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## **Session 990F**

### **Stop-Loss Insurance for Provider-Sponsored Organizations, Managed Care Health Plans and Self-Funded Groups**

**Track:** Health  
**Key words:** Reinsurance, Managed Care

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*Summary: This open forum and panel discussion presents current issues involved in providing stop-loss coverage for provider-sponsored organizations (PSOs), managed care health plans, and self-funded groups. In addition, the panel explores the type of coverage available and the pricing of stop-loss reinsurance.*

**Mr. P. Anthony Hammond:** With all the other issues that we wanted to address as the program was being set-up, we couldn't really find enough time to do three or four sessions on stop-loss, although I'm sure we could actually use up that much time covering all the issues. We tried to condense some of the issues into three presentations. One of the presentations is going to deal with just what is stop-loss, what's available and where you get information, where do you get manuals, and so on. Mike McLean is going to speak on that topic.

Jim Murphy is going to talk about pricing of stop-loss. He'll discuss how you put together a manual if you're doing it for your own company or if you're developing one as a consulting company. Then Harry Sutton's going to give us a perspective on some of the new rules related to provider-sponsored organizations and requirements that the Health Care Financing Administration (HCFA) and the federal government have in store for us. Harry also has some general information that he has gained from all his years of experience in doing all this. So we're going to get started with Mike, first, since he has the fancy computer and presentation and let him take us through the first part of the presentation.

Mike is the CEO of Medical Risk Managers , which is a managing general underwriter (MGU) specializing in group medical stop-loss. He has been running Medical Risk Managers (MRM) for over ten years, and built the stop-loss block from about \$2 million to about \$120 million. He was previously an Assistant Vice President at the Hartford and an actuarial associate at the Travelers. Your company is currently being sold, correct?

**Mr. Michael R. McLean:** We sold one subsidiary to the parent of Standard Security, and we are selling the other one to ING. We sold 20 of our employees in one direction and the other 53 are going to ING.

What we're going to cover are some of the trends going on in the industry, like the continued migration to self-funding and how there's currently an excess of reinsurance capacity out there, although that might be changing fairly soon. Then we'll talk about the national carrier networks and getting access. We'll also briefly discuss regulations and legal considerations and why you shouldn't price your stop-loss as a percentage of claims. Then Jim Murphy will be covering how you should price it, and then we will talk a little bit about consolidation.

The good news on stop-loss is demand for the stop-loss product is very strong. In fact, if you looked at the most recent KPMG study, you'd agree that it's a great study. The study a year ago showed the percentage of conventional plans that are self-funded. This source is KPMG, so it's the percentage of conventional plans meaning traditional indemnity. Some people would say there is no traditional indemnity left. At least our little plan with 53 employees is fully insured, and there is no managed care. So some of them do exist. There is still a trend towards self-funding and away from fully insured.

Some people would say, "PPO plans don't matter; it's really HMOs that count." The most recent KPMG study that came out showed that PPOs gained a lot of market share and HMOs actually lost market share. I believe they lost 3% market share last year according to that study. There is an increase in the percentage of plans that are self-funded. In fact, the study showed that there was an increase in the percentage of self-funded plans for all plan types—for indemnity, for PPOs, for point-of-service, and for HMOs. The number of HMO plans that were self-funded in the country went from 15% at the end of 1995 to 20% at the end of 1996, so there's a lot of bodies that are self-funded. What seems to be happening is the same thing that happened to the insurance companies back in the 1980s. They didn't want to go to self-funded plans. They preferred to keep them, but the employers are dragging them kicking and screaming into the self-funded world. The good news is that demand is strong. The survey started at 200 lives and up. The Foster Higgins Study showed that the percentage of small employers' self-funding and purchasing stop-

loss recently increased from 11% to 24%. So even in the smaller end of the market, there's an increasing penetration of self-funding. We had one client that raised their minimum deductible to \$4,000. A \$4,000 deductible quacks like a fully insured duck and looks like one. They used to be at \$1,000. So it's possible to go to very small case sizes.

Some other good news is that inflation is relatively low and reasonably predictable. There was a comment in an article that said that, "The elimination of marginal stop-loss players may spark a jump in stop-loss rates." This comment was made a year-and-a-half ago. It just didn't happen. It said, "Stop-loss rates will rise promptly." That didn't happen either. Another quote: "Many anticipate 1997 will be the best time in four years." Maybe 1998 will look good. We've had about three years with no rate increases in the industry, and sooner or later, the reinsurers will lose their sense of humor.

The bad news is trend is not currently less than expected. Back in the 1993-94 era, life was pretty good. It was before things were reasonably predictable and aggregate stop-loss was sleep insurance; you were never supposed to have an aggregate hit. That has changed dramatically. In fact, the aggregate hits are way up. We saw one block with \$7 million of aggregate premium and \$26 million of aggregate claims. They made a little money on the speculation, but not much. So there's a lot of loss ratios out there in the 200-300% range on the aggregates.

One of the reasons this is happening is the brokers are now more involved and trying to match the HMOs' premiums. Now, that's kind of hard to do when you consider the HMOs probably have better discounts than we do. I have an indemnity bias, so I would argue that the HMO populations are younger and healthier, at least historically. It's still harder on the self-funded side. They're not the younger or healthier groups.

Also, the HMO takes money and, traditionally, keeps it. We don't get to keep the excess profits on the good cases. We just get \$8,000 a year for aggregate premium. Some HMOs are making an awful lot of money on the Medicare risk contracts. In fact, there's a rule that says you must have at least 50% of your business in the commercial market. So they were making so much money on the HMO, they would write other stuff at a loss just so they could continue to make money on the HMO. That's also kind of tough to compete against.

The aggregates used to be very simple. The underwriter would take the claims, trend them forward, and add a corridor and things were fairly predictable. Now, it's coming from Aetna's plan three PPO in Detroit and it's going to ABC Rent-a-PPO plan two. No one really knows whether Aetna's plan was better or worse. That

increased volatility due to the change in the PPO networks is causing an awful lot of swings in aggregate hits. That's something that is not going to go away unless you know the discounts in every location of the country for every competitor out there and can judge one going to the other. Maybe that's why you need to hire consultants. I think people are not going to be looking at aggregate stop-loss going forward as just sleep insurance. There's irresponsible underwriting going on. At the Self-Insurance Institute (SIA) roundtable, the best line I heard was that there's a lot of underwriting without adult supervision going on now. When I see some of the loss ratios, I have to agree with that statement.

Some of the stop-loss carriers seem to be taking a long time to pay their claims. Part of the reason is they just have so many aggregate hits. They audit all aggregate hits so they just can't get to them. You can't solve the problem by outsourcing to the claims firms, because they're gainfully employed at this time and they're quite busy. There's also rumors of people sowing claims down to not hit the aggregate, such as if you happen to be in cahoots with the third party administrator. People have always accused some companies of doing that. At the Aetnas and CIGNAs of the world, the left hand probably doesn't know what the right hand is doing, so they would never be able to participate in collusion, and they wouldn't do it anyway. However, reinsurance capacity seems unlimited. Lee Sherman, who's been doing this for about 15 years, said that in all his 15 years, he'd never seen an MGU go out of business because of lack of capacity. In other words, it doesn't matter if you're currently in jail for fraud or whatever; you can get reinsurance behind you, so it's kind of a scary thought.

Specific loss ratios are up in the industry and closed ratios are down.

Everyone knows what leverage trend is. It's something that's needed. I think the underwriters and salespeople thought we just created this to get bigger rate increases. It's kind of like gravity; it's there. If inflation goes up, the deductible is fixed, and the liability will leverage. It's kind of hard to say, "I think trend is X and my leveraged trend is 150% of X." It doesn't matter. You're not going to get that in the street rates.

Renewal rate increases. For the last three years, the industry has been flat. In 1998, we are finally starting to see some change. I would say the rate of deterioration has declined on the loss ratios. I don't know that it's necessarily getting better yet.

Adherence to a manual. Part of the problem here is it's really the actuaries that were at fault. When you talked to reinsurers five years ago, they would say, "A PPO is worth 5-8%." We really don't want to give any more than that. In reality, the PPOs were worth a lot more than that. You can get 30 points off on your claims.

That leverage is quite nicely in reverse through your stop-loss liability. So what happened in 1993–94 is the liabilities went down a great deal. The manuals didn't reflect that, and everybody stopped believing in the manuals because they weren't competitive; however, the loss ratios were good. They've pretty much thrown out manuals. We've seen some blocks of business where people are at 15% of their manual. They just really didn't trust their manual.

Some other things missing in action are the rational stop-loss marketplace. It's rational unless you're taking risk out there. There is a reasonable aggregate factor. Again, that's causing a lot of aggregate hits and profits to the risk bearer on the TPA side. The ASO side is still reasonably profitable.

I moderated the Self-Insurance Institute of America Roundtable in September 1997. I went to a bunch of the risk bearers in the industry and asked them about loss ratios. I knew no one would tell me their actual loss ratios, but I was able to convince them it would be in their best interest to tell me the changes in loss ratios. We took specific and aggregate stop loss combined and went to a bunch of direct carriers who took the risk themselves. There was about \$500 million of gross premium and about \$1.3 billion of street premium for the reinsurers. I didn't bother going to the fronting companies, because a lot of the fronting companies take 5% of the risk and don't care what the loss ratio is because they only have 5% of the risk. If the loss ratio goes higher than 200% on the net premium, then they might start to be concerned. But if it's less than 150%, they honestly don't get concerned. They're not that interested.

I saw a survey in about 1993 that showed that the majority of the plans out there were 90% or more reinsured, so the fronting companies just didn't care. They got their 5% fronting fee, plus premium taxes and put it in the bank. I also didn't go to the MGUs because I knew they would have lied to me anyway.

There was a change in loss ratios from 1994 to 1995. We surveyed 12 companies. Company A was the only company in the survey that had a net decrease in its loss ratio over the three-year period. These are additive. I just asked for the change in loss ratios, not the multiplicative percentage change, so they had a 1% decline. One company is specific stop-loss ratio only. Company E admitted that its 1996 treaty year was going to get better, even though it hadn't seen any rate increases and there was inflation. The last good number of the whole survey was really Company F and it only deteriorated 8% over the three-year period. Then there is a huge jump for the seventh company out of the 12. It had deteriorated 18% over the period. It lost its sense of humor in 1996.

It starts to get worse. Company I admitted that its 1996 number was also preliminary at the time, so things are probably going to deteriorate worse than the 22% it was showing. The worst one on the list was 26% deterioration from one of the companies.

You can weight all of these 12 companies together by premiums. I split them off into the risk-bearing carriers where there was about an 8% deterioration over the year. They were responsible for their own risk, so they took a little more interest in it. The reinsurers were backing a lot of MGUs and fronting companies and the MGUs and fronting companies get paid as a percentage of premium, so it's easy to figure out that you're supposed to write a great deal of premium. The reinsurers deteriorated just about 20% over the three-year period and, in fact, lost their sense of humor in 1995. They just didn't know it until early 1997, when they started losing a lot of the money. They lost about 15.5% over the period. There has been a rapid deterioration in loss ratios throughout the industry. I didn't update this survey for this particular meeting, but there's no reason to think that things got much better.

There's an imbalance of the supply and demand. The demand for the product is good, but the supply is too plentiful under reinsurance capacity. What we've been telling reinsurers is if you're just capacity, you're part of the problem. If you can provide value added that will reduce the claim liability, then you're part of the solution.

What corrective actions need to be taken? You often have to terminate relationships. ING had three MGUs that they were dealing with a year ago. They canceled two of them and bought one, and I lucked out and fell on the side that got bought. You need to align the interest of the reinsurer, the fronting company, the MGU, and the intermediary. What happens is the fronting company, the MGU, and the intermediary get their fees. Everybody is taking a percentage of premium. Nobody cares about the risk. The fronting company is only taking 5% of the risk. Then the reinsurer wonders why things are bad. When you have a fox in a henhouse that happens.

What you need to do is put the fees meaningfully at risk. On the other hand, the reinsurers have to be willing to meaningfully share profit sharing. When I started in this business they would share after they made their 15%. On net premium, they would share a portion of it. They have to start sharing a little before that. In today's times it's hard to make 15% or 16%. But there needs to be a reward for the improvement, and you need to penalize the MGUs for deterioration.

You must monitor things closely. Oddly enough, many reinsurers don't have a clue as to where their carriers and MGUs are relative to manual. This is pretty astonishing from an actuarial standpoint. The discounts can be 70% off manual. We used to be 96% off manual on renewal and 98% on presale. We're not that high anymore either, so I'm also guilty of having a manual that's too high. You need to have a manual that people can trust and you need to adhere to it.

If the block's writing at 120%, you need to get it down to 90%. That's a 33% needed increase. You want to hit it with leverage trend. Let's say leverage trend is only 10%. You might realize that there are some other loads that are needed. Your needed increase may be 55% but blocks aren't going to get 55%. I'm not sure that a lot of these blocks are, in fact, salvageable.

You also need to look at closed ratios. They've declined over the years and if somebody hasn't declined, they could be buying business. Persistency has deteriorated until recently. We're starting to see persistency get better in the industry. Loss ratios have deteriorated significantly again.

If you've seen one PPO, you've seen one PPO. The ability to differentiate between the multitude of PPO networks is the single most important aspect of a successful MGU or carrier, because it changes the liability an awful lot.

You have to allow TPAs access to a national carrier network. We hooked up a deal with ING and CIGNA to get access to CIGNA's networks to bring them to the TPA marketplace. It's the albatross around the big ASO carriers' necks. They don't pay claims well. They charge a lot for it, and their service isn't good. That's what the TPAs do well, and we let them do that. We hope to be able to take this to the TPA marketplace. There are a lot of advantages.

When we were pitching this to the TPAs and the carriers, we had 1.2 million lives covered for stop-loss. ING has more than that. We've got all these bodies, but I wish we had some meaningful discounts. On the other hand, you've got the national carriers out there saying we've spent hundreds of millions or billions of dollars developing these networks. We need to put some bodies in the networks. We just want to be the matchmaker that puts the two together.

So what happened in this instance is CIGNA Health Care gave access to CIGNA Reinsurance. We pass on the networks to the TPAs who do the marketing to the brokers. The brokers then market to the employers. The employers encourage their employees to go into the particular hospitals in the CIGNA network. Then you have more hospitals and more bodies in these hospitals and they'll give even better discounts to the CIGNA network.

In this case, the advantage to the national carrier is CIGNA has millions of additional members in their networks, better negotiating clout, and virtually no marketing costs. These are members that aren't in the competition's networks. You get high profit margins because it has found bodies and, in fact, they get stop-loss reinsurance. Fifty percent of the risk is reinsured back to CIGNA and CIGNA has made a lot of money on this over the years.

The advantages to the risk bearer are lowered stop-loss liability, more profitable stop-loss, more competitive stop-loss rates, product differentiation, and value added to the TPA. For the TPA, his employers get access to a better network, good name recognition, and great discounts. It's pretty easy to sell a CIGNA-type network to a broker. He gets low stop-loss rates, but the most important aspect is he gets survivability into the future. There is also product differentiation. Hopefully, there is less pressure on his administration fees. The employer gets a great nationwide network, low administration costs, and the excellent TPA service. It's really the best of all worlds.

Within a PPO there is network development, marketing, and repricing. The network development is what the carriers do well. We'll let the TPAs do the marketing. The MGUs will market to the TPAs, and the TPAs will market to the brokers. Either the TPA or the national carrier can do the repricing.

Let's talk about the Mental Health Parity Act. The law just became effective and deals with the total cost implications on the claims. The Congressional Budget Office says that there was a 0.4% increase in premiums. After you have employer responses, like cutting back on coverage and putting in internal limits, they estimated the increase was only 0.16% which was fairly low. Coopers and Lybrand's numbers came in lower with 0.12% and 0.05%. However, the Coopers and Lybrand study was prepared for the American Psychiatric Association, so you have to take everything with a grain of salt. It's not that I think they would do anything wrong, but I would probably prefer an impartial Congressional Budget Office number.

There's a minimal impact on the aggregate attachment points. However, if you're increasing the annual and lifetime maximums, which is what the law essentially did, it will impact shock claims and then overall claims. If you have a \$25,000 limit, and you're taking it to \$1 million and you have a \$25,000 deductible, the entire increase goes into the specific stop-loss. So if you have a 0.4% increase spread across 10% of your premiums or 10% of your claims, then really it's increasing your stop-loss claims by 4%.



Let's discuss pricing specific stop-loss as a percentage of claims. Many Blue Cross plans and ASO carriers are still doing this type of pricing. Aetna was doing it until we put our underwriters on site at their shop four-and-a-half years ago. Travelers was doing it until we got our underwriters on site. They've seen the light so to speak.

The bottom line is demographics and managed care impacts shock claims in a much different manner than overall claims. Females have overall higher morbidity costs than males for total claims, but on specific stop-loss shock claims, the age/sex factor looks more like a morality curve than a morbidity curve. Of course, the type of claim that's \$50,000 is also the type of claim that will kill you. So what ends up happening is females are, in fact, much less expensive on shock claims than males, yet anyone doing a percentage of claims pricing would be loading female groups, whereas, we, as the niche stop-loss players, are discounting them.

Based on the Society of Actuaries study of 40,000 shock claims, where a shock claim is defined as anything over \$25,000, you might not want to use percentage of claims in pricing. It's expedient, it's easy, and it's right on average, but it's wrong in every case.

One other thing, a lot of the ASO carriers don't think they have any problem with stop-loss. They say that they are really having a problem with being competitive as far as their administrative fees. When I start talking to them, I ask, "What are you throwing in for expenses on your stop-loss?" They say, "Nothing." They're pricing to a 100% permissible stop-loss ratio. They are not even throwing premium tax in there and pricing as a percentage of claims. They don't think they have a problem, but their administration fees are too high. That's because they have thrown all of their expenses into their administration fees. The TPAs sometimes are breaking even on administration fees, but they're making ten point commissions on the stop-loss. In the TPA world, the stop-loss players have permissible loss ratios that are around 65%. If you're pricing to a 100% permissible loss ratio, you can probably compete against them by pricing inefficiently. It still doesn't make it the right thing to do.

Another thing going on is the Blue Cross plans have such wonderful discounts. That also covers a multitude of pricing sins from a stop-loss perspective. So you can probably get away with it, but it's still not the right thing to do.

Consolidation. In the MGU industry the largest carrier or the largest block of stop-loss business would be found at U.S. Benefits. It purchased Global last year. Houston Casualty has purchased two large and one medium-size MGU, Lockwood, Dipple, and Green (LDG) Guarantee Insurance Resources (GIR). This will make

them about \$200 million in stop-loss premiums and that was all done through acquisitions. ING has just purchased MRM. Most of the people looking to do the purchasing are interested in the risk and most of the blocks out there aren't, so that makes it interesting.

There's consolidation going on in all industries, not just the insurance industry. For reinsurers, there's consolidation. General Re was just purchased for \$23.5 billion. I think that there will be a consolidation amongst PPOs especially when CIGNA starts to market to TPAs. That wasn't available before, so that will be additional competition for these regional PPOs.

The fact that CIGNA is now allowing access to their networks could cause a reduction in reinsurance capacity. If you don't have access to a great network and somebody else does, meaning, if you're on the wrong side of an unlevel playing field, you might as well get out. I wouldn't want to be competing against them. Obviously, the people in the fully insured market came to this conclusion a long time ago. You don't see too many mid-sized and small carriers jumping into the fully insured health market nowadays because that's not a smart thing to do. However, it could be in the future if these giant Apple computer-type companies began to wonder why they should spend \$1 billion dollars to buy a block of business. They might wonder whether they should give them the network? I'll get access fees out of it. I'll get 50% of the reinsurance for free. I wouldn't have had to spend a penny and I'll get all these extra bodies in my network. Convincing these large companies to do that is easier said than done, but once that happens, then it might allow small to mid-sized companies to survive into the future.

**Mr. Hammond:** I want to introduce Jim Murphy. Jim is the manager for Health and Welfare Actuarial Services for Howard Johnson and Company that's based in Seattle. He's also the Vice-President of health for the Society of Actuaries and was previously, for about six years, the Executive Director of the American Academy of Actuaries. Jim is going to talk about pricing.

**Mr. James J. Murphy:** I'm going to discuss the markets, the coverages with respect to pricing, and then show you some considerations with respect to base rate determination in each of those areas. We'll focus a little bit on the factors that take you from base rate to manual rate in a stop-loss manual situation. I'll get into managed care implications in pricing, and I'll look at the question of using manual versus case-by-case approaches in pricing by market.

There are three market areas I'm going to talk about, though my focus will be primarily on the employer self-insured market for specific and aggregate. This is a very mature market, and, as Mike discussed, there is a lot going on in this market.

The impact of managed care is affecting the way we deal with this market. We'll talk a little bit about HMOs where capitation and the staff models reduce the need for the reinsurance issues. Hospital-specific approaches are the most common approach, and we'll address that a little bit. And then we'll talk a little bit about provider excess loss. We're talking about specific coverages, at least that's what I'm going to talk about. This is quite a new market. It's growing along with HMOs and PPOs and all the other approaches that increase capitation to providers out there. Therefore, more risk is being passed on to providers. While some of them still don't realize that they have a risk and that it is a problem in and of itself, they are realizing that they need some stop-loss coverages, and that has produced some problems for a number of you.

We'll get into the base rate considerations starting with specific stop-loss. The key in all of these is developing a base claims distribution. It's the critical starting point and, as with anything we do in pricing, you need data. If there's one thing that's hard to find in the health insurance field it's data, particularly in the volume that you want to have to develop a credible base for manuals.

In the area of published experience data, the most significant entry into this field in recent years was the Society of Actuaries' Medical Large Claim Experience Study. It has been a boon to the stop-loss industry, as a specific area, to have actual solid data for claims. You can also consider your own data if you're big enough or perhaps data from your clients if that's possible. In either case, the data are always running behind.

The first Large Claim Study was based on 1991-92 claims and was published in 1997. The committee is hoping and planning to be more efficient this next time around, but probably trending for at least four years or more will be necessary with the next study. Even when you're using your own data, you always have to do some trending just because of the timing of developing the information. This kind of trending can actually double the claim costs over the period that you've looked at in order to develop your rates.

Going from the data and the need to trend it, the question is where do I get my trending information? You've got to look at the medical consumer price index (CPI), utilization trends, what's happening in technology, cost shifting and, of course, the impact of deductible leveraging. One source I'll mention is our own trend report, which many of you may have received. I had hoped to bring the recent issue here, but for some reason it didn't arrive. If you're interested in getting a copy contact me.

Another question that arises is how far can you go with just trend if you're using some data that you were able to get once, but now you can't get more data? How far can you go? I guess you just have to follow your experience and that's always a couple of years too late. At some point, you have to reaffirm where you are and get new data. How close your manual is to your book of business is the real question.

So if you're able to do all that, you'll get some base rates for specific stop-loss, and you'll have to give it one more look. This really reflects what Mike discussed regarding the pressure of the marketplace. It may not come up in the manual development of pricing development, but it's certainly going to come up in the way that manual is applied. So don't forget market pressures.

Let's discuss the aggregate stop-loss traditional employer approach. You can use the same base claims distribution if it includes all claim amounts, so the Society Large Claim Study would not be appropriate since it starts at \$25,000 and above. You've got to go further than that and find some claims data that are appropriate.

In terms of working with aggregate stop-loss, there are two considerations. One is the aggregate attachment point and the other is the premium. In this marketplace and in developing pricing and manuals, the aggregate attachment point is really the more critical point. When developing a manual, we develop a premium. We use Monte Carlo simulations to come up with the premium. It will vary with group size and with the margin. The premium, even more so than other areas, are set by the marketplace. As I said, the material, critical issue is setting that aggregate attachment point and the margin is a key part of that.

Next, let's discuss a little bit about shifting into base rate considerations in the HMO field. I'm primarily talking about hospitals. The key consideration is exactly what is covered. Is it hospital only? Does it include out-of-area? Are physicians or specialty coverages included? The important thing is to nail it down. Know what you're covering. Define the claim because there isn't a claim in an HMO. There's just a service provided, but you must translate that into dollars. Are you going to use diagnostic related groups (DRGs), per diems, or a Resource Based Relative Value Schedule (RBRVS) or actual charges in those cases where that applies? Define the claim amount.

You still need a base claims distribution to work with and that's not always easy to get to with HMOs. Though their data systems are getting better, data are not as readily available as an indemnity field. Ideally, you can get information on the specific covered services. If not, perhaps you can use some total claims information and adjust to the coverage you're providing. For example, a percentage from the

Large Claim Study for the assumed hospital proportion of the total and perhaps some other sources are available to you to develop some assumptions for that part. To some extent, in the HMOs, the insured controls the claims and this needs to be handled in your design and definition and to help control claims. Sharing the risk is not a bad idea in setting the plan up.

The toughest area is provider excess. It's going to vary by the type of provider. Are you dealing with a hospital? Are you dealing with a physician group? Are you dealing with a specialist group? You need a clear definition of what is covered and how it is measured and here, even more than in the HMO field, that is critical. Specific data are probably not going to be available and you may have to use some adjustment of total claims distribution as an estimate. You're really going to be using the art of actuarial science more than the science. There's no question about that. That's why the first two items are so critical in working with whatever data you have. You're going to have to adjust it and really know these products and what's defined.

More than in the HMO, the insured controls the claim. What services are provided and to some extent how much is charged, how they're defined, etc., is under the control of the physician or the hospital and that means more importance in the contracting than the pricing. This is a new product. There is minimal standardization in the marketplace. Everything is different, and every case is new. In a lot of areas, and perhaps in some cases, because of the state requirements, we're seeing casualty approaches used. And I'm not a casualty actuary, so I'm not going to sit here and try and tell you how to do that.

Let's get into old-fashioned stop-loss. The base rate is critical. It's your starting point, but, obviously, you've got to get down to a manual rate that, ultimately, gives you a basis for applying to a case. There are a number of issues to keep in mind beyond the base rate considerations. Obviously, you're going to have to use trend because the effective date and the date of your pricing are not going to be the same. You must consider the geographic area. It's typically three-digit zip codes. The underlying plans are going to be different than the data you were using and some adjustments are going to be necessary for that. The contract form that you're providing affects the pricing. Adjustments for industry factors are important, and there are some industries you still wouldn't want to cover. Managed care adjustment, which I'll talk about more in a minute, is becoming more and more critical and something we've been building into our manuals for a number of years to try and deal with some of the concerns that Mike mentioned. Obviously, the age/sex factor has to be brought into play with respect to a particular case.

So let me talk a minute about the managed care piece. Primarily, because of the availability of data and the nature of the business for a number of years, the claims distributions have been based on indemnity plans. Today, more and more of the plans out there have at least some managed care component, or are very big into managed care. In fact, some have said there really isn't any true indemnity anymore. There's always at least some aspects of care management taking place.

The kinds of things you need to adjust for to recognize the degree of managed care include network adjustments (discounts), case management, demand management, other cost containment features (hospice, hospital bill audits, second surgical opinions, etc.). These things, of course, are leveraged in the stop-loss situation because they have a greater impact in that case than they do on total claims when you're dealing with the particular specific stop-loss situation. They can be very important. Mike is right. In the early years, they just weren't properly reflected in the manuals and that has to be handled.

Another thing you have to think about as you consider making these adjustments is how much further are they going to go with managed care cost reduction? Not only has the turnip been squeezed quite a bit already but regulations and potential laws out there are going to have an impact on the so-called managed care backlash in Washington, D.C. Is that going to turn the situation around, and are we going to start seeing increases in managed care costs rather than the relative decreases? Managed care is an important piece of stop-loss today, and you need to reflect it in your manuals. We've been doing that in our manuals for some time now.

Finally, there is the question of whether you should be using manuals that are your own, or whether you're capable of developing those in terms of data and staff, or should you use a consulting firm? Should you be going case-by-case? This is primarily a market issue, and it's fairly logical.

Traditional stop-loss is a mature market. The manuals are readily available out there, and there are data available if you want to develop your own manuals. Case-by-case pricing doesn't really fit except perhaps on some very large cases where there is credibility. You're probably looking at \$1 million in premium as a measure of full credibility in determining whether you want to do case-by-case pricing.

The HMO market is a less mature market. There are manuals available that can be adjusted to situations. Perhaps case-by-case pricing or using adjusted manuals is the way to go. It's not a clear-cut decision one way or the other.

The provider excess field, on the other hand, is the very new market and it is very diverse. Every case is unique in terms of definition of what's covered, the definition

of claim, and how you measure it. It's very difficult to try and put that in a manual setting. You really have to look at each case individually. It's challenging pricing and both art and creativity on the part of the actuary and the underwriter is required. Once you've priced it and placed it, you want to watch the experience closely.

Session 69 was on "Provider Excess Loss, Where Has All the Money Gone?" That alone is enough to tell you why you have to be careful in pricing this area if you want to price it at all. You may not want to be in the market.

Listed below are some references on this subject:

- Group Medical Reinsurance
  - SOA Study Note 320-29-87
- Reinsurance in the Managed Care Environment
  - SOA Study Note 320-51-96
- Pricing and Underwriting Stop-Loss Insurance
  - SOA *RECORD* Vol. 22, No. 2, S48PD, 6/96 Colorado Spgs
- Reinsurance in the Evolving U.S. Medical Market
  - SOA *RECORD* Vol. 22, No. 2, S124PD, 6/96 Colorado Spgs
- Excess Coverage Reinsurance for Health Care Providers
  - SOA *RECORD* Vol. 23, No. 1, S4PD, 5/97 Palm Desert
- Health Provider Excess Stop-Loss Issues
  - SOA *RECORD* Vol. 23, No. 1, S123TS, 5/97 Palm Desert
- Stop Loss 101
  - Duncanson & Holt Group, San Francisco
- Health Trend Report
  - Howard Johnson & Company, Seattle, WA

Stop-loss pricing is fun in today's market. There are good manuals out there, but even the good manuals are discounted. If you're getting too far from manuals, then you've got to start looking at the marketplace. We keep saying, as Mike said, it's going to get better, but it doesn't seem to happen. It just goes back to market pressure.

**Mr. Hammond:** The next presenter is Harry Sutton. Harry started out with Prudential for about 25 years and then went into consulting for about 20 years and did a lot of reinsurance and other things. I've heard it said that Harry was around when they invented HMOs, but I think the proper way to say that is Harry was probably at the table when they figured out how to do it right. Harry's going to tell us some more about the new PSO requirements.

**Mr. Harry L. Sutton, Jr:** While my current company is heavily involved in HMO reinsurance and I'm in the business of writing POS or indemnity wraparound coverages and out-of-area coverages for loose employees that are scattered from the HMO sites, I'm not going to talk about that. I am going to talk about what we call physician incentive plans (PIPs). PIPs were originally set-up because Representative Pete Stark (D-California) said about ten years ago that it's not fair to put the physicians at risk if they're going to deny care to Medicare beneficiaries because of the risk they're at. Five years were spent coming up with some very simple rules which, essentially, didn't change the ground rules at all. Now the government is trying to privatize Medicare, or, in other words, convert to a defined contribution for Medicare and get everybody enrolled in some kind of a health plan with a guaranteed premium. Then, the government can just negotiate down the prices and lay all the blame for cost going up on HMOs raising their premiums or Medigap contracts having a big premium rate increase.

What they've been doing for the last couple of years is making it very difficult for HMOs. There has already been some discussion of the HMO reinsurance market, which is, essentially, hospital coverage, but it's now expanding into the provider system coverage. Formal discussions with the top four or five carriers that I am familiar with shows that almost all of them have lost a lot of money. Some of them have lost it on the hospital side, and others have lost the money on the medical side. As the previous speakers have talked about, the market is very unclear. There is no data on the physicians.

I'm going to add one thing to what they said. The problem is underwriting. If you meet with a bunch of physicians and they don't know anything about managing care or controlling costs, you'd better not sell anything to them. We've been asked to quote on a lot of them and when you meet them, they say they want to put the care of the patient back in the hand of the physician. I'd say you should stay away from that company. Most of the ones set-up by organized medicine have been in deep trouble or lost money.

In the previous session I was at it was said that there are at least two county or statewide medical societies that have set-up indemnity plans. The first one lost so much money that it was close to going out of business in one year because it wants to give the physician complete freedom to do whatever he wants. That's the whole point of what they're doing. Another one is just starting in Texas, but each physician puts up \$50 and they collected \$4 million for capitalizing a health insurance company. Everyone (at least the people who know what's going on) is waiting to see how long it takes before it runs out of money.



Provider reinsurance is very difficult. The reinsurance that we have now is basically hospital coverage, because that's where most of the expensive claims come in. In some cases, we reinsure the physician part of the coverage that applies to the hospital stay. The other alternative is to provide separate coverage for physicians. The deductibles range from \$7,500 to \$15,000 or \$20,000, so you're only covering high costs for physician services.

The Health Care Financing Administration (HCFA), which regulates Medicare and Medicaid, has set up these standards by defining what's called a substantial financial risk. There's one other element here that's also going to affect risk-based capital for PSOs or HMOs, which is called fiscal intermediaries. This is a brand new format for risk-based capital for managed care organizations, which should have been approved in the past week or so by the NAIC.

An intermediary, for example, is an individual practice association (IPA) model that converts a capitation, assuming the IPA is a corporation, and then pays the physician's fee. It is considered an intermediary. You could take a reduction in your risk-based capital because you had laid off the risk with those physicians. Nobody knew if that IPA was solvent or not. They either have to prove that they're solvent or you can't take credit in your risk-based capital for doing it. There's some overlapping in what I'm talking about with the federal problems.

I've had doctors call me up on the phone saying, "I want to buy coverage. I want you to guarantee that I'll get 80% of my regular fees. I want an aggregate coverage that covers all of my HMO operations. That's a tremendous incentive for increasing utilization because, if they could collect 80% of their regular fees all the time, they'd be retiring shortly.

I want to get into the PIP regulations and these were designed to protect Medicare and Medicaid members from having too much incentive. Having too much risk is defined as the physician having the risk of losing 25% or more of his revenue. It also goes up and down. For example, if you could pay the physician his fees minus a 25% withhold, which would be used to absorb the risk of a cost overrun, then you couldn't pay the physician a bonus, so it goes both up and down. You can have a risk band of 25% of the expected compensation of the physician. If you had a 25% withhold, you couldn't pay a bonus under their rules. These do apply to PSOs. These have been in force since January 1, 1997. All these rules are on the HCFA website.

Most HMOs that are very large can pool their non-Medicare and non-Medicaid populations, as long as they have the same risk-sharing arrangements with physicians. But if you had a clinic that had a small number of capitated people on

risk for referrals, it's generally considered a referral risk for physicians that they're trying to block. Their withhold might be used to cover either referral overruns or hospital cost overruns.

If you have a three-man primary care group and they're taking a capitation and they have any liability for referrals at all, they must have these limits. In other words, if you're starting a PSO and all you have is less than 1,000 Medicare members and no commercial members, theoretically, you would have to have a hospital deductible of \$10,000, which nobody sells. It was estimated that a premium for that might cost \$84 a month for a Medicare patient. Remember, the hospital cost for Medicare is approximately \$300 per member month. So we're talking about taking 20% or 30% of the HMOs revenue just for protection. In some areas of the country, the average cost per hospital admission under Medicare is higher than \$10,000. Because they wanted a separate one for physicians, they split. Actually, you have a lower limit for combined and a \$3,000 limit for professional. Nobody would sell anything this low and after we discussed this with HCFA, we said nobody would sell it.

We received a lot of inquiries in our reinsurance when the original draft rules came out in 1996. Institutions like medical schools or the Mayo Clinic had all kinds of arrangements of how to compare referrals and sometimes departments did have risk. Essentially, these rules must be complied with under your physician contracts. There's no way of writing this type of reinsurance simply.

Look at Blue Cross of Chicago. They have an HMO with some 200 clinics and they have different agreements because of the different specialities in these clinics. One of them could have 750 Medicare patients, and they don't want the same risk for non-Medicare. They would have to, for that one clinic, provide limits on the risk of that clinic.

The big plans are being heavily audited by HCFA, so nobody writes this reinsurance. We've told the clients you have to put it in their contracts with the physicians. But HCFA is auditing to be sure there haven't been some exceptional cases that weren't picked up by the health plan. So a big HMO with a million members and large medical groups with 300 physicians or even the Mayo Clinic, doesn't have the problem because everything is self-contained. But when you have a small clinic and a whole network of clinics that may be paid at capitation or some share of a capitation and have part risk, you've got to be able to protect them according to these rules.

The government seems to be auditing only the big ones because they can cover more area by doing that. My guess is the smaller HMOs don't know anymore about

this than you or I do, and the state regulators certainly don't know. I've been to several state regulatory meetings. Last year this was presented by HCFA at the regulators' meetings and when the speaker asked how many understand this, no one could say that they even heard of it. However, all the HMOs in their state are supposed to have these internal limits in their physician contracts or reinsurance that would cover that.

If you have 25,000 or more people under the same kind of a physician agreement contract or HMO provider contracts, then you get away from all this Mickey Mouse stuff. This is why HCFA has said these rules apply to PSOs. PSOs are supposed to start in more rural areas that have a very low cost because there aren't many providers there and they may not have very many people to enroll either. So it's probably going to be much more of a problem for a PSO starting in a low population area to figure out what to do with this than it would be for a big HMO where they're pulling hundreds of thousands of people in one of these areas.

This applies to every existing HMO that has a Medicare risk contract, and it could apply to a PPO with an insurance company. It's supposed to apply to MSAs or anything else that has Medicare Plus choices that should be starting in November 1998 and effective January 1999.

I have just a couple more brief comments. It's really an addendum to federal intrusion into the normal operations of HMOs, or insurance carriers, or anybody. I have a small amount of data showing the reimbursement methods used by managed care plans in 1994, and some of this was collected by the American Medical Association (AMA) in surveys. The data are broken down by type of HMO, including a PPO. PPOs have little risk sharing, but many are picking a capitation more for primary care and almost all of them have some kind of risk-sharing arrangement, so that if these are small areas and there are providers with these kind of risks, all those rules are going to come into play, particularly if they have risk that's more than the 25% limits. My pet problem these days is physician management companies, which I think, essentially, are on the verge of going insolvent. If you've capitated them, the HMO is responsible to deliver the health care, and then they go bankrupt. There's almost unlimited risk. In my opinion, your risk-based capital is going to double or triple if you've laid it off with that intermediary company. These rules are going to apply, because if, in fact, they refer out and they are taking risk, they don't have any contracts with physicians that set-up that reinsurance arrangement. That HMO plan is at risk and they have to follow those rules as far as risk is concerned.

In another set of data, the variation is by area. It's just a subset of the data on reimbursement methods used by managed care plans. Almost all of these areas

have some risk sharing that. The fact that it's a capitation doesn't mean they aren't at risk. In many cases, they have a capitation, but there's a withhold from the capitation or if the claims go above a certain level, there's a risk. The U.S. participation in HMOs or similar organizations is close to universal.

The last item is an example of the federal way of thinking. When these rules were being installed at the beginning of 1997, they characterized all risk-bearing arrangements between HMO's risk contractors, medical groups, individual physicians, hospitals, and intermediaries. The example I'm referring to is a contract between an intermediate entity like an IPA and a clinic or a medical service company. These are required to be sent by the HMO, reflecting every single working arrangement they have in the HMO. Is it capitation, is it bonus, is it withhold and what is the amount? The federal government can determine whether you're violating the rules or not. You can have entities contracting with entities, and you have to explain all this stuff.

Now, they have simplified this greatly. They've changed it to one form and they give you a set of instructions on how to fill out the form to describe how your entity relation works. You'd have to give information about your reinsurer, your doctors, your medical groups, if you have an IPA model, if you have it on many plans. With all these variations in the plan, there's almost no way they can comply with all this that I can see. So the amount of paperwork is immense.

If you are at risk with a fiscal intermediary or there is no reinsurance structure like that in your contracts, in addition to furnishing all this other information, you have to survey a segment of your active population and do a separate survey of people terminating coverage, whether they're changing jobs, or moving out of the state, or whatever. If someone was denied health care because of the physician risk, they want to know if they had a hard time getting to a specialist. They're asking active employees to tell what's going on. This is where there's substantial risk with the physicians. They're asking terminating employees if the reason they're terminating is because they couldn't get health care, or thought they couldn't get health care, or somebody turned them down for a referral, or whatever.

The massive paperwork that the government's planning on doing with Medicare reform is just unbelievable. It's hard to see sometimes how anyone, unless you are a huge company, could set all this up. Everyone will probably have to redo all their provider contracts to put this in it. If they don't, they'll have to survey everybody to be sure they like the health care they're getting and that they don't feel they're being disturbed. This is just another example of federal interference.

Part of the reason it was set-up is to cover the complaints on Medicare. I asked them, at the time they went through this with me, how many complaints they got from HMO members and Medicare recipients for appeals. They said that over the past five years they have received about 3,000 complaints. During that period, there were five million Medicare recipients covered, so they get approximately one complaint per year, per 5,000 or 10,000 members. That causes an emergency in the eyes of Congress. Congress just tells HCFA that it has to do this and they come out with all these rules. We could have paid each one of those complainants \$10,000 and saved money. It is not going to be easy to be a PSO. There will be administrative hassles they will have to go through just to get licensed, particularly, when they bypass the state regulations and the capital requirements. The capital requirements are lower, so I think we're in for a very interesting time.

**Mr. Hammond:** There's a couple things I'd like to add. Mike and I were using the term MGU and I realized that we hadn't explained that. That's a managing general underwriter for anyone who doesn't know that. That was a new term for me, but I wanted to share that with you. Jim talked about the data analysis and lack of data for analysis. Some of the new statistical methods that allow for getting some degree of credibility with smaller amounts of data may actually help improve the creation of manuals. It still means that you need to have a breadth of data to cover all of the situations. If you don't have enough data that you can at least stratify, you're still kind of stuck with not really having enough information to do this. There is a Society Work Group that's also working on all aspects of credibility from developing manuals to doing underwriting, and so on. Some of us have been working on that. In some ways, it shows that you can get credible results with even lower amounts of data than we've looked at before.

One other thing that I heard you mention was the \$1 million criticality level. I thought that was interesting, because, generally, we talk about needing \$10 million to be a critical HMO plan. As an indemnity plan the level might have been a little lower years before. You need at least \$10 million or 10,000 members, to start being a plan that can survive on its own. Ten percent of that would get you to the \$1 million number. That's the other number that I often hear. Ten percent is how much you should be reinsured.

There are a couple other things that I heard we should not use. One is the percent of premium method of pricing. I thought it was real good point about how the age/sex factors impact your method of pricing.

The manuals seem to be heavily discounted. To me that kind of means two things. Either I'm using the manual wrong or I'm doing something wrong on the pricing when I'm that far away. When I'm doing just regular pricing, not stop-loss as a

pricing plan, I expect to be within a percentage, maybe plus or minus 20% of my manual depending on my plan, depending on what I'm doing. If I'm at 50%, I need to start worrying.

Harry pointed out that the compliance issues related to PSOs or just HMOs, in general, related to PIP. The new rules are going to be a nightmare. It's important to know that somebody is going to be dealing with that. You've got to be real careful with provider stop-loss coverage. Jim pointed out that you have to define what you're covering. The last thing I came away with was—it's the underwriting.

Mike, can you tell us what the difference is between a managing general underwriter and just a carrier or a fronting company?

**Mr. McLean:** We don't take risk, and fortunately, that's the main difference. Most MGUs simply rent the paper from a fronting company. They do all the marketing, the premium administration, and they readjudicate the TPA's claims. The most important thing they do is set the premiums. They underwrite the individual cases. We, as an underwriter, use the distribution forces of other client insurance companies like ING and AIG. Their sales forces go out and sell the product and we do the case underwriting, but, again, we don't take the risk. It's kind of a fox in a henhouse situation where the people setting the rates get paid a percentage of premium and so they just want to sell more cases. It's a dangerous situation if there's not proper controls.

**Mr. John Francis Ames:** Mike, what's your average or what do you see as an average MGU fee?

**Mr. McLean:** It depends on whether you do the marketing or not. If people were renting paper, an MGU fee might be around 10% or 12% of the premiums. They would do everything; we don't do the marketing. Doing the underwriting and claims adjudication costs us about 1% of premium. We'll tend to be around 7.5% of premium to do soup to nuts underwriting, actuarial work, help with filings and things like that.

**Mr. Ames:** Do you find there's pressure right now to reduce those fees or the retention?

**Mr. McLean:** There's a lot of pressure to put fees at risk for anyone standing in line because of the fox in the henhouse situation. The real pressure that's coming on us is we have always enjoyed seven figure profit sharing checks along the way, and it's just harder to keep those in the seven-figure range because profit margins are declining. I think it's appropriate to put fees at risk. We've had several situations

where we have put at least half of our fees substantially at risk. We've been fortunate that the times we have put them at risk, nothing has been taken and we've gotten some good profit sharing out of it.

But I think it's a good idea to put fees at risk. Some of the situations with MGUs are becoming a little more desperate. They're willing to say, here's our books, here's everything we make, including all of our salaries. They will completely open up audited statements to show the risk bearers just what they need to survive. Give us this. They're truly willing to put them heavily at risk, but their loss ratios are also running 150%. They're not doing that out of the goodness of their heart; they're doing it because they probably have to in today's environment.

**Mr. Sutton, Jr.:** I remember working in a reinsurance area as a student. We were looking for loss ratios of 50–60%. We weren't expecting loss ratios of 75%. I hear you saying numbers that are much higher than that. When I'm negotiating with a stop-loss reinsurer, we're really trying to get them about 75%. It sounds like it's much worse than that at this time.

**Mr. Murphy:** Part of the problem is the expenses. Thirty-five percent of the gross premium dollar is disappearing for expenses. The loss ratios I'm quoting are to net premium, so if somebody's writing at 110% that's 110% of 65%. Many of the direct carriers wouldn't think that a 71% or 72% loss ratio is bad, but the reinsurers are losing money at that level.

**Mr. Robert J. Trocki:** It seems to me with stop-loss business that the regulators particularly, in the states that are more stringent with their regulations such as New York and Florida, are looking at the stop-loss a lot more closely than they traditionally have. How do you reconcile the difference between manual rates and what people are actually pricing on the street when you're presenting rate filings to regulators?

**Mr. Murphy:** I don't want to touch that one.

**Mr. Hammond:** Are we talking about the premium that the HMO is charging a group or are we talking about the stop-loss reinsurer's premium?

**From the Floor:** This would be, in the case of my company, an insurance carrier that provides stop-loss insurance.

**Mr. Sutton, Jr.:** I don't know how much you can get away with, but if you're going to file a rating manual or some indication of how you underwrite, then you list a whole bunch of factors that would allow you to raise or lower the rate, including

actuarial judgment, which is almost undefined. All that leaves you with is the latitude to do whatever you want. But most of them will accept a whole bunch of factors like, how many times has this product changed carriers, did they have lousy experience, and so on. You just have to give yourself an almost unlimited amount of freedom. If you have a rate book and you have to use those rates, then you're in trouble.

**Mr. McLean:** Right, I will caveat that by saying that about a year ago, New York really started getting strict, and so has Florida regarding the underwriting adjustment factor. If you didn't have a factor in your formula, you weren't allowed to use it. For years you could just have a factor that could be up to 10% different or something. They wanted you to start defining to what and when you apply that factor and for what purpose, so it has gotten stricter more recently.

**From the Floor:** What we've been finding is that they forced us to define some factors. As Mike was pointing out, if you have deviations of up to 70%, and probably more than that off manual, it's hard to quantify enough situations that would justify going off manual by more than 25% or 30%.

**Mr. Sutton, Jr.:** Lower your manual and increase most of your rates.

**Mr. Hammond:** The base for your manual may have actually changed while the data underlying it may not have. That may be part of the case for that. Is that what you're seeing, or do you leave your manual kind of where it is?

**Mr. McLean:** You take the manual down.

**Mr. Murphy:** Yes, it moves with the market a bit. I was going to say that some of the recent discounting was due to the managed care impact, and in order to reflect that, you had to discount some manuals. I know ours does. It explicitly includes a number of factors, which you can use in varying degrees of sophistication, to reflect the degree of managed care. That's an element that can then be filed with your rate filing to explain. It can take care of much of the discount and make things a little more reasonable. It won't take care of all of it, because you still have that marketplace pressure, but it does help.

**Mr. McLean:** Yes, I'm not sure what you're pricing, but from a risk perspective we've seen the capitation factors can be as much as 60%.

**From the Floor:** A question for Harry Sutton with respect to his discussion of the provider risk situation. What you presented was a summary of the alarming circumstances with respect to reinsuring the provider risk under Medicare risk



contracts. Is there any indication of extrapolation from these concepts into the provider risks under other HMO contracts, particularly, the extremely complex situation that will be faced by a provider group that has multiple contracts with multiple HMOs?

**Mr. Sutton, Jr:** In the original version of the bill, you had to keep Medicare and Medicaid. You could combine those populations to set the limits. You can use your commercial population to aggregate all of those to set limits, but that means you have to change your contracts with the commercial arrangements, which you might not want to do, particularly, if your Medicare and Medicaid population is small. I just don't happen to think they're very workable. They're enforcing the contractual changes with the providers to fit your Medicare and Medicaid population. In some parts of the country, the commercial rates were being subsidized by Medicare, and Medicare is losing its margins. I would expect big rate increases in those areas for the regular business.

If the worst version of the bill were to pass, it would mandate this same thing for all commercial business, including surveying people that terminate. Essentially, it's consumer protection and they view this as consumer protection.

The big players buy plans, and they all have different contracts. They must have a difficult time trying to get the contracts fixed up to cover this problem. The only blessing we have is that since they've decimated the work force at HCFA and they're worrying about other areas, there might not be anybody around to audit what you're doing for a long period of time. I don't think it will go away with this Congressional concept of protecting everybody from himself or herself.