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TRIPLE OPTION PRICING CONSIDERATIONS -- WHAT HAS CHANGED?

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- o Actuarial versus experience pricing
- o Unified pricing and underwriting
- o Marketing problems
- o Analysis of results
- o Risk sharing

MR. DAVID V. AXENE: My perspective of the triple option product has to do more with the public's reaction to it. The public is demanding a much more sophisticated product. The whole basis for this multiple-option-type product is a reaction to demand by the public for certain aspects in a product, and we will be talking about this. My presentation will be background information about the issue, pointing out a few areas that I'd like you to think about, and the other speakers will be speaking on more specific issues.

The current marketplace is quite chaotic. Currently, most employers have multiple managed care plans, plus one or more indemnity carriers or health maintenance organizations (HMOs) trying to bid for their business. It's really frustrating for those carriers or plans that experience adverse selection because no matter what they do, they can't seem to solve the problem. Before the 1988 HMO amendments occurred, it was quite chaotic. There was extensive shadow pricing, along with many other aspects that everyone was concerned about. The carriers were very concerned because of a concept called shrinkage where more and more of the preferred provider organizations (PPOs) and HMOs were pulling members out of the employer's mix. Therefore, it seemed that there was a group with ever increasing cost that was left for the carrier to underwrite. It is often called hyperinflation, and everybody faced it. That, combined with the last economic cycle, has caused many problems, probably not due to mispricing, but rather to this selection pattern.

In the past, there has been significant demand for product enhancement. Employer after employer was saying, "My costs are going up too rapidly. During the last recession you promised that PPOs would take care of the economic cycle. The results of 1987 and 1988 show that it didn't." They kept wanting something that was better for them as a plan sponsor. At the same time, flexible benefits and demands for flexibility by the employees have emerged, and so there is this increasing demand for product enhancement.

As I alluded to already, there have been significant problems with adverse selection, and that problem will probably be with us forever. I choose to refer to that as understanding selection patterns because while it's unfavorable to one player, it's very favorable to the other. One day you will be on one side, and the next day you will be on the other side. Therefore, it is more important to understand the whole aspect of selection management or selection patterns.

The financial results of the industry were disastrous. I thought that the recession in the early 1980s was the worst that had ever been on record, and the many people exiting the group market

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at this time suggest this to be true. Many carriers are no longer in existence, and many had these disastrous results.

One of the most important aspects of this product was a demand for stability. The employer wanted flexibility for his employees, but also something where he would be able to reasonably budget for the product in the future. The current marketplace, demand for product enhancement, problem with adverse selection, the industry financial results, and the demand for stability have led to the triple option product.

The triple option product can best be perceived as a bull's-eye (Illustration 1). In the center there is something that is like an HMO, and I prefer to call it ultimately managed health care. The middle ring is what usually is looked at as a PPO, and I refer to that as moderately managed health care. The outside ring is the indemnity or unmanaged health care. The differences between these three rings has to do with the aggressiveness by which you pursue managing the health care system, and each ring can be labeled with the colors of a stoplight. The center of the bull's-eye, the HMO, is comparable to the color green because it has the greatest chance of controlling the costs of the employer. The indemnity ring is red and is comparable to the losses that the carriers have had in their products. The PPO is like the yellow in the stoplight and represents the mediocre results between the red and the green. Keep these colors in mind as they will be referred to something else later.

The key to the triple option product is that it allows people to pick and choose any one of these bands. In the very first version of this product, you had the far extreme where you chose once a year or once a quarter. During an open enrollment period you chose either the HMO, the PPO, or the indemnity option. Some people might have only had two bands where they chose between the HMO and PPO, where within the PPO you swung between indemnity and PPO. More currently, there is the point-of-service multiple option which says that any time you need a service, you choose which one of those bands to go into. It can be thought of as selection to the infinite power. If you thought it was hard to make predictions within a traditional program, you can imagine how much more difficult it is to predict for a point-of-service product. Therefore, this bull's-eye approach helps one to understand how the triple option product really works.

The bull's-eye approach can be used to talk about some of the conflicting advantages and disadvantages of this product (Illustration 2). Start first with the degree of health care management. The HMO, which is in the middle of the bull's-eye, has the tightest control, or should have the tightest control. It is comparable to the color green, analogous to the stoplight situation that was mentioned earlier. The indemnity product, on the outside, has the lowest degree of health care management.

On the other hand, picture the degree of freedom in the upper right-hand corner. Obviously, the outside ring, the indemnity, provides the greatest degree of freedom and it is this one that is comparable to the color green. The center is red -- you have a stop sign there stopping you from doing what you want.

In the bottom left-hand corner is degree of provider flexibility. Again, it looks much like the upper right-hand corner where under the indemnity product you can go anywhere you want. Under the HMO you may be restricted to a small group of providers that have had contracts. Again, you'll notice the PPO is always the middle band, and it really is sort of a blending of all of these extremes.

The bottom right is the degree of cost control. Inefficient HMOs can't claim this, but efficiently managed health care plans can claim that they have the biggest and most advantageous cost control mechanism to control the delivery of health care. Therefore, when you are dealing with this as actuaries, you are trying to predict all four of these extremes at the same time and trying to price it traditionally. I think this is a challenging process that requires very sophisticated actuarial techniques.

Getting back to the product evolution a little more, you will recall what I mentioned earlier. The original product had three distinct products where you had to sign up once a year. Gradually, the PPO and the indemnity became a blending of the two, and now we're moving into combination products where it's based entirely on point-of-service. The products and concepts are the same,

ILLUSTRATION 1

TRIPLE OPTION PRODUCT

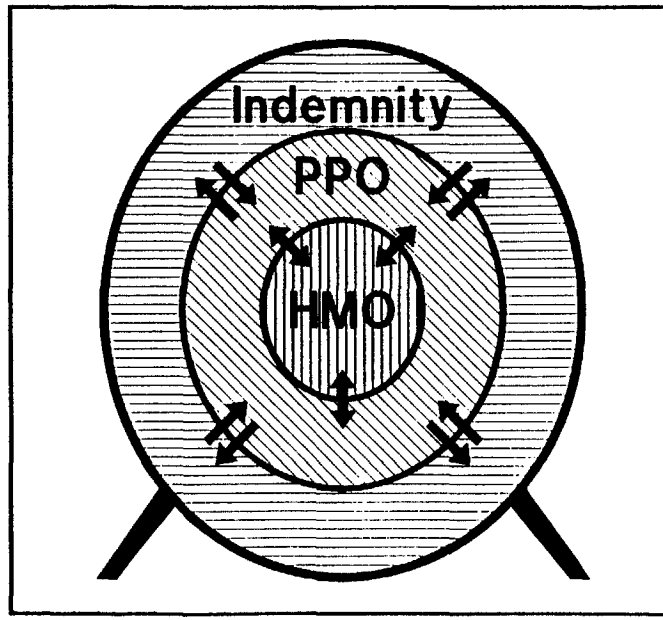
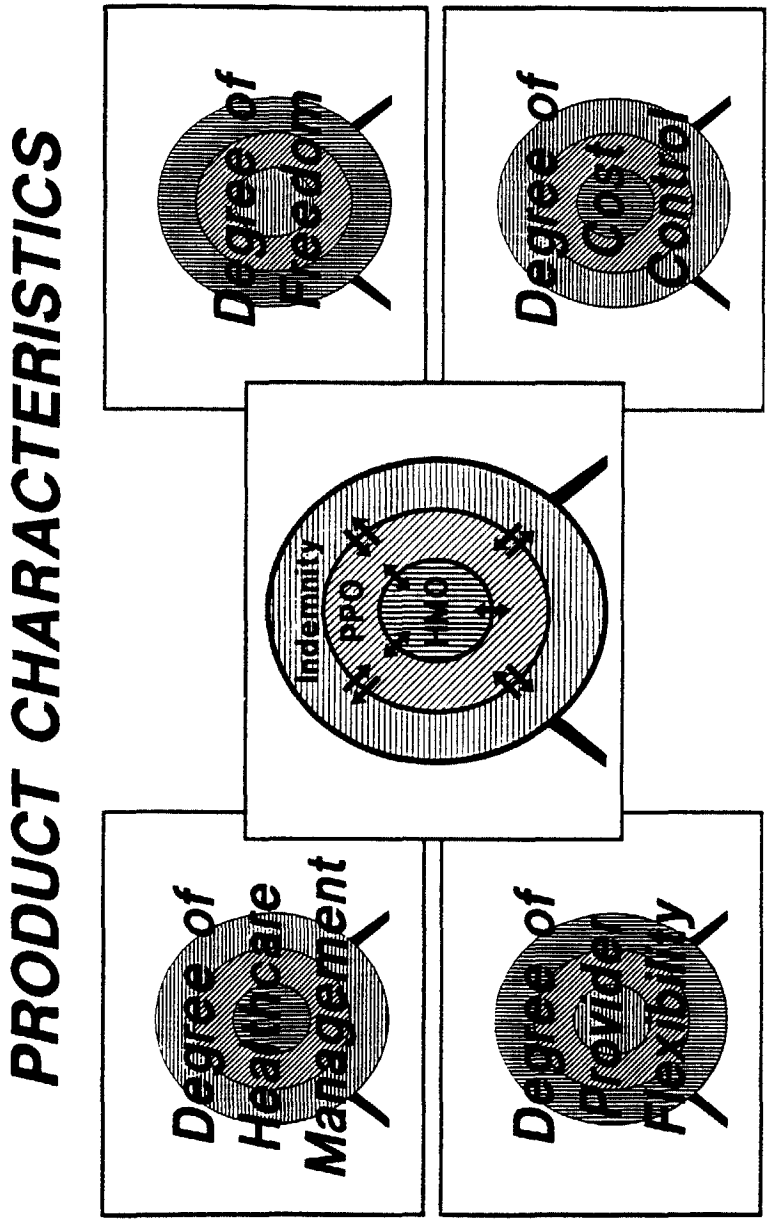


ILLUSTRATION 2



but there is a greater degree of flexibility that is allowed to the enrollee. There are many options and combinations, but the basic idea is that the beneficiary chooses at the time of service where he will go. It becomes a free-for-all for the employee and allows a great degree of flexibility.

From an actuarial perspective, you can no longer independently price the three options. You cannot independently price an indemnity product, then a PPO product, and then an HMO product and hope that they balance. It requires coordinated or integrated pricing. You must be able to predict the choices where people will go for services. When you have a complete free-for-all where people can go out and use any doctor or service, unless you can predict the choices where people will obtain services, you're going to have a very hard time managing this product. You can never predict where they will go, but you can predict enough of the characteristics of them that you can enable some of the pricing to make sense.

To do this, one must understand why people make choices and selections as they do. Therefore, the key to this product is not sophisticated actuarial science, but rather understanding why people choose what and where they go. You may not be able to accurately anticipate each of these choices, but maybe try to accurately anticipate the basic choices. Pricing, provider reimbursement systems, benefit designs, contribution levels, degrees of health care management, and the extent of other choices all must be coordinated and taken into account and they can't be done independently.

An illustrative selection algorithm may help to clarify this, but a few definitions are needed first. The first definition or phrase is replacement versus nonreplacement. Replacement means that you are the only carrier that's going to be there. There will be no other carriers or HMO options, and the program will be exclusively offered to all employees of the company. If you are coming in side-by-side with another HMO or another carrier, it's a nonreplacement product. This is a very important "Y" in the road since the analysis required for one is radically different than that required for the other. Therefore, before you start pricing, you need to first decide how and where the product will be marketed.

A second definition has to do with the distinct categories of beneficiaries that will sign up for this product. There are those who are willing to sign up for a product involving managed care, and there are those not willing to sign up for a product involving managed care. Currently, the carriers are enjoying the utilization experience of those not willing to sign up for HMOs. However, there is a subset of that group that would actually sign up for an HMO product if you gave them more freedom. There is also a bunch of hard-core people that will never sign up for that product, and you can never expect to have 100% penetration into an HMO unless it is mandated for a small group.

If you take a look at those willing to sign up for a product, there are four categories of people. There are those who will stay within the plan and always use the plan, even if they are given complete freedom. These people are the ones similar to those who sign up for HMOs right now. Second, there are those that I label as swingers, or the PPO types, who will go back and forth on a repetitive basis. One day they will use a doctor inside the system, and the next day, they will use a doctor outside the system. They perpetually go in and out of the system, and obviously, belong in the PPO group. The third group of people are those who are willing to sign up but will always go outside of the plan. They're saying, "Ok, I'll sign up for this multiple choice product, but I'm going to go where I want, when I want and as often as I want." The fourth group of people are nonusers or people who sign up and never use the system. They are the ones that pay for the rest of our health care consumption.

The second class of people are those not willing to sign up. They are broken down, obviously, into the users and nonusers. They are the ones who, if you enter on a nonreplacement basis, will always sign up for the carrier and stay there. On a replacement basis they are the ones that you try to move into the previously mentioned group -- those willing to sign up always go outside of the plan.

The actual distribution of beneficiaries varies radically by the environment in which it's operating, and there are a number of factors that impact this. First of all, the replacement versus nonreplacement concept is very important. The extent of out-of-network usage is highly dependent upon whether or not it is a replacement or a nonreplacement product. Our experience favors

a replacement product, since we have found that the replacement product works well in a small, medium, or large-sized group. Another factor affecting this distribution is the magnitude of the benefit differentials, also called the degree of lock-in. If you have a big enough benefit differential for staying inside the network, people will stay. Therefore, through effective plan design you can lock people into the plan by carefully designing the benefits. Unfortunately, this is not 100% true because there are some people who are so stubborn that they will go out of a network no matter what the benefit differential is, even on a self-pay basis. A third factor involved in the distribution is the price advantage of managed care plans in the local marketplace. If you go to Los Angeles, the HMOs are the best priced vehicle in town. In other words, it often costs more to sign up for a carrier product in the Los Angeles market. However, if you go to Kansas City, the HMOs cost more. Those two markets are radically different for this product design because the cheaper the managed care product, the more reputation it has in the area, and the better off the selection will be towards managed care. The final factor is the maturity of the managed care plan's local marketplace. If you look at a city where there is a small percentage of people who have a managed care product versus a city that has a high percentage of the people with a managed care product, a radically different distribution assumption results.

Table 1 is an illustrative choice situation. This was an actual client project's numbers that we believed were best estimates in this particular locale, and there were a number of key assumptions that led us to determining these numbers. First of all, this was a lock-in product. There was a 40% benefit differential in this product so that the people would strongly be encouraged to stay within the plan. We did this to try to encourage people to stay within the system. This product was also in a very competitive HMO market, and it was a replacement product. In other words, this was going to be a stand-alone product, where it would be the plan of choice, and it was a very mature marketplace from the standpoint that both HMOs and PPOs had been around for a reasonable period of time. Notice that since it was a replacement product, there were zeroes down at the bottom under the unmanaged plan. There wasn't going to be an unmanaged plan, but rather a multiple option managed plan.

TABLE 1

ILLUSTRATIVE
CHOICE PATTERNS

Distribution and Type of Enrollment

Managed Plan	Contracts	Members	Members/Contract
In Only	58%	68%	2.73
Swingers	15	15	2.29
Out Only	20	14	1.65
Nonuser	7	3	1.11
Subtotal	100%	100%	2.34
Unmanaged Plan			
Users	0	0	--
Nonuser	0	0	--
Subtotal	0	0	--
TOTAL	100%	100%	2.34

- Key Assumptions: Lock-in Product Design (i.e, 40% Differential), Very Competitive HMO Market, Replacement Product Design, Mature Marketplace.

From the table, you can see that about 58% of the people were predicted to stay within the program, 15% were swingers, 20% were out-only, and 7% were nonusers. If you switch that over to total members, including the spouses and children, you will see that 58% increased to 68%. Now, if you take half of the swingers' 15% in the second column and add it to the 68% who stay in the program, you get about 75%. This says that at most you would expect 75% of the members to be using the HMO if you assume half of the swingers will use it. Now note the members-per contract differences in the right-hand column. The nonusers were basically contracts that were very small, the ones without kids. Note that the in-only had the highest member per contract, and that is where all the children went. Therefore, from this perspective one can see a radical difference in demographics among the different options.

Table 2 shows the overall utilization. Notice that out-only users had 142% anticipated utilization. Some of that was from demographics, while some of that was from health status. Notice that right now the HMO was able to show 95% utilization. Therefore, if you start looking at the utilization and claim cost differences, you will see that this selection is expected and reasonable.

TABLE 2

ILLUSTRATIVE AGE/SEX AND
HEALTH STATUS DIFFERENTIALS

Managed Plan	Utilization	Claims Cost
In Only	95%	94%
Swingers	107	107
Out Only	142	148
Nonuser	0	0
Subtotal	100%	100%
Unmanaged Plan		
Users	0	0
Nonuser	0	0
Subtotal	0	0
TOTAL	100%	100%

The questions facing many people right now are, "Why are my trends going up? Why are my claim costs going up? Why can't I compete? Why are our employers all upset?" It all has to do with pricing issues, and one of them is the widely different use patterns. The problem is how people make decisions and why they make them. It's very similar to the high-low cost spiral that many of you are familiar with where the high gets higher and the low gets lower, and it demands subsidization and equalization from each of the options. You cannot independently price each of the options separately. You have to pool the experience or subsidize one with the other because there is a guaranteed adverse selection. If you are in a carrier environment which is trying to work with an HMO, you must consider having a risk-sharing arrangement with that HMO or else they could take all the money and run. That is one of the reasons that many of the joint ventures are falling apart; they didn't have adequate risk-sharing provisions. The providers must share in the risk. If you don't do that, it's going to cause a problem. You also have to make sure that you have a reasonable difference in health care management between the options to hold the costs down, and, frankly, you need to concentrate on blended assumptions rather than distinct assumptions. On a PPO you can never accurately predict the number of users who stay in the network or go outside the network because the same people go in and out. Therefore, you must consider looking at your blended assumptions, not on just the HMO, just the PPO, or just the indemnity, but as a whole.

There are a number of basic considerations that one must take into account on these triple option products. First of all, the product's success is based on the ability to control or manage selection

patterns. If you can't predict them, manage them, or control them, you should stay away from this product. A second consideration is the potential to capture a larger proportion of a group. We have a number of case examples where we have seen the penetration tripled when an HMO has developed this product. From a carrier's perspective that means there are a lot fewer people for the carrier to pick up and a lot worse selection from their point of view if it's on a nonreplacement basis. If it's on a replacement basis, the carrier no longer has a product anymore in that group. It's not always guaranteed to give you triple, but it will give you a significant increase because you are involved with many more people. That has an amazing value in controlling and keeping your rates more competitive, which is another factor to consider. Therefore, it will help you maintain competitive rates. This, in turn, helps you provide meaningful promises to providers. Far too many HMOs and PPOs have promised movement of members into volume shifts. Volume shifts have not existed. I have seen and heard too many times that people will not leave their physicians no matter what the circumstance.

Another factor is that this product allows you to lure people into managed care. It also simplifies plan administration for an employer and is easily integrable into flexible benefits. You must also keep in mind that these flexible benefits require enhanced administration. There are only a few systems in the country that can administer a highly complex kind of product effectively. Another consideration is that this product works the best when the providers are involved with the out-of-network risk. Benefits are not enough to hold members in the plan completely.

The market is now beginning to accept this product. Several major carriers tried to introduce this product three or four years ago, but at that time, the market didn't want it. They needed to go through a health care spiral to want this product. The market is demanding this product in many areas, and fortunately, the 1988 HMO amendments have allowed plans to do more experience rating which is required on this kind of a product. A final consideration is that the TPA marketplace has found out about this product, and they're very excited about it. They like it because it enables them to integrate managed health care into a self-funded TPA-based product.

MS. ANNE L. THIEL: I'm going to share with you how we have seen the triple option pricing considerations change in the last few years. I believe the way that we have addressed the market is the same type of evolution that we have seen happen throughout; that is, the evolution of HMOs and PPOs in our marketplace. As you know, the Minnesota market has had multiple options, including HMO plans for well over 10 years. It is really quite a seasoned market that has seen dramatic changes, especially in the last four to five years. I would like to share with you some of the market considerations that we're seeing. The very first consideration, of course, is competition. Back in the late 1970s there were 11 HMOs in the Twin Cities, and that is now down to five. This year, fortunately, the financial results are positive, and overall the HMOs have shown about a $1 million profit which in most cases is just a break-even situation.

Another consideration is that the marketplace really has stabilized. For example, in the Twin Cities' market between 50% and 60% of all enrollment is in the HMOs. That has pretty much stabilized, and in some cases we're starting to see a decrease in that. This decrease is primarily due to the fact that the newest products are those offered by hospital-based PPOs. The advantage of the hospital-based PPOs is that the insurance companies are able to justify the rates that they are going to be charging.

One must also consider that in more recent years we've also seen the number of options being limited, reducing it from six and seven options down to one or two. Finally, the most dramatic change has been that of the medical providers. They have become a very vocal group and are no longer accepting very low reimbursement for their services. I believe that three of the five HMOs that exist today have had litigation in the last two to three years because the HMO was not providing adequate reimbursement to the medical providers. Given this rapidly changing market environment, we, as a corporation, Blue Cross/Blue Shield, in our limited market of Minnesota and with our affiliated HMO, Blue Plus, have tried to address the market as it's changed, and I'd like to let you know where we are today. Most of our efforts go into how to price triple option programs to be very viable in the market. Our response has been one that has integrated all the different facets of the corporation; that is, we are concerned about how the plan design integrates well with the financial approach. Of course, we always have to take into account the marketing considerations.

TRIPLE OPTION PRICING CONSIDERATIONS -- WHAT HAS CHANGED?

I would now like to share with you some of the results that we have seen in the last few years due to the new product design and integrated financial arrangements that we've put in place. When we talked about multiple options or triple options a number of years ago, we were concerned with integrating a traditional fee-for-service program with a PPO and also an HMO product. When I think of the multiple option I think of any number of these programs, between two and four combinations, being offered at one time. The old way of thinking of multiple option or triple option was that you had multiple plans, possibly multiple rates, and every year the individual selected what program to be involved with. As we've changed over time, we have been directly involved with the point-of-service product. There are two types of point-of-service products. One is the PPO, which is really a multiple or a two-level product where an individual can either select to belong to the PPO or to receive services from the PPO provider. The other is to opt to go into the universe of medical providers.

The last or most recent development is in the triple option point-of-service product. Since 1986, we have been offering a program that involves three different levels of benefits. It's one plan, and the individual, at the point of service, determines which level of benefits is going to be provided based upon the provider that they seek care from. Our plan design includes approximately 100% payment if you use your designated primary care physician, or gatekeeper, or an authorized referral from the gatekeeper. If an individual wishes to select the PPO plan, which in our case happens to be the Blue Cross/Blue Shield network, which involves about 90% of all providers in the state, they receive a lesser benefit. Finally, there is the third level of coverage which is the universe. I must add that we have a limitation in Minnesota -- the least that you can provide for benefits is 75%. That's why our third level, or our indemnity program, is set at 75%. Certainly, if we had more flexibility and plan design, we would pay at a lesser level.

I might comment that in the development of a triple option program, the biggest problem we had was with all the state mandates and requirements. We, in fact, have had to issue two contracts. We have to issue an HMO contract and a Blue Cross/Blue Shield contract that involves a PPO on the indemnity side. There are other considerations in a triple option program that have created problems for us, and most of them were all the Minnesota-mandated benefits. Minnesota's regulations are probably the broadest as far as coverage for mental health and chemical dependency, and what we see is a lot of usage in the second and third tier, or the PPO and the indemnity, because you have to provide the full level of state-mandated benefits. Within the Blue Cross/Blue Shield contract you also have to have a level of benefits within the HMO network. Therefore, people actually have double benefits for mental health and chemical dependency. Minnesota also has a regulation that says chiropractors are to be treated the same as other medical providers. We have seen extensive usage in the second and third tier of chiropractic benefits because within a gatekeeper approach the utilization of chiropractors within an HMO is very, very limited. Those were the concerns that we had to address. I know each of the Blue Cross/Blue Shield plans and other carriers are having to address the state regulations that they see in their marketplace.

In all of our plan designs, key concerns were determining how to integrate our provider agreements with our rating and underwriting structures, being assured that we were coming out financially, and having a product that would be accepted in the marketplace. For a number of years, the first concern of marketing was what the product would cost. Now it is what the provider agreements are and from there we worry about the cost. That seems to be the key today. You need to consider what the managed care and provider agreements are and what the risk arrangements are before establishing what the cost of your programs are going to be. One of the key concerns we had in addressing the provider arrangements was to figure out how our HMO provider agreements could be interacted. The key concern that we had there was that the primary care provider as a gatekeeper still had to have an incentive to provide the services, and he also had to have an incentive to control the utilization. We had to have flexibility in offering alternative funding arrangements. The large employers in our market were demanding self-insurance for their HMO and their PPO alternatives, and we had to address how we could integrate that into our provider arrangements.

One other thing I'd like to add, when we were considering how to establish our provider agreements until that point our HMO had been what I call fully capitated; that is, the physicians were responsible for all of the costs for their own services, the referral services, and the hospital services. Therefore, about 90% of all health care costs were the responsibility of the providers. When we started to consider how to integrate the provider agreements, we recognized the

capitation probably did not allow us the flexibility that we needed. One of the reasons was that we wanted to be able to look at the experience of the total account. We didn't want to have to segregate the HMO from the Blue Cross/Blue Shield side and set different rates. The other concern was if the selection was positive for the HMO, that meant that the providers were the ones who were benefitting, and we did not have those excess funds to offset the losses that we were seeing on the indemnity side of the program. Then, in our goals we had to consider how we were going to establish a provider agreement that was not based upon capitation, yet meet all of these goals and be integrated with our product line.

To address this, we first of all established reimbursement based upon fee schedules. Within the fee schedule we did have a withholding, for the primary care giver, our gatekeeper, that could be returned based upon utilization goals. These utilization goals included not only the services that the primary care physician provided but also the referrals that they provided. The hospital services and self-referrals or the usage of the PPO and indemnity program had to be built back into their performance goals. We were trying to meet our objective, which was that all the services or most of the services should be controlled by the primary care physician, and they should not be encouraging people to seek care elsewhere. To accomplish that, we integrated or included in their performance goals the usage for those services in the PPO or indemnity program.

Once we'd established our provider agreements, then we could look at the rating considerations. In establishing our rates for Blue Cross/Blue Shield products and our affiliated HMO we considered the total account, and then established the rates for the different programs. In establishing the rating and pricing considerations, we set the rates so that they reflected the delivery system of the program. They also reflected the benefit differences that we offered within the plans. We also took into consideration the account strategy. We went and talked to the employers, who, because of the past, had to offer a high-option program. If it was their intent to phase that out over time, we would artificially price the high-option program slightly higher to discourage people from enrolling in that program.

While we set this strategy of having our rates in alignment, at renewal time the way that we addressed it was to come up with a melded overall rate increase, build in a factor for some selection problems that we faced, and then apply the melded rate increase to all the product lines. Again, if there's a strategy to encourage people to join a certain program, that would be reflected in the rates.

One other consideration in offering multiple products or the triple option point-of-service is the control you have on selection. A number of years ago we decided that we did not want to offer too many programs to an account. There is no reason that 100 employees in an account should have the option of four or five different benefit programs. That makes no sense at all, and it's almost impossible from an administrative point of view to control the costs. Therefore, by account size we have established the number of offerings that can be offered.

We have also limited the offerings as far as plan design. We don't allow a $1,000 major medical deductible program to be offered with a full-service program, where people can opt in and out every year. That certainly is just far too much selection to even be able to control or estimate any rates. We try to make some reasonable differentiation between the programs but control, to the extent we can, a selection criteria.

The other thing that we established when we offered multiple products is that there's only one, a selection once a year; we don't allow people to move back and forth between programs. That would just aggravate the selection that we were seeing.

As I mentioned earlier, when we were establishing our provider agreements in setting up our underwriting and rating strategy we wanted to have flexibility in funding arrangements, and we wanted to be able to offer self-insured programs to the large employers. Our provider agreements lent themselves very well to that. The key thing we said as a corporation was that we no longer were going to have a self-insured Blue Cross/Blue Shield program and a fully insured HMO. We decided that both plans were to have exactly the same funding arrangement. They're either insured or they're self-insured, and if they're self-insured, you can offer a stop loss that includes all of the different programs under one stop loss agreement.

Our results have shown us to be very fortunate through this last recession. We only experienced financial losses in 1987. Remarkably we have grown by about 5% per year for the last three or four years, as far as enrollment is concerned, and we now have somewhere between 25% and 30% of the market share. Back in the early 1980s, when HMOs were first introduced, we were down around 15% of the market share. We have seen a growth in enrollment, and much of this has to do with what's happening in the market. About three years ago we decided that if there are other carriers involved, other HMOs or PPOs, we really could not estimate from year to year who was going to be in a program and what rate level was needed. Therefore, we tried a number of different strategies and came to the final conclusion that the only way for us to be able to survive financially in an account was to be the replacement carrier or the sole carrier with a multiple or a single product of our own.

Being the sole carrier has been a very difficult marketing strategy, but it's led to a great deal of success. From an employer's viewpoint they can have reduced administrative costs by dealing with only one carrier that can offer all the products that are needed. From our viewpoint the biggest concern was whether or not we could come out financially. Certainly being a replacement carrier affords itself far more opportunity for us to achieve the black bottom line.

Employer needs also have changed over time, and Section 89 has really changed how multiple offerings are addressed in the marketplace. We feel that by having the triple option point-of-service product you can meet the employer's needs, have only one product offering, and also minimize any problems that might exist under Section 89.

With these strategies, here are some results. We have done quite well in the last few years, much of it probably a direct result of our decision that we had to be a replacement carrier. About 10% of our enrollment is in this plan that's been offered since 1986. It's really been only in the last year to year and a half that the employers have seen a need for this product, and we have seen rapid growth. We're seeing the most success for a replacement product with this triple option in the accounts of approximately 1,000 to 5,000 employees. Those employers are seeing this as an answer to their multiple option offerings. They're very concerned about the Section 89 implications, and that again has been our greatest success in those areas. They're also self-funded so we face minimal risk in offering the triple option point-of-service.

Here are some of the results on the usage that we have seen in the PPO and indemnity networks. Our nonnetwork usage or the PPO indemnity usage has ranged between 10% to 12% on the average, but it varies widely by account. We have seen anywhere from 5% to 20% usage of those two products. In the cases where there is about 20% usage, we have seen that those plans had a strong indemnity program for many, many years. On the other hand, in the cases where we have seen 5% usage, there has been extensive enrollment in the HMO product. As a replacement carrier product, however, we see the cost of the triple option point-of-service being anywhere from 3% to 5% higher than if we just had a pure HMO in place. That, obviously, has to do with the individuals who continue to use a PPO in indemnity networks and the increased utilization that you have there.

I have tried to cover some of our marketing strategies in the very limited market that we face in Minnesota. We feel that we have been quite effective in addressing the market and have been very successful with our results.

MR. STEVEN M. HICKMAN: I am going to cover the pricing issues associated with the traditional or first generation triple option product. By that, I specifically mean an enrolled plan, an HMO or an exclusive provider organization (EPO), which stands alongside an indemnity PPO plan. We have recently tried to develop point-of-service plans, but we feel that these plans are not appropriate to put into place everywhere today and may not be appropriate in the future.

The information that I present is my interpretation of Lincoln's experience. We operate in numerous sites all across the country and operate in a wide cross-section of environments. This includes some places where the HMO penetration is very large, some places where it's very small, some places where the HO rates are very attractive, and others where they are not.

In a broad sense, the pricing issues of the triple option plan arose because the plan is married to two separate entities, entities which have had separate evolutions and have faced separate

challenges. The HMO-EPO enrollment plan has a rating structure that can be characterized as class- or community-rated prevalent. It's also subject to constraints on federal qualification statuses as well as state regulations. The HMO-EPOs have had to compete against other HMOs and EPOs, and they've had to compete for a select small subset of a group. The indemnity, on the other hand, has a rating system that is experience-rated prevalent, has fewer regulations and state constraints, and is competing against other indemnity carriers for the entire group.

The two separate entities also have different expense structures. Our goals in the triple option products are to combine these two entities. When this is done, each entity is subjected to situations that they are not really used to. Then you add the constraint that the product in total needs to make sense to the employers and employees, it needs to return profit to us, and it needs to bring lives to the network. All of this presents a pretty tall order.

What are the dynamics underlying the pricing impacts? They tend to arise because of enrollment patterns, so the first thing you must do is analyze the enrollment patterns that are occurring, determine the variables that either predict or affect the enrollment patterns, and then measure the cost impacts and reflect those in the pricing.

Let's take a look at what variables affect or predict the enrollment pattern. The most obvious predictor would be the current enrollment pattern. The second is the site average enrollment pattern. The third that we've found is the employee contribution or out-of-paycheck expense. Other items of less impact, such as the distance of the employees to the network and who happens to be the enroller, need to be viewed in the context of the average for the site. Therefore, you have to look at each particular case and what part of the country it is in to determine its effect on the enrollment pattern. For example, the items that ordinarily impact the penetration up or down don't seem to make nearly as much difference in a place with high HMO penetration as they would in a place with a more moderate HMO penetration. As far as benefit plan specifics, the correlation in our data is not as strong as we anticipated. We're not sure if that is because it is not really that important or because we don't have enough experience to date to confirm or deny. These are some of the variables that we found to be significant, and from there you can take those variables and predict either a site average enrollment pattern or a case-specific enrollment pattern.

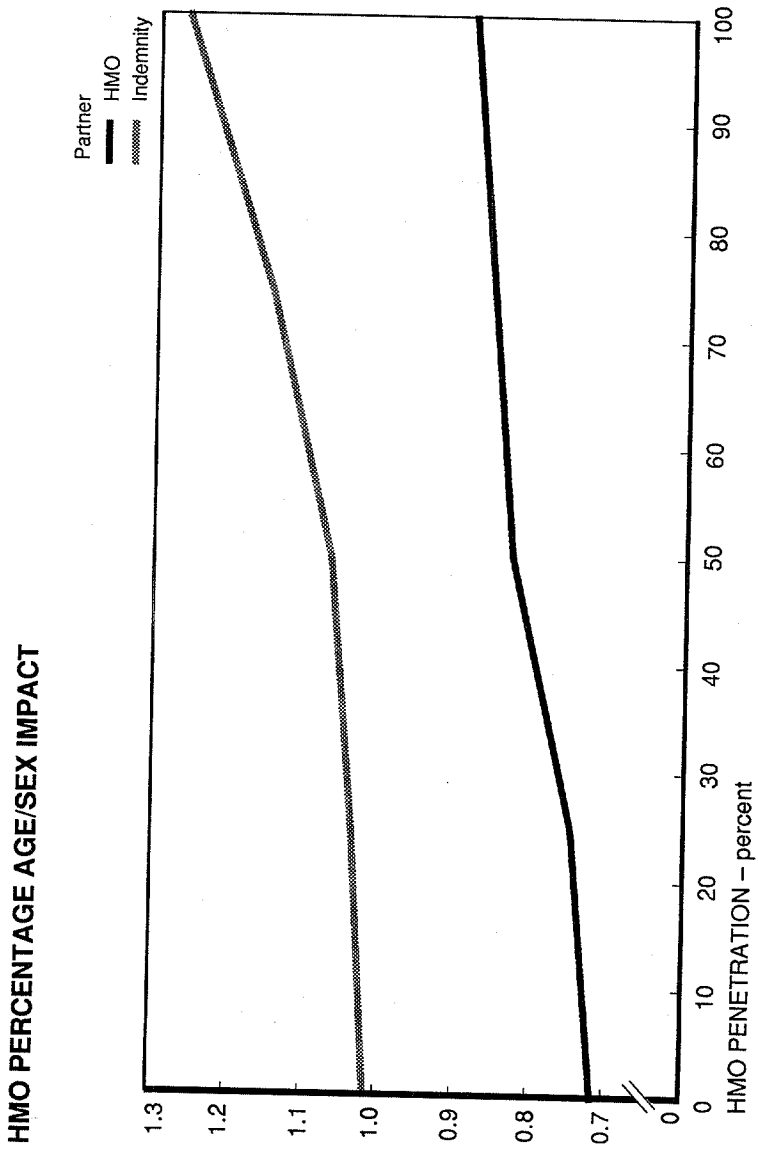
Now let's look at the impacts that these enrollment patterns have on pricing. The basic concept is that demographic enrollment patterns vary between the HMO indemnity options. They result in cost differences, and those cost differences need to be reflected in the pricing. There have been numerous studies done that confirm that. Our own studies do show a clear age bias towards the HMO on triple option cases. The top line on Graph 1 is the indemnity price impact of the enrollment. Notice that as HMO penetration increases the indemnity price impact increases also. I want to point out that these numbers are illustrative only and do not reflect our own experience exactly. The bottom line is the HMO line, and you can see that it starts off with a very select group. As its penetration increases, that favorableness declines in a leveling out fashion.

There are a couple of other issues that I want to discuss about the age-sex impact. The first of these issues is what happens at very, very low HMO penetrations. What appears to be happening is that people are enrolling because their providers are in the network. If that's the case, those people are probably average and not select like you would see at a 20% to 25% penetration. The second issue is that I would anticipate this pricing impact curve to flatten out over time. As HMOs become more widely accepted and as some of the older people begin to enroll, I believe that we will get more and more of an even distribution enrolling in both the indemnity and the HMO.

Another concept that has been around is that beyond age pattern enrollment, a further cost impact is generated by differential selection patterns. These selection patterns favor the HMO for any health-impaired individuals, even among individuals in the same age bracket. Our studies indicate that this, too, is occurring on triple option business. Therefore, you've got another cost impact, and thus, a price impact. Graph 2 indicates this to be true. The top line again is the indemnity plan starting out at the whole group. As the HMO penetration increases, the indemnity cost impact also increases, and in this case I would strongly suggest that you will have an upward sloping tail at the very high HMO penetrations. The HMO on the other hand starts off with a very select group, and as the HMO penetration increases it increases, but more in a leveling out fashion versus the upward sloping tail on the indemnity side.

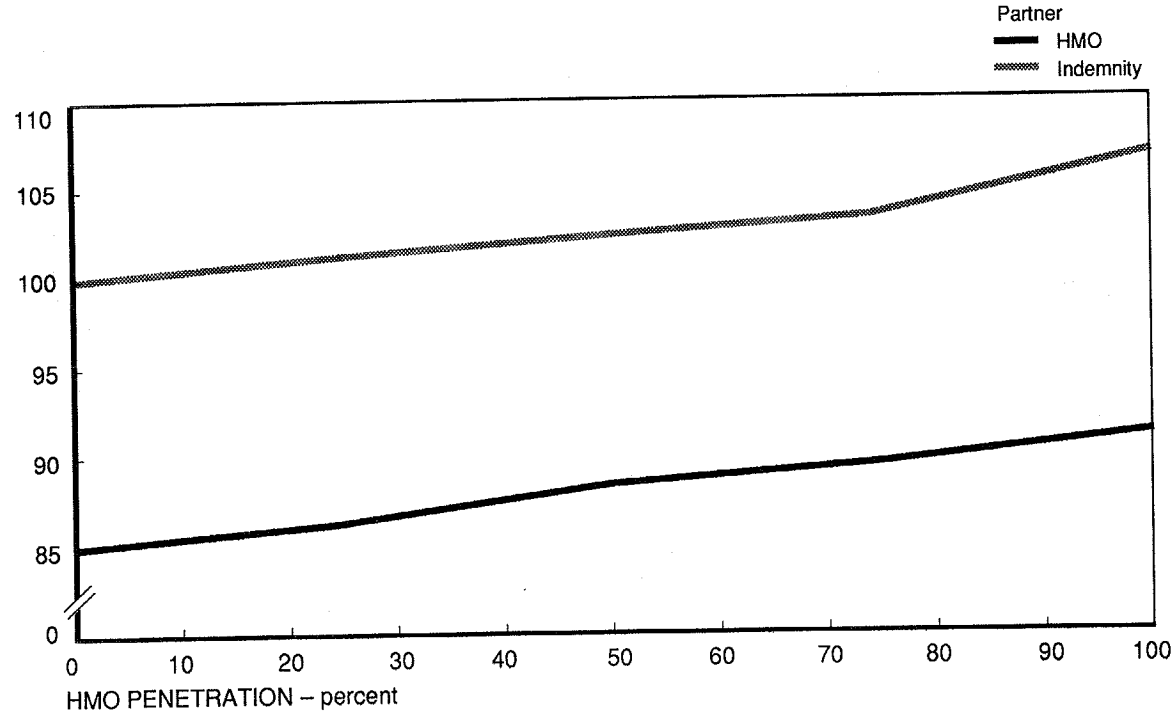
TRIPLE OPTION PRICING CONSIDERATIONS -- WHAT HAS CHANGED?

GRAPH 1



GRAPH 2

HEALTH STATUS IMPACT



The bottom line of both these analyses is that the enrollment patterns can have plan-by-plan cost impacts, and these need to be reflected in the pricing. Therefore, what we can do now is predictthe enrollment levels and enrollment patterns, consider what the likely cost impacts of those patterns will be, and then adjust the price.

The last pricing issue that I will be discussing deals with retention. The challenge facing the actuary on retention is to first understand what the true, functional costs are of the triple option product. These functional costs need to be understood as to how they vary as the enrollment pattern varies. In some places if you have a completely integrated system, they may not vary at all. In other places where you don't have a completely integrated system, they certainly will vary. On Graph 3 the line which starts out at the 0.15 factor and climbs is an illustration of what the indemnity functional cost of a triple option product may look like. The horizontal line, which is the middle one, illustrates what the HMO might ordinarily charge in their classic community rate. The downward sloping line might represent the functional cost of the HMO. The functional cost of the combined product, of course, is simply the sum of the bottom and middle lines. From this, the actuary must again estimate what the enrollment pattern will be, and determine how that impacts the cost. In this case, they also have to consider any possible retention rating constraints that are in place in the triple option product and then adjust the price to reflect the cost.

Let's take a step back and look at the overall product performance. Interestingly enough, you can tell from the earlier graphs that the plan rates for each option may actually increase as the HMO penetration increases, but does that mean that the total policyholder dollar outlay increases? Not necessarily. Consider any scenario where the HMO or the enrolled plan can enroll everybody at a price that is less than the nonenrolled, or indemnity, plan. You would then have a downward sloping total policyholder dollar outlay as the HMO penetration increased. This is a reasonable occurrence and will happen whenever the combination of the additional provider discounts and utilization control in the enrolled plan versus a nonenrolled plan more than offset the benefit differentials. There are many examples and Los Angeles is a perfect one. In a case like that, the policyholder has a true financial advantage by introducing managed care to his employees. He could develop a function to predict future costs. This function would clearly illustrate to the policyholder what his enrollment strategy should be. It also would illustrate what would happen if you changed the plan design or, more specifically, if you changed the employee contribution arrangement. It also could be used to predict any future costs.

If you can develop this function, you will end up defining for the policyholder what his long-run enrollment strategy ought to be. That can very well be different than the short-run enrollment strategy. For example, it might make sense to introduce a product like this in the first year even though it might cost him a little bit more. However, in the next year when the HMO is the lower-priced option, he can take full advantage of the higher enrollment that is likely to occur since he introduced it the year before.

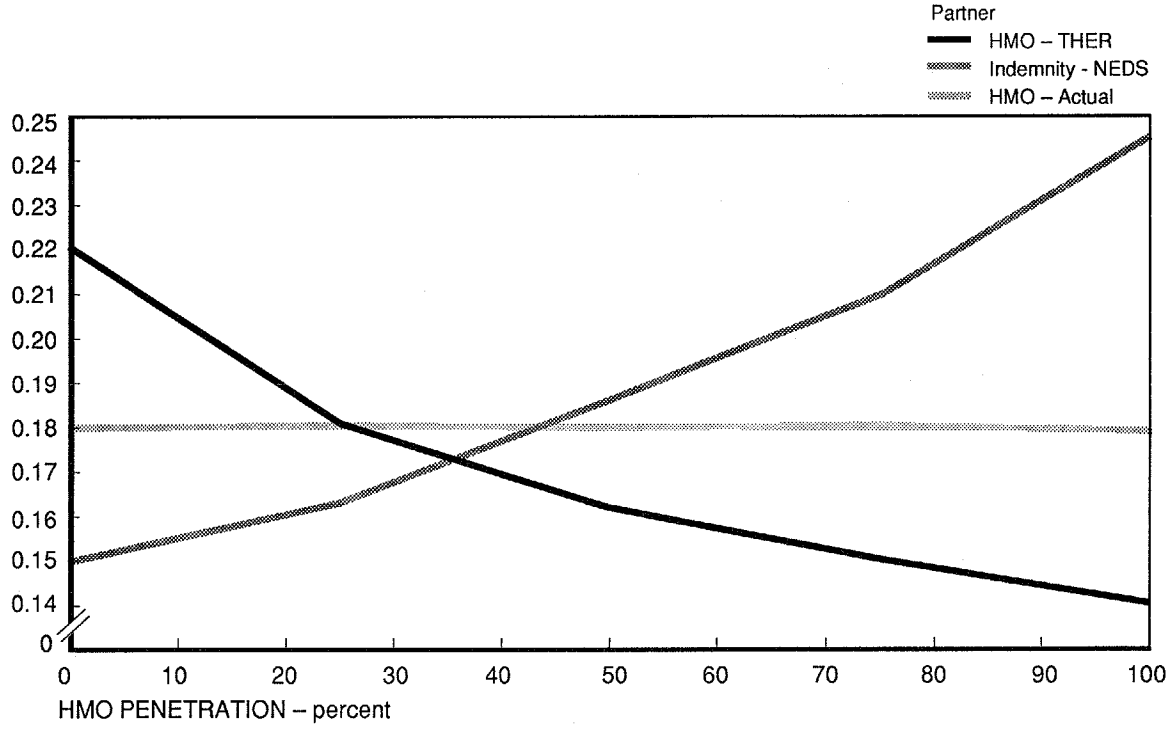
We've talked about the rating issues. We've talked about the impacts of those issues, and about the need to build those into the price. That, then, concludes my presentation.

MR. BRUCE A. CARLSON: I'd like to make some remarks about my organization and what we're doing with triple option products. I'm the director of employee benefits for North American Life & Casualty. We're a Minneapolis-based, medium-sized, stock life insurance company with about 450 employees. We've got an individual marketing operation which markets primarily traditional and variable individual life and annuity products. We have a mass marketing division which is a market segment-oriented operation serving the reinsurance, association, group, and employer-employee marketplaces. We own no HMOs nor have we sponsored any PPOs. I'm going to tell you how we got into multiple option products, and by multiple option I mean either dual option or triple option products, what some of the risks are that we face, and also how we've addressed those risks.

We have been reinsuring HMOs on a stop-loss-specific basis for some time now, and we have over 300 plans in force. HMOs have approached us to underwrite the indemnity side of a multiple option product so they could improve their market share by offering to the employer a package deal of HMO, PPO and traditional fee-for-service indemnity products while having only one administrator to deal with. Ideally, this product would be offered on a replacement basis, but we recognize that would not be possible in all situations. You must understand we are a stock life

GRAPH 3

RETENTION PERCENTAGE BY HMO PERCENTAGE



insurance company, and we're in it to make a profit. We're not so concerned that we will make money on the medical product because we will sell a lot of ancillary life, AD&D, and disability income products along with it. Therefore, if we can make a little money or not lose a lot of money on the medical products, we're happy.

This was a natural fit for us with these HMOs because in our organization we do not administer products but rather deal primarily through third-party administrators. We put them through an approval process before they're allowed to market any of our products. With an HMO, however, they will act as an administrator for us, and we put them through the same approval process. They will market the product and are really the ones in control. We have no desire to market the product or to control it. It's good for the HMO as well because most insurance companies which they approach to underwrite the indemnity side have a distribution system which they have to support, and therefore, they want to market these products themselves.

Our concerns with this arrangement stem from the fact that we're the underwriter or the risk-taker on the PPO and the fee-for-service indemnity product. Those two products are on our paper, whereas the HMO obviously is on the HMO's paper. This is in sharp contrast to Mr. Hickman's and Ms. Thiel's situation where they own all three of the pieces. Therefore, profits on one can offset losses on the other, and they're not so concerned with each piece standing on its own. They are more concerned that in total they are going to make a profit. Our concerns are on the PPO and the indemnity, since only those two products are on our paper.

Let me first address what the risks are with these products, and what we've done to minimize these risks. The first is obviously the adverse selection risk. You're not sure which members will enroll into which products. Our feeling is that you are going to get antiselected against on the indemnity and the PPO side. First of all, members who are under a current treatment plan with their physician who do not want to change to another physician because they're under this treatment plan may not opt for the HMO product if their physician is not within the network. Second, you typically have the elderly who have a longstanding relationship with their current physician and do not wish to change. And, third, there are catastrophic cases. If the network does not have a contract with a good tertiary care facility, you may see your catastrophic cases leaving the service area if they know, for example, that next year they will need a heart bypass operation.

There is a different school of thought on this, being that the HMO will be the one that's anti-selected against because the heavy users of health care services will go to the product where there's no claim forms to fill out, no deductibles, no coinsurance and only small copayments. In fact, there seems to be some evidence that that's the case. This adverse selection is more of a concern within the service area than it is outside of the service area.

A second concern we have, along with the antiselection patterns, is with HMO insolvency. HMOs are typically thinly capitalized, and many do not have a good financial track record. Therefore, they do go insolvent. In fact, we have been involved with several as the excess reinsurer. You must be very careful and understand what happens when an HMO goes insolvent and who's liable to pay those claims, particularly on your PPO product if that network dissolves when the HMO goes insolvent. In many cases the HMO network is the same as the PPO network. Also, in our situation the HMO acts as the administrator, and they're paying claims on our behalf since we don't have the ability to do that in-house. Therefore, we would have to find a subsequent administrator to take over that function.

In order to minimize the financial impact of this adverse selection, we require risk sharing on every deal that we do. By risk sharing I mean we require that the HMO participate in the PPO or the indemnity risk, and in some cases we will also participate in the HMO risk. If you can accomplish that, then you don't have to worry about which members are going to which product. All you have to be concerned with is that you're getting enough in total premium that all three plans cover the total health cost for those members. Remember, risk sharing is a theoretical concept. The way I describe it is if you have a claim, who pays it? In managed care, it is a game that you are playing, and you're trying to shift the risk between the various parties. You have the employer and the employee, the providers, the HMO, and the insurance carrier. All of them are risk takers, and the game you're playing with those contracts is trying to shift the risk off your table onto someone else's table.

When you attempt to put these risk sharing agreements into place you have to keep two basic premises in mind. First of all, the arrangement should be such that you are both in the same boat. In other words, you both profit or you both lose, although the extent to which you profit or lose may be different. You don't want to enter into an adversarial relationship with your HMO where adverse selection on the PPO or the indemnity product translates into favorable selection on their part. You must keep in mind that they are really in control of this business. They do the enrollment, the billing, and the administration. You want to avoid putting them into a situation where it's in their best interest to encourage a poor risk member into an indemnity plan. It's very difficult to control that. You must set your contracts properly up front so the incentives are there for the HMO to look after your best interest.

There are a number of things to look for when dealing with an HMO. First of all, you must determine what motivation the HMO has in wanting to get into multiple option products. Are they a for-profit or a not-for-profit HMO? If they're a not-for-profit HMO, then I ask, "Are all the interests the same?" What I have found out is even if they're a not-for-profit HMO, they're still in it to make money, and the trick is to figure out how they make their money. Second, you want to find out who the owners of the HMO are. If it is a provider-based HMO, they may be more interested in simply running bodies through the system and filling hospital beds than they are in generating a positive bottom line. Third, you must look at what hidden profit margins they may have built into their expense allowance. Since they are administering the product on our behalf, a ceding allowance comes out of the premium to pay them for the administration. You must understand exactly what it costs them to actually pay those claims and that they don't have a hidden profit margin built into what they're charging you. You don't want to get into a situation where they're making money on the expense allowance and, therefore, have no incentive to generate an underwriting profit for you. Finally, if the HMO has negotiated contracts with the providers, you must understand how those contracts work and also what risk the HMO really has.

I talked about risk sharing and how we may participate in the risk on the HMO product. One of the reasons we may do it is to generate profits to offset our losses on the PPO or the indemnity product. However, if they've effectively shifted all of the risk or most of the risk to the providers, either through a capitation arrangement or through a modified fee-for-service contract, they may have very little risk left that they bear. You must remember that risk is just the flip side of reward potential. Therefore, if there's no risk, there may be no reward, and then I question whether or not we really want to participate with this HMO product. You also must look at the management of the HMO and decide if you feel comfortable with what they are doing. If they have a history of making profits, that may influence your decision as to whether you want to participate in the risk on the HMO.

The second premise with risk sharing is that the HMO must make available on an unconditional basis sufficient funds to cover their share of claims should the worst case scenario materialize. Virtually all the HMOs we have talked with about multiple option products agree up front to risk sharing in some format. However, many of them are either unable or unwilling to make funds available on an unconditional basis if losses do occur. You can't rely on their capital and surplus to cover their share of the losses for two reasons. First of all, they are typically thinly capitalized, and it may be insufficient. Second, you might have a legal problem in that the state insurance department or HMO regulators are now saying that the HMO is sharing in indemnity risk. You also should not rely on potential profits from the HMO product to offset any losses on the PPO or indemnity product. There are two reasons for this. First of all, those profits may not exist since they may lose money on the HMO. And, second, through their arrangements they have shifted all that profit potential down to their provider.

The way we get around these legal problems varies on a state-by-state basis depending on the regulators. In one state the HMO simply went to the regulators and said, "Look, what we're really trying to do here with risk sharing is eliminate the unknown as to which member, the good risks or the poor risks, are going into which products. And to the extent that we can do that, we've enhanced the solvency of both the insurance company and the HMO, and there's a social good in doing that." They agreed with that, and they also agreed that the state insurance laws and HMO regulations haven't caught up with this new wave of products, and therefore, they let us do it. We simply put together a reinsurance agreement whereby at year end you throw all the profits and losses into one pot, and then you split those based on some preestablished formula like enrollment. Now we've effectively solved the adverse selection problem.

However, that does not address what I call the deep pockets problem. If there is a loss, and the HMO has to cut us a check, is there enough money in their capital and surplus to do that? That approach does not work in other states because the regulators will not allow the HMOs to share in that indemnity risk. In particular, they do not want the HMO to cut a check to the insurance company at the end of the year for losses on those insurance products. The way we get around that is a two-step approach. First, we place a cap on the maximum loss that the HMO can incur on those indemnity products, and you can do that with an aggregate cover. Since you're taking on 100% of that risk, you obviously must charge a premium for that. There are several ways to write that aggregate cover. You can do it on each product individually or one aggregate on all three products. Second, once you've capped that maximum risk you have to then have the HMO set aside enough money to fund that maximum risk. To do that, they could just put the money up front if they have it. But since most of them don't have it, what we typically do is withhold it out of the commission that we pay them to administer the product. Then at the end of the year we've got this commission withhold pot of money out of which we take their share of the losses on the indemnity product. If there are no losses, we then give them back that money in some form of a profit sharing arrangement.

The whole purpose of this managed care system and these triple option products is that you want to get the members into a controlled environment and out of the uncontrolled environment. You want to get them into a situation where your health costs are under contract. There are three primary factors involved in which product a member will select. The first of those is price. If there is anything the members understand, it's what they're paying for the product. The second most important factor is the strength of the network. Is my doctor in the network or is he not in the network? The final factor is really the benefit design. They may not understand deductibles, coinsurances, copays, inside limits and all of that. The intent of a triple option product is to get as many people into the HMO and as few people into the PPO and indemnity product as possible. However, to ease the administration, a lot of the HMOs say they need a levelizing of the premium; in other words, the same rate for all three products. In our case, we have to obviously be careful that we don't artificially reduce the rates on the PPO or the indemnity product and raise the rates on the HMO product or else we won't get our fair share of the funds. There are a number of risks associated to both of us from the premium leveling concept. First of all, if the enrollment differs substantially from what you assumed when you leveled the products, then the HMO or the indemnity carrier may get more or less money than they need depending on how accurate they were in forecasting the enrollment. The second risk is the insolvency risk. Through the premium leveling concept we have artificially reduced the rates on the products which are written on our paper. Say we take it out of the HMO's commission; we now have to go find another administrator to administer the products, and there may not be enough money left in the expense allowance of that product to do that. The third risk you have with premium leveling is that at renewal time, you may have to change your product parameters if, for instance, the indemnity experience is poor. You must bring the expected claims cost in line with that of the HMO.

My final comments will be on our relationships with our third-party administrators or HMOs. When we deal with them, we're obviously relinquishing a substantial amount of control to them since they do the marketing and administration for us. However, they have more of a stake in maintaining a long-term relationship on this product than we do. You must remember that they came to us. We didn't go to them to underwrite the indemnity risk. It takes a long time to put one of these deals together, and if we terminate the deal because our needs aren't being met, in other words, we're not making money, the HMO will be hard pressed to find another replacement carrier. We share with them the financial results, and we try to structure our arrangement such that they are trying hard to make sure that our needs are being met. We recognize that there are extra risks that we're undertaking on the medical side. However, we hope that we have significant margins built into the ancillary coverage and that we write a significant volume of ancillary coverages such that in total our needs will be met on this product.

FROM THE FLOOR: Mr. Hickman, I wondered if your approach to the HMO relationship differed significantly from CNA's. You identified the desire to get HMOs in a program and described some of the results, but how do you go about developing? Did you develop HMOs yourself or have you contracted as CNA has, or what differences would there be there?

MR. HICKMAN: We started this game around 1986 or so, and we have done just about everything under the sun to get into this managed care game. We joint ventured with some, we bought some,

and we have tried to develop some. We really haven't taken one approach, to be perfectly honest. We've purchased more of them or joint ventured more of them than we've tried to build. Recently, we've tried to consolidate those. We went ahead and got out of the joint ventures and ended up purchasing and owning 100% of the HMO.

MR. HARVEY SOBEL: Mr. Carlson, you basically described how you effectively underwrite HMOs before you enter into a joint venture. I was curious, given your prudent underwriting standards, exactly how many HMOs passed the rigorous tests.

MR. CARLSON: I didn't say we underwrite them. I said we approve them as an administrator.

MR. SOBEL: You described a series of standards that you would go through. In other words, you want to make sure that there is enough capital. You want to make sure that there are sufficient funds to cover adverse experience. You described a whole series of steps which are essentially designed to prune out HMOs that you might not be able to enter into a profitable arrangement with. That's why I viewed it as underwriting standards. Therefore, it just leads me to wonder how many HMOs, given that a lot of them are thinly capitalized, do you actually end up working with after all this is said and done?

MR. CARLSON: Not many. We've got many years of experience dealing with HMOs. Through these years of experience we know the good HMOs and the bad HMOs, and things you must look for. First of all, look at the quality of the management with the HMO. We will often terminate our reinsurance agreements with them simply because management has changed. What I was referring to more in my comments was we approve them as an administrator. Do they now have the capability to pay indemnity and PPO claims, recognizing that they do have experience paying HMO claims? We haven't done many of these deals. Each one seems to be structured a little differently. They're difficult to administer, they're complex, and they take a long time to put together. Control becomes a big issue with us. We often end up saying, "Boy, were we dumb to do that. Let's shoot that and go on and do something else." Some of them work and others don't. But we are going to learn a lot through this process, and we're not averse to taking those kinds of risks.

FROM THE FLOOR: This whole question kind of intrigues me because I've been struggling with the rating considerations, and I was first concerned with what multiple choice was. When I say multiple choice I'm thinking of writing a Blue Cross product alongside some other HMO, or health plan or whatever. Now what we're seeing is another question of choice, and one of the points that was made is, should we have point-of-service choice or should we just have point-ofenrollment choice? There's a great deal of risk here, obviously, and I just wonder how much risk carriers can assume, and how much are they willing to assume? I think I heard one of the speakers say that they would not do what I referred to as multiple choice. I've been trying to get that through to our management, and management doesn't want to do that, and I can understand the reasons. Would anyone care to comment on how essential it is to do the point-of-service? And, if so, to what degree is there an additional risk?

MR. AXENE: There is significant risk with point-of-service. First of all, in the point-of-service versus point-of-enrollment options, I think that risks can be controlled, and I think you have to get beyond that risk issue and look at what's best for the employer and the employees in controlling the cost. If you can do something to get everybody under one program, I think that minimizes the overall risk to the employer from a controllability point of view. If you force people only into one option, you'll never be able to get all of them. Therefore, yes, you pick up some risk for point-of-service, and if you can come up with ways of controlling that risk, you will be fine. I think that you need to look at it in a long-term risk control point of view. Someone made a comment earlier about the high HMO penetration marketplace where you don't really want to open up the risk of letting people out of that by having a point-of-service program. We've had a lot of people who have talked about that risk, too; that risk being that all of a sudden if we go to point-of-service, we will lose half the people that are in there because they'll want to go outside the network. That may or may not occur. But I do think the chance of having everybody under one umbrella to pull it back into one is worth a tremendous amount to offset all these other risks.

MS. THIEL: I would like to just comment on that from our perspective, the difficulty that you have from a marketing perspective, requiring yourself to be the sole carrier. We'll be the sole

carrier and require that on an insured basis. If we're in there on a rated basis with other HMOs, we'll give them the option of having our continued coverage as long as they're on a self-insured program. This, in effect, shifts the risk back to the employer. It's been a very difficult decision, and for a number of years we tried every alternative to survive in a multiple choice environment with other carriers. As I earlier commented, we realize that long term we could not financially survive. During the last few years, we've had to put the financial survival ahead of the marketing considerations, and that was the reason for our decision. Fortunately, it's paid off, and we've seen growth rather than a decrease in enrollment because of it.

MR. AXENE: One other comment is that prior to the 1988 HMO amendments, everybody talked a lot about shadow pricing and all of the other gamuts of trying to get as much money as you can in case you get the bad risk mix. From this, the HMO industry has picked up a lot of bad press because of their shadow pricing and skimming and whatever else. Since the 1988 amendments, it is now possible to do what's called risk-based contributions, where the actual contributions to the program can vary based upon the risk mix of the people that are signed up. Therefore, you no longer have to have mandated equal contributions. This, in itself, is going to minimize some of the concerns about replacement versus nonreplacement. Prior to that you really had a problem with that. And so I think that it'll be interesting to see what flows out of that as a result of the 1988 amendments.