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Session 10PD
Design and Development of Point-of-Service (POS) Products

Track: Health
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Recorder: TIMOTHY J. FEESER

Summary: Panelists will discuss:

- *The regulatory environment for POS products, including the contract forms required to effectively market an out-of-network managed care product and state-to-state variations,*
- *Design considerations for POS products, including appropriate co-insurance levels for out-of-network benefits, and other appropriate benefit differentials, including out-of-pocket limits and limiting out-of-network benefits for certain categories of care,*
- *Effective distribution and underwriting of POS products, and*
- *Provider contracting and POS products, including how to avoid providing an incentive for in-network providers by encouraging out-of-network usage.*

Mr. Timothy J. Feeser: There are employers out there who are afraid of change, and can't make the transition from indemnity to health maintenance organizations (HMOs). The obvious alternative is the POS product, often called a transitional product, which employers purchase to help ease the pain from traditional indemnity to managed care products.

Walter Hoskins with Lakely and Associates will define the POS product and talk about the issue of detailed benefit types and provider compensation issues. Jim

Drennan from Towers Perrin Integrated Healthsystems Consulting (IHC) will get into the reasons the POS product has developed and the market forces to push the POS product along. He will also discuss the risk management issues and what regulatory considerations need to be addressed. Finally, Jamie Meyers from Oxford Health Plans, will anchor the discussion. He will get into the designing and development issues associated with the POS product from a health plan's perspective.

Mr. Walter H. Hoskins: We're going to try to teach you about some of the issues with the design and benefit of POS plans. We're also going to help you try to avoid some of the pitfalls of the product.

One of the dimensions of the POS product is the benefit level. Members are given the choice of in and out-of-network benefits. In addition to that, there are issues surrounding in-area and emergency benefits. When is a member considered out-of-area? These are all dimensions that you're used to working with when developing an HMO product. Other dimensions, more specific to POS that we need to look at are how certain benefits or costs are affected by referral authorization. We need to also look at member cost-sharing provisions. Finally, we'll get into developing the prices, looking at the provider compensation and the provider risk assumption issues. When you're working through POS product development, make sure that you're touching on all these issues and looking at them early enough in the process so you don't forget them.

Most of us think of a POS product as being like a preferred provider organization (PPO) product, with an in- and out-of-network piece to it. You must not look at just those dimensions because, for certain benefits there is no network. You may have a drug card or an ambulance benefit which is just a regular indemnity style benefit, (i.e., you get the ambulance, we'll reimburse you). Drug cards may go across the whole spectrum. It's not easy to do a chart that includes in-network and out-of-network, and have it all be consistent. In other words, you have to realize that the type of provider may vary by certain benefits.

There are also issues surrounding in-area and out-of-area networks. If someone gets service in the area, but out of the network, you have to decide if the network was available and whether the member had an emergency keeping them from accessing the network. When you move to a POS, you have to deal with the different variety of out-of-area benefits. On top of this, emergency situations override many of these situations. Be careful to adhere to various state mandates about exactly what you can do for steerage in the HMO or HMO POS plan with regard to emergency.

The next issue has to do with referral authorization. How do people get to a particular provider? I use the words authorized referral as opposed to gatekeeper,

which sometimes has a negative connotation. There is what is being called open-access HMO, where you can get to certain network providers without having to first go through your primary care physician. This may be a blanket open-access HMO, or it might be for certain services (e.g., obstetrician/gynecology services). Many provider groups are trying to carve out their particular specialty from being under a gatekeeper or authorized referral.

When you're developing the benefit structure or the cost structure, you recognize different classes of covered benefits. They may have different cost-sharing provisions, and they may have different costs for the providers. You have basic and comprehensive. You have to work on whether you're going to have preventive in-network (the HMO part of it), or the indemnity out of network. Some of these will be optional. There are some very limited POS plans that only have, for instance, physician visits out-of-network. You have to look at all these different categories and ask, how are they going to be treated in the network and out of the network?

Our meaning of POS, for this session, is HMO-provided networks and benefits in network. It's not necessarily HMO-style benefits, but HMO-provided benefits in network. An insurance company or indemnity company provides benefits outside the HMO network. I call this a true POS; some people call it POS/HMO. The insured person decides which set of benefits to access at the point of service, and hopefully, they'll make the right decision that enhances the cost effectiveness of the health care. We have new developments all the time and HMO-provided benefits in network may include both a gatekeeper and an open-access benefit with different benefit levels. If you go through authorized referral, you're going to get this benefit. If you want open access, you can do it, but it's going to cost you more. On the other hand, you can get some of the triple options of having an HMO style benefit in network. Out of network you have two choices, a PPO in-network, which is not the HMO but maybe another network you can wrap around it, and the PPO out of network where it's really not a network. You can have a couple of different dimensions across where you have the three tier approach, or theoretically you can have four tier. You have to be sure you define these items early on; otherwise people may not realize whether you are talking open access, gatekeeper, or both?

What POS does not include, for this session, is a gatekeeper POS/PPO. Some people call that POS, and again, the reason for that is when PPO adds the gatekeeper they think they're more like the HMO and the HMO adds the out of network and thinks they're more like a PPO. They think they're moving together and they call that POS, but in this discussion we're strictly talking about HMO provided network, benefits in network, and indemnity company benefits provided out of network. The kicker is that the insurance company could probably offer any POS product we talk about. It would look and seem just like that, but the fact is,

the insurance company is providing it under a single contract. What we're talking about is where we're jointly offering in-network HMO provided benefits, and then insurance company benefits out-of-network.

The State of Florida has proposed regulation of POS contracts. They describe POS as that providing an option at the time medical services are secured, of accessing benefits provided by a licensed HMO organization, or accessing benefits provided by a licensed health insurer. In their particular definition, they talk about a POS coverage meaning any coordination of policies and certificates, whereby an insured has both a health insurance policy issued by a licensed health insurer, and pre-paid health benefits under a health maintenance contract issued by a health maintenance organization, whereby the insured may choose, at each time of service, whether to access indemnity benefits under the health insurance policy, or benefits under the health maintenance contract, but not both. There are many other interesting things in this regulation which we will discuss later.

Mr. James E. Drennan: In talking about why POS, one of the obvious answers is the market demands it. There's more to it than that. I want to use a story which you may have to stretch a little bit, but this is a real story and it seems to fit. I spoke at a meeting recently. I went to pick up my rental car. My normal request at Avis all the time is a mid-sized or a compact, something in the middle, nothing fancy. I went over to the spot and I looked, and there was this gigantic Suburban. Nine or ten passenger vehicle, and I'm by myself. I thought that wasn't what the customer wanted. I went back and I said, “this is a bit large.” They gave me a second car, which was a compact. I went to that spot, it was not there. I went back a third time and they gave me a Dodge Intrepid, which is a real nice full-sized sedan. That was there and I got that and I was very happy. I would compare the Suburban to an indemnity plan that covers everything. It's just too large and you know that driving it is going to be very inefficient. It's great for certain things, and for certain employers, an indemnity plan is appropriate. You know in the long term that it's going to cost you more (gasoline, in my case). The second car I would have liked is more like an HMO; it was a more efficient car but it wasn't there. HMOs are not everywhere. You may have a need for an HMO, but if it's not where you are it doesn't fit. My Dodge Intrepid was in between, and it fit my needs. It's a little stretch but it starts to give you an indication of why POS is becoming popular.

I want to talk about the market forces that are driving the popularity of the POS product, risk management which is more from the insurance company or HMO side, and then regulatory consideration.

In general, the HMO has been pursued by the market as being too restrictive. POS has more out-of-network access, and obviously, broader networks. You can almost

say the perception of POS is more than HMO. That may not always be true, but the perception is very important in the marketplace. Regulatory agencies on the HMO side are putting controls on the maternity stay, putting controls on things that you can pay and what you cannot pay.

The PPO lacks controls. Cost can just be ratcheted up unless you use some fee schedules or some other method, and then there are always the out-of-network claims. The solution is to have high cost sharing, which causes some client dissatisfaction if you really hit somebody with a high price. For instance, if you have a 50% copayment on a large out-of-network claim, those out-of-network claims can create some unhappy members. From the risk management side, full replacement limits the selection. In other words, there's no need for another HMO option. You have the appropriate POS product that can also provide much more consistency in the options. You don't have to have two or three HMO options with different carriers. I've seen a lot of HMO plans that are in between or above or below, and there won't be any sense between the pricing and the benefits for all the options for one large employer. For a POS, have one controlling entity and make them all make sense if you have out-of-network claims. A single risk pool should be lower than the combination of separate pools. I've had great difficulty in educating clients about this. When you have two plans and you add the total claims together, it generally will be more than one plan combined, if there's an option by people to select. People will tend to select to their own benefit. In addition, the rates can then be set to match the benefits.

The last force is one-stop shopping. The employers always prefer to deal with one vendor. We've always seen that with life and long-term disability (LTD). You can generally just wrap them around the medical, but the employer would prefer to have one vendor. It reduces the administration. It really cleans up and has some efficiencies all the way around.

Regulatory considerations are outside the why, but they make some sense because we are getting into a new era of regulatory considerations. Indemnity carriers are well established. Solvency is well regulated. Consumers are protected. We haven't had any real problems with indemnity carriers.

On the HMO side, we still had good protection, and there's less restrictive solvency regulations. Risk-based capital is coming in, which is important. The POS forces a combination there, and as Walt said, if you have one vendor doing all the administration, then that controls your solvency problems. Some HMOs do take all of the risk instead of having an outside party do the out-of-network claims. My concern is the other managed care organizations, such as the physician hospital organizations (PHOs) or the physician-sponsored networks, that are not in any of

these regulated areas. Some agencies have them, and some states regulate them. I think we will have some fiascos that will cause some physician-sponsored networks to go under. They won't be able to pay their claims, because they won't have enough funds, and then all the regulatory agencies will just overstep their bounds and set very onerous regulations, (that's unless, before that time, federal legislation comes into play).

The customer wants something that fits their needs and our job is to react to that, not only for what they want, but what's most efficient for them. If what's most efficient for them is not a Suburban because there's only one person, then we shouldn't be just trying to force on them what they don't want. The same rule applies to our old PPO or indemnity plans. We should be designing plans that fit the needs of the customers.

Mr. Jamie Meyers: I am going to focus on how you can design a POS plan to have medical costs as low as an HMO, yet have greater margins and greater market share.

Most people in our society like choice; that's the American way. Even if they don't choose to go a certain way, they still like to have that choice. As such, they are willing to pay a little bit more for that choice. The more choice we can provide, the happier the member becomes. At the same time, if you design the plan carefully you end up with a lot of in-network utilization anyway. People choose to go in-network, whether it's due to economic considerations, or whether they just find that managed care isn't as bad as they thought it was. With a strong network, both in optimal size, as well as in the quality of care that is given, people will go in-network for the majority of their care.

Of course, one of the keys to this is to keep your members in the plan. There are several things you need to consider to maximize your in-network utilization. One key aspect is your physicians. If you have happy physicians in your network, they are going to help steer your membership in. Whether it's because your specialist panel is of high quality and your primary care physicians feel very comfortable referring in, or just because of the relationship which the physicians have with the health plan. One of the keys to this, though, is to make sure that your members are seeing your primary care physicians.

Another key aspect is that you're going to provide preventive care. That's one of the basics of HMOs. Keep preventive care in-network only. Don't give them the option to go out-of-network, and there are a couple of reasons. You're encouraging them to see the primary care physician by providing no copayments. The more they go to the primary care physician, the better the relationship. Just like in an

HMO plan, the PCPs are managing the care better. The other positive side to this is the PCPs will continue to refer their members into the network. Many members don't have existing relationships with the specialists. They might talk to their neighbor who had a certain procedure done to get a referral. For the most part, people are going to listen to their primary care physician. Referral requirements are helpful in that regard, too. If you don't have a network referral requirement, you're just leaving it up to the members to decide. Many times the economics will steer them in-network, but nonetheless, if they're of better means, that deciding factor could be when the primary care physician is referring to an in-network specialist.

One of the more abused out-of-network benefits that I have seen is mental health benefits. Generally speaking, if members see an out-of-network provider for mental health benefits, you're not going to be able to control that utilization, and more often than not, they're going to use every single visit that you let them under their benefit plan. On the other hand, if you have a good managed behavioral health care system, and if you go in-network, you're going to be able to keep them down as low as 20% 33% of the number of visits they might have if they went out-of-network.

One strategy you can try to keep them in the plan is to keep mental health benefits to an in-network benefit only; however, not all states will allow that. The next strategy would be to make it costly enough to go out-of-network. It’s not so much that the out-of-network benefit is a facade, but so that at least they are making a true decision. For the most part, you have 100% benefits in-network on most benefits, maybe an 80% differential on referral benefits, and for mental health, I would suggest at least a 30% spread. The greater the economic incentive, the better. Another thing that may seem obvious would be to combine your in- and out-of-network visit limits. Don't let them use all 30 visits in-network and have 30 more visits out-of-network. You're encouraging nonnetwork use and then next year, they just may go directly to the out-of-network provider. Separate out-of-pocket limits may also be a consideration. In other words, you don't want a member having surgery, satisfying their deductibles and co-insurance, and then have free mental health benefits after that. That's another thing to consider. Prescription drugs should also be in-network.

The last issue I want to focus on for incenting in plan utilizations is your out-of-network deductibles and co-insurance. There's no magic here. I think you need to consider the dynamics of your own marketplace when you consider some of these issues; such as your own situation, the competitive environment, and the market demands. The larger your network, the lower the out-of-network deductibles and co-insurance you can offer with your benefit plan. If you have a very small network, and you're just covering 25% of the providers as a part of your network,

you have to be careful about how low you go with your deductibles. If you go up to the larger end of the scale, and you have 75% or possibly even 90% of the providers in your network, you can offer almost anything. It's not going to be an economic situation, it's going to be the fact that you have so many doctors in your network that they're going to fall into your network, almost by default. The consideration with that, as you probably realize, is that if your network becomes too large, you undermine your negotiating leverage and your relationship with the other providers who expect more drive and more patients into their plans. You can only go so far.

The greater the perception of the quality of your network, the more network utilization you're going to get. It doesn't necessarily mean including teaching facilities, but that could be an option. If you have a lot of them in your market, maybe you just want to have a couple of them. Many members, if they don't live near that institution, are not going to go there anyway. If they just see it in your roster, that's a big plus. If members perceive quality, then they're willing to trust the rest of your network better. Perception of quality does not necessarily just apply to teaching institutions; it could have to do with more efficient managers of care. If you have a reputation, and if you keep your panel to Board Certified physicians and so forth, you have a better perceived quality and more members are going to use your network. You must be real careful with the teaching facilities because they can drive up the cost of your plan, make you more competitive, and cause selection problems or adverse selection. There is a balance there.

Another key consideration is your comparison of in- and out-of-network benefits. You must be careful if you have a high office visit copayment plan, and how low you go with the deductibles. For example, if you have a $5 copayment per office visit, in many markets that's perceived as almost free. You're going to go with very low deductibles and co-insurance; $250 deductible plans are perceived as being much more expensive than a $5 copayment. On the other hand, you go down to a $20 copayment, which, with some smaller companies becomes more popular. You have to be real careful again. With a $250 deductible versus a $20 copayment, the member might be more willing to go out-of-network. One more factor in the in-plan utilization is, the greater the maturity of the market, the more people who are already used to coming to the managed care. They are not necessarily coming from their own environment, as they may be moving from a PPO or indemnity plan. If their neighbors are using managed care plans and they're not having problems with it, lower the deductibles because it allows them to be pre-disposed to using the network.

I want to change the subject a little bit. Most HMOs have some kind of capitation or provider risk-sharing arrangement. Let’s discuss some considerations with a POS

plan. As I said earlier, you want to use your physicians almost as ambassadors of your plan to help you steer your utilization in-network. You have to be careful because with certain capitation arrangements you might provide the exact opposite incentive. One of the strategies might be to provide a reduced capitation through a percentage of your HMO capitation; maybe 70% of the HMO capitation would be appropriate. The problem with that is you have a win/lose situation. If there's excessive in-network utilization then the providers essentially lose, and vice versa, if you have lower network utilization, you come out on the losing end. Over time, you can work it out and you might be able to establish an in- and out-of-network benchmark split, but that takes a lot of time because it changes. The more mature the market gets, the more the members get used to the product itself, and the more people use in plan providers. Staying ahead of that curve can be very difficult. Plus, any time doctors can encourage out-of-network utilization, they win.

An alternative, which has it's own down sides, is a full risk. By full risk, I don't mean they're 100% at risk; I just mean they're at risk for both in and out-of-network utilization. It's very tricky to convince physicians that they can do well under this arrangement and that there won't be excessive out-of-network utilization so that they're just going to wind up with reduced income. Essentially, what you need to do is establish higher capitations than you would under an HMO, which depends on the benefit plan. Recognize that at first, your costs will be a little bit higher under a POS plan, but then reduce the costs on a reconciliation type basis at the end of the year. There are a couple of key points, though. You're going to have the providers doing what they can to keep utilization in network because this is more favorable for them. You're setting up a win/win situation which is favorable for them, favorable for you, and everybody should be happier.

A couple of underwriting pricing considerations. I'm not going to get into too much detail, but there are just a couple points to consider. As I said at the outset, you can charge more for a POS plan, depending on the benefit plans. You can charge more for a POS plan than for an HMO, but if the employees of a plan have a choice to go to an HMO, you must be careful that you don't get selected against. You can only price it so high, there is a limit, and that's all the more reason why you must be careful about controlling your costs.

One other issue that I've encountered, as we tried to hit lower pricing points, is that many of the market forces have driven us to offer higher deductibles. Sometimes you see $1,000 deductibles and you might question that. People do buy it. It's more catastrophic in nature, more out-of-network, but it still gives them the security to know that they can go out-of-network with some coverage after a certain point. When you get to a certain point with out-of-network benefits, the out-of-network benefits can be so low that medical costs are actually lower if a member goes out-

of-network than if they go in-network. This happens because the deductibles and co-insurance can exceed the value of your discounts and your medical management. On the other hand, as the deductibles go up, you steer more utilization in-network. What can happen is as the deductibles go up, the price of the plan bottoms out somewhere, and it can start turning up again; basically, it can cost the same as an HMO. If you have a 70/30 co-insurance, essentially you're going to have 95% in-network utilization, and it can price like an HMO. Whereas say a $500 deductible plan might actually cost less than an HMO. If you have a $500 70/30 plan you still might get enough out-of-network utilization so that it costs less than the HMO plan.

Let's consider two benefit plans, both with the same in-network benefit; one with a $500 deductible and one with a $1,000 deductible. It's very simple, the value of the in-network plan might be $100, and, as my premise was, the out-of-network benefits are lower. If you have $90 as the value of the $500 deductible plan and $80 as the value of the $1,000 deductible plan, as you shift more utilization in-network you can see the cost of the $1,000 deductible plan might end up higher than the $500. This isn't going to be the case in every instance; it's just a point to consider. Don't take it for granted that the higher deductibles are lower cost. The other point of that is you just don't even want to offer that $1,000 plan if that's the case.

Jim discussed full replacement plans and how favorable they are for selection. In the market, there are still many employers who still want to offer their members HMOs because, if they have employees who are happy with their HMOs, and it's a popular benefit they want to continue with it. Full replacement has taken on a little bit less than its true meaning. For the most part, it's a minimum 75% participation because on 100% participation, you're going to be closed out on many deals. Even though it doesn't make sense because your POS plan provides an HMO benefit, there's still a lot of perception that it's not the same. The 75% participation is a large enough block of the business that you should still get the average utilizers, even if you don't get a lot at the low end.

There are some things you can do, as well, to avoid adverse selection. Although this may seem counterintuitive, one of the things you can do is demand, as a POS plan offered alongside an HMO, that your in-network benefits are actually less than an HMO's benefits. What this can do is it can get some of the people that are going to use the network anyway, so their decision might be to use the HMO plan, so you get some of the higher utilizers into the HMO. It doesn't necessarily get you positive selection, but at least it keeps you from getting more of the negative selection. Another thing this does is it can balance the prices between the HMO plan and your POS plan by having the HMO plan be a little bit richer than your in-

network benefits. Their cost comes up a little bit relative to yours, so there's a bit more balance there. It's not a magic solution. It's just one more thing to consider.

Another odd thing that I've seen develop, at least in the markets that I've been in recently, is the demand for point-of-enrollment products where you actually have more than one POS plan offered side by side. For larger plans, that may not be too much of a problem, but I've seen it demanded down in lower group sizes. We've tried to avoid that as much as we can. Market forces sometimes prevent that, but you should try to avoid it. It's a real problem when you have community-rated products, mostly because not all of your groups are going to have point-of-enrollment products. What happens is for the point-of-enrollment product you have the same networks, what's going to happen more often than not is the people who use out-of-network benefits are going to choose the higher plan. People who use the in-network benefits and the lower utilizers, in general, are going to use your lower benefit plan because the cost is less, and essentially, it is going to start reverse spirals where your high benefit plan is going to turn into more of an indemnity plan. If you're in a community-rated environment, it can cause problems because your higher benefit plans are also going to be purchased by groups who are not in a point-of-enrollment plan, and the cost will become excessive, and you'll be uncompetitive for some of those plans.

One of the other things that surprises me sometimes is that I've had people ask me for a high plan and a low plan with the same in-network benefits. It should be obvious that you can't do that because you are just exacerbating the situation, and there's no decision to make other than am I going to go in there or go out-of-network. Your high option plan becomes an indemnity plan. If you should choose to allow this point of enrollment option, be very careful in what you allow. I wouldn't just allow the whole spectrum of your benefit portfolio and say, here choose two. I would be very careful to select benefit plans where the benefit differences and the pricing differences both, in combination, encourage a better mix of selection. As an example, maybe you'd have a $5 difference in your office visit copayments. Maybe you had a copayment in your in plan benefit. If you do have some plans to develop full networks and more restricted networks where they have more restricted utilizers, you need to have some other differentiations, higher deductibles, and so forth. The key point there is the rates. As an example, there's a $10 differential on the rate; you have members looking at $120 for an annual premium. I can afford to join a lower plan even if I'm going to use my benefits, because that $120, at a $5 differential for an office visit, is much of the office visits. You can still get some of your higher utilizers into the low plan. That's really what you're trying to encourage.

When establishing a POS plan, in most states, you need to have an indemnity carrier to offer the out-of-network benefits. I will say that's not true in all markets. There are some states that do allow HMOs to offer out-of-network coverage. I imagine it's relatively few, but I know they're there. Essentially you have three options. One, you can partner up with an indemnity company, and an independent company that's separate from your own organization. Another one is to actually have an affiliate acquire an insurance company license, or you can just have a parent company which runs both the HMO and the indemnity company, so you have the indemnity license. The second two are much cleaner in terms of relationship. Utilizing this same organization causes less fear. With the partnership, you must be careful to avoid win/lose scenarios so that if you have more in plan utilization than you expected, you're collecting enough premium, and the HMO is still going to stay whole. It's a lot like the capitated arrangements I spoke of earlier. You have to be careful not to be so rigid that the HMO gets X and the indemnity company gets Y. Then if you have excessive in-network utilization the HMO loses or vice versa.

From the Floor: What have you seen in the treatment of dependents who are out of the service area, but the primary subscribers are in the service area, (e.g., college students)? Are they generally covered under these POS plans if they are completely out of the company's service area? The second question I have is, it seems to me that there are so many different factors that affect relative costs, and that it's really difficult to identify the specifics. What has been developed by any of your organizations in terms of modeling utilization (not just in percentages)? Who actually is moving from in-network utilization to out-of-network utilization?

Mr. Drennan: You have to wait until your dependent needs services; call the area, get the name of a doctor, and then get them into the system. Otherwise you just try to schedule everything over their vacation or when they come home.

Mr. Hoskins: Jim, you referred more to the in-network use of services when you're out of area because, for the most part, with a POS plan, the point is you can go out-of-network. We would cover the cost under out-of-network. One of the positives of a POS plan is that you still have out-of-area coverage. I'll take that a little bit further. I know you used a college student as an example, but for the most part, if you have an employer who's in our service area who has some, but a very small number of members who live outside of it, we'll cover them. However, there are many regulatory issues you have to be careful of in some states. Of course, most of these members' utilization will be out-of-network, but many of the plans will have $250 deductibles; it's no worse than most indemnity plans.

Mr. Feeser: On the second question, I think the problem is a lack of data. For the most part, we rely on judgment.

Mr. Geoffrey L. Kischuk: First I think the point was made that full replacement can be better for the employer because they're only dealing with one carrier. Having been in the California market for a long time, there's a tendency for employers to play one HMO off against the other. Going with one carrier eliminates the ability to get savings by playing different carriers against each other. Second, the example on the cost differences between the higher deductible mentions a value of the benefit. I'm not sure if you mean that to be cost, I don't know how to relate to it either way. Doesn't that cost comparison depend a lot on what percentage of the benefits are capitated? If the capitation is paid on all the people opting for the POS, I think that in your example, you'd still be better off driving everybody, as many people as possible, into the HMO, if the capitation represents a significant part of the cost.

Mr. Meyers: I don't think full replacement brings on reduced competition. The employees make the choice at the point of enrollment, but you do have a bid process at the beginning of the year, so you still have the HMOs bidding against each other for that POS plan. To be that full replacement carrier, you still have price competition.

As far as your second point goes, it does become more difficult. I agree.

From the Floor: Jamie, you recommended implementing combined in-and out-of-network visit limits for mental health. When you're in a partnership approach where you have the HMO, the indemnity system, and the administrative system in different places, how do you administer such a combined limit? Related to this, Jim, how do you take advantage of the single risk pool that you recommended to try to hold down costs?

Mr. Meyers: To be honest with you, I'm not sure how you administer joint limits in that scenario. I imagine you could do it, with great difficulty. That is one of the down sides of working with independent carriers as opposed to one organization that has either a holding company or the HMO with the insurance license. I think that could be difficult. I imagine there could probably be some links you could make through tape systems or something, but I would imagine it becomes very inefficient. I would just say that is one of the down sides of that type of arrangement.

Mr. Drennan: If you want to have a combined risk pool, it's a little more difficult if it's two entities. You could still do it with a holding company. You could do that

more easily than you could a benefit. Clearly, when you have unrelated entities with no joint ownership you lose that advantage.

Mr. Robert B. Hardin: When we started this discussion we called a POS benefit a transition benefit. I wonder if that's really your opinion. Given no major discontinuities in the way health care is going to be delivered over the next years, are we going to see this as a transition as more people go to HMOs or is it possible that this is a stable product that we'll be able to compete with, and we'll, in fact, successfully compete with HMOs?

Mr. Drennan: I think it's still a transition, but I think that transition has become longer because of the lower trends and less problems with discontinuities in the last few years. In other words, back when we had the real high increases every year, employers were looking for anything and they were planning to move towards an HMO faster. Things have smoothed out and that pressure has been taken off; therefore, there is more of a tendency to stay with something that is more comfortable, even if it's maybe not as price controlled.

Mr. Meyers: When Tim made that comment in his introductory remarks I made a note to myself. I'm not sure I agree. I see the POS as a very viable long-term product. I think one of the reasons I feel this way is because it has become very popular and people like choice. I think even members who have belonged to HMOs for a long period of time, see an attraction to a POS benefit. Much of it depends on what was the selection decision in choosing an HMO. More often than not, it was economic. I believe people will want that choice.

Mr. Hoskins: As we go through the regulatory process and they start regulating a lot of the other managed care organizations, maybe HMOs will be allowed to take on a limited degree of out-of-network benefits; therefore, they won't need to partner up with an insurance company. I think the choice, from the insured's point of view, is probably something they're going to want for a long period of time. They'll be willing to pay a certain amount for it, and there will probably be someone willing to offer it to them.

From the Floor: Given our provider contract structure, the biggest cost associated with a POS plan for us is the use of out-of-network hospitals, where we have no significant discounts. We think we have enough to offer coverage and it's sellable to the employers, but an individual member who chooses to go out-of-network on a fairly expensive stay will increase our cost well in excess of the difference in out-of-pocket maximums. From a plan design perspective, is there anything you can do or you've seen that encourages in-network hospital utilization?

In one of our markets we have about 40% of the hospitals. The remaining 60% of the hospitals are teaching facilities. We get probably 50–60% discounts on the in-network and nothing on the out-of-network. If you have a difference of $2,000 in your out-of-pocket maximums and you have a $50,000 stay, you're losing money quickly.

Mr. Meyers: If you have a 40% network, you must be careful. Can you offer a $250 deductible out-of-network? Probably not. You might need to go to $500, you might need to go 70/30. Those are expensive, they look expensive, and it might make the plan seem less attractive. On the other side of the coin, it's a very important educational issue for the sales forces, but you have the option to go in the plan. Yes $500 looks like a poor benefit plan, and yes, 70/30 looks poor; so go in plan. We still think we can keep you happy going with our in plan providers, and you can get full coverage.

From the Floor: My company is located in western Massachusetts, which is just about the most highly penetrated HMO market in the country. The most successful HMO in that market has just recently begun to offer coverage on a limited basis at some of the major teaching hospitals in Boston. I think this just goes to prove the point, and I agree with the panel members on this—the POS is more than just a transitory product.

We are an insurance company that provides the out-of-network coverage for a POS product that we partnered with an HMO to provide. We're in the second year of this product. In the first year, when we were setting the initial pricing, there was a lot of dispute between the actuaries for our company and those from the HMO, in terms of what the in-network utilization would be with the product. We had priced it using our traditional PPO models and were coming out with much lower in-network utilization models than they were telling us they would get. Now that we've completed a year, the assumptions actually were that we got actually higher in network penetration than even they had been assuming. We pulled back and increased the network utilization quite a bit for the second year of pricing. Now, one thing that I want to add is that the HMO pays all of the claims for this product. We believe that they're calling some of the claims in-network, even though they may actually be out-of-network claims. We're in the second year and we're assuming much higher network utilization. What can be done in terms of premium sharing agreements or maybe some sort of reinsurance agreements, to make things as fair as possible for both sides?

Mr. Meyers: There's a couple of strategies you could use. I'm not going to suggest that I've seen any of these in practice, but I have some ideas. I had worked with one plan that it was a separate entity and some creative ideas came out of that, like

a retrospective rating, which you do for an employer. At the end of the year, you sit back and settle up with the HMO. You have to check that out with your legal department and talk to the regulators to see how they feel about that, but I think most of them would be open to that. You have a concern about what are they calling in-network and out-of-network. For the most part, it would take care of that, because if they're calling it in-network, they're bearing the risk for it as well, so they get the premium. Of course, you probably want to keep your revenue up. Maybe you need to look at some kind of audit, but you need to be careful. You want to keep that relationship positive, and that could be looked upon negatively.

Mr. Drennan: Some of the arrangements I've worked with have a risk pool for some of the out-of-network providers, and if that goes up too high, then there's a certain sharing of the excess out-of-network utilization so that the HMO is at risk for some of it, which seems to be contrary to the regulation that says that HMOs can't take indemnity risks. In Florida, on the proposed regulation, they do provide for a retrospective adjustment. At least annually, you have to go back and make a payment based on actual claims. In that respect, Florida appears to be liberal in allowing the HMO to take on a significant part of the out-of-network risk.