with health care continuation provisions under COBRA.

An earlier survey by *Business Insurance* of its Employee Benefit Board found that 76% of firms that tracked their COBRA data reported that claims outstripped beneficiary premiums (*BI*, June 4, 1990).

Since the law's enactment in 1986, employers have complained that premiums paid by COBRA beneficiaries don't come close to covering claims costs. Employers say that is because of adverse selection, with those opting for COBRA coverage anticipating using medical services.

The new NAM survey reveals just how large the difference is between premiums collected by employers and claims incurred by COBRA beneficiaries.

"The extension of COBRA to beneficiaries involves a significant employer subsidy," said Ms. Canner.

For example, during the first six months of 1990, only 25% of firms reported spending less than $1.10 in claims for each $1 received in COBRA premiums, while 50% spent at least $1.90 in claims for every $1 in premiums and 25% said they spent at least $3.14 in claims for every $1 in premiums.

In 1989, 25% of firms said they spent less than $1.02 on claims per $1 received in COBRA premium, while 50% reported they spent at least $1.67 on COBRA claims for each premium dollar and 25% said they spent at least $2.60 in claims for $1 of COBRA premium.

Only in 1988, when the COBRA law still was relatively new and employee awareness of the benefits was not that high, did a significant percentage of employers report that COBRA premiums paid by beneficiaries covered incurred claims. In 1988, 25% of employers said they spent less than 67 cents for each $1 collected in COBRA premiums, while 50% said they spent at least $1.83 on claims for each COBRA premium dollar and 25% spent at least $2.60 on claims per $1 of COBRA premium.

Twenty-eight percent of employers said their COBRA-related administrative costs in 1990 were equal to 10% or more of beneficiaries' premiums, while another 28% said administrative costs were equal to 2% or less of the premium. Twenty-six percent said administrative costs were between 2.1% and 5% of the premium and 18% said administrative costs were between 5.1% and 10% of premiums.

The biggest hassle in administering COBRA, according to respondents, is notifying beneficiaries that they are eligible for coverage.

Notification can cause problems since the beneficiary, such as a divorced spouse, typically lacks a direct employment relationship with the company, said John Caldarella, a consultant in the Arlington, Va., office of TPF&C.

Other problems that employers cite in administering COBRA in order of difficulty include setting up benefit administration systems, collecting COBRA premiums, communicating the plan and responding to questions regarding coverage.

Despite the hassles, most employers continue to administer COBRA internally and have not had to hire additional staff to comply with the act, the survey found.

Seventy-eight percent said they administer COBRA internally, while 22% use an outside firm.

Smaller firms, though, are somewhat more likely to administer COBRA internally than larger companies, according to the NAM survey.

For example, 85% of firms with fewer than 2,000 employees said they administered COBRA in-house, compared with 69% of employers with 2,000 or more employees.

Similarly, just 3% of small firms said they had to hire additional full-time staff to administer COBRA, compared with 38% of larger firms. And, 2% of small firms said they hired part-time staff to help administer COBRA, compared with 12% of larger firms that added part-time staff.

Other survey findings include:

- Typically, about 20% of eligible beneficiaries actually opt for COBRA coverage.
- Beneficiaries retain COBRA coverage for an average of three months.

●

A limited number of free copies of "COBRA: Survey Results," are available from the National Assn. of Manufacturers, 1331 Pennsylvania Ave. N.W., Suite 1500, Washington, D.C. 20004-1703; 202-637-3093.

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Antitrust litigation

Continued from page 1

alleged that the defendants—which included major U.S. insurers and reinsurers, the Insurance Services Office Inc. and the Reinsurance Assn. of America, several London underwriters and assorted other defendants—engaged in a boycott involving approval of ISO's commercial general liability policy form (*BI*, March 28, 1988).

Specifically, the suits contended the defendants conspired to manipulate the U.S. commercial liability insurance market. ISO, the suits state, was forced to rewrite its new CGL form to exclude coverage for pollution and to include a retroactive date in the claims-made version of the form.

The defendants also allegedly conspired to eliminate occurrence-based general liability coverage and to include defense costs within policy limits.

In his September 1989 decision, Judge Schwarzer dismissed the litigation on several counts, including that the states had failed to establish that the insurance industry defendants violated the McCarran-Ferguson Act by engaging in a boycott (*BI*, Sept. 25, 1989; Aug. 7, 1989).

The limited antitrust immunity granted to insurers under McCarran-Ferguson does not extend to boycotts or coercion.

In his June 18 decision, however, Judge Noonan disagreed with Judge Schwarzer's reasoning on this issue.

"The defendants' position is that they could confer and agree on the terms on which insurance would be offered; the immunity in so doing is incontestable," said Judge Noonan in the appellate decision. "But they are charged with much more."

"Agreements to boycott and acts of implementation on the agreements are, in short, explicitly set forth in the complaints," he said.

Hartford Fire Insurance Co. and other defendants "enlisted the reinsurers to compel capitulation by ISO and the insurers who had refused to go along with the Hartford demands. The London reinsurers did similarly in denying retrocessional coverage on policies covering pollution risks," Judge Noonan noted.

In what both insurer attorneys and plaintiffs identify as a key paragraph in the decision, Judge Noonan asks: "Why were the charges of the complaint not as plain to the district court as they appear to be on appeal? Because the district court took the position that the insurers' and reinsurers' agreement on terms was immune and that such agreement 'comprehends efforts to seek agreement by others, including those who might be unwilling to agree were it not for economic exigencies,' " said Judge Noonan, quoting Judge Schwarzer's decision.

"But when 'the economic exigencies' are produced by conspirators who refuse to supply reinsurance if the unwilling insurer does not agree, a boycott is in effect and is being implemented. The defendants are charged with boycotts, and the allegations, taken as true, destroy their McCarran Act immunity," Judge Noonan stated.

Judge Noonan also disagreed with Judge Schwarzer's decision to dismiss the case on the state action doctrine.

That doctrine provides immunity from antitrust laws if the anticompetitive restraint of trade reflects a state policy and if the state actively supervises any private anticompetitive practice.

The defendants' argument on this issue fails, Judge Noonan said, "because nothing in the affidavit evidence submitted by the defendants shows that the relevant states supervised or approved the boycotts used to produce agreement on the forms."

Judge Noonan agreed with Judge Schwarzer, however, that the defendants are in the business of insurance, which is the third condition under which immunity under McCarran-Ferguson is granted, in addition to not engaging in a boycott and regulation by state law.

He disagreed, however, with Judge Schwarzer's dismissal of foreign defendants from the case on the basis of comity, a reciprocal respect for foreign law. Judge Schwarzer had granted the dismissal for several reasons, including the difficulty of exercising jurisdiction over the foreign defendants.

In his decision, Judge Noonan said he does not doubt the accuracy of an amicus curiae brief by the British government that states that application of the antitrust laws to the London reinsurance market would lead to significant conflict with English law and policy (*BI*, Aug. 13, 1990).

But, Judge Noonan said, this is outweighed by several other factors. "The presence of the American plaintiffs, many American defendants and some American subsidiaries (in London) is a factor pointing towards the exercise of jurisdiction."

Furthermore, Judge Noonan said, "it would not be unrealistic to expect an American court to be able to obtain compliance with its orders by the (foreign) subsidiary of an American parent and to be able to affect the way the foreign defendants conducted themselves in the United States."

Other factors weighing in favor of exercising jurisdiction over the non-U.S. defendants are the significant impact of these defendants' activities in the United States, the fact that their conduct was intended to have an effect on business conducted in the United States and that these effects were foreseeable.

"No authority warrants us in creating a special immunity for insurance regulated by Britain," said Judge Noonan.

The 9th Circuit panel also ruled that the plaintiffs should have the opportunity to replead their charge that the defendants were guilty of a general conspiracy.

Judge Schwarzer had granted a motion to dismiss this claim because of a technicality. He had then refused the states permission to replead it because he said it would not "stand under law."

Judge Noonan, however, disagreed. "The plaintiffs' basic theory is maintainable," he said.

State attorneys general applauded Judge Noonan's decision. "We couldn't be more pleased. We really feel vindicated," said California Deputy Attorney General Kathleen E. Foote.

"The 9th Circuit really puts its finger on the errors in Judge Schwarzer's opinion," said New York Assistant Attorney General Richard L. Schwartz. The appellate court judges "really do rip it to shreds."

The appellate ruling is not surprising, Mr. Schwartz added.

"Judge Schwarzer was really very, very wrong" and the 9th Circuit court "quite properly reversed him."

Mr. Schwartz said he is confident the plaintiffs will win the case. "I think now that the law is clear, there's a clear road ahead."

"It is a resounding victory for the states," commented Richard D. Monkman, former assistant attorney general for Alaska and now an attorney with Dillon & Findley in Juneau. Mr. Monkman still represents the state in the litigation.

"Fantastic," commented Thomas M. Alpert, a Massachusetts assistant attorney general. "We think it's a great decision."

Insurer attorneys and the defendants were understandably unhappy with the ruling.

"It's rugged," said Molly Boast, an attorney with LeBoeuf, Lamb, Leiby & MacRae in New York, which represents Lloyd's of London underwriting agencies in the litigation. "Obviously we're disappointed."

Pointing specifically to the paragraph of the appellate ruling dealing with Judge Schwarzer's discussion of "economic exigencies," Ms. Boast commented, "It was just a completely different take on the facts, a completely different reading of the facts."

Lloyd's in-house counsel, William Beckett, who is overseeing defense for Lloyd's syndicates, former Lloyd's underwriter Robin Jackson and former Lloyd's Chairman Peter Miller, commented: 'The judgment is terribly disappointing."

An ISO spokesman said, "We're disappointed that the appellate court decision keeps this case going rather than dismissing it." ISO remains confident, however, that its activities "were entirely legal and proper," the spokesman said.

He stressed the decision did not determine whether the allegations by the attorneys general were actually true. "The appellate court did not rule on whether or not there was a violation of the law and did not determine what the facts were in the case."

The main implication of the ruling is simply that the litigation will continue, the ISO spokesman said.

"On one level, it's hard to see how this case is going to have broad implications" because it arose out of the very particular circumstances surrounding the implementation of the new CGL form, he explained. "It's difficult to see how any decision in this case will be analogous to anything else."

"It's a disappointment, but there's still several avenues to try," commented Paul R. Haerle, an attorney with Thelen, Marrin, Johnson & Bridges in San Francisco, who represents defendant Terra Nova Insurance Co. Ltd. of London.

"We're going to win the case factually," said Alan H. Silberman, an attorney with Sonnenschein, Carlin, Nath & Rosenthal in Chicago, who represents defendant Allstate Insurance Co. in the litigation. The attorneys general "have a technical, legal victory at this point."

Michael Lovendusky, counsel and litigation manager for the American Insurance Assn., which is not a defendant, commented that "the case clearly diminishes the value of the McCarran protection for insurers."

It also diminishes the value of the state action doctrine that would operate in the absence of McCarran, said Mr. Lovendusky.

"I think it will play an important role in the ongoing debate" over reform of McCarran-Ferguson, he said.

A vote by a House subcommittee on legislation introduced by Rep. Jack Brooks, D-Texas, that would overhaul the McCarran-Ferguson antitrust exemption is expected soon (*BI*, June 17). The insurance industry strongly opposes the Brooks proposal.

"We're obviously disappointed that Judge Schwarzer's decision dismissing the case wasn't sustained," said Richard de Saint Phalle of Crosby, Heafey, Roach & May in San Francisco, who represents Hartford Fire Insurance Co. in the litigation. But, at worst, the ruling means the case will return to trial, he reasoned.

There is simply no truth to the allegations, Mr. de Saint Phalle stressed, charging that the attorneys generals' complaint has an "Alice in Wonderland-like quality."

"If there was this alleged conspiracy, it was the biggest failure in the history of conspiracies," said Mr. de Saint Phalle.

Defense attorneys say two of the options they are now considering are an "en banc" rehearing by an 11-member panel of the 9th Circuit or a petition for review by the U.S. Supreme Court.

Neither approach is guaranteed, however.

Robert N. Schiff, an attorney with Fisher & Hurst in San Francisco, who represents Thomas A. Greene & Co. Inc. in the litigation, said there could be a rehearing en banc only if a majority of the 38 9th Circuit appellate judges agree the case is of "exceptional importance."

The case would then be heard by 10 judges, selected by lottery, plus the chief judge of the 9th Circuit. The three judges who already ruled against the insurers could also serve on the review panel, he noted.

In addition, it is far from certain that the Supreme Court would agree to review the case. One defense attorney noted that the court only selects about 200 cases from the 3,000 to 4,000 annually presented to it for consideration.

The question, attorneys say, is whether the case is of such compelling interest to either court to overcome the odds against a review.

"We hope that a hearing en banc might be possible," said one defense attorney. "The hope would be in this case the matter is of sufficient magnitude and the issues of sufficient novelty that it might be worthwhile to take a look at it."

However, Mr. Schwartz, the New York assistant attorney general, said that "the chance of the court rehearing it is virtually zero, particularly because this is a unanimous decision. These sorts of motions are very rarely granted."

Mr. Schwartz also does not expect the Supreme Court to review the case. "There's nothing of interest to them there," he said.

But Ms. Boast, who represents Lloyd's underwriting agencies, said she believes there is a "pretty good chance" that the Supreme Court would be interested in reviewing a case involving McCarran-Ferguson, which it has not examined extensively since its 1978 decision in *St. Paul Fire & Marine Insurance Co. vs. Barry*.

This is a "most interesting case" said Mr. Haerle, Terra Nova's attorney, who gives it a "better than average chance" of being heard by the Supreme Court.

Another attorney was less optimistic. While the case is important, "it's not true that all important cases get reviewed by the Supreme Court," he said.

Attorneys agree that if the case is tried, it could cost millions of dollars in expenses for both defendants and the states, though they were generally reluctant to attach a particular dollar figure to the process.

"When the 19 attorneys general allege a global conspiracy against 32 separate defendants, the costs will obviously be enormous," said Mr. de Saint Phalle. "It's not conducive to reducing costs."

Some of the most expensive law firms in the world are involved in this case, said Mr. Schiff. "Everyone's going to be charging top dollar for this."

Furthermore, Mr. Schiff estimated pursuing the case could cost plaintiff states from $20 million to $30 million at a time when states' budgets already are strapped.

"It's not an irrelevant point to be made," he said. "If everything is done in this case, it would be enormously expensive," Mr. Schiff added. "I don't think there's any case that's bigger in America, potentially."

The cost of the litigation "depends on what allegations plaintiffs want to pursue, but if they pursue the complaint as it is presently defined and pursue the allegations in their entirety, discovery could be quite extensive and could last for years," said John D. O'Connor, an attorney with Tarkington, O'Connor & O'Neill in San Francisco, who represents Kemper Reinsurance London Ltd. in the case.

"Defendants would hope to narrow the case and keep it sharply focused. The more the plaintiffs are allowed to pursue in unfettered fashion the claims of global conspiracy, the more expensive and time-consuming the case would be," Mr. O'Connor said.

Expenses are "going to depend entirely on how a court exercises control over the issues," said Mr. Silberman. If proper pre-trial management is not exercised and the court allows depositions on all issues related to the case to be filed for two years, "then I think it would not be unrealistic to say there's going to be several million dollars spent."

But if the court decides to "scrape away the rhetoric and get to the bottom of what's really involved here, then it could be done very efficiently" for as little as $500,000 total, Mr. Silberman said.

"It depends, again, on how it is done." ■

Defendants in antitrust litigation

The defendants in the insurance antitrust litigation pending in federal court are:

- **U.S. insurers:** Hartford Fire Insurance Co.; Allstate Insurance Co.; Aetna Casualty & Surety Co.; and CIGNA Corp. and subsidiary Insurance Co. of North America.
- **Domestic reinsurers:** General Reinsurance Corp.; Prudential Reinsurance Co.; North American Reinsurance Corp.; Constitution Reinsurance Corp.; Mercantile & General Reinsurance Co. of America; and Winterthur Swiss Insurance Co.
- **Lloyd's of London defendants:** Former Lloyd's Chairman Peter N. Miller; Merrett Underwriting Agency Management Ltd.; Robin A.G. Jackson, Merrett director and a former Lloyd's underwriter; Three Quays Underwriting Management Ltd.; Janson Green Management Ltd.; C.J.W. (Underwriting Agencies) Ltd.; Lambert Bros. (Underwriting Agencies) Ltd.; Murray Lawrence & Partners; D.P. Mann Underwriting Agency Ltd.; Edwards & Payne (Underwriting Agencies) Ltd.; and Oxford Syndicate Management Ltd.
- **London market reinsurers:** Continental Reinsurance Corp. Ltd.; Unionamerica Insurance Co. Ltd.; Terra Nova Insurance Co. Ltd.; Excess Insurance Co. Ltd. and Excess Insurance Group Ltd.; Kemper Reinsurance London Inc.; and CNA Re (U.K.) Ltd.
- **Brokers:** Thomas A. Greene & Co. Inc. of New York; Ballantyne, McKean & Sullivan Ltd. and R.K. Carvill & Co. Ltd., both of London.
- **Trade associations:** Insurance Services Office Inc. and Reinsurance Assn. of America.

In addition to a group of private plaintiffs that have joined the litigation, the states that have filed suit against the defendants are California, the lead plaintiff; Alabama; Alaska; Arizona, Colorado; Connecticut; Louisiana; Maryland; Massachusetts; Michigan; Minnesota; Montana; New Jersey; New York; Ohio; Pennsylvania; Washington; West Virginia and Wisconsin.

The Texas attorney general filed a separate antitrust suit—containing similar but not identical allegations—in a state court in Texas against a group of insurance industry defendants, including many of the defendants named in the federal suit.

All of the defendants in the Texas case have agreed to settlements with the state totaling $6.6 million (*BI*, April 1).

While the Texas attorney general said the settlements will lead to broad reforms in the way insurers operate in Texas, insurers disagree.

Volcano losses

Continued from page 1

Philippines are located away from the damaged area.

The eruption, which killed more than 100 people and spread ash as far as Manila, 56 miles away, damaged bridges, schools, buildings and agricultural crops and closed Manila's airport.

Mount Pinatubo—a 5,874-foot-high volcano in southwestern Luzon—had been showing signs of activity since April. The volcano, one of 36 in the country and part of the Pacific Ocean's Ring of Fire, last erupted about 600 years ago.

On June 12—a week after another volcano erupted in Japan—Mount Pinatubo erupted sending a plume of ash more than 12 miles into the sky and causing molten rock and superheated gas to cascade down its slopes. Several other eruptions occurred over the next three days.

Then, on June 15, Typhoon Yunie hit the Philippines, turning the volcanic ashfall into thick mud as far away as Manila.

Media reports claim that the damage from the volcano totals 3 billion pesos ($110.6 million), according to Keller Insurance Brokers Inc. in Manila.

However, a Philippine government National Disaster Coordinating Council report last week estimated the cost of damage from the eruption at 1.1 billion pesos ($40.6 million).

The NDCC estimates that most of the damage occurred to the infrastructure and crops in the neighboring province of Bataan, totaling 1 billion pesos ($36.9 million).

The NDCC's loss estimate also includes substantial damage in the Zambales Province, where the volcano is located, to:

- School buildings, totaling 30 million pesos ($1.1 million).
- Roads and bridges, totaling 2.5 million pesos ($92,175).
- Crops, totaling 3 million pesos ($110,610), and fruit-bearing trees, totaling 4 million pesos ($147,480).
- Private buildings, totaling 45 million pesos ($1.7 million).

The NDCC's report said the infrastructure was damaged in five provinces of Luzon.

Despite the extent of the damage, insurance industry officials expect total insured losses to be less than those from a massive earthquake that hit the Philippines last year. The earthquake killed more than 1,000 people and produced several billion pesos of insured losses (*BI*, July 23, 1990).

Property and automobile insurance written in the Philippines excludes losses due to earthquake or volcanic eruption. Policyholders can buy endorsements covering these risks for an additional premium if the issuing insurer offers the coverage. However, very few buy the coverage.

Munich Reinsurance Co.'s Manila office last week told its home office in Munich that Filipino property policies give "no automatic coverage for volcanic eruption," a spokesman in Munich said. "It can be bought back as an endorsement to the policy, but it is believed that not too many policies have that endorsement."

Ironically, Munich Re does offer automatic volcanic eruption coverage in its reinsurance treaties to ceding companies, the spokesman said.

U.S. multinationals that buy all-risk property coverage outside of the Philippines will likely be covered for claims for damages from a volcanic eruption, said Hugh Houseman, vp of the international department at Johnson & Higgins in New York.

He speculated that most Filipino subsidiaries of U.S. companies would have some form of all-risk property coverage written outside of the Philippines.

An all-risk policy would be written outside of the country because the Philippines permit only "named perils" property insurance.

Coverage for volcanic eruption and earthquakes can be purchased separately but at "horrendous" prices, Mr. Houseman said.

Most of the country's major insurers—including CIGNA Corp., American International Group Inc., Pioneer Insurance & Surety Corp., Provident Insurance Co. and New Zealand Insurance P.L.C.—have reported no known losses from the volcano so far.

"We have not had any claims. We have properties in the Manila area, but as far as we know there's been no problems with them," a spokesman for Industrial Risk Insurers in Hartford, Conn., said last week.

"No claims have been filed" from policyholders in the Philippines, said a spokeswoman at Zurich-American Insurance Co. in Schaumburg, Ill.

"No claims are expected from the volcano," said a spokesman for Chubb Corp. in Warren, N.J. Much of American industry in the Philippines is located away from the mountains because of the possibility of volcanic activity, he noted.

FGU Insurance Corp. and the Union Society of Canton Ltd. have received notices of claims in Angeles City and San Fernando but these claims are not expected to be significant.

The Government Services Insurance System, a government-owned insurer that cedes its risks to local insurance companies, also has yet to receive notice of any claims.

However, the Property Replacement Fund—a self-insured scheme of the Philippine government that pays for replacement of government-owned buildings in the event of loss—is likely to be hit. The fund, which is managed by the GSIS, has allocated 500 million pesos ($18.4 million) for potential volcano losses.

Preliminary loss estimates to agricultural crops and livestock in Zambales, Tarlac and Bataan provinces as well as the surrounding area is reported to also be about 500 million pesos ($18.4 million).

The Philippine Crop Insurance Corp., a government insurance institution that insures crops and livestock, said loss reserves for rice and corn crop claims in the five affected provinces of central Luzon is set at just under 18 million pesos ($663,660).

According to Keller Insurance Brokers, one of Alexander & Alexander Services Inc.'s correspondent brokers in the Philippines, poor communications are making it very difficult to gauge the extent of the damage from the volcano and the size of resulting insurance claims, an A&A spokeswoman in New York said.

But, because many U.S. businesses are located away from the immediate volcanic area and not directly threatened by the eruptions, property damage should be "minimal," said Mr. Houseman. "There are probably not many American companies on the ground in the area. I don't think that there will be much claims activity," he said.

Some U.S. firms with Philippine operations so far have not received reports of any damage.

"We apparently have not suffered any damage—only a coating of ash," said a spokesman from Citibank N.A. in New York. Citibank has offices in metropolitan Manila, as well in larger cities like Cebu.

The Coca-Cola Bottling Co., which has plants in San Fernando, has reported only very minimal losses.

And, many U.S. companies are still going about their day-to-day functions.

"Business has been shifted appropriately" to offset the effects of the eruption, said a spokeswoman from Bristol-Myers-Squibb Corp. in Princeton, N.J., which has sales and marketing facility in the Philippines.

One possible loss could be the Dizon Silver-Copper Mines, a mining subsidiary of Manila-based Benguet Corp. in Masinloc, Zambales, which is insured by the Malayan Insurance Co. Inc. under an industrial all-risks property policy. Impassable roads have prevented loss adjusters from determining the exact loss.

Manilla-based San Miguel Corp., the largest conglomerate in the country, also reported only minimal losses.

It is still too early to know whether there will be any insured losses resulting from the closure of the Ninoy Aquino International Airport on June 15 due to ash in the air, on the runways and the aircraft. The airport reopened for outgoing flights on June 19, but is expected to be closed for most incoming flights until June 24.

Volcanic ash sucked into aircraft engines has caused severe partial hull losses in the past.

However, "we don't know if there are any losses" at the moment to Philippines Airlines aircraft, said Alan May, claims director of the airlines' London-based reinsurance broker Nicholson Chamberlain Colls Aviation Ltd. The airline's hull and liability coverage is insured with the GSIS and 99% reinsured into the London market, led by the British Aviation Insurance Group.

It could be that the aircraft just need to be wiped off, Mr. May said. "It's a question of whether the aircraft flew through the ash."

Although hull damage due to volcanic eruption is covered under the airline's hull and liability program, the coverage would not include business interruption losses, Mr. May said.

Other aircraft stranded when the airport was shut down have since flown out of Manila.

Meanwhile, the U.S. State Department is advising U.S. citizens to avoid travel to any location within 19 miles of the volcano, and those living in that area and in the Angeles City area are advised to evacuate temporarily.

All U.S. citizens living in or visiting the Philippines are strongly urged by the State Department to register with the U.S. Embassy in Manila or at the U.S. Consulate in Cebu.

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International Editor Stacy Shapiro in London contributed to this report.

Update

Keene to appeal Texas awards

Continued from page 2

limitations in their home state had expired. Those plaintiffs and Mr. Mason's family also sued in Texas because their attorneys are based in Dallas.

As of March 31, Keene had $89 million in proceeds from settlements with its insurers to pay asbestos-related claims, a spokesman said. Under the settlements, the insurers pay Keene periodic payments for asbestos claims, which Keene defends, settles and pays.

P&I clubs shun guarantees

LONDON—Protection and indemnity clubs are refusing to provide $500 million certificates of financial responsibility for oil tankers visiting California, claiming that financial guarantees required by the state will encourage lawsuits.

The refusal will force oil companies to assume financial responsibility for tankers stopping at California terminals, said Edward Mocatta, a director of P&I club manager A. Bilbrough & Co. in London.

California's Oil Spill Prevention & Response Act of 1990, which will take effect Jan. 1, initially requires a $500 million guarantee. That increases to $750 million on July 1, 1995, and to $1 billion on Jan. 1, 2000.

The 15 members of the International Group of P&I Clubs refuse to guarantee the certificates and have warned tanker owners to make contingency plans. The P&I clubs view the law as too harsh and say it may encourage claimants to seek $500 million in compensation because they know the sum is guaranteed by the clubs, Mr. Mocatta said.

Briefly noted

Basking Ridge, N.J.-based **Crum & Forster Inc.** eliminated about 400 positions at its Crum & Forster Corp. and Crum & Forster Commercial Insurance units. The move reduces the Xerox Corp.'s insurance unit's headquarters staff by roughly 22%. Crum & Forster Chairman Robert J. Vairo said the cuts are part of a continuing effort to strengthen the insurer's financial position. . . .The Port Authority of New York and New Jersey and the Port Authority Trans-Hudson Corp. filed a lawsuit in New York state court June 3 against dozens of liability insurers and Lloyd's of London syndicates seeking indemnification for the cost of **removing asbestos from city buildings** including the World Trade Center, John F. Kennedy International Airport, LaGuardia Airport and many city bridges and tunnels. Preliminary estimates for the cost of removing the asbestos are $500 million or more.

Pension annuities

Continued from page 2

would constitute" an unreasonable risk, Mr. Lockhart said.

- Assistant Labor Secretary David Ball disclosed that the department is investigating cases where employers may have purchased "third-rate" annuities to replace workers' and retirees' pension benefits.

The department earlier this month sued Maxxam Inc. of Houston and MagneTek Inc. of Los Angeles charging that their purchases of annuities from Executive Life to cover beneficiaries of their pension plans violated fiduciary standards established by the Employee Retirement Income Security Act of 1974 (*BI*, June 17).

Sen. Metzenbaum asked why the department had not sued Maxxam and a subsidiary, Pacific Lumber Co. of Scotia, Calif., sooner, noting that the department's enforcement staff issued a memo 15 months earlier alleging that the companies had violated ERISA's fiduciary standards in selecting Executive Life.

"Why did the administration sit on its butt?" the senator asked.

Mr. Ball responded that the department acted with all due speed, noting that litigation should not be "leaped into."

- Sen. Metzenbaum released a list of 47 employers that had purchased annuities from Executive Life, most of which had terminated overfunded pension plans and purchased the annuities to replace promised benefits.

The employers collectively recovered about $800 million in surplus assets after terminating their pension plans and replacing pension benefits with the annuities purchased from Executive Life.

The list includes Blue Cross of California, Bulova Watch Inc. of Woodside, N.Y., RJR Nabisco Inc. of New York and Revlon Inc. of New York.

The Labor Department's Mr. Ball said the department is contacting all the employers on the list to ask that they guarantee that former pension plan participants receive all promised benefits. They could, for example, purchase new annuities to cover any shortfall in benefits.

Mr. Ball earlier strongly suggested it is likely that the Labor Department will sue other employers that had purchased Executive Life-issued annuities but are not covering any shortfalls for beneficiaries.

Executive Life Insurance Co. of California, one of two junk-bond laden units of First Executive Corp., was seized April 11 by California insurance regulators. The other unit, Executive Life Insurance Co. of New York, was taken over the following week by New York regulators. The New York company, though, may have sufficient assets to pay benefits.

Under a conservator's order, Executive Life of California now is paying only 70% of promised benefits to annuitants, including former pension plan participants. In all, 44,000 retirees whose companies purchased Executive Life annuities have had their benefits cut, while 40,000 future retirees face benefit cuts, according to Sen. Metzenbaum.

Executive Life also is not making payments to employees whose 401(k) plans purchased Executive Life guaranteed investment contracts.

However, attorney Alan Wolen, a partner with Barger & Wolen in Los Angeles, said he will ask Superior Court Judge Kurt Lewin, who is supervising the Executive Life conservation, for a clarification of his statement at a hearing this month that individual 401(k) plan participants and beneficiaries covered by GICs would not be excluded from seeking hardship benefits (*BI*, June 10).

Mr. Wolen represents retirement plan fiduciaries who have formed the Group Annuity Participant Protection Assn.

Several employers have agreed to cover benefit shortfalls to annuity holders and GIC participants, while others are being sued by employees for their purchase of Executive Life products.

The notice of possible new rules governing the purchase of annuities for pension plan participants is clearly in response to the Executive Life debacle.

"The ramifications of workers losing benefits because an insurance company has collapsed is political dynamite," observed Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Other experts note that it is significant that government agencies are asking for public comment on the content of the annuity rules rather than just issuing rules.

In not first publishing rules, "the agencies are recognizing the complexity and potential controversy surrounding such standards," said Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

Questions being asked by the Labor Department and the PBGC for public comment include:

- If the Labor Department and the PBGC were to adopt minimum standards for the selection of annuity insurers, should those standards be based on ratings from insurer rating organizations?
- Are there significant differences in the reliability of ratings from the different rating services?
- If an insurer is required to have a rating from one of the agencies, what should that rating be?
- Should minimum standards for the selection of an annuity insurer be based on the insurer's reserves, surplus, type of investments and other objective criteria?
- If the Labor Department and the PBGC developed their own criteria, should those criteria be used alone or in conjunction with ratings from rating organizations?

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Associate Editor Louise Kertesz in Los Angeles contributed to this article.

Lloyd's taxation

Continued from page 2

bill.

Under the amendment, Lloyd's members' ability to offset underwriting losses against income in the current year and the preceding year would be extended to include the three preceding years.

However, the amendment would not provide tax relief for Lloyd's 1988 accounting year because those accounts already have been closed. According to market analyst Chatset Ltd., Lloyd's will announce a 278 million pound ($536.5 million at applicable exchange rates) loss for that year when it announces its global 1988 results on Wednesday (*BI*, May 27).

However, the amendment would have applied to the 1989 year, which Chatset predicts will show a 1 billion pound ($1.71 billion at current exchange rates) market loss.

The proposal produced a storm of protest from opposition members of Parliament, who accused the Conservative government of seeking to bail out the rich with taxpayers' money and alleged that the government would be protecting its members, since 62 Conservative members of Parliament are members of Lloyd's.

A group of Labor members of Parliament led by Dennis Skinner offered a motion in the House of Commons condemning the proposals.

"This house refuses to hand over taxpayers' money to the Lloyd's insurers who have gambled and lost; draws attention to the fact that millions of people gamble on football, horses and dogs and never expect the government to bail them out when bets are lost; and demands that those who use the posh gambling den at Lloyd's should neither expect nor receive special treatment from other taxpayers," the motion read.

In a letter to the secretary of state for social security, Michael Meacher, the Labor Party's shadow social security secretary, said that despite the losses no Lloyd's members would be reduced to depending on social security for a living.

"If to govern is to choose, and if there is money available for tax concessions or for the poor, will you choose those who rely on the Social Security system or Lloyd's names?" Mr. Meacher asked.

Lloyd's also found itself the center of press attention as newspapers ridiculed the suggested amendment in editorials and cartoons.

The amendment was rejected Tuesday evening at a meeting of the committee considering the finance bill after Lloyd's had hurriedly organized a press conference scheduled for the next morning to outline its case, which it believed had been misrepresented.

Lloyd's rebutted the allegation that it was looking for special treatment for members, saying it was merely looking for tax parity with British companies.

The three-year carryback was proposed in March and was regarded as a means of helping British companies cope with the current economic recession. However, Lloyd's—which is made up of individual members and is not a company—was not included in the proposal.

If Lloyd's had been included, the proposal could have saved members about 50 million pounds stemming from the losses that have hit the market since 1989, which would have been the first year in which members could have benefitted from the legislation, said Ken Goddard, general manager of taxation at Lloyd's.

'Millions of people gamble on football, horses and dogs and never expect the government to bail them out when bets are lost,' the Labor motion reads.

Lloyd's members are now being asked to meet large cash calls stemming from the string of catastrophe losses that have hit the insurance market since 1987. Some members expect to make six-figure payments to cover the losses.

"Lloyd's members are in business in the same way as companies and we are seeking equivalent treatment to companies," Mr. Duguid said.

The possibility of an amendment to the bill still cannot be ruled out, Mr. Duguid said.

Francis Maude, the financial secretary to the British treasury, said the Conservative government would "lend a sympathetic ear" to Lloyd's but added that "dramatic changes (which) will transform hugely the prospects for Lloyd's are unlikely."

Lloyd's problems did not arise from taxation and they would not be solved by taxation, he added.

Mr. Taylor withdrew his amendment after Mr. Maude made it clear that it would not receive government support. If the government introduces its own amendment to finance bill, it would have to be included before July 8 when the bill is reported to the House of Commons. However, given Mr. Maude's comments, such a move seems unlikely.

Lloyd's will continue discussions with the government over alternative ways to relieve members' losses, Mr. Duguid said.

Mr. Goddard started discussions with the Inland Revenue over the possibility of allowing Lloyd's syndicates to set up tax-deductible catastrophe reserves earlier this month.

Currently, British insurers, including Lloyd's syndicates, must justify its reserves for known losses and incurred-but-not-reported claims to the Inland Revenue. And, British insurers are not allowed to build up tax-deductible catastrophe reserves for unknown future losses.

Most continental European insurers are permitted to build up some form of catastrophe reserve to pay for future claims, Mr. Goddard said.

"Insurance is a risk business and we have to meet all sorts of unknown losses so we say that there is a need for reserves," he said.

British insurers regularly make this plea to the Inland Revenue, but the agency has always been concerned that the reserves would be used as a means to delay paying taxes.

Meanwhile, the Assn. of Lloyd's Members has set up a telephone advice line for distressed members. The insurance "agony aunt" is Valerie Robinson, former regional chairman of the ALM and a member of the Lloyd's hardship committee that reviews the cases of members unable to pay losses. ■

State fund covers HMO's enrollees

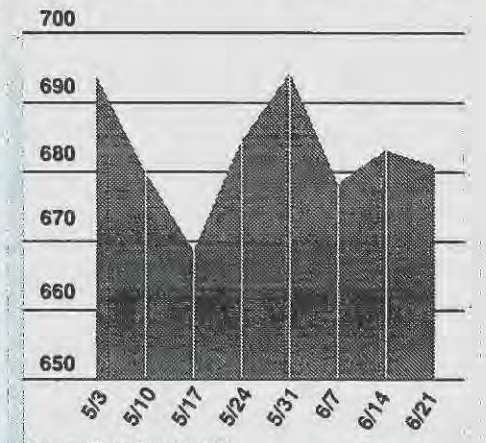
CHICAGO—The Illinois guaranty fund for health maintenance organizations is seeking alternative HMO coverage for all 5,990 area enrollees of Multicare Inc. of Chicago, an HMO declared insolvent last week by a Cook County Circuit Court judge.

James W. Schacht, the acting state insurance director, petitioned the court to declare Multicare insolvent and place it in liquidation. A financial examination had revealed that Multicare's capital and surplus account was at least $400,000 below minimum state requirements.

The two Chicago doctors who owned the seven-year-old HMO agreed to the liquidation.

The Illinois HMO Guaranty Assn. will assume responsibility within statutory limitations for claims submitted by enrollees. ■

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks fell slightly last week as the *Business Insurance* Index dropped 2.3 points to 680.4 on June 21, from 682.7 on June 14. Advancing issues for the week were led by Safeguard Health Enterprises, up 18.6%; FHP International, up 6.5%; and Harleysville Group, up 5.0%. Declining issues for the week followed Hilb, Rogal & Hamilton, down 10.0%; Kemper Corp., down 8.2%; and Chandler Insurance, down 7.1%. The most active issue for the week was Sears, Roebuck (Allstate), with 3.1 million shares traded. The *BI* Index was down 0.3%; the Standard & Poor's 500 dropped 1.2%; the Dow Jones 30 Industrials were down 1.2%; and the New York Stock Exchange Composite dropped 1.2%.

British Issues

June 20 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	508	N/M	30.7	6.0	508	498
Genl Accident	542	N/M	35.7	6.6	542	535
Gdn Royal Exch	200	N/M	15.9	8.0	202	198
Royal	448	N/M	34.7	7.7	451	445
Sun Alliance	375	N/M	18.7	5.0	376	375
Brokers						
Bradstock	150	17.1	6.0	4.0	150	150
CE Heath	453	15.4	34.5	7.6	463	453
Hogg Group	203	12.3	10.7	5.3	204	203
Lloyd Thompson	355	23.6	10.0	2.8	361	355
PWS Holdings	83	10.1	4.7	5.7	86	83
Sedgwick Grp	270	25.9	16.0	5.9	270	264
Steel Brit Jones	285	15.1	16.3	5.7	285	285
Willis Corroon	296	15.7	17.6	5.9	299	296

Source: Philip Olsen, Insurance Industry Analyst London

BI Industry Stock Report

JUNE 17, 1991 THROUGH JUNE 21, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	22.00	0.00	-4.86	27.63	16.13	145	1.00	4.55	17	9.77	2.25
Gallagher Arthur J. & Co.	NYS	23.13	3.35	-0.54	28.38	19.75	27	0.64	2.77	17	5.88	3.93
Frank B. Hall	NYS	3.50	0.00	-3.45	4.13	2.00	61	0.00	0.00	-7	-5.24	-0.67
Hilb, Rogal & Hamilton	OTC	14.63	-10.00	-0.85	17.50	11.25	56	0.36	2.46	22	3.56	4.11
Markel Corp.	OTC	17.63	-4.73	50.00	21.00	10.25	17	0.00	0.00	9	3.56	4.95
Marsh & McLennan	NYS	76.88	0.99	-1.44	87.25	59.75	586	2.60	3.38	18	14.77	5.20
Poe & Associates	OTC	11.00	2.33	71.87	11.25	6.25	3	0.32	2.91	13	2.09	5.26
BROKERS	AVERAGE		-1.2	15.8					2.3	13		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	29.50	-3.28	-21.33	32.25	19.00	94	0.32	1.08	16	23.89	1.23
Berkshire Hathaway Inc.	NYS	8525.00	0.59	27.72	8900.00	5675.00	0	0.00	0.00	-27	4612.00	1.85
ITT (Hartford Group)	NYS	59.38	-0.63	23.70	63.00	40.25	1271	1.72	2.90	7	64.01	0.93
Sears (Allstate)	NYS	40.00	-0.62	57.64	40.88	22.00	3093	2.00	5.00	14	37.38	1.07
CONGLOMERATES	AVERAGE		-1.0	21.9					2.2	2		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	41.38	1.53	6.09	53.88	29.00	1208	2.76	6.67	8	64.23	0.64
American General	NYS	39.00	0.32	26.83	48.25	23.50	771	2.00	5.13	8	37.14	1.05
American Heritage	NYS	30.00	-5.88	42.86	32.25	19.63	7	1.04	3.47	13	19.25	1.56
American Indemnity/Fin'l	OTC	7.00	0.00	115.38	7.50	2.75	12	0.08	1.14	13	12.93	0.54
American International	NYS	86.25	0.29	12.20	102.00	57.00	2508	0.48	0.56	12	45.34	1.90
Aon Corp.	NYS	37.75	-2.27	8.63	41.75	26.75	227	1.60	4.24	10	18.50	2.04
Argonaut Group	OTC	28.25	-0.88	32.42	33.38	17.75	117	0.68	2.41	8	48.26	0.59
AVEMCO Corp. (s)	NYS	22.13	0.57	31.44	22.88	14.13	19	0.24	1.08	17	9.55	2.32
Baldwin & Lyons Inc.	OTC	22.75	0.00	21.33	25.25	17.00	0	0.28	1.23	8	24.29	0.94
Belvedere Corp.	ASE	3.38	3.85	35.00	4.00	1.75	4	0.04	1.19	24	7.65	0.44
Chandler Insurance	OTC	3.25	-7.14	-52.73	8.88	2.75	36	0.00	0.00	-3	5.95	0.55
Chubb Corp.	NYS	68.50	-3.01	26.27	75.25	34.63	642	1.48	2.16	11	35.15	1.95
CIGNA Corp.	NYS	46.75	-1.32	14.37	56.75	33.25	578	3.04	6.50	11	73.15	0.64
CNA Financial Corp.	NYS	79.25	0.00	15.48	92.50	49.50	122	0.00	0.00	13	70.23	1.13
Continental Corp.	NYS	27.88	-3.04	12.06	30.63	15.75	491	2.60	9.33	11	37.83	0.74
Durham Corp.	OTC	32.88	0.38	17.41	33.00	23.00	283	0.92	2.80	17	28.04	1.17
Fund American Corp.	NYS	63.50	0.00	22.41	65.25	32.50	72	0.68	1.07	14	36.11	1.76
Fremont General Corp.	OTC	23.75	0.00	63.79	24.75	10.13	418	0.88	3.71	7	19.13	1.24
Frontier Insurance Group	NYS	25.38	-0.49	33.55	33.00	15.38	27	0.00	0.00	10	11.20	2.27
General RE Corp.	NYS	93.25	2.47	0.27	102.50	69.00	942	1.68	1.80	13	37.50	2.49
Hanover Insurance Co.	OTC	28.00	1.36	5.66	30.75	21.00	46	0.44	1.57	9	37.44	0.75
Harleysville Group	OTC	31.25	5.04	36.61	31.50	13.50	21	0.64	2.05	10	22.99	1.36
Hartford Steam Boiler	NYS	60.25	-1.03	23.59	63.75	43.50	47	1.80	2.99	16	17.05	3.53
Kansas City Life Ins.	OTC	35.25	0.00	14.17	36.50	30.00	1	1.20	3.40	9	39.22	0.90
Kemper Corp.	NYS	32.38	-8.16	36.32	42.38	17.13	458	0.92	2.84	59	34.20	0.95
Lawrence Insurance Group	ASE	8.75	-2.78	25.00	9.50	6.38	4	0.48	5.49	13	4.71	1.86
Liberty Corp.	NYS	43.00	-3.64	4.56	50.25	39.00	16	0.92	2.14	14	23.86	1.80
Lincoln National	NYS	46.75	-0.80	8.72	56.00	30.75	192	2.72	5.82	10	45.16	1.04
NAC Re Corp.	OTC	38.25	2.00	15.91	42.50	25.50	54	0.20	0.52	14	18.90	2.02
Navigators Group	OTC	31.75	0.79	45.42	34.00	16.50	8	0.00	0.00	17	13.52	2.35
Nobel Insurance LTD.	OTC	3.63	-3.33	20.83	4.38	2.38	26	0.00	0.00	-	7.76	0.47
NWNL Companies	NYS	25.75	-0.48	52.59	32.88	11.75	75	1.40	5.44	6	42.73	0.60
Ohio Casualty Corp.	OTC	49.13	0.77	19.82	50.13	26.75	189	2.48	5.05	11	36.38	1.35
Old Republic Int'l	NYS	28.13	-4.66	22.95	31.13	17.38	111	0.72	2.56	7	33.09	0.85
Orion Capital Corp.	NYS	28.75	-0.86	64.29	29.50	13.00	28	0.92	3.20	9	20.42	1.41
Phoenix RE Corp.	OTC	9.50	-2.56	22.58	11.25	5.00	5	0.20	2.11	12	13.30	0.71
Protective Life Corp.	OTC	21.75	3.57	46.22	21.50	10.25	37	0.84	3.86	10	16.29	1.34
Provident Life	OTC	19.00	0.00	8.57	24.75	12.00	317	0.92	4.84	5	25.88	0.73
Re Capital Corp.	ASE	17.00	-2.16	32.04	18.63	11.75	22	0.20	1.18	12	15.05	1.13
RLI Insurance Corp.	NYS	14.25	-1.72	-1.72	16.38	9.63	59	0.44	3.09	7	14.41	0.99
St. Paul Companies	OTC	63.25	4.55	0.80	74.25	47.00	1319	2.60	4.11	7	52.00	1.22
SAFECO Corp.	OTC	40.38	0.31	22.81	44.75	25.13	354	1.48	3.67	10	31.50	1.28
SCOR U.S. Corp.	NYS	12.88	-6.36	4.04	15.25	8.38	10	0.24	1.86	8	11.19	1.15
Seibels Bruce Group	OTC	7.50	0.00	76.47	10.50	4.25	51	0.36	4.80	-150	7.35	1.02
Selective Ins. Group	OTC	15.00	-1.64	13.21	18.00	12.50	24	1.04	6.93	8	18.91	0.79
Statesman Group Inc.	OTC	4.38	0.00	179.91	4.88	1.25	897	0.00	0.00	-44	2.48	1.76
Tokio Marine & Fire	OTC	43.50	-1.14	-7.94	56.50	34.50	12	0.00	0.00	-	70.93	0.61
Torchmark Corp.	NYS	50.88	-4.91	4.09	58.50	38.00	278	1.60	3.14	12	16.70	3.05
Transamerica	NYS	32.63	-1.14	0.00	39.63	23.25	1147	1.96	6.01	10	36.56	0.89
Travelers Corp.	NYS	22.75	-2.15	36.84	30.38	11.50	936	1.60	7.03	-12	41.44	0.55
Trenwick Group Inc.	OTC	27.75	1.83	20.00	30.00	16.25	127	0.60	2.16	11	21.71	1.28
United Fire & Casualty	OTC	44.00	0.00	25.27	58.00	28.75	1	1.32	3.00	8	35.39	1.24
USF&G Corp.	NYS	9.63	-2.53	28.33	27.38	7.00	1350	0.20	2.08	-1	11.96	0.80
UNUM Corp.	NYS	62.50	-2.15	34.05	69.00	32.13	300	1.04	1.66	11	37.25	1.68
USLIFE Corp.	NYS	42.38	3.35	51.34	41.75	23.25	114	1.64	3.87	11	60.34	0.70
Unitrin	OTC	35.75	-7.14	16.26	41.50	24.50	763	0.80	2.24	13	30.70	1.16
Washington National	NYS	13.88	0.91	27.59	21.63	9.38	14	1.08	7.78	-7	26.86	0.52
USLICO Corp.	NYS	20.13	0.63	26.77	21.88	14.75	106	1.00	4.97	9	29.44	0.68
Zenith National Ins.	NYS	17.63	0.71	29.36	18.50	9.88	8	1.00	5.67	-73	13.14	1.34
INSURERS/REINSURERS	AVERAGE		-0.9	27.7					3.2	5.4		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	24.50	6.52	60.66	29.75	8.86	695	0.00	0.00	21	5.44	4.50
HMO America Inc.	OTC	13.50	-1.82	107.69	17.13	4.25	223	0.00	0.00	17	0.61	22.13
Pacificare Health Sys.	OTC	35.75	3.62	120.00	36.75	12.00	393	0.00	0.00	21	6.55	5.46
Safeguard Health Enter.	OTC	6.38	18.60	34.21	7.63	4.00	14	0.00	0.00	22	3.53	1.81
Sierra Health Services	ASE	21.88	-0.57	59.09	29.50	5.50	178	0.00	0.00	38	1.78	12.29
United Healthcare Corp.	OTC	48.00	-1.05	106.45	50.00	13.13	1504	0.06	0.13	31	3.76	12.77
United Medical Corp.	ASE	10.00	-3.61	25.00	11.38	6.63	5	0.20	2.00	13	3.79	1.14
U.S. Healthcare	OTC	33.25	-2.56	13.19	38.00	10.00	2805	0.32	0.96	24	3.38	9.84
HMOs	AVERAGE		2.7	65.8					0.4	23		
ALL COMPANIES	AVERAGE		-0.5	29.5					2.7	8		

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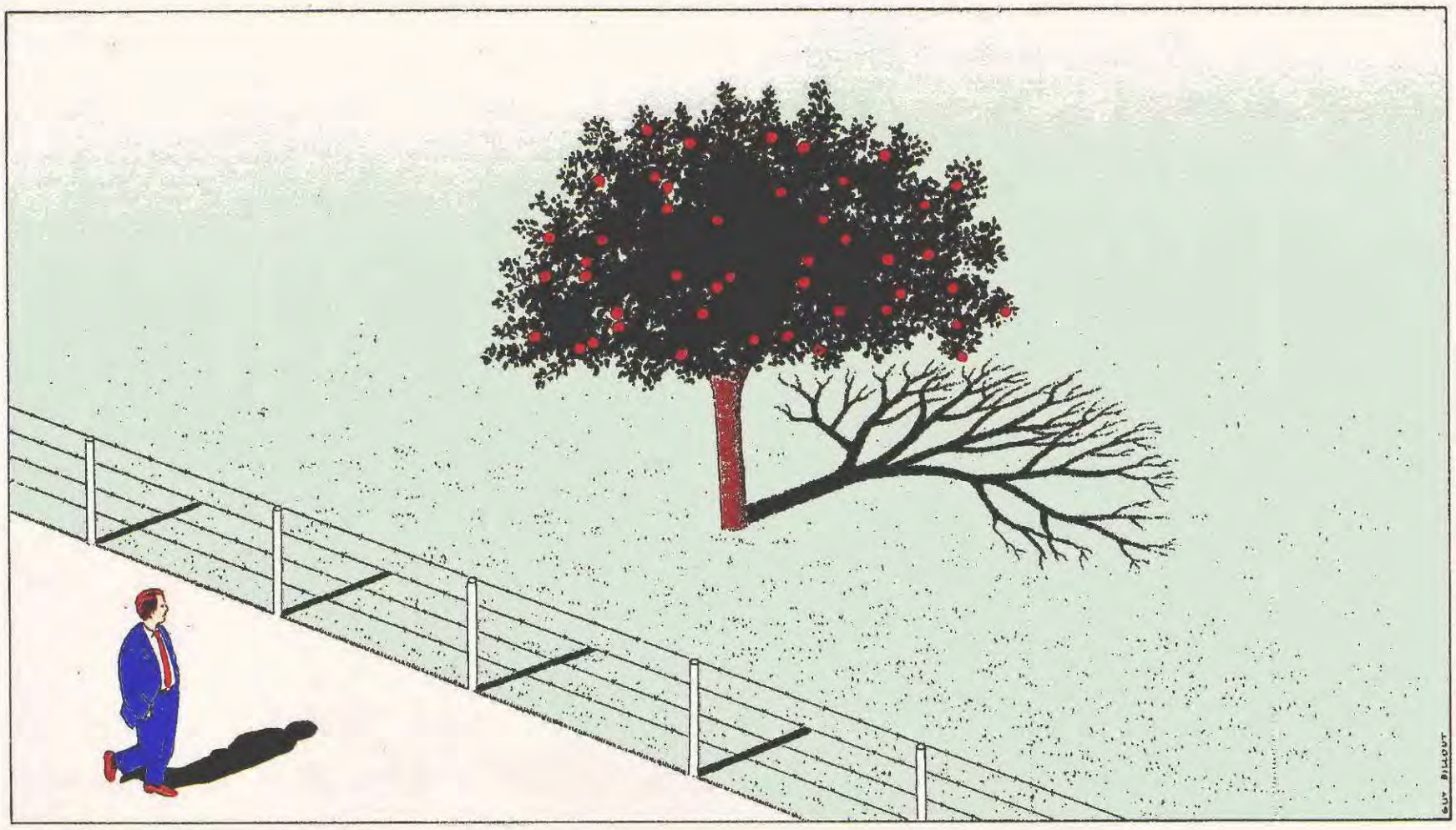

emerging issues in employee benefits -- the provision of practical, economical group long-term care coverage -- and moved to implement it. Today, those we serve have this coverage available to them -- because our experience and the resources we command made it possible early. ◆ Clients who depend on your advice want to know how well group insurance companies know the industry. Now you can tell them how we make our experience and expertise work for them. For more information, call Tom McKellar, Director of National Accounts, at 1-800-877-1052.

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