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ALTERNATE DELIVERY SYSTEMS -- WHERE ARE WE GOING?

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- A discussion on what the prevalent form of health care financing will be in the future:
  - -- Health Maintenance Organizations
  - -- Preferred Provider Organizations
  - -- Managed Care Fee-for-Service Insurance Contracts
  - -- Triple option products?

MR. TIMOTHY M. HARRINGTON: The first speaker, Mr. Brent Greenwood, comes to us from Towers, Perrin, Forster and Crosby (TPF&C). Mr. Greenwood, can you tell us a little bit about your experiences?

MR. BRENT LEE GREENWOOD: I'm part of the Health Maintenance Organization and Preferred Provider Organization (HMO/PPO) consultant unit of TPF&C. Primarily we have four consultants who spend 100% of their time in this prepaid health care environment. We have consulted with over 250 prepaid health plans.

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I'm the neophyte of the group, but I've been in the consulting business for nine years.

MR. HARRINGTON: Mr. John Price comes from IHC Health Plans in Salt Lake City, Utah. Mr. Price, tell us a little bit about yourself.

MR. JOHN A. PRICE: I initially worked for several years in the Blue Cross and Blue Shield system and most recently for Inter-Mountain Health Care, which is a hospital company that has recently been involved in the development of PPO and HMO prepaid plans.

MR. HARRINGTON: Mr. Richard Bilisoly comes to us from The Wyatt Company. Mr. Bilisoly, tell us a little something about yourself.

MR. RICHARD BILISOLY: I have worked in the Chicago office of The Wyatt Company for over 20 years. During most of that time I've been engaged in working on group type benefits of which HMO experience forms some of my past. Prior to working with The Wyatt Company I worked as an underwriting actuary with several insurance companies.

MR. HARRINGTON: I'm also going to be on the panel. I'm the assistant actuary at Blue Cross and Blue Shield of Massachusetts and I've been there for 20 years. We've been a rather progressive plan among the Blues. We were one of the pioneers of group dental coverage in the late 1960s; that was one of my first assignments. We were one of the first to get involved with HMOs, with the Harvard Community Health Plan in the late 1960s, so we have a long history of that sort of coverage. We were one of the first to pioneer major organ transplant coverage and that was in the early 1980s. Our latest attempt has been to get into managed care fee-for-service options so that we can have a full range of coverage for our subscribers. We began that work in the early 1980s and I played a major role in all of those involvements.

The purpose of our session is to try to stimulate some thought about the delivery systems of the future. None of us claims to know any more than you do about what the future holds. We're all pretty much in the same boat as you. We hope to stimulate you so that we can hear your input at the end of our debate. We're each going to take a position. Mr. Greenwood is going to

support the position that HMOs will be the wave of the future. Mr. Price will argue the fact that he feels PPOs are the delivery system of the future. After Mr. Price finishes, I'll take the position that fee-for-service managed care is really going to be the wave of the future. When I finish, Mr. Bilisoly will try to convince you that he believes that triple option is the wave of the future.

But remember as we go through this, we all may take extreme positions that we don't necessarily believe in and that is what a debate is: you don't necessarily have to believe in what you are debating. So if you hear some things that perhaps get your hackles up, we're trying to stir you up a little bit to see if we can get any reaction.

MR. GREENWOOD: Historians have always said that in order to predict the future you have to look at the past. And if you look at the past for HMOs, it's been very bright and all predictions for 1987 and beyond indicate that the future of HMOs is going to be bright as well. Now for the past few years HMO enrollment has grown significantly (between 20% and 30% per year) and by year end 1986 there were close to 26 million members in over 600 operational HMOs in the United States. This makes up approximately 10% of the population. I think reasonable estimates for 1987 are that HMO enrollment will reach approximately 32 million with a little over 700 plans in operation. Now we have to ask ourselves why have these HMOs been so successful in the past? Well, I believe that the health care system of the present and the future must provide benefits to several different segments of the health care arena including the consumers, the providers, the employers and to the private sector. Now what I would like to do is outline some of these advantages for each of these different segments.

One advantage to the consumer is simplicity. The HMO is very simple. The way the benefits are structured, if you go to an HMO provider you get benefits, if you go outside the network there are no benefits. (Now the PPO gets a little more confusing. There are two levels of benefits, depending on which provider you go to. And then there's also the question of coverage. Under a PPO the preventive services will be covered if you use a PPO provider. If you go outside it's not covered so it becomes a little more confusing to the enrollee as far as how his whole benefit structure works and what's going to be covered.) It is also simple for the employee to very easily budget his medical expenses with an HMO. He knows what his out-of-pocket expenses are going to be, he

knows what his premium is so he can look at his checkbook and tell what he spent last year. He can compare that to his premium, it's going to be a good deal for him and it's very simple. He doesn't have to worry about deductibles and coinsurance and trying to budget what he is going to be paying in the future for health care.

Another advantage is comprehensive benefits. The advantage here is that in the standard HMO benefit package you have very comprehensive benefits including preventive services. It is 100% coverage or minimal copayments. The thing that is advantageous here, as well, is that there is no restriction to care. That enrollee knows that as long as his provider orders the test or that the provider makes that referral, it's going to be covered and he doesn't have to worry about any coinsurance or deductibles. As I said before, there is a minimal out-of-pocket expense. (Now some of the PPOs' indemnity programs might tell you that they have maximum out-of-pocket limits but you have to be careful. Those little words *usual* and *customary* come into their contracts. If you go outside their network and everything is based on usual and customary, that doesn't necessarily mean that you are only going to be paying 20% of the bill if your provider's bill is in excess of that usual and customary. So you have to be careful about that and this is one of the hidden costs that a lot of consumers don't realize exists until a bill from the provider actually hits them. From an administrative standpoint, there are no claim forms. The HMO has this big advantage over all the other programs. (The indemnity side obviously involves claim forms. On the PPO side, if you go outside the network, claim forms are involved.) A lot of people choose the HMO just to get away from all that administrative hassle.

Another administrative hassle is related to the managed fee-for-service program. They have a participatory precertification program. A lot of times you have to call up someone three or four states away and say you're going into the hospital and ask if that is okay. If you happen to forget, you could be punished for that. Under an HMO this is invisible to the enrollee and he doesn't have to worry about it. So this is another administrative headache that the enrollee does not have to worry about.

Obviously there are a lot of issues involved with respect to the HMOs and quality of health care. I'd like to quote a recent Rand study that said the quality

of health care in an HMO is equal to or better than the fee-for-service environment. This study was done over a three to five-year period and was based on physical exams, just not surveying people on how they felt after treatment.

Local management is another advantage. I think it's very important that if a problem does arise or if there is a question you can go to that HMO management and actually see the person there in your community and discuss on a person-to-person basis. You don't have to call someone far away or write letters.

Next are the provider advantages. The first one is maintaining or increasing market share. Under the HMOs you walk your patients into the HMO provider network, so if you are part of an HMO network, especially if it is a gatekeeper type process, it's more likely you are going to at least maintain your market share, if not increase it. The HMO has the leverage of shifting patients to their providers just because of the benefit design. Also, the HMOs would help provide access to other markets that the provider may not be into currently, such as Medicare and Medicaid. As we'll talk later, HMOs are in the forefront of getting into these markets and so it possibly can help increase the provider's market share with these different segments of the population.

Improved cash flow is the second provider advantage, especially if the HMO provides capitation payment. It greatly increases the cash flow of the providers. If it is a capitation, the providers are paid prospectively for both patients they see and don't see. This is important. They are also paid for those patients they don't see. Thus they receive a stable basic income for all of those patients assigned to their panel. (Under the PPO or indemnity product this stable income is not there. They only receive revenue if the service is performed and their revenue is increased based on the services they perform or the patients they see. They get no reimbursement for the patients they don't see.) Our copayments, if there are any in the HMO, are collected up front; therefore, they don't have to worry about collecting any deductible or coinsurance later on. The remainder of their fee is paid by the HMO based on some negotiated fee. Therefore, there really is no uncollectible fee for the provider with respect to the HMO person who is their patient.

Comprehensive benefits is a third advantage and you may ask why comprehensive benefits are an advantage to a provider. The real reason is that the provider

knows that if he orders or refers that test, it's going to be covered by the HMO. He doesn't have to worry that if he orders some test or if he refers it, it might not be covered because it's not part of the indemnity plan coverage. Also he doesn't have to worry that 20% is coming out of his patient's pocket. So, there is a comfort level with the provider -- knowing regardless of what he is doing it's going to be covered and it's going to be at no expense to the employee.

Incentive payments is a big advantage that really sets the HMOs apart from the other programs. A lot of the HMOs are going to a case manager and physicians are almost demanding it. They want control of their own destiny. In the past this wasn't the case. They wanted pooled risks and didn't really want to be set aside for their own responsibilities. But now they've changed. They want their own destiny. The way that these incentive payments work is that their experience is compared to what is budgeted for them and if there is a surplus at year end they will share in that surplus. So the HMO is sharing the surplus with the physicians and they are rewarded for their cost effective management of cases. (This is not the case under your PPO and managed care system, although I think some of the PPOs are seeing the light and starting to go to some of these incentive payments. But in most cases the only way a physician can increase revenue is by increasing services and that just seems like the wrong incentives in order to contain costs.) Now what these incentive payments do is give the provider the potential to receive more than their fee-for-service revenue. A recent study by *Medical Economics* indicated that physicians with HMO contracts had income approximately 11% greater than the average. I think that this is just showing that these incentive payments do help with respect to the provider's income.

Another advantage is local management. I think the big advantage here is that it gives more flexibility to the physicians because the management can respond to their needs quickly, for particular procedures or instances that might come up that are unusual.

Possible ownership for representation is also very important. This is where the providers can have a chance to change policy within an HMO regarding many different aspects of the HMO's operations. I think this is a very important aspect of the HMO advantage.

Next are employer advantages. The HMO creates competition. By offering multiple options it gives the employee and not necessarily the employer the burden of choosing which health plan; therefore, you probably find less complaints. It also creates competition with respect to price with the other indemnity product. I have to say that a big function of that price competition is the employer contribution strategy and we will get into that more later because that has an effect on the selection as well. (Now under the triple option, this competition is eliminated. You are going to be dealing with one carrier and the employer is going to have to decide on this one carrier. His decision is going to have to be made without really knowing the effectiveness of this system. Then the employer is really going to get into trouble later on when he finds out the system is not really effective. He is going to have to terminate this triple option and, instead of affecting just one segment of his population, he is affecting everybody. Everybody might have to change providers or at least they are going to have to change health care programs. So by putting in the triple option that employer is really narrowing the choices in the aggregate to his employees.)

HMOs are full risk. Through the community rating and prospective premium process the employer knows ahead of time what his costs are going to be for health care regardless of his experience, whether it's greater or less. He can budget for that health care expense. I think you'll find that future rate increases for HMOs are going to be more level than what you'd find under experience rated programs or other managed care fee-for-service type programs. HMOs are not the short-term fix. I think they are in there for cost containment on a long-term basis. Hopefully the increases are going to be more level than what you'd find in other programs.

Cost containment is another employer advantage. Based on everything I've read, I don't think there's any question that HMOs have helped control utilization even after age and sex adjusting. Employers are able to benefit from the cost containment programs of the HMOs which include provider contracts, utilization review and incentive arrangement. (PPOs and managed care service programs only control their costs through benefit designs and discounts with the employers. Now there is some utilization review (UR) in the PPOs but there are no assurances to the employer that their utilization won't increase because of the discounts involved with the providers. The other thing is that on the PPO

indemnity programs, the employee better be careful in analyzing their costs of the previous years to be sure that the providers that are going to be used aren't the more expensive ones and that the discounts are not going to incur any savings to them.) So it's very important to analyze your previous years' experiences before evaluating any program.

The HMO has a quality assurance peer review program. I don't think you find this under the managed care program and I don't understand why a managed care program might have better quality of care versus an HMO, even though the same providers might be reimbursed under both programs. My contention is that at least this program is in place in HMOs and having one is better than not having one at all.

Local management is important for employers because obviously they can respond to the employer's needs quickly. They can be more flexible in the negotiations with employers because the employers are not dealing with someone a couple of states away. Again UR is much more effective when it's on a local level than if its done on a national level. If it's a one-on-one type of relationship and they know the medical community, it's much more effective.

All I'd like to say about public sector advantages is that HMOs have been in the forefront in entering into the different sectors and I think the other programs can't really say that they have been heavily involved in these different segments. One thing that is coming up as a hot subject is worker's compensation. Many of the employers want someone to help them manage their worker's compensation cases. I think this is a tremendous opportunity for HMOs to help manage their worker's compensation costs. The uninsured are going to be in there regardless of what is proposed by the government.

Federal, state and city employees are groups that love community rating. Based on the experience of these groups if they went to experience rate them they'd be in tough shape. Even though HMOs can experience rate them, in most cases they strongly urge the HMOs to community rate so that in this area they are saving considerable monies for the government.

What I'd like to do now is go over some of the future HMO developments as I see them. The combination plan is an "at risk PPO" or you might say, an indemnity

wrap around. If a person goes to an HMO provider he gets his HMO benefits. If he goes outside the system he is going to get coverage but it will be subject to a deductible and coinsurance. I think this is the first step in blurring the differences between the different health care systems. In Minneapolis the combo plan now covers close to 70% of the total HMO population. And in some HMO plans it even makes up 90% of that HMO's total enrollment. I think this combo plan is especially effective in those small group markets where the HMOs are trying to penetrate because this provides them with the opportunity to replace the carrier that is currently in there. You don't have the selection problem or the problem of having two carriers in a very small group.

I think experience rating is coming. I think only a few people are really screaming for experience rating. The thing that I don't understand is how all the employers can tell us that their experience is below average. I have a hard time believing that one. Everyone wants to experience rate. I think once the data comes out, people are going to be satisfied with the community rating or wish they went back to that. (One of the things that is touted as being an advantage of the triple option is the experience rating. Well, I think the thing that the employer has to be careful of is the HMO component of that triple option. If that HMO is federally qualified they have to get a capitation arrangement. They have to get their capitation which is community rated or if that HMO has a capitation arrangement with providers that is their experience. Or I should ask, how is the carrier going to estimate the experience under the HMO? Are they using the capitation or the actual experience? So, the employer has to be leery of how that experience is going to be determined.)

Detailed employer data will also be coming. In fact, in the Independent Practice Association (IPA) it's already here; the trouble is it's a no-win situation for the HMO. Show an employer he has good experience and he wants experience rating. Show the employer that he has bad experience, he loves community rating. He'll stick with you forever. So it's been a no-win situation. Experience will help the employer determine his employer contribution strategy.

Employer contributions is HMOs select against the indemnity plans. However, I think a major contributor to this is the contribution strategy selected by the employer. If age and sex are used in determining the employer's contributions, I think a lot of these selection issues will be minimized. I would say another

function of the selection is the newness of the plan, so any plan that is introduced is going to select against your present plan. PPOs have shown that they have selected against regular indemnity plans as well. So I think adjusting your employer contributions is going to be the key in deciding the selection issue.

I think the repeal of the federal mandate law is coming. But what this will do will allow the employer to limit one or two HMOs of their choosing which will ease the administrative burden of the employer.

What I've tried to do is outline some of the advantages of the HMOs over the other health care systems. Now I admit there are some disadvantages to the HMOs but I think the advantages significantly outweigh those disadvantages. In reality, I can't believe that one system will really dominate the others. In fact, as the systems evolve they probably all are going to be looking more alike and price competition is going to become even more intense between each of the plans. What I do believe though is that the HMO is going to be an integral part in the development of any future health care system. HMOs have already greatly influenced our health care system and this can be seen through the PPOs and indemnity carriers who are adding HMO equivalents, provider contracts and utilization controls. So I guess in conclusion I have to ask you, if HMOs aren't the health care system of the future, then why is everyone else trying to copy them?

MR. PRICE: I'd like to talk about why I believe PPOs will be the wave of the future and do that mostly by analyzing the characteristics of PPOs, comparing them to the two principal forms of competition, the HMO and traditional insurance, and then drawing some conclusions. I will be looking at the characteristics of the PPOs, the contracts, the comparisons, who can organize PPOs and the major weaknesses of its competitors.

The PPO starts with traditional insurance benefits where the consumer has a free choice of any provider he may wish. On that basis PPOs build an option with higher benefits if the consumer uses the preferred panel providers. In the design and development of the product the preferred providers have been credentialed to assure quality medical care and they have agreed to accept the utilization management standards of the organization and very importantly they have agreed to hold the patient harmless from any payments beyond copays in

the processing of the provider's bills. The utilization management program of the PPOs can be most useful in a form where preauthorization is required from the provider rather than the insured, although both forms do exist.

Trying to compare PPOs with HMOs and traditional insurance can be easy if you picture a chart that is laid out in two dimensions. Across the bottom, going from left to right, is increasing consumer choice and program cost. Vertically, going up the scale, is the transfer of risk from the organization to the employer. There are three columns: on the right is traditional insurance, which is where health insurance started; on the left is Health Maintenance Organizations and what they represent; and in the vast center between the two is the Preferred Provider Organizations.

Traditional insurance, in the right hand column, is representing unmanaged care. This has evolved with several funding and risk transfer options for the employer. At the bottom it represents community rating, which over the years evolved into different forms of experience rating, minimum premium, flexible premium arrangements and finally, self-funding. Traditional insurance covers all three major areas of this transfer between employers and organizations. More recently, traditional insurance has developed something called managed care. They're trying to enhance benefits for insureds when they have reviewed the planned treatment or care in advance.

As traditional insurance evolved and costs rose, the motivation for Health Maintenance Organizations occurred. We can see that those HMOs with the lowest cost typically are staff model HMOs, although it may not always be true, and the more liberal and flexible of HMOs are typically IPA models. HMOs in general are restricted to community rating and tend to follow community rating philosophies. So employers who are willing to assume a position of risk don't really have a product available to them to meet that need. It only takes a small percentage of the employers who know their utilization is a little bit lower, to undermine any community rating structure if there is a competitor who is willing to give them credit for their own utilization. That is the disadvantage for the employers with higher utilization. However, that is the real world.

In the middle, PPOs span a broad spectrum. In the simplest of forms they may represent a group of physicians who have agreed to a discount and some

facilities who have provided a discount and are agreeable to some utilization management standards. As we move towards more restrictive delivery systems, that is a greater cost containment feature, we see a strong traditional development of PPO delivery systems and in its strongest form we might even recognize it as an Exclusive Provider Organization (EPO), where the consumer may not have the traditional fee-for-service benefit alternative. These represent flexibilities, degrees of flexibilities EPOs can't assume in meeting market requirements, either in balancing the choice consumers have and the cost of the program, with the amount of risk employers are willing to assume.

In the internal organization and in designing PPOs there are several options available and a reimbursement of medical services for physicians that may be something as basic and simple as a reasonable and customary fee schedule they have agreed to or a percentage discount. In more aggressive PPOs they may have agreed to withhold from their payments, which is contingent upon achieving certain utilization goals, or perhaps there is a bonus if the plan is profitable. In some extreme cases, packages of medical care services may be capitated to the preferred providers in which case the whole delivery system begins to look a lot like an HMO in function. Facilities may also be reimbursed in several different arrangements, such as discounts, per diems, diagnostic related groups (DRGs), withholds and bonuses based on profit, and even capitations up to the delivery system in the marketplace to negotiate where the solid ground may be. But it may represent a broad spectrum of alternatives for the PPO.

As the PPO is organized it can incorporate degrees of accountability among the physicians in the panel. And these can be organized at levels that are very broad, at hospital staff levels, or even at group practice or clinic levels where peer pressure can be an effective method for physicians to control utilization. PPOs can also enjoy the effects of peer review not only in maintaining quality of care but in assuring an appropriate level of care. One of the advantages the PPO then has is with the utilization and cost savings it has enjoyed. It can offer other richer benefits to help offset those savings and maintain a competitive price. Some of those are typically in the areas of wellness programs and preventive care. PPOs generally may be only restricted to state insurance codes or even just ERISA requirements if it is a self-funded employer benefit plan for which it is organized. This allows broader definition of benefits, particularly in areas where costs in a region may be unusually high for certain services. (The

HMOs are generally required to provide a minimum benefit of 50% of the cost of the service to any insured.) Another area where PPOs have an advantage over indemnity insurance is the way they are able to discriminate between provider types in most insurance codes. In many states, insurance companies are not free to discriminate in areas of service or practices of medicine that may present undue risk and PPOs generally can be free of some of this if they are organized under ERISA.

Another area where PPOs have flexibility is in the funding arrangements they have. We can see that the whole spectrum of funding arrangements that are traditionally used by insurance are also available to the PPO and it can go further by unbundling itself. What I mean by that is the PPO may offer just its delivery system to an insurance company or an employer or offer the delivery system and utilization management. It may also include administrative services, it may bear risk so all the different components that go into the health insurance product can be bundled or partially unbundled to meet the market demands. In doing this the PPO can bring together the employer, the providers and the insureds in a risk sharing arrangement that is flexible enough to adapt to the market conditions in each region.

PPOs, like traditional insurance, are free to act in ways useful to control risk. For example, medical screening at the group and individual level would allow PPOs to be marketed to very small groups where risk is greater. (HMOs have great difficulty in controlling risk in small employer units because they are required to accept enrollees without regard to their health status, which as a result, can undermine their community rating system if they are not adequately controlling risk.) In general, it can be easier for a PPO to become organized. (HMOs who need to be focused on bricks and mortar and fixed localities have certain restrictions placed on them by that very nature that will not make them as readily developed into broad geographic areas.) The ideas of the PPO concept can also be applied to dental coverage, psychiatric care, prescription drugs, vision care, and several areas of medicine that present unusual cost to insurance companies and to the public.

Looking next at the areas where PPOs can be organized, there are several entities that can organize them on their own. In addition to insurance companies subject to state insurance codes, third party administrators may help preferred

provider organizations. Hospitals or physicians may group together and form the organization, employers can develop it for their own programs, particularly if they have large numbers of employees concentrated in specific geographic areas. Government entities can start their own PPOs for their own benefits. Even HMOs, to be more flexible, could create subsidiary PPOs in a lot of applications.

To recap, here are some of the major weaknesses in HMOs and traditional insurance products. Federal requirements placed upon the HMO limit it because of community rating. We mentioned how experience rating can undermine the effectiveness of any community rating program and the realities of that. The scope of benefits and the ability to control are also limited. For the consumer, one overriding area of limitation is their choice of providers. If the consumer enrolls in an HMO and finds that unacceptable, they're typically stuck with that for the whole year until their next open enrollment. That may meet with adverse market results if the HMO has not been able to maintain adequate customer satisfaction. Many of the alternative funding arrangements for group insurance are not available to most HMOs and that makes them a little less flexible. In the most extreme case, HMOs are more subject to a conflict of interest than any other delivery system and they therefore have a responsibility to watch over the quality of care for the consumer because they are both insuring and delivering the medical care.

In traditional insurance some of the problems are more obvious. Insurance companies cannot readily control costs or utilization contractually. They can try to motivate the insureds by precertifying benefits and offering a higher benefit level, but there is no hold harmless protection, no quality assurance. In many states, insurance companies are subject to mandated benefits and the insurance that they provide has cost consequences that may require them to be less competitive. The minimum benefit requirements of several state insurance codes also place an obligation on insurance companies to, for example, cover psychiatric benefits where no control or cost containment is readily available. It therefore makes their programs less cost attractive to the public.

One other large challenge for insurance companies in managing health care is that it does take a great deal of time, people and money to adequately organize a managed care product. Some insurance companies are well equipped for it and

some aren't; but it is a drain on their resources and if they don't do it right they can easily spend money that will not result in successful financial results. It also requires a multistate insurance company to become more focused and localized in the management of any care program so that it is in tune to the local medical community and marketplace. Managed care focuses very closely in working actively with the providers of health care in any region. And that's a departure from traditional insurance where the biggest localized efforts an insurance company may have are in the areas of policy compliance and distribution systems for the sale of the products which very rarely need to be managed at a local level.

So in conclusion, the main reasons why I see PPOs providing a broad spectrum and therefore a potential wave for the future are that PPOs provide a broad range of choices for the consumer from traditional insurance to almost HMO-like limitations. Also, flexibility in the way providers are reimbursed has a direct correlation with the cost of the program, strong utilization controls and quality assurance, freedom from most federal requirements regarding benefits, rating and underwriting. In general PPOs have an ability with this broad appeal to maintain a strong cross section of risk within an employer unit. Those in HMOs may typically be lower risk; however, that can be balanced with the limited benefits for people who have greater medical need. These people may not be interested in the restrictions of the panel and as such may require them to be less competitive. As a matter of fact, if HMOs do tend to enroll better risks there will always be a product to offset that and it will have to be something in the form of a PPO to be viable.

Looking back at history, traditional insurance may have been the original form that we all became familiar with and as its cost rose an antithesis was created at least from a funding and choice perspective in the form of the HMO. I believe the PPO represents the synthesis of the two concepts bringing out the strongest points of each. In one context, if you look back 30 to 40 years at the evolution of Blue Cross and Blue Shield plans, many of them that have had participating provider agreements both with hospitals and physicians, have in fact functionally been PPOs and their success has been borne out over the years in market results. The newest twist is that many are now incorporating managed care into their programs. What does all this mean? It looks like traditional insurance is becoming more like a PPO and HMOs may need to become flexible and more like a

PPO. It will become a large blur someday in the future when we try to separate what's different about all these delivery systems. Therefore, I believe PPOs are the wave of the future.

MR. HARRINGTON: I'll try to convince you that managed care fee-for-service is the wave of the future. I'm sick of hearing people say fee-for-service is dead because I certainly don't believe it. Let me just tell you a little bit about our managed care fee-for-service program in Massachusetts. We took our best first dollar, full semi-private program and added a lot of benefits to it to make it look like an HMO benefit package and added that to the rate. Then we introduced the concepts of managed care: preapproval of admissions, concurrent review, and second surgical approval. That took away from the rate so the net effect of those additions and deletions is a rate for my managed care on a fee-for-service program that is about 6% less than the standard first dollar coverage. So, I can sell you more for less. Our product was designed basically so that we could have a full array of products to offer to our group customers and also to meet the challenges of HMOs that have sprung up in Massachusetts.

I think that my managed care fee-for-service program has many advantages over those types of programs that it competes with and it will hold those advantages in the future such that it will emerge as a strong contender.

I think the first advantage of my program is the attractive premium rates that I can charge. As I mentioned, if you would like to switch over to my managed care fee-for-service program from your unmanaged major medical, you can do it for 6% less. I guarantee the savings right up front and you've got all the HMO style benefits. But what I can also say to you that other people cannot say to you is that I will continue your full prospective and retrospective rating program. This is something that they want to hear in Massachusetts -- full prospective and retrospective rating. You'll continue to get your refund of premium when it's due and that's very important in our plan because we give each account, regardless of its credibility, a full refund of premiums. There is no credibility adjustment factor other than some differences in risk factors. So, my rates compare favorably with the rates that other people bring to the same large account and I consider that to be a major advantage of my program.

Another major advantage that we talk about continually is freedom of choice of providers. I love to be able to say that when I go out to an account with some of the marketing people. Stay with my program and you can choose any provider that you like. That is important in the Boston area and I'm sure it's important in your area. In Boston we have many fine physicians and many fine hospitals to choose from and it's much easier for us to be able to go out and say, "your subscribers and your patients can choose any one of our fine hospitals and fine physicians without any penalties whatsoever." That scores an awful lot of points for us in our deliberations with our accounts.

I'm able to say I have first dollar coverage and the reason I say that is because sometimes the commercial insurance approach to some of the HMO competition has been to go to a comprehensive major medical program with large front-end deductibles and large coinsurances. I believe the idea behind that was to try to get rate parity with some of the competition. Our findings in Massachusetts have been that it's not just the rate that makes the difference when people choose in a multiple choice situation, although it's one of the major factors, but it has to be mixed together with a very good benefit package. So I'm right there to tell them that they are going to maintain their first dollar coverage. That's important in the northeast part of the country. And I think it's important that a fringe benefit package still has first dollar coverage.

I'm able to say that we're not at all ashamed of our benefit package because, as I told you in the beginning, we took what we had and added a lot of benefits to it. What did we wind up with when we did that? We wound up with a program that provides full semi-private, inpatient hospital care for an unlimited number of days, full coverage in the outpatient department of a hospital, and full usual, customary and reasonable payments to a physician for his services that he performs in a hospital without any balance going to the patient. The provider has to accept that as payment in full. And you can go right down to the physician's office for all your medical care and for your routine child care and physicals up through age 14, including immunizations. You get all these things for $5 co-pay. You can go to any physician that you'd like to for that.

You can get drugs. All you have to do is go to the drugstore, show your card and you can get any prescription drug that you want as long as you have $3 for

generic drugs or $4 for nongeneric drugs. So basically, maybe we've got more than HMOs. Some of our HMOs don't have drug coverage.

There is no more supplemental major medical as we knew it. People are not stuffing prescription drug receipts or office visits receipts into a shoebox. There is no need for that any longer. There are no claim forms. There is no supplemental major medical; everything is a basic benefit now. There is full maternity coverage with all the pre- and post-natal care included. We also provide care for home health agencies, skilled nursing care facilities, hospices, and just about anything that you can get but cosmetic surgery. So we've got the benefits that young people are looking for: doctors' office visits and routine care for their children and immunizations. It's there, we've got it, it's working, and we are proud of it.

Do you believe that an adverse selection spiral is generated by a big difference in benefits and a big difference in rates between the indemnity plan and the alternatives? If you believe that, and I do believe it after many years of experience in studying it, then you can see how my program blunts or even reverses adverse selection in accounts with multiple options with their employees. We have offered the program and we have seen the spiral stopped and in many cases, we've seen the spiral reversed. We've seen some of the good, younger risks come back to our program because we have what they want, we have the benefits that they are looking for, and we have a good rate for it as long as they are willing to submit to the managed care aspects of it, and they do that willingly. I get my rates down at a level that are very competitive with any of the other plans that are in there in a multiple choice situation and with those benefits and a good rate parity I'm in business.

The next advantage that I'd like to talk about is the fact that my program is willingly accepted by most employers and that's very important. The first point of marketing these days is to the employer and the second point of marketing is to the subscriber himself in a multiple choice situation. We have to convince the employer that we've got a good product. Generally, that's fairly easy to do, because when he switches over to our current product he basically had our initial product and he's going to maintain his existing relationship with us or with any carrier who has a program like it. That's important to a lot of employers and despite what Mr. Greenwood said about experience rating, my

experience in Massachusetts has been that the employer definitely wants experience rating. There's no question about it. There are employers in Massachusetts who won't let a plan in if there is no experience rating. So we're able to continue the very same experience rating program that the group was on with our standard coverage. When we talk to the employer about our program he likes the fact that we guarantee our managed care savings right up front in the rate. We weren't sure the rates were going to work but now that we're looking back, we've been marketing this thing since the beginning of 1985, and as we look at settlements and retrospective calculations account by account, the rates that we've quoted with those savings in there are working just fine. And the reason for that is that we have a staff of professional nurse reviewers doing the actual management for us. They are very good at doing it. They have very good relationships with the hospitals and physicians. They have their goals and objectives to meet each year and they are able to do it.

The employer likes our program because he sees no need now to bring in a lot of alternative delivery systems. He doesn't have to deal with five or six plans to really get what he's looking for. And what he's looking for is utilization savings. If we are willing to go in there and say that we'll guarantee it up front, he believes it.

The other nice thing that the employer likes that we didn't count on, and it was kind of an after-benefit, was the fact that as nurse reviewers from our plan begin to deal with the patients, they sometimes become an advocate for the patient. They get to know the patient, they are able to steer the patient through a maze that sometimes exists in the health care delivery system, and for some people it's a crutch for them to be able to talk to this nurse reviewer who's trying to direct them to the best, most efficient hospital care. A very big plus that we never counted on at all is the fact that a lot of people love to talk to that nurse as they go through their medical treatment.

Another advantage that we've seen in our program compared to others is the comparative ease of administration for both the employer and the carrier. The employer can continue with his existing procedures with the carrier; it's just a small change to go to the managed program. He can continue to have all his flexible options by paying his regular premium, straight cost plus, cost plus with aggregate insurance, cost plus with individual insurance, or administrative

services only (ASO) arrangements. He wants to continue these. He doesn't see them offered by the alternatives and when we're there to say, "Don't worry, just continue with the financial arrangement that you've had with us on the unmanaged program. It will be transparent to you," he likes to hear this.

I will say that it is difficult to be fair in some of the administrative procedures. We do have to educate the employees in every one of our large groups. And we take the responsibility for that, rather than the employer having to do it. But the employees have to be made available to us so that we can explain to them their responsibilities for notifying us prior to certain elective admissions, for agreeing to listen to a second surgical opinion for five or six procedures, and for doing the things they have to do to become a part of the program. So in all honesty, we would have to say that is one drawback on the administrative side, but it generally only happens once. Their identification cards have all the instructions on them and our mailings to the enrollees on a regular basis are able to keep them well informed. We find that very few people are not abiding by the requirements to notify us in certain instances.

I think another advantage is that after people have been in our program for a while, the real utilization savings are apparent to them because we're right there with our managed care reports. They can see what has happened. We have special reports where they can see the reduction in hospital claims or the reduction in average length of stay per claim, or the movement of claims from inpatient to outpatient, elimination of weekend admissions, and a drop in the elective surgery rate. We have a staff of professionals who do that, who are able to examine the statistics account by account and give them a very professional report, because we know that's important to the account. Mr. Greenwood says his HMOs are someday going to be able to make reports to the accounts. We're able to do it now. And I would suggest to you that for those of you who are associated with insurance companies, you have the know how to do it and that's an advantage we have over some of these alternate delivery plans. We've been working with the accounts for years. We know exactly how to give them the reports they want to see. We're the experts in that field and we don't capitalize on it. It's easy to do it with some small expenditures. We're there to show them what the savings are in a very credible way. With the guaranteed savings up front they can see that we are willing to take the risk and we are able to save on overutilization for their account.

At this point, I'd like to move to some disadvantages of the other systems that we face. We all know that getting involved in HMOs and sometimes PPOs causes a lot of high start-up costs: the bricks and the mortar that Mr. Price talked about. They all have their own staffs and duplication of medical equipment. It's just a completely different aspect to get involved in a closed panel HMO. It is a very expensive proposition. A lot of times to get started with HMOs and PPOs you have to start contracting with providers. A lot of indemnity insurance companies have never done that in the past and that would be something new for them to have to face. It's not necessarily true for a fee-for-service managed care system. You don't need contracts with the providers. You also can purchase the utilization review services that you need with a credible program from companies that offer it. So if you don't want to hire your own nurses or hire your own medical professionals to get involved in it, the services are available from companies who offer it. Most of the other systems that we deal with in the Boston area have a very limited selection of providers. Their provider selection is just not a very good sales tool in Boston because, again, it is considered a medical mecca of the east coast and it's a drawback for the alternate systems.

I think I heard Mr. Greenwood mention that he did admit that HMOs may be a catalyst for adverse selection. Adverse selection is a problem. We've seen it in the Boston area. We've looked at the experiences of some of our larger accounts and we've looked at those people just before they migrated to alternate delivery systems and compared these experiences to the experiences of those who remained in the account for a given policy period. The results are dramatic. We're not just looking at ages. I look at the claims experience of those who left and in large accounts it's credible and you can see it in account after account. And there are many accounts in the Boston area who, unfortunately, will not allow alternative delivery systems to knock on their door because they are petrified of adverse selection. There are a lot of very astute buyers out there who know it, understand it for what it is, and find it to be a problem. Adverse selection may indicate that the alternates are reducing the care but then after one sees the results, one wonders.

We haven't found any alternative delivery systems in our area yet that can offer experience rating.

So, at this point, having sold you my ideas, Mr. Bilisoly is going to talk about the triple option and see if he can convince you that that's the wave of the future.

MR. BILISOLY: These foregoing speakers have given such wonderful descriptions of these ingredients that I have very little left to do. Just imagine the best of these ingredients put together to form a delicious salad rather than a chemical dump as some might think. I would like to present the triple option plan from the standpoint of our clients and tell you why it does represent a very good way to go for them.

I will briefly describe the triple option plan. It's employee choice of HMO, PPO and the standard indemnity plan under one administrative or financing roof. All the enrollment can be done at once in any of those choices. The sponsor of the triple option plan is ordinarily a single insurance company, an insurance company in a hospital chain, or a chain of HMOs, or even some CPAs are getting into it. The alleged advantages of the triple option plans, and I really do think they are advantages, are that it does maximize employee choice. You've seen it mentioned, there's kind of an inverse correlation between the amount of choice and the amount of benefit. If the employee wants into a triple option plan to retain his choice of provider he can take the standard indemnity plan. If on the other hand, he wants to get more benefits he can avail himself of an HMO. There's a great deal of flexibility in these triple option plans in getting into and out of the HMO. One sponsor, for example, offers you the chance to get into and out of the HMO every three months if you wish.

Another advantage of the triple option plan includes the opportunity for cost management. One big advantage is that savings ordinarily accruing to an HMO, which has been shown before has a tendency to skim off the better risks, is now at long last able to accrue to the employer who chooses the triple option plan.

I want to touch on several of the design parameters of a triple option plan. The provider network is almost in place, at least with the triple option plans being offered right now, and oftentimes those provider networks are the same for the HMO and the PPO components. Obviously, the service area is important.

I want to touch on the financing and rating, to show you the kind of flexibility that does reside in this triple option plan. Providing that the number of people covered is a sufficient number, the financing can be made to parallel what you see in the standard indemnity plan; that is you can have full experience rating that Mr. Harrington just described. You can have the experience rating with or without stop loss reinsurance.

With regard to the HMO segment, some of these triple option plans still retain the idea of a community rate. But others are taking the good experience that would ordinarily come out of the HMO and, in effect, applying that to the experience on the other segments; applying it to the core experience, for example, that might emanate from the standard indemnity plan. How do they do that? By paying dividends? Not yet. They don't pay dividends yet on any HMOs that I'm aware of. However, prospectively they would allow the employer choosing the triple option plan to have a lower rate on his indemnity plan or PPO part than they might otherwise retain were it not able to get relief from the HMO.

The enrollment period, as I said, is fairly accommodating. You can get down to as low as three months in some of these plans. You must stay in an HMO for a three-month period but after that you can get out if you like.

Design incentives follow the idea of the PPO design and go along with the spectrum of choice that the employee is offered. The design incentives are such that it will attract people to actually take the HMO option or PPO option. In most instances, that will enhance the use of managed cost care, cost containment, and utilization review: although, as Mr. Harrington just pointed out, these weapons are fully available in standard plan design as well.

Let's look at utilization. As I hinted at before, the idea of utilization review and cost containment is heavily included in all of the three options. I think I will skip the requirements of some of these plans inasmuch as they are sometimes regarded as cons to the triple option plan. Here is what I see as the pros to the triple option plan. There is a lot of employee choice. The employee by choosing the HMO can probably get the greatest range of benefits. On the other hand, if he stays in the standard indemnity plan he can retain full free choice of doctors. He does that in the PPO, too. The benefits of the PPO may be just between those of the standard indemnity plan and the HMO. There is

simple administration and financing under one roof. Even the enrollment in all of these three plans is typically handled all at once. There is a promotion of cross management, as has already been mentioned, because utilization review schemes and cost containment measures are included on all of the plans.

The next advantage I'd like to dwell on in particular is the opportunity to participate in the savings that ordinarily come out of the HMO. Our experience correlates with that enunciated by Mr. Harrington. All our experience we have seen indicates that the HMO does indeed leech off by far the best body of experience. Here is a chance at long last to apply some of those savings, which ordinarily would stay with the HMO, to the other two options. So the employer is the gainer.

There is the opportunity to compare experience. In the triple option plans we have looked at, there are utilization reports that actually compare the utilization and experience under each of the three options so it becomes apparent what is really happening experience wise in the plan.

Again, there is great flexibility as it relates to the risk sharing available. Employers are able to take a great deal of the risk upon themselves if they wish and go to experience rating by using those concepts that have been prevalent for many years. Or on the other hand they are able to resort to full insurance if they're small employers and feel that the fluctuations inherent in these coverages would preclude self-insurance.

There is great flexibility of change, as has been mentioned, and many of these triple option plans being fostered by large organizations offer the opportunity for the employer to get into wellness programs. The efficacy has yet to be proven, I guess, but they look good to most of us. So that concludes my summary and my indication that I think the triple option plan is the wave of the future, at least for our larger clients.

MR. CLAYTON A. CARDINAL: I have three questions and the first is for Mr. Harrington. To what size group is the managed program extended and, as part of that, do you bring that to your community rated business? Also, it was suggested elsewhere that a managed program which did not give a six-to-one return on costs was inefficient. You have suggested a 6% reduction. One of

the gentlemen indicated that the administrative costs for their programs were about 1-1/2%. This might indicate a five-to-one return on your particular program.

Mr. Greenwood, I'm very concerned about HMOs which become bankrupt for each of the three major modalities -- staff, group, IPA. Would you discuss the disposition of those participants who are either individuals or members of small groups? And Mr. Price, could you talk a little bit about the screening process in determining your providers? I'm concerned about the quality of care issue.

MR. HARRINGTON: When we began our managed care fee-for-service program we marketed it to experience rated accounts which were 50 lives or greater when we started and it was not an option. We went in and put the whole thing on the managed care program. Now we are selling it to our small community rated groups of five or more very successfully. Again, this is the same program and it fully replaces the program that you have if you so choose it. And interestingly enough, we replaced all of our nongroup or individual coverage with the managed care type program. So, it's well embedded in our structure and is very important to us.

The second question is relative to the savings. My 6% savings was after I added a lot of benefits. So let's talk a little bit more about the savings. Basically, the presumption is that it will save about 20% of the inpatient days that would have been there otherwise. Now I can say that in Massachusetts, because Massachusetts tends to be an area that's overutilized, if I can use that word. So I have the opportunity to save 20%. However, if I were in another location, I'm not sure that opportunity would be there. So the presumption is that about 20% of the inpatient days will be saved on the inpatient hospitalization side with a concurrent drop in inpatient physicians' costs of about 10%. It is not one-for-one because we pay global fees in certain instances and a reduction in length of stay does not reduce the global fee paid to a surgeon. But we do see a reduction in the daily medical payments made to a physician if the length of stay drops. So it's a fairly hefty cut and it brings us from about 600 days per 1,000 to about 490, and that's the goal. We do charge a little extra in administrative expense, 1-1/2% in Massachusetts. But, that's still included in the overall package with new benefits and managed care savings, and we still can go in there and sell it for 6% less than the indemnity program we replace.

MR. GREENWOOD: The insolvency question is probably raised because there are a lot of rumors going around about plans losing money right now across the nation and there's a couple of reasons for that. First of all, there is a lot of price competition out there for a lot of starting HMOs. The prices really based on the experience may be inadequate to begin with for the expenses that are rolling in and the kind of an adverse selection type that is happening with the HMOs.

The other thing to realize is that between 30% and 35% of the HMOs in existence are less than one year old. Now, it is a common fact that in their first three or four years of operation they lose money, until they can gain their enrollment. The trouble is that with the price competition and markets being so saturated it takes them a much longer time to get their enrollment up. I have to admit there are some problems, and deep problems, with other IPA model plans that are mostly the fee-for-service IPA plans which don't have a gatekeeper. We have run across several that have either dropped out or the states have essentially taken over and have tried to reorganize them. The main trouble with those plans is that they were developed in a combative nature and were against other HMOs and had no gatekeeper. They were strictly a fee-for-service type mechanism and without the utilization controls and the provider contract per se, they didn't really materialize. And now what they are trying to do is turn around and implement gatekeeper and primary care capitations.

As far as the solvency, what happens to the enrollees? Obviously there is solvency insurance which is required by most states. In most cases the HMOs do have hold harmless clauses with their providers but that still doesn't eliminate the problem as to where these enrollees go afterwards. The insurance and the hold harmless will take care of them if they are in the service mode to begin with. But afterwards, it does become a big problem for state regulators. If these plans do go under, where do they go? Now the thing that has worked to the advantage of a lot of regulators is that so many people or organizations want to buy HMOs that they're willing to buy these defunct HMOs, take them over, and infuse capital before they go completely out of business. But, it is an issue that won't be as apparent in the future as these HMOs become more mature. Based on what we've seen, the inflation rates for the indemnity carriers are going to be increasing probably at a faster rate than the HMOs, thus alleviating some of the price competition.

MR. PRICE: Regarding your question for credentialing providers, I can relate to you what our delivery system has done. For example, we approach providers on the basis of being open and willing to share their history and information regarding their practice, their malpractice, and their legal problems if they have had any. We also require that they are board certified in their specialty. We also talk to them at length up front about the utilization management program, preauthorizing services and our delivery system. Should they overlook pre-authorizing an admission or surgical procedure, they are not reimbursed and they are not allowed to balance bill the patient. So the stakes can be high, but they have to be willing to accept those. Also, our models, which are gatekeeper models, require that they have a basic set of services and office hours and accessibility. Our utilization management department itself is staffed mostly by nurses.

One comment I'd like to make regarding insolvency of HMOs is that some HMOs are indiscriminate in the type of risk they're willing to assume. They have little or no standards. The accepted group risk is really very costly and they pass that off onto some of their providers. Even if they have a capitation model the providers react by either leaving the panel or wanting higher payments to cover the kind of people that are enrolled in their practices. And that can, in some cases, cause an insolvency problem.

MR. WILLIAM T. HOLT*: My question pertains to the legislation to which Mr. Price referred. A lot of states are passing PPO legislation and there's recently been, as I understand, some model National Association of Insurance Commissioners (NAIC) legislation that has some interesting requirements relating to out-of-area coverage and referrals to non-participating providers. It basically says that these situations have to be covered on the same basis as the preferred benefit level as opposed to the nonpreferred benefit level. It seems to me that this might be counter-productive, as HMOs traditionally have a very limited coverage for those kinds of situations, if any at all. I'd be interested in your comments as far as the impact of this -- to what degree insurance departments will adopt that particular provision and perhaps even why the NAIC chose to include those provisions in that manner.

* Mr. Holt, not a member of the Society, is a member of the American Academy of Actuaries and is Vice President at Mutual of Omaha Insurance Company in Omaha, Nebraska.

MR. PRICE: I'm not familiar with the exact wording that they are using. I can understand their not wanting to severely penalize an individual who is out of the area on vacation, traveling on business as we are, and has a medical emergency. If the out-of-area requirements for benefits are focused around medical emergencies, it shouldn't present any undue problems to the HMO or PPO. If it's carte blanche and wide open, then it could allow people who live in the west and want to go to the Mayo Clinic to expect the full compendium of benefits without having to limit themselves to the choice of providers and the controls of the plan they enrolled in. It would let them play both sides of the fence, which would be unfortunate.

I guess I would just say that it would depend highly on how they define emergency. This will give the PPO the most flexibility in how they are really going to be covering all services.

MR. JERRY L. BROCKETT: Mr. Greenwood, you commented that you felt that the trend in HMOs is lower than the trend in fee-for-service. I'd like for members of the panel to give some estimates of trends in 1987 and 1988 for HMO, PPO, managed fee-for-service and unmanaged fee-for-service.

MR. GREENWOOD: Well, we're computing rates now for 1987 and 1988 and the trends that we're using in Boston are about 9% per annum. But to what is the 9% per annum attached? We feel that no matter what trend we are going to use we're still going to come out with a program that's about 6% cheaper than our standard fee-for-service program, because that's the way we're structuring it. We're seeing trends of about 9% per annum for the future.

With respect to the HMOs, most of the rate filing that we've been seeing coming in with HMOs resubmitting their rates have been more in the 5% range. It is very rare that you find anything up in the 6% to 8% range. As a matter of fact, it's interesting that some states are now mandating that HMO increases can't exceed a certain limited amount, which a lot of the HMOs are questioning. But it's interesting how the state legislators are becoming more active, I would say, than on the managed fee-for-service type side, I think you're going to see larger increases than what Mr. Harrington was saying. I think from what we've seen from managed care services a lot of them mis-estimated what their premium savings were going to be. Their costs are

coming in greater than what they expected their savings would be. Thus we would expect significant increases in the managed fee-for-service arena. However, usually those organizations have deeper pockets and I don't think you're going to see the total increase implemented. But I would tend to agree that on the managed care you'd probably be looking at about a 9% to 10% increase.

Trends that we're seeing in the Western U.S., where we're located, are a little bit less than double digit. But it looks like for fee-for-service may be slightly higher, managed care slightly lower. However, there is underlying pressure on the providers of care which will ultimately pass through even the managed care system at some point. If they do not, they will create a new tier of risk or cost transferring between managed care systems and fee-for-service. Much has happened in the past between federally funded programs and the private sector.

MR. CARDINAL: Could I add one more thing? Something that's going to have an effect on the HMO rate increases as well is the employer contribution strategies. The new legislation may limit the employer contributions and you may even see some rate decreases or some revisions in these rate filings. They can hold down expenses as much as possible in order to meet the demands of the employer that are going to be coming up based on these new employer contributions. So when I say 5% to 6%, that's assuming a status quo. But until we really know how the employers are going to be changing their contributions, if this comes into play, we might see rates even lower than that.

For the various review organizations, what type of liability insurance are these agencies who perform these precertifying and continuing care functions carrying? My comment is that we observed that some states have imposed limitations on the increases on HMO rates and we think that's a pretty good idea, not only there, but possibly for individual medical insurance. So if some of you do business in that area, it's an area that New Jersey will look at. We feel it might impose an external discipline in the marketing and underwriting of those products that we perceive as not being there. It doesn't mean we're going to do that, but it's something that we are considering.

MR. HARRINGTON: Mr. Cardinal, we have recognized what we have called a malpractice liability in our management activities and have bought appropriate insurance, but I don't know what it is. I'd be happy to find out for you though, because it was an issue.

In summary, I must say that what we all believe is that there'll be some blending of what we're talking about in the future, but the least common denominator will be managed care. So, we really don't believe everything we said. We see the blending as the future of the alternate delivery systems.