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ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS FOR SMALL EMPLOYERS

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- Characteristics common in HMOs concentrating on the small employer market
- Preferred Provider Organizations marketed to small employers
- Items requiring special attention when marketing Alternate Delivery Systems to small employers
- Alternate delivery options in an integrated multiple options package

MS. JEANNIE M. WODARCZYK: I will be addressing Alternate Delivery Systems (ADSs) aimed at the group of employers with fewer employees than those employers we generally refer to as large employers. Specifically, my comments will be directed to the Health Maintenance Organization (HMO) activity in this area.

I have been working with several HMOs in the Chicago marketplace who have targeted the small employer group as their market niche. In order to address that situation properly, I think I need to set the stage a bit as to the competitive forces at work in Chicago.

The health care market in Chicago is basically overcrowded. There are roughly 25 HMOs, and that number is increasing every week. It has been estimated that the population will reasonably support 12 HMOs. Late in 1985, insured Preferred Provider Organizations (PPOs) gained legal status. There is a flurry of activity in that arena as well. Large insurers and other large health care investors are active there and willing to buy certain segments of the market. The health care scene is one that is rapidly changing. There are ads

everywhere: billboards, radio and TV ads, and even home mailers. I recently received a piece of junk mail from one of these organizations which came with a discount coupon for my next visit to its doctor. So, I guess the bottom line is that everyone is informed that there is something out there called an HMO. There is debate about whether it is a good or bad thing, but most everyone on the street is well aware of the HMO presence.

Now we come to the HMOs I will describe for you. They are reasonably similar to some I have been working with in this environment I've just described, and I'll call them HMO A and HMO B. Neither is federally qualified nor are they out to buy a marketshare. They do not have large insurer backing, and their investors are not willing to sink large sums into purchasing business to establish a presence. This is part of the reason each considers the small employer its target market.

HMO A

1. Background
   HMO A is not federally qualified and not presently seeking qualification in the near future. It has suburban orientation and will be branching out to locations outside of the Chicago market, although the small employer niche will still be the target. In addition, this HMO will selectively market to the small college market. These colleges do not have Health Service facilities and are typically religious institutions which attract older graduate students with families. Both faculty and student coverage are sought to replace the current indemnity plan. Each institution is rated based on previous indemnity experience.

2. Marketing
   This HMO does not market individual sales. Employer sales are all through brokers, although the college market is sold directly. Commissions are roughly 8%, with some exceptions based on volume. Some HMOs in the area pay slightly higher commissions, while others pay less. There has been some discussion of putting the brokers at risk for the quality of the business they sell. A holdback of some of the commissions would be set aside to reward those brokers with good business and a certain volume amount. This is still in the discussion stages.

3. Plan Design

HMO A provides a high and low option plan design. The high option plan provides the usual medical HMO coverages. Extras are out-of-area hospitalization and prescription drugs. The non-emergency out-of-area hospital coverage requires consent of the Medical Director. This was the result of a concept that grew out of the small college market, which required this type of benefit to make it viable to students. The low option plan eliminates the out-of-area frills, and prescription drugs are an optional add-on. In addition, there is a $250 co-pay for hospitalizations. In Illinois, we cannot have deductibles -- only co-pays. The co-pay amount must be less than 50% of the charges made on a fee for service basis. There are other HMOs in other parts of the country that have deductibles at much higher levels. To date, HMO A is leaving the high-low choice up to the broker of the employer. It is not imposing design on the employer based on size or competitive indemnity plan, although this is certainly an option.

For really small groups, those under 10 lives, a short medical form is required for each insured. These lives will be accepted on an individual basis. A pre-existing condition rider has been considered but rejected to date. The expense of follow-through and potential misunderstandings has made this option one HMO A prefers not using.

HMO B

1. Background

HMO B, on the other hand, has a city orientation. It is also not federally qualified. It is, however, evaluating the Medicare market and is looking at the Competitive Medical Plan (CMP) approach. In addition to the small business market, HMO B sells to individuals on a direct basis.

2. Marketing

The marketing is entirely through the staff at HMO B. This HMO has been approached by brokers but does not want to go that route at this time. A special target market for HMO B is the Spanish speaking community, which provides many small employers. Contracts and other materials have been written in both English and Spanish in an effort to attract members of

this ethnic group. As people in California may already know, providing these written materials is no small task. There are several meanings to many Spanish words and phrases depending on the ethnic background of the reader. Materials had to be reviewed for clarity from a number of perspectives. Bilingual physicians have been contracted to provide services.

3. Product Design

Groups under ten lives are marketed as if they were individual sales. A medical questionnaire is required. HMO B is attempting to use the pre-existing condition rider, but there is no experience on this yet.

A full coverage HMO plan is offered. Pricing is performed for the group based on the age and sex of members who sign up. In addition, there are some occupational ratings. Physicians are capitated on an age and sex basis as well.

Large groups assume a standard mix of members, and a single capitation is used.

I would now like to address the reasons for interest in HMOs on the part of small employers:

a. Advertising -- There is at least a curiosity factor among employers as to what an HMO could mean to them. Everyone has heard of HMOs and interest has been aroused.

b. Coverages -- Full coverage with less out-of-pocket expenses appeals to the employer with relatively unsophisticated employees. If the cost is reasonable and services are readily available, this type of coverage can avoid some of the hassle involved with the employee who doesn't understand the concepts of deductibles, preadmission certification and the like. In the Chicago market, at least, some of the HMOs are quite competitive with the indemnity plans.

c. Cost shifting -- Right now there are two types of people, the "shiftees" and the "shiftors." Hospitals and other providers are all

trying to retain market share. In an effort to do just that, these providers are granting discounts to HMOs and PPOs in exchange for the promise of s slice of the pie. Some of these discounts cannot be supported in the long run. The small employer, as a part of the indemnity plan without the advantage of discounts, becomes the shiftee in this situation. As a result, the cost of the indemnity plan increases to a point where the move to an entity such as an HMO is a cost effective approach. It provides full coverage at rates very competitive with, and sometimes cheaper than, the indemnity coverage it replaces.

In conclusion, I would like to make three points:

1. There are a number of markets out there still waiting to be tapped even in the most competitive environments.

2. The small employers are interested.

3. There is no one way to address a market. Innovations and creativity are still the key features of a successful venture.

MR. THOMAS L. HANDLEY: I will be concentrating most of my remarks on PPOs. My company, Blue Cross and Blue Shield of Kansas City, markets its PPO to small employers in the Kansas City area. We consider a small employer one with at least two full-time but no more than 99 employees. Much of the plan design and underwriting considerations are very similar to those we normally deal with when marketing to the small employer market.

1. Benefit Options available should be limited in terms of packages:

   One or two for groups of 2-9
   Two to four for groups of 10-19
   No more than five for groups of 20-49
   Five to eight for groups of 50-99

2. None of the options should have very rich levels of benefits. A $100 deductible program is risky.

3. You need an underwriting system that assigns the group into proper risk classes based on employer contribution, percentage enrolled, industry, etc.

4. You should use age or age/sex specific rates for groups of less than 20 employees.

The issues I have addressed so far are pretty standard for small group, so now I want to shift to those issues that are unique to PPOs. Your plan design or underwriting regulations must address the following guidelines:

1. Who will use preferred providers? Who will use non-preferred providers? Will the healthy risks select one set of providers and the poor risks select the other set?

2. How much patient shifting to preferred providers will occur? Will the amount of shifting vary with the *number* of preferred providers or *who* those preferred providers are?

3. What impact will the benefit levels of preferred vs. non-preferred have on shifting and utilization levels? If the preferred benefits are too high, will you see over-utilization?

At Blue Cross and Blue Shield, we don't need a very long memory to remember what full service benefits did to utilization rates.

With these questions to address, we developed the following:

1. Our PPO was a replacement program and was not marketed to small groups as an option.

2. While the rates are basically a community rate, we do use age and sex to modify the community rate base.

3. The PPO must have *both* hospitals and physicians in the network to attract the needed and desired patient shifting.

4. We required a higher total percentage enrolled because of our concerns about patient shifting and obtaining a reasonable spread of risk. We asked for 85% enrollment rather than the usual 75%.

5. There should be only one PPO option in the group.

6. We applied a standard discount (i.e., a community discount) to each group rather than develop a unique discount (as we do with large groups based on which combination of providers the group typically utilizes).

7. We maintain at least a 10% coinsurance difference between preferred and non-preferred providers and do not allow preferred coinsurance to exceed 90%. A program with a 90% coinsurance rate for preferred providers and 80% elsewhere proved most successful.

While our primary thrust has been to market the PPO as a replacement program, we have considered marketing it as an option. The elements we feel are critical to successful marketing of a PPO as an optional program include:

1. Very strong utilization controls, including pre-admission certification and concurrent review;

2. Capitation of as many of the PPO services as possible, including possibly prescription drugs, lab, x-ray and primary physician care;

3. A sound provider risk-sharing arrangement as another means of controlling costs;

4. A rate structure that reflects the age and sex characteristics of the group or the persons in the group most likely to enroll; and

5. A strong provider network that has a broad distribution geographically and proportionately to attract a high percentage of the employees and therefore ensure a reasonable risk spread.

The last issue I want to address, although Ron Harris will discuss it in more detail, is the dual offering by one carrier, of a PPO and an HMO. Blue Cross and Blue Shield of Kansas City is in the process of putting this together, and we have decided upon the following conditions:

1. The HMO will be non-federally qualified.

2. We will use a risk class arrangement to classify groups. The class will be based on combined HMO and PPO enrollment.

3. We will combine the HMO and PPO for rating and use the profits of one to offset the losses of the other.

4. The benefits and rates of each will be reasonable in relationship to the other. Generally, the HMO will have higher benefits and rates.

5. We will use a community rate (varying by risk class) that will reflect the age and sex census of the group. We will use this same census for each program offered within the group.

MR. RONALD G. HARRIS: Given that most persons in attendance seem familiar with ADSs, I will confine my remarks to the small employer market.

An entire spectrum of alternative health care delivery systems is available in many parts of the country today. Most of the early forms focused on large employers in major metropolitan areas. As the development of ADS forms has progressed and shown marketing and financial successes, program sponsors have expanded their scope of operations to include increasingly smaller employers and increasingly smaller communities. Some of the unique features of this segment of the market, however, place constraints on the types of ADS programs which are feasible.

Chart 1 outlines a number of areas of consideration which require special attention with regard to alternate health care delivery systems for small employers:

CHART 1

Areas of Special Consideration for Small Employer ADS Programs

A. Benefit levels

B. Distribution system

1. Size
2. Control
3. Expense
4. Understanding

C. Adverse Selection

1. Employee
2. Employer

D. Underwriting

1. Selection of risk
2. Contract limits

E. Rating/financing

1. Rate development basis
   - o Community rating
   - o Characteristic rating
   - o Recognition of experience
2. Dual choice vs. whole group
3. Partial self-funding

F. Administration and service

1. Expense
2. Geographic considerations
3. Medical community acceptance

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1. Comprehensive Major Medical benefits -- frequently with relatively high deductibles and high out-of-pocket limits -- are common in the small employer group market. Benefits typically offered by HMOs, and frequently by PPOs, tend to be relatively rich, resulting in expected net claim costs which are substantially higher for the ADS program than for the traditional indemnity program. My experience has been that the benefit plans to be offered in this segment of the market by an HMO or PPO have to be reduced substantially below those typically offered to large employer groups with relatively comprehensive indemnity plans.

2. The relatively small size of employers in this segment makes distribution or marketing a difficult and expensive undertaking. In addition, brokers and agents frequently control a sizeable portion of the market. These factors combine to produce several problems: (1) the marketing and related employee enrollment effort required for a dual choice ADS program tend to be prohibitively time consuming and expensive; (2) direct access to employers and employees is frequently difficult; and (3) the potential for misunderstanding with regard to a complex program such as an HMO or a PPO is very high.

3. ADS programs offered to small employers, in my experience, have tended to be subject to a greater degree of adverse selection than similar programs offered to large employers. The sort of adverse selection to which I'm referring occurs in situations where the ADS program is offered on a dual choice basis. In such situations, the adverse selection has been attributed to both employers and to employees. When employees select an ADS program where the ADS option is substantially richer in benefits and higher in price than the traditional indemnity plan, anti-selection by such employees can be anticipated. More subtle, however, is the opportunity provided for an employer to "dump" uninsurable or impaired lives into the ADS program.

4. The need for underwriting under an ADS program offered to small employers is as great, in my judgment, as it is for traditional indemnity plans offered to small employers. This may include individual medical underwriting for very small employers, careful group underwriting (including

short forms) for slightly larger groups, and the incorporation of appropriate pre-existing conditions and other contractual limitations. I would note that many Federally Qualified HMOs have managed to adopt such practices, despite Federal regulations.

5. A major actuarial problem, faced today by employer groups of all sizes, is the fundamental inconsistency between the rating methods of many ADS programs and those of traditional indemnity programs. In the case of HMOs, the traditional practice has been one of using community rates, although some recognition of a group's age and sex characteristics has begun to appear. For small employer traditional indemnity plans, characteristic rating (using age, sex, industry and/or other characteristics of the group) is fairly standard, with some groups in this size category being at least partially self-funded or having rates which reflect, in part, the experience of the group. Until this fundamental incompatibility is solved, my judgment is that ADS programs will be severely limited with regard to viability in the small employer group marketplace. I would note, however, that this is not a problem when an entire small employer group is covered under the ADS program. I would note, as well, that several rather creative approaches to rate setting have been developed for use by Federally Qualified HMOs.

6. Administration and service, like marketing and distribution, become increasingly difficult and expensive as we move down in size to the smaller employer market segments. This argues for the design of an ADS program to be sold on a whole group basis rather than a dull choice basis. However, geographical and residential considerations, as well as medical community acceptance in areas of relatively low population density, make this task difficult. These factors, in addition to frequent problems obtaining access to employees for educational purposes, increase the likelihood of misunderstanding regarding the characteristics of the program. This is particularly true with regard to any restrictions on the use of certain providers, or the need for following certain procedures in the cost containment provisions of the program.

All of these factors serve to reinforce the importance of careful design in the product to be offered to small employers. Primary among the design considerations are the benefit levels to be offered, the rating arrangements to be used, the product distribution system to be adopted, and simplicity of administration.

I am firmly convinced that the future will hold a multiplicity of delivery and financing mechanisms in the health insurance marketplace, rather than a single approach. I would like to outline for you what I view to be the elements of one such approach, which I would describe as an integrated approach to offering traditional indemnity and ADS options to small employer groups. By an "integrated approach" to coverage options, I am referring to the packaging of such options into a single program for an employer. This particular technique is applicable to large groups as well as small groups; however, I believe it has the greatest degree of potential in the medium and small group market, where a structured product is feasible and, in fact, is necessary.

The basic purpose of an integrated multiple options package essentially is three-fold in nature:

1. to make a unique and attractive product available in the marketplace,

2. to optimize the positioning of all of a carrier's or all of a plan sponsor's product options within an employer group, and

3. to minimize any potentially adverse effects of selection patterns among options.

As can be seen from the first item on Chart 2, an initial strategic issue is the basis on which the multiple-options program is to be differentiated in the market -- i.e., price vs. benefits. The answer to this question will shape, to a large extent, many of the remaining issues. The question of a basis for differentiation of the product has a second remaining issue. The question concerns the way in which the various options within an employer program will be distinguished among each other -- on the basis of the price of the option, or the benefits and other features of the option. The use of benefit

CHART 2

Elements of an Integrated Approach to Small Group ADS

A. Marketing strategy

1. Differentiation basis
   - o Price
   - o Benefits
2. Distribution system

B. Program design

1. ADS programs
2. Multiple options benefit packages
3. Pricing relationships
4. Selection pattern analysis

C. Underwriting

1. Individual
2. Group

D. Rating

1. Whole group focus
2. Fixed pricing relationships
3. Group characteristics (age/sex/industry/etc.)
4. Rating method compatibility
   - o Group rating techniques
   - o Provider payment arrangements

E. Internal allocation of premium revenue

1. Allocation of total revenue
2. Recognition of group characteristics
3. Recognition of other factors

differentiation among options, within a packaged program, rather than price differentiation, provides a number of administrative and actuarial advantages.

In order to build an integrated program of traditional indemnity and ADS options, each individual optional program must itself be attractive to employees and be financially viable. This typically means, among other things, that it must effectively manage utilization. The next step in the design of a multiple options program, then, is to put together combinations of coverage plans that are compatible with each other. Compatibility, in this context, means that they offer the price and benefit differentiation desired for the overall design of the program.

If the options offered within an employer program are to be distinguished on the basis of benefits, then all of the options offered within the package must have the same level of expected cost per person (i.e., benefit differences are offset by discount and utilization control savings, ignoring differences in exposure characteristics). This approach has administrative advantages, as well as the very important feature that any losses from adverse selection against one of the options will be largely offset by gains under the other options.

As a practical matter, some price differentiation among options is likely to be necessary and desirable. So long as fixed, reasonable relationships in rates can be maintained among options, any adverse effects due to anti-selection can be minimized. The final steps in program design, then, are to establish pricing relationships among options which are to be maintained over time, and to analyze the impact of different selection patterns on the overall rating and financial viability of the entire program.

Favorable or unfavorable selection among traditional indemnity and ADS options within a program cannot be totally eliminated. Under an integrated approach, the adverse consequences of selection patterns are minimized through a combination of several program features. First, underwriting and rating are based on the entire employer group, and all rating reflects group characteristics or other factors normally used by the sponsor in setting small employer group rates. Second, benefit plans included in a given package have been selected

such that fixed price can be maintained among the options. To the extent that any differences in rates among options are perceived by employees to be commensurate with the value of differences in benefits or other program features, the program sponsor has an increased chance of achieving a reasonable cross-section of risks in each of the options. Third, a single rating method is used -- one which establishes a reasonable rate level for the particular group involved, and one which reflects appropriately any unique features of the provider payment arrangements involved under the ADS options. This last rating step -- establishing rating method compatibility among all of the program options -- is perhaps the most challenging technical task faced by the actuary. Although the mathematics can become tedious, the two most important elements of the solution are (1) the adoption or modification of the sponsor's HMO or PPO provider payment arrangements so that they are compatible with the sponsor's group rating method, and (2) the adoption of procedures for an equitable after-the-fact allocation of total premium revenue generated, among the various program options. The first of these two areas -- compatibility between provider payment arrangements and the sponsor's group rating method -- essentially requires that the same characteristics which are used in setting rates for a particular group (e.g., age/sex or experience) also be used in determining capitation or incentive payments to providers under the ADS option. A number of my HMO clients that currently are operating on a free-standing basis have established such techniques, so that their rates are widely competitive in the marketplace, and so that they are at least partially immmunized against differences between revenue and capitated costs. For Federally Qualified HMOs, the task is made somewhat more difficult, but it can be and has been done on numerous occasions.

The final element of the integrated approach to packaging small group traditional indemnity and ADS options is an internal allocation of premium revenue among the various options. If the design features of the program have been constructed properly and if rating has been performed on the basis of the entire group, then payment to each optional program becomes a matter of allocating total revenue. I would suggest that total revenue be allocated to each of the options on the basis of pricing relationships used in setting the rates for the whole group, but with an after-the-fact recognition of the actual characteristics of the employees within the group who elect a particular

option. This might mean, for example, that one option within an employer program actually gets a higher than average portion, if the average age of employees within the group electing the first option is higher than the average age of those electing the second option. To the extent that morbidity differences among options are present which are not reflected in the age-sex or other group characteristics recognized, some explicit adjustment for such "other factors" may be appropriate.

In addressing the issue of alternative health care delivery systems for small employers -- and, in fact, in addressing the issue of health care options in general -- we as actuaries face significant challenges and responsibilities. We must be careful to incorporate in our thinking such important considerations as risk selection patterns among employees electing various health benefit options, the growing complexity of risk-sharing and risk-transfer arrangements, and the tremendous diversity in specific ADS program features. An essential part of this challenge is the development of measurement techniques and information systems necessary to monitor and evaluate these ADS systems which link together the financing and delivery of health care programs.

MR. GREGG SKALINDER: Ms. Wodarczyk has done a nice job of giving us a case study of some of the things going on in Chicago. In our work with our clients, which tends to be in the 100 and up life size account, we have found that the aggressive stance taken by the HMOs has caused a good deal of trouble. We have a number of clients who have communicated to the employees the need to reduce utilization by raising deductibles. They have also said, "We will pay the usual price for an HMO, and the employee must pay the difference." We have, in the last six or eight months, frequently run into a situation where the price quoted for the HMO was lower than the insured program, even with its deductibles. You can imagine what kind of message that gives to the employees of our client. The fear that we have, and we have gotten some feedback indicating that this may be happening, is that the service provided by the HMOs may be deficient prior to complete financial collapse. This collapse usually consists of purchase by another HMO. On the insured side, we frequently have gone back and gotten the insurer to lower its rates. You then frequently encounter a hidden deductible through the administration of the reasonable and customary provision of the contract. The chaos, even though it results in

lower short term costs for the employers, really causes a great deal of difficulty. I guess my only point is I certainly hope that it sorts itself out, and we wind up with what Ron has referred to as a more consistent rate structure in the area.

MS. WODARCZYK: That all is true of the Chicago market. I guess I alluded to that a bit when I said that people are out there trying to purchase their market shares. I think that is a false purchase and a short term purchase. I think in the long run everyone will be the worst for it, but it happens to be out there right now.

MR. JOSEPH W. MORAN: This is a question for Mr. Harris that's prompted by his discussion about the characteristics of his multiple option program. In that program you presumably are including traditional insurance, PPO coverage and HMO coverage. The last item you talked about was internal revenue allocation. Isn't this really a question of the real allocation of revenues between the HMOs entity, the entity that's underwriting the traditional coverage, and the entity that is underwriting the PPO coverage? It is more than just an allocation for internal revenue purposes of one entity's revenues.

MR. HARRIS: Perhaps you could elaborate just a little bit. I'm not sure exactly what you're getting at in terms of distinction.

MR. MORAN: Take the situation where there might be two groups with identical census characteristics that were signed up for the triple option program. In one of the groups the only people who signed up for the HMO option were age 22. In the other group, the only ones who signed up for the HMO option were age 62. You were going to use that to manipulate the calculation of the average premium rates payable to each of the two. Then you talked about an internal allocation of the total payable that would be different from the actual amount payable to each of the two entities.

MR. HARRIS: Let me ask a question first: Are you referring to the situation where the two entities are part of perhaps a joint venture or affiliation, as opposed to owned by the same entity?

MR. MORAN: I am talking about a collaborative relationship for marketing an HMO along with an insured product that has a PPO provision in it and uses the PPO network.

MR. HARRIS: I guess what I am suggesting is that we have a three step process. The first step is to establish reasonable relationships in expected costs among the various options, assuming that exposure characteristics are the same among people going into each of those options. Let's take the simple case where we design our programs such that the expected cost for each of our options, whether that be two options or three options, is $100. The first step, then, is to do that design so that we establish the relationship that we anticipate between those options not yet considering differences in characteristics of people that go into each of those programs. The second step is to establish rates for a group, be it a large group or a small group, that are appropriate given the characteristics of that group. These could be demographic characteristics of that group in total, the experience characteristics, or others. The third step, then, is to establish, after we know who elects which of the options, appropriate amounts of revenue for each of the programs involved.

MR. MORAN: This would actually govern the amount that the employer pays to each of the two organizations supplying the coverage: the HMO entity, and the insurer or other entity supplying the PPO coverage.

MR. HARRIS: Let's suppose that we do decide an expected value of $100, and in fact this group happens to have characteristics that are precisely consistent with a $100 rate. Then a single billing would be made for $100 per employee, regardless of the option the individual employees pick. Once that $100 bill has been sent and been remitted by the employer, there would be an allocation of the total dollars collected from that employer among the program options. The allocation reflects the characteristics of the individuals who actually did select each of those options, so the employer and employees would be unaffected by this. This would be strictly an internal allocation of money.

MR. MORAN: You mean the employer won't even know how much of the money, that it sent in, is going to the HMO organization and how much is going to the insurance company?

MR. HARRIS: A simple example would be a case with a $100 rate. Behind that there are two age/sex categories. One of them carries a rate of $80, and one carries a rate of $120. For argument's sake, half of the employees are in each category. Then the average rate for that group is $100. If the expected cost is the same between the two programs, then what we really have is a table of rates -- $80 and $120 for each of the two. What I am suggesting is that the $100 is the average rate paid by the employer on behalf of all the employees. Once that money has been collected, the HMO would get paid $80 for each of the employees that falls into the $80 category and would get $120 for each of the employees that falls into the $120 category, and similarly for the underwriter of the indemnity program. It's that sort of concept that I'm describing.

MR. HANDLEY: It's the collecting entity that is going to allocate the money internally, so that both entities turn out making money or losing money, depending on the allocation.

MR. MORAN: I'm concerned about the extent to which the employer has a contractual agreement with each of these two risk underwriters: the HMO and the insurer that's supplying the difference between the payments to the two of them.

MR. HARRIS: Well, certainly I would anticipate that with a program like this there would be a single group contract with the program sponsor. In turn that sponsor would have contractual relationships, either by ownership or by contract with the other programs involved in it. You're right, you'd run into some very serious problems if you had two unrelated entities and not a single contract with the employer. What we are trying to get across here is the difficulty that's faced when people with different exposure characteristics pick one option versus the other option, and how you properly compensate the sponsor of each program. What I am suggesting is a way that establishes a reasonable amount of total revenue and makes a fair and equitable distribution of that income between options.

MR. SCHUYLER W. TOMPSON: Can multiple choice options work in the small group market: under 100, 50, or 25 employees? I have my own preconceived notions, but I'm not sure just how much fact is behind my opinion. Could the members of

the panel indicate what their preferences are, or what their opinions are?

MS. WODARCZYK: I guess I've got to believe it can work, because it is.

MR. TOMPSON: Under 25?

MS. WODARCZYK: Yes.

MR. HARRIS: I guess the comment I would make is you have obviously a very serious administrative concern dealing with just the sheer expense of administering the program, such as educating the employees involved, and doing the record keeping and so forth. The other feature comes back to this issue of separate, unrelated rating arrangements which may create perverse incentives for employers or employees to pick one program versus the other. The example obviously would be the employer whose experience is reflected to some extent in the indemnity rate and is not reflected in any way in the community rates in the HMO or a freestanding PPO. There are then incentives to direct people to one option or another because of the financial consequences.

MR. HOBSON D. CARROLL: I think that at some point in the future for all size cases, not just small cases, HMOs will realize that they cannot exist with their old-fashioned open enrollment with small groups. I don't think it can work under a hundred lives, because I don't think the employer should allow it to work. If an HMO wants to get that group, it is going to have to become a PPO in order to get the whole group off of the dual option.