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Managed Care Response to Growth in Point-of-Service Products

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Summary: Point-of-service products are proliferating in the marketplace as HMOs look to expand market share by providing coverage opportunity outside their networks and PPO and indemnity carriers look to increase the management of care in their products to compete more effectively with HMOs. Panelists discuss the impact point-of-service plans have had on both HMOs and indemnity carriers.

Mr. Richard Thomas Hall: We're here to talk about the HMO reaction to the growth of POS products. We have determined that that really means HMOs' and insurers' reactions to the backlash against primary care gatekeepers, the referral system, limited access networks, and so forth. So we will discuss not only the different types of POS plans, but also all of the open-access issues surrounding these plans.

I am with Towers Perrin in Atlanta. I will give an overview of open-access and POS products. Bernie Rabinowitz of the Blue Cross/Blue Shield Association in Chicago is going to talk about some open-access plans that are currently being offered in the marketplace and their critical success factors. Shereen Jensen from Allianz Life Insurance Company in Minneapolis will talk about HMOs partnering with an indemnity carrier to offer a POS plan.

At Towers Perrin, we have one unit that consults with HMOs and providers and another unit that consults with employer groups. Except in a few areas of the country, there has been a backlash against primary care gatekeepers on the

employer side. In general, the human resources folks from large employers are not satisfied with the current direction of the health care system.

Dating back to the early 1960s, there was a predictable underwritng cycle every six years: two years of profits, two years of losses, and two years of break-even. That cycle continued for 25 years, from the early 1960s to the late 1980s. Then, about the time the cycle was supposed to turn down in 1992 or 1993, it was an election year and Clinton put pressure on national health care and pressure on the providers to control health care costs. This forced providers to keep trends very low, relative to what they were in the late 1980s. So the down part of the cycle never came and profits extended into the mid-1990s.

This meant that prices were relatively stable and employers were very happy. Then the cycle started to kick in again. Health plans got greedy and wanted to grab market share because of all of the profits around the table, so they started lowering their prices to get sales. They also kept their prices low on renewals.

With relatively stable premium growth, employers were happy and everyone was satisfied. But underneath all that provider trends were starting to go back up and, boom, in 1996 and 1997, HMOs started losing money. Now they're trying to recover from those losses by instituting bigger rate increases, and it appears the cycle is back.

Employers, though, do not want to see these rate increases. Right now they're getting pressure from a global economy to downsize and be more efficient. They want HMOs to do the same thing, yet provide more information at the same time. Employers want healthcare employer data and information set indicators, indications on quality of care for the network, and more access. They don't want gatekeepers, but still want the prices to come down. There's a lot of pressure right now, particularly in the large group marketplace. Obviously, something has to give.

Why the growth in open-access plans? The primary reason is employee dissatisfaction with the gatekeeper concept, because many want to go directly to a specialist.

Another reason is the limited choice of providers. Four or five years ago, physician hospital organizations (PHOs) were formed in an attempt to change the traditional adversarial relationship between physicians and hospitals. The big term back then was "vertical integration," so the hospitals and physicians got together. But many of those PHOs failed because they didn't have the infrastructure and the governance to

operate successfully. Even the successful ones were relatively small in the marketplace and could not cover all services or a broad geographic area.

What happened was that HMOs had to negotiate with other providers outside of the PHOs to supplement the network. Once that happens, all the capitation and risk-sharing arrangements are thrown up in the air. You can't easily pass all the risk down to the provider when you have a PHO network supplemented by other specialists and primary care physicians (PCPs).

Government pressures also have been fueling the growth of open-access plans. President Clinton recently announced that the Patient Bill of Rights was going to apply to Medicare folks. The bill mandates that HMOs allow self-referral to some specialties such as OB/GYN, which means direct access to a few specialties. Many states have put laws in place limiting the gatekeeper concept.

There is also a question about whether gatekeepers actually lower costs. For instance, Blue Shield of California instituted an open-access plan that allows patients to bypass the gatekeeper to access care within the network. Blue Shield of California found that 80% of the people still check with their PCP anyway before seeing a specialist and that 96% or 97% of the people that went directly to the specialist would have been referred there anyway. In theory, it seems that all the gatekeeper does is add an extra layer of administration. But they're still important, and I'll get into some reasons why later on.

Providers, themselves, are not fond of the gatekeeper concept. They don't want to be excluded from any network. This reflects the "any willing provider" laws. However, the more providers that are allowed into a network, the more difficult the gatekeeping function and the ability to manage risk.

The lack of managed care in rural areas is a big reason for the growth of open-access plans. With a single hospital in a rural area, there is absolutely no incentive for this hospital to join a network or give a big discount. There's no incentive for the PCPs to join the network, because they're going to get the patients anyway. When they do participate, they want much higher fee schedules.

Finally, there is a current focus on disease management, which we will talk about later at length.

The types of open-access products include the PPO and POS, traditional, partial, network-based, and specialist coordinator products. Let's talk about these one at a time.

In the HMO/PCP model, the patient must go through the PCP to get referred to a specialist. There are no out-of-network benefits or direct access to specialists, and all care is coordinated through the PCP.

A PPO has in-network specialists and PCPs to whom you can self-refer. Generally, the in-network benefits for HMOs are more comprehensive than those for PPO plans. PPO benefits include a small deductible and about 80% or 90% co-insurance in-network, plus a 20% differential on out-of-network services.

PPO plans are very popular because of broad in-network panels that cover large areas. Many HMOs have partnered with PPOs or are offering PPO products simply to have more of a portfolio to offer the large employer. The HMO networks are fairly limited in a metropolitan area. Overlaying them are these PPOs that have much broader networks and still allow employees who live far outside of the network to get some managed care and relatively high benefits. Also, the PPO networks are being in multi-location situations where there's a local HMO. If an employer has people who live in many different locations, the employer doesn't want to sign up with a lot of different HMOs.

The POS plan is similar to the PPO plan in that patients must go through the PCP to access the in-network benefit levels. Also, the benefit levels are generally higher in-network for the POS plans than for the PPO plans and often as high as the HMO benefits. If someone self-refers to a specialist in-network, they generally receive out-of-network benefits.

As an aside, when you have a captive set of providers in-network, the reimbursement arrangements get a little tricky. Obviously, you can't capitate POS providers the same amount that you would under an HMO benefit, because there's going to be leakage out-of-network. But if you do want to capitate, there are ways around it. Generally, health plans pull out some percentage to cover the out-of-network risk, let's say 20% of the medical dollars. They might be 95% confident that that amount will cover all the out-of-network usage, and funnel any surplus back to the in-network as a bonus situation.

Traditional open access is similar to an exclusive provider organization (EPO) plan, where patients can self-refer to any PCP or a specialist and receive no out-of-network benefits. The reimbursement arrangements are key under these types of plans. For example, United Health Care pays its PCPs on a fee-for-service basis and capitates its specialists. That way, when somebody self-refers to a specialist, that episode of care is covered under the capitation.

A partial open-access HMO is similar to the Clinton bill, in that it allows self-referral to some specialties, such as an OB/GYN or a cardiologist, but most of the care still is coordinated through the PCP.

Network-based open-access plans are similar to the Blue Shield of California model. They have three networks available and the patient selects one of them and self-refers within that network. The networks are all affiliated with each other so Blue Shield could capitate if it wanted to. In theory, then, it would be up to the providers to control the utilization, the referrals, and so forth. Instead, Blue Shield chose to control costs through a copayment design. If patients coordinate their care through the PCP, there's a $10 copayment and everything is covered after that; if they self-refer to a specialist, there's a $30 copayment. There has been less than a 1% increase in cost on that product versus the PCP gatekeeper product, and that's important because Blue Shield was struggling in California and added about 800,000 lives since it introduced this product about a year-and-a-half ago.

A specialist coordinator open-access model has a PCP gatekeeper for most folks, but uses a specialist as the care coordinator for those with chronic conditions. For instance, if somebody has heart problems, a cardiologist would be the PCPs. We're not talking about the referral process here, but the idea of someone coordinating patients' care, understanding their needs, knowing what types of services they've had performed on them, and so forth. We think this model has some extreme merit for the future, particularly for Medicare.

Taking this one step further, on the PCP side, HMOs are starting to realize that 5% of the people create 50% of the costs, 20% of the people create 80% of the costs, etc. It's more important to manage care effectively for people who are sick, so perhaps it isn't necessary to have a gatekeeper for well people. For people who are not chronically ill, you might have a fee-for-service-type reimbursement and no gatekeeper. But once someone is identified as being sick, their care is coordinated through a specialist. You could offer broad network coverage as well, because you wouldn't necessarily need to negotiate with a PHO. You could build your own network and make it as expansive as you wanted it to be. You could offer incentives to steer chronic patients into a managed situation, such as full benefit coverage and cost coverage for things that you wouldn't normally cover, such as insulin.

Under this plan, instead of having vertical integration across hospitals, physicians, PCPs, specialists, etc., we would have a group of cardiologists, for instance, banding together to accept what's called "contact capitation." Once a patient is identified having a chronic heart condition, this group of specialists becomes the main contact

for this person. The HMO pays the group a contact capitation, let's say a $100,000 a year, and it's the cardiologists' responsibility to take care of that person.

The specialists—or a nurse working for the specialty group—would monitor heart patients' diets, provide education, make periodic home visits, etc. That's known as disease management, and it's employed for many chronic conditions, including arthritis and diabetes. We're seeing a definite move toward those types of plans because they're easy to sell. Patients have broad access and no gatekeeper and HMOs can educate and manage the patients.

There are two ways to look at contact capitation. One is the example I gave of paying $100,000 to take care of a patient for year. Another way is to divide a pool of dollars among physicians based on their contact with the patient, rather than paying physicians on the basis of current procedural terminology codes or relative value units. Whenever a patient comes into the specialist's office, he or she gets one point toward a contact capitation. For the next two months, regardless of how many times this patient comes into the office and what services are performed, the physician still has only that one point. Then, at the end of a specified time frame, the HMO divides the pool of dollars by the number of contacts, and pays each physician that number of dollars per contact.

One of the questions about this plan is how open-access products differ from fee-for-service or EPO plans. The primary difference is that the specialist coordinator model focuses on disease management. Some plans include a nurse navigator program, which is similar to employee assistance programs, except that the nurse navigators are much more educated on all the available options. They establish relationships with the employees of the plan, and the employees come to rely on these nurse navigators, instead of the PCP, to send them in the right direction for care. Another difference is the contact cap, as opposed to a fee-for-service methodology.

With the specialist coordinator, preauthorizations are still required. One thing we've noticed is that most managed care plans focus on knocking down the inpatient utilization number. But outpatient utilization has shot up lately, particularly MRIs, CAT scans, and outpatient surgeries. Costs for the latter have shot through the roof, especially when they're done in a hospital setting. So we still highly recommend that those things still have preauthorization assigned to them and that the nurse navigator point them in the right direction, such as an ambulatory surgical center as opposed to an outpatient surgery in a hospital setting. The cost differences are a ratio of 2.5:1 in those two settings. Medicare is also looking at the

cost differences in outpatient surgery and definitely will do something about that in the next few years.

You can also do physician profiling, which was never done on a fee-for-service basis. If you're a payor or a provider group, it is critical going forward in this business to be able to capture practice patterns and other data and report back to the physicians in a meaningful way. Many plans that are looking to invest in information technology are saying, "It's going to be too difficult to make the transition, so let's just patchwork our existing system." If that's the case, they'd better make sure that the existing system can do physician profiling, because this is going to be most the most critical factor going forward in managing care.

In the open-access model, you might have protocols and certain procedures to follow on the protocols.

Another big trend we're seeing now is the use of "hospitalists" or "intensivists." Before, when someone was admitted to the hospital, the admitting specialist and perhaps the PCP would visit on a periodic basis to be sure everything was okay. Now hospitals are hiring physicians to make those and take over the patient's care in coordination with the specialist. Hospitalists cost from 30–50 cents per member, per month, and the savings are just incredible.

Finally, one of the differences between the old fee-for-service EPO model and open access is plan design differences such as charging a higher copayment if members self-refer, as in the Blue Shield plan. With this type of plan in place, it's not difficult to see how this could actually cost less than a PCP gatekeeper model, provide more access, and be much cleaner for the consumer.

Several factors influence the pricing of open-access plans (Table 1). The first one is demographics. For instance, the demographic selection relative to the HMO is going to make the PPO price higher, as indicated by the plus sign. This is because, generally, older people select the PPO plan and younger people select the HMO plan. And the same thing holds true for health status.

TABLE 1
FACTORS THAT INFLUENCE PRICING SPECIFIC OPEN ACCESS PRODUCTS

	PPO	POS	Traditional Capitated	Traditional FFS	Partial	Network	Specialist Coordinator
Demographics	+	+	+	+	0	+	0
Health Status	+	0	0	+	0	+	0
Marketing Strategy							
Product Design	+	+	0	+	0	0	0
Network Design	-	+	0	0	-	0	0
Utilization Management	+	0	-	+	0	0	0
Provider Reimbursement	+	0	+	+	+	+	-
	-	0	-	0	0	-	-

In a larger employer setting, one of the big drivers of what an open-access product costs will be the plans offered alongside of that product. If, for instance, a POS product and an HMO product are the only two offerings from a large employer and the networks overlap substantially, the folks that choose the POS plans are likely to be ones who will go out-of-network. So that's something important to remember when pricing a POS product.

By the same token, if you offer a POS product alongside an indemnity product, the folks that are likely to go out-of-network generally will pick the indemnity products and your in-network use will be higher on the POS plan. When you're offering a POS plan, you want to look at the prior in-network penetration if it's a full replacement plan. For instance, if you had an HMO plan and an indemnity plan in place before, look at the selection of the HMO versus the indemnity. That will give you an indication about what the POS utilization might be in-network versus out-of-network.

With POS plans, I've seen people make one mistake over and over. They price the in-network benefit first, taking into account discounts and so forth, and then price the out-of-network benefits, taking into account the cost sharing and so forth. For example, 75% of the people go in-network and 25% go out-of-network, so they blend those to get the rate. They end up offering a full-benefit plan in-network and 80% benefit out-of-network, like some of the union plans do.

One problem you can run into with this is that your in-network discounts can be so large that they outweigh the out-of-network cost sharing. If that's the case, your product ends being priced lower than a straight 80% indemnity plan, and I have seen so many companies make that mistake. What you're actually offering is an 80% indemnity plan at a low price. It's better to equal out the discounts and the out-of-network benefits. This way, you're not hurt if you miscalculated and a lot of

people go out-of-network or in-network, because your utilization assumptions and your discounts are offset by the plan design cost sharing.

There are several requirements for success with open-access plans. First, you need a clear definition of how much care is directly accessible. For example, one company switched from an HMO plan to an open-access plan where people still had to stay in-network. The problem was, they didn't communicate that clearly to the members and many went out-of-network for care, because they thought "open access" meant direct access to anybody, whether they were in the network or not. Risk-sharing methodologies are probably one of the most critical success factors, and you still need to have incentives for providers to manage care appropriately.

Another success factor is having providers who are experienced in managed care. If you look at heavily penetrated HMO markets, the big question always is, "Do the providers practice care the same on the HMO patients as they do on the PPO patients and POS patients because they're used to practicing care that way?" Personally, I think probably a large percentage of them do. They don't know when the person walks into their office whether they're an HMO patient or a PPO patient. But a small or maybe a reasonable percentage do not do that, and those are the ones creating the problems in the first place. So I don't necessarily buy into the philosophy that physicians are going to change their practice anyway because the HMO's penetrated in the market, so we'll just offer a PPO plan and piggyback off that.

You also must have strong demand management programs in place, such as the nurse navigator program, to make sure that the people go in the right areas at the right time and that they're moved out of the hospital into a home setting and so forth. Ongoing physician education programs, good plan design, a rating strategy, and an effective reporting and monitoring system also are important success elements.

In the HMO business and in general, there are some early warning indicators that your pricing is off. For instance, if you're pricing any kind of product in the small group marketplace, for example, and your sales in the one to nine life group start to increase rapidly, you'd better do a competitive analysis. Your product could be very underpriced and losses will start to come in a year. In the case of Blue Shield of California, I think the sales increase is legitimate because it's a product that was not available in the marketplace.

Disease management is a final success fact. A healthy population should have more choice; a sicker population should be more managed. Employers, large and small,

are screaming for this, and I honestly think this is going to be the wave of the future in managed care.

The last thing I'm going to talk about is the Medicare open-access and the Balanced Budget Act of 1997 (BBA). In the past, Medicare providers would receive fee-for-service payment if somebody got care. The Medicare risk plans in place calculated, by county, an adjusted average per capita cost (AAPCC) for an HMO. If a person wanted to go through that HMO, Medicare would say, "Here's the AAPCC. We'll knock 5% off of it and pay that to the HMO." That amount, in essence, was the premium payment. However, because it varied by county, the amount was very high in urban areas and plans could make money, whereas they couldn't in rural areas because the amount was very low.

The BBA took that concept one step further. First, it allowed providers to organize themselves into groups similar to HMOs with lower capital requirements and other incentives to get providers to accept the risk directly as opposed to going through HMOs. Then the designers of the Act decided to do the same thing for PPOs and fee-for-service plans. This is setting Medicare up to be similar to a defined contribution instead of a defined-benefit arrangement.

In the fall, the federal government will send out health care brochures to every Medicare-eligible person offering several options side-by-side. If they choose an HMO plan, it will have HMO benefits associated with it. And, because the AAPCC is so high in some areas and the expected cost for care is low, the HMOs have added benefits to these plans, such as prescription drugs, which is a huge hot button for the senior population. Medicare enrollees can still opt for the fee-for-service plan and pay deductibles and coinsurance, but they will have an HMO option as well. Ultimately, the National Committee for Quality Assurance will probably rate these HMOs for quality.

If you take that one step further, there won't be any in place for PPO and fee-for-service options in a few years, because right now the Medicare folks that choose an HMO benefit are generally younger and healthier than the average population. So there's a windfall right off the bat from this HMO population because they're younger and healthier. But PPO plans and indemnity plans wouldn't necessarily have that windfall, so you won't see necessarily development immediately in that area. However, in 2001, the Health Care Financing Administration has mandated applying risk adjusters to the payment level and are working on the risk-adjuster mechanisms. Currently, it's based on the inpatient care and the ambulatory care group. Once a risk adjustment is made to these payments, the HMO won't have as

big a windfall. Instead of the payment being set at the AAPCC, it will be lower for a healthier person. That could spur an increase in PPO and POS benefits.

Right now, the government is allowing Medicare beneficiaries to stay in the fee-for-service market, but in the future, they might have to pay a $200 premium. Currently, it's about 25% of Part B, which is a nominal amount. Ultimately, Medicare is going to manage the cost, because it's scheduled to go broke in 2023 or 2027. This defined contribution strategy could save the program.

The plan design for Medicare open access also includes a "snowbird" benefit. Before the BBA, Medicare recipients could only be out of the service area for three months. Now they can be out six months and still remain enrolled in that plan. This means the snowbirds in the north can go to Florida, Arizona, and Texas for the winter months and still be covered under the plan. That gives a huge advantage to Blue Cross/Blue Shield and United Health Care, because now they can have these networks available both in the north and in the south. Blue Cross is working very hard on that enablement.

One note on prescription drugs. When you're offering a Medicare risk plan, you do not want to be the only prescription drug plan in the market or offer an unlimited prescription drug plan if everyone else has limits, because, once again, you'll get selected against.

Disease management is imperative in Medicare to be successful in the long run. The HMO windfall will evaporate with risk adjusters and as baby boomers, who are a little more used to HMOs, begin to retire. The selection will also go away.

Managing the Medicare and Medicaid population is completely different from managing a commercial population. Their problems and the way they view their problems are much different. For one thing, transportation is much more difficult for the Medicare recipients. Then there's the issue of social isolation. Some plans have social workers visit Medicare enrollees because social isolation is a big driver of usage in the health care system. Similar issues apply to Medicaid recipients, particularly, communication and transportation problems.

Mr. Bernard Rabinowitz: Open-access HMOs are the fastest-growing HMO product today. Enrollment increased by 27% in 1997 and an additional 7.8 million lives were added. Premiums are about 2–10% above traditional HMO prices. Driving this growth is employers' and employees' desire for freedom of choice, but at HMO prices and benefit levels.

The problem with the gatekeeper system is referrals. The patients are unhappy because their PCP might deny access to a specialist. The PCPs are unhappy, because when patients are unhappy, it hurts their relationship. Also, the physicians don't like to be told by the nurses at the HMO what to do. What's even worse is that a PCP who has contracted with five or six HMOs has to be set up to handle five or six different kinds of authorization processes.

The HMOs are not happy with the process, either. First, it's expensive. The authorization process costs as much as 3–5% of premium, which is enormous. Second, surveys have shown that the authorization process is the leading cause of disenrollments.

So how do we control utilization without a gatekeeper? The first thing we have to do is realize that only 2% of referrals are denied. So the problem has to lie with the cumbersome administrative processes and with the poor data links with providers.

Like marketing labels, open access means different things in different plans. In general, there are two open-access models. One is patient self-referral to a specialist within the network. The other is PCP referral without prior authorization. These two models can be subdivided into two categories: The patient can access without prior authorization all specialties or a limited number of specialties. You can further subdivide that into two classes: with or without additional copayments. In other words, open access does not mean complete freedom of access.

The most critical success factor for making an open-access plan work is the availability of large, multispecialty networks or groups. Because the patient can only be referred within the network, the bigger the network, the more types of benefits and services that can be provided.

Another critical factor is that the medical group has to learn to manage and coordinate care. The gatekeeper system essentially did two things: eliminated unnecessary and inappropriate care and coordinated quality care in a cost-effective manner. The question is, "Do you need a gatekeeper to do that?"

The group also has to be able to manage a looser benefit structure. This works if the consumer is educated about to how to use services wisely. This is known as demand management. A prime example is the nurse navigator concept that Rich talked about.

The next issue is reimbursement. It's absolutely critical that incentives are aligned with what you want accomplished. In the traditional plan, HMOs capitate the PCPs

and pay the specialists on a fee-for-service schedule. This would be a disaster under the open-access model. The best method is to make global payment to a medical group. You give the group a large sum of money and distribute it either by units of work, contact capitation, or some other method.

The next best method is the reverse capitation concept Rich talked about, where you capitate the specialists and pay the PCPs on a fee-for-service basis. But, no matter what method is used, the financial incentives have to be aligned with the HMO's objectives.

Let's look at the utilization differences between the traditional HMO product and an open-access product. Benefit differences will affect utilization; for example, Blue Shield of California's $30 copayment for seeing a specialist without a referral decreases specialist utilization.

Another important utilization factor is network capability—its breadth and depth, the number of different specialties it has, and how widely it is disbursed. You also have to look at the degree of medical management within the group, because if you take two identical open-access HMOs, and one's in California and the other's in Mississippi, you will probably get two different results.

Provider reimbursement is another factor affecting utilization. If reimbursement is properly aligned, then utilization will be properly managed. Finally, the sicker lives are more likely to select an open-access rather than the traditional model.

The following are some typical utilization differences in moderately to well managed plans:

- Hospital outpatient use typically increases 0–5%
- PCP utilization decreases by about 5%
- Specialist utilization increases 5–10%
- Ancillary services use, a small portion of the total cost, increases about 5%
- Pharmacy use increases 5–10%, primarily because specialists tend to prescribe a lot more drugs and more powerful drugs

Let's look at some specific cases. Blue Shield of California's product allows self-referral within the network. Its has a $30 copayment for seeing the specialist without a PCP referral versus a $10 copayment with a referral. Blue Shield deals through individual practice associations (IPAs), which are essentially capitated, although it's a little bit more complicated than that. In its open-access HMO, Blue Shield capitates the PCPs and puts aside a global amount of money for the specialists. If the specialists are overutilized, obviously, they will be hurt. But, if

they do it right, there will be some bonus money left over and all the incentives will be in the right place.

To date, Blue Shield has had a less than 5% increase in specialist utilization, and it was expecting between 10% and 15%, the average utilization increase for a POS.

Blue Shield also saw a small increase in drug costs and hospital outpatient use. The risk pool provided for the specialists was more than adequate, so they made money and were very happy. The participating IPAs saw their patient base from Blue Shield of California grow about 40%, and that's because it picked up patients from the IPAs who did not want to participate.

United Health Care has an open-access product called "The Choice Plan." In this model, the patients can self-refer within the network with no increase in copayment. However, premiums are somewhere between 1% and 3% higher than a traditional HMO, depending on geography. The physicians are compensated on a reverse capitation basis and there are incentives based on utilization. The IPA must provide claims data and utilization reports and adhere to strict quality standards. United Health Care provides support services such as intensive case management, telephone triage, and disease and demand management.

The results are that 80% of the patients still check with their PCP first, and most of those who self-referred would have been referred anyway.

Empire Blue Cross just introduced an open-access plan in New York. It's a self-referral plan within a tighter network than the one available through its regular HMO, and it carries a premium increase of 3%. The product was introduced in early 1998, and sales are well ahead of projected, but, unfortunately, there's no credible experience yet.

PacifiCare Health Systems offers an open-access plan, under which the PCP can refer within the network without preauthorization. The PCP is limited to referring to 14 specialties and ordering routine lab and x-ray services. Premiums and copayments are the same as under the traditional HMO product. The medical group is capitated and the IPA or medical group must provide encounter data as a condition for getting paid.

Then we have Oxford Health Plans. Remember, Oxford hit the news when its stock plummeted from $75–16. It turns out the company wasn't doing too well in terms of data systems and didn't know what its experience was. In any case, the Oxford model is a PCP referral model within the network with preauthorization covering

individual specialists and specialty care teams. If you need a bypass, they might give you profiles on four teams. Neither I nor they know what their experience has been.

Finally, not everybody in the business runs an HMO, and there are other companies that are using EPOs to run up against open-access HMOs. An EPO is similar to a PPO, but tends to have a more limited panel or a tighter network and no benefits are provided for going outside of the network. The price of an EPO is about 10% higher than for a traditional HMO product or about 6–8% higher than an HMO open-access product. The benefits of an EPO are a much wider service area, a much wider choice of providers, and greater benefit flexibility. The product is very attractive to groups that have lower utilization and are probably paying too much, because the HMO that they've joined is capitated. EPOs do have somewhat higher provider reimbursements but much lower administrative and fixed costs.

As you can see, the product differences are becoming very blurred. Each plan needs to figure out what its own competencies are and try and match these competencies against what the marketplace wants and then just hope and pray.

Ms. Shereen J. Jensen: I'm going to switch gears and talk about "dual certificate" POS products, where you have two carriers involved: an HMO, which is writing an in-network benefit that looks similar to a traditional HMO product, and an indemnity carrier, which is writing an out-of-network benefit that resembles a typical indemnity benefit. The insured member receives a certificate for both the HMO and the indemnity carrier. So this is a pretty clearly defined type of product versus all the other open-access products that we've been talking about.

Basically, a POS product gives the employer more flexibility and helps an employer and its employees become comfortable with managed care. Many employers are not comfortable locking their employees into an HMO product if they've never had a managed care product before. The POS allows employees to opt out of the HMO plan until they get comfortable with the network. Once they've had the POS in place for a while, employees might move to a more traditional HMO product.

This might be a controversial viewpoint, but your goal should be to get people into the most managed environment possible and the POS product should only be a transition. Many HMOs do not agree, but that's what we do in designing our products—incent people to move into the in-network benefit and, eventually, into the more traditional managed product.

A dual certificate POS product allows a local HMO to compete with some of the larger companies. Some states require an HMO that's offering a full replacement product for a group to have some type of out-of-network benefit.

The reason you might want to offer a dual certificate product instead of having an HMO write a POS product on their own paper is that, in some states, the IRS or the states themselves might limit the amount of risk that an HMO can take. A not-for-profit HMO can only take about 10% indemnity risk and retain its not-for-profit status under the IRS rules, so an indemnity carrier allows more leakage into that out-of-network portion of the product.

An HMO could start up its own insurance company and develop an indemnity product on its own, but that would be time-consuming, difficult, and expensive. It's cheaper and easier to contract with an indemnity carrier that is already set up to do this and, in the long run, it might be a quicker to get to market.

Also, the indemnity carrier might have some experience in setting up these types of products and can take some of the risk. A smaller HMO, in particular, might not feel comfortable taking all that risk up front.

Finally, some large employers require certain ratings for a carrier on the out-of-network portion of the product. If an HMO starts its own insurance company and it isn't "A" rated, the HMO will not be able to write some large groups.

With a dual certificate product, it is imperative that the two companies can work together. It's probably going to become a long-term venture, especially now with HIPAA's guaranteed renewability requirements. Once you begin partnering, it's going to be tough to get rid of those groups, so it's very important that the incentives of these two companies are aligned.

If the partners are competitors, or if one company is going to market and the other company is not, what happens down the line if that competition gets in the way? You need to think about that in advance if this is not going to be an exclusive arrangement. My company partners with multiple HMOs in the same area. If an HMO wants an exclusive arrangement in a particular area, we will not do that. But there might be another carrier willing to give them an exclusive in that market.

With respect to marketing expectations, this is going to be a difficult product to set up. You won't have your filings in and be ready to go to market in a couple weeks. So both companies need to examine their marketing expectations and whether it's worth all the up front work that goes into it.

The indemnity carrier needs to find out if the HMO is financially stable. What happens if that HMO becomes insolvent? Do you lose your in-network contract? The members still have a certificate and you've received 25% of the premium. How are you going to pay those benefits? I come from an HMO reinsurance background and that's something that we look for on the reinsurance.

The HMO's network should be broad enough to limit the out-of-network risk. We want to partner with an HMO whose network has enough providers with good reputations, so that people are buying this product because they want to get into that network and just want the option to leak out occasionally.

Finally, you want to be certain that both partners have the resources to devote to the product, because it will be time-consuming and expensive.

Risk sharing is a key element of this type of partnership. You must have some plan to keep the partners' incentives aligned and some way to ensure that both parties profit in a reasonably equal fashion. You don't want that premium split between the in-network and out-of-network to be so far off that one carrier makes a lot of money and another carrier loses a lot of money and there's no way to transfer that back and forth. This is one of the key things our actuarial department works on in structuring these arrangements. It's best to look at the total product, instead of dealing with it as two pieces.

We have an initial premium split. If that split is off, but the product in total is profitable, we look at that total overall profit or loss. If there's an overall loss on the product, we share in that loss, and there can be situations where the indemnity carrier has too much premium up front as well. So you want to have some way of looking at the total profit on the product at the end of day and splitting what each carrier gets. We try not to think about how much premium we receive and how many claims we paid out on our side of the product. It's been a little bit difficult. Certain states don't understand this product, and we have had to educate them that this is one product. In total, our premium is pretty close to being right, but the chances of predicting that split exactly are slim to nil.

The POS product should complement and not compete with the HMO. And it should be priced higher than the HMO product. As Rich said, that's one mistake a lot of companies make. It's just asking for trouble. Employers will choose your product as their indemnity option, and their employees want indemnity, so they choose your POS because it's the cheapest way in the market to get there.

The product design will vary based on the area. Allianz with HMOs is all across the nation, and we don't have the same product in any two locations. Health care is a

local thing, so you should design your product differently based on the HMO's and employer's needs in the marketplace.

You will have to agree on the division of labor when it comes to controlling the marketing strategy. For example, if the HMO's representatives are going to market this product, do they understand the out-of-network benefits, or, if the indemnity carrier's going to market the product, do they understand managed care well enough to explain the product to employers?

In your marketing plan, you also need to determine if the new product will be offered to existing groups. If you have employees that are currently in the HMO, do you want to offer them the ability to step back and go into a less managed product? You need to think about whether that makes sense in your market and in your environment.

Who is going to underwrite the dual certificate product and, more important, who will have the final say? If a case comes in and one of the partners thinks it's a great opportunity but the other partner thinks it's a huge risk, who will make the final decision? This is where the risk sharing is very important. If you're looking at the profit and loss on the total product, maybe you can do it. If not, you need to be very careful that those incentives are aligned. Some states allow more flexibility on the indemnity piece. For example, in New York, you can experience rate on the indemnity part of a POS product, but the in-network part must be community rated.

How will the administration be done? If the HMO is going to do the administration, can its system incorporate a usual and customary indicator to process indemnity claims? If the indemnity carrier is going to process claims, does its system have the capability to apply a fee schedule to the claims? Both partners need to have loadings even if only one partner is doing the administration, the marketing, or everything. The other company still needs to include something in the product for overhead. When you think about putting two companies' loadings into one product, that can make it difficult to compete with the companies that can write this product alone. However, if one company really needs this product for some reason, they might be willing to take less on their administration than they usually would to get the product to market.

Which company will offer the conversion policies? Generally, as indemnity carrier, we would much rather have the HMO offering those conversion policies whenever possible. If the HMO is a reinsurance client of ours, we are offering the conversion when the employee moves out of the service area. We would like to have the HMO do it when the employee is in the service area.

Mr. Hall: What are the states' requirements on that?

Ms. Jensen: As far as I know, you have to just offer something. This isn't my area of expertise, but I was talking to one of the other actuaries at our company and he said that, in most states, it's possible for just the HMO to offer those conversion policies if the person is within the service area.

Mr. Hall: So the insurance company would not have to offer a conversion policy on the POS side?

Ms. Jensen: I believe that's correct. The benefit design is critical. If this product is going to be offered next to traditional HMO products, the in-network benefits must be more restrictive than the HMO benefits. And, if the group is converting from an indemnity product, especially in a system where managed care is fairly new, the out-of-network benefits should be more restrictive than those of the most prevalent indemnity plan available. Again, you are penalizing members for going out-of-network, which is key. If you offer preventative care only in-network, it forces the employee to develop a relationship with an in-network physician. If members develop a relationship with and feel comfortable with the physician, that will eventually lead them to be more comfortable with the network in general.

In the same vein, if you offer a plan that has a preexisting condition limit out-of-network, and someone has a chronic condition when they join the plan, he or she will have an opportunity to develop a relationship with an in-network provider. Generally, the benefits should encourage in-network utilization. For out-of-network coverage, I recommend at least a 20–30% differential in coinsurance, a $250 deductible, and a $1,500 out-of-pocket maximum. For many people the deductible is the key element in deciding which plan to choose. In today's environment, $250 is a bit low, so if you can have a higher out-of-network deductible within your market, I would recommend that.

Mental health and substance abuse are highly utilized out-of-network, but the benefits are mandated by many states. One good option is to offer mental health and substance abuse only in-network. Your maximum should cover the product as a whole, so people won't be able to get 20 visits in-network and then go out-of-network and get another 20 visits.

From the Floor: Wouldn't insurance commissioners require that to be separated into two policies that are issued if the first one was two separate parts?

Ms. Jensen: I know we have products where we do have one maximum over the whole product, but that is a good question.

From the Floor: I think some state commissioners will probably require it. If they hold two cards, they get the maximum of both.

Ms. Jensen: Yes, I agree. That probably is the case in some states. But if you can do it, it's better to have those maximums as a total on the entire product, otherwise, you are giving somebody double the benefits.

In defining your claims, you need to agree in advance on what is going to be an in-network claim and what is going to be an out-of-network claim. Otherwise, once you get the product up and running, you're going to spend all your time arguing about where the claim belongs. If a member self-refers to an in-network physician, for example, will that be treated as in-network or out-of-network? Deciding these things in advance is especially important if you're not the partner that's paying the claim, because you want make sure that you're comfortable with the way your partner will administer the product.

Recently, I've seen a lot of plans using the in-network fee schedules as the out-of-network reasonable and customary amount. This is not something that I would recommend, but if you're going to do it, you must ensure that the members understand it. If your plan design specifies a $250 deductible and 20% coinsurance in-network, it might jump to 40% coinsurance out-of-network. This must be spelled out to members because they're going to be billed a significant amount and it can lead to some problems. We've seen some competitors in the market do this so their premiums were low to attract these groups, and when employers find out that employees are unhappy, they drop the plan. So you might gain some market share for a while, but your persistency is just not going to be there once people figure out what's going on and it's confusing for the members. If you're not very clear about what the members are getting, you might even open yourself up to some lawsuits.

With respect to the out-of-network risk, as Rich said, one of the most important things is the offering scenario. He pointed out that, if the POS product is sold alongside an HMO product, the POS becomes the indemnity option. That's an important thing to think about when designing and pricing your product. Also, if your product is one of multiple options versus carrier replacement, you have to consider those other options in designing and pricing your product.

Older members may not be as comfortable going in-network because many have an established physician relationship, so you have to consider the demographics of the target populations as well as the size and the reputation of the HMO network, because that drives how many people feel comfortable going in-network.

If the HMO pays a significant portion of its providers on a capitated basis, an adjustment is usually made to keep the product marketable. You can't pay the same capitation that you're paying on the traditional product. One of the problems here is that the physicians worry that they won't get more members than they did under the traditional product, so they might not be happy about decreasing their capitation. But if you have a significant amount of capitation in your network and you don't decrease it, your product cannot be competitive.

Also, some states do not allow providers to accept capitation for out-of-network services. They will allow physicians to accept capitation for services that they can provide themselves, but not necessarily for services that are provided outside the HMO's network where there's no cost control.

We have large problems getting data on these products, and you need data. You need to be able to get the in-network and the out-of-network experience and combine them. You need to know what your premium split is so you can adjust it for future years. You need to be able to look at that total experience to do the risk-sharing settlement and determine profit or loss on the product. You might think administering the dual certificate POS is no different from administering any other product, but I can tell you from experience writing a number of these, we don't get the data.

One unique thing about Allianz is that we don't do any of our own administration. The HMOs do all of the administration, so we need to get data from both sides of the product from them. It's amazing how difficult it is to get data on their side of the product. You'd think that would be easy because they're doing it; it's not. So here's my word of warning: This is probably the most important thing that you're going to need to do up front.

Write this type of product in the small-group market and it adds a whole array of complications, such as determining which entity is responsible for product compliance and certifications. Are you going to treat this as two products for small group certifications? Of the 13 states we've surveyed, all but one said that the POS product can be considered the HMO's product because it is taking the majority of the risk.

Most state laws have a requirement that you need to rate and underwrite your product consistently. And assuming that this can't be a separate class of business, it needs to be consistently rated with one product or the other product. If you're treating it as two separate products and both carriers are going to certify, then you have to rate the product consistently, with both carriers rating on their other products in the state. I have not figured out how to do that. So you might want to

think that through before actually trying it. First find out how the state treats a POS product and then rate the product consistently with that carrier's other products in the state.

I don't think we have two clients that have the same risk-sharing deal. You can set up risk sharing in a number of different ways and it only depends on what the carriers want to do with the product. For example, we had a client whose goal was to grow its commercial membership. It conflicted with our goal. We are a for-profit company looking to make a certain profit margin on this product, and this wouldn't happen with the membership they wanted. So we needed to think through, in advance, what method we might use to enable both of us to reach our goals.

There are a number of different ways to structure risk sharing. You can design:

- A quota share reinsurance arrangement, if that is allowed by the state
- A retrospective settlement based on the profit and loss on the total product or each separate part, if that works better
- A contingent commission on the admin fees. If one company is doing the admin for the whole product you might want to put the admin fees at risk
- An escrow fund to cover losses on the product
- A premium split adjustment going forward to keep both companies in about the same place

In some states, you have to file your risk-sharing arrangements and all states do not allow the same arrangements, so you should check that in advance. Some states will limit the amount of indemnity risk that can be passed back to the HMO, making it a bit more difficult to look at the dual certificate POS as one product. Some HMOs worry that the arrangement will jeopardize their nonprofit status, so you have to be creative without making it seem as if the HMO is a for-profit company that's passing money back to you as the indemnity carrier.

Mr. Hall: You mentioned that the scheduled out-of-network benefits that pay the same amount as the in-network would pay to the providers means more cost sharing if a member went out-of-network. We have seen that work well in the small group arena, and there aren't as many complaints as you would think.

Also, we've seen a lot of companies go to a resource-based relative value schedule (RBRVS) as the out-of-network schedule, or a percentage of RBRVS, for instance, 150%, instead of reasonable and customary fees. When members do complain, we argue that we're paying them 50% more than Medicare does so talk to your doctor, and that generally works. The doctor generally does not balance the bill at that point.

The second point I wanted to make is that risk-sharing arrangements also can apply in a multiple offering situation to a small group. We've seen a lot of HMOs partner with indemnity companies to offer joint products for small groups. And, of course, there's a selection issue associated with that, where the healthy folks will pick the HMO product and the unhealthy people pick the fee-for-service or the indemnity product. Risk-sharing arrangements can be structured to encompass the group as a whole as opposed to each of the products individually. And, similar to the POS, you spread the losses and the profits between the HMO and the indemnity company. Some state laws don't allow that, but there are ways around that through reinsurance mechanisms and so forth.

Mr. William A.J. Bremer: You said that the member receives an HMO certificate and an indemnity certificate. Don't people have to make a choice between the two at the time of enrollment? Otherwise, how would you get the income split unless you multiply by the number of enrollees who select each company?

Ms. Jensen: Because this is a POS product, the members choose whether they're going to an in-network or out-of-network provider at the time the service is provided. We come up with an estimated premium split up front. So we might assume that 75% of the benefits will be provided in-network and 25% will be provided out-of-network. That is why we need to look at this as one total product, because that split is even more difficult to predict.

From the Floor: What do you think Blue Shield is going to see? Also, in the specialist coordinator open-access HMO model, I'm having trouble seeing this as open access because of the referrals. Your PCP refers patients to specialists and then you need a referral from your specialist to see a PCP and another specialist.

Mr. Hall: Maybe it's not an open-access plan, but it's not a primary care gatekeeper model, either. A physician is still coordinating the care, but, in many instances, the specialist would be the best coordinator. The plan is open access for the healthy folks and a specialist care coordinator for the chronic conditions.

Mr. Thomas G. Ruehle: Everybody mentioned that it's often difficult for the HMO to get the data it needs to monitor the experience. What is the best way to guarantee that doctors submit data on encounters, and how do you know that you are getting all the data?

Mr. Hall: Try to structure an arrangement whereby some payments still are made for the fee-for-service data submitted. For instance, instead of paying straight capitation, you could set up target utilization budgets. If the actual utilization comes in below the target budget, perhaps you share the windfall 50/50 with the

providers to ensure that you are getting utilization data from the providers. If utilization comes in above the target, there's a 50/50 share in that loss as well. Not only does that allow you to get data from the providers, it also, from a provider's standpoint, in theory, means that the HMO still has significant risk in the game and will not aggressively price a product on a percent-of-premium capitation or accept any risk that comes along because they passed the full risk onto the providers.

Under full capitation, the HMO can set up bonus incentives for providers to submit data. Also, we've seen capitation arrangements in which providers' encounter data go towards developing capitation for the following year, so if they don't submit the data, capitation might be reduced.

Ms. Jensen: As an indemnity carrier working with HMOs, it's important that the HMOs can provide us with data. We look at their system up front to make sure that they are coding the groups and claims in a way that is useful to us. You don't want to write the product and then suddenly find out that they can't tell you which of these groups are the ones where they have the HMO written side-by-side with your product. If something is important for you to know, you have to make sure the HMO is going to track that. And be sure to see proof and not just take their word for it.

You also need an audit after the fact to make sure you are getting everything. We had a case where some groups were not set-up correctly and we ended up getting prescription drug claims for about $1.5 million after the fact.

Mr. Hall: I have one point to add on the contact capitation. Generally, we would not recommend setting up a straight amount for a chronic patient, say, $100,000. Instead, it would be a target of a $100,000 with sort of risk-sharing corridor. If actual fees came in within 10% of that corridor, the provider receives $100,000. Anything above that would be shared 50/50 with the providers. This works on a straight and contact capitation basis.

Mr. Kirk A. Smith: Shereen, for small groups, you said most states consider POS products to be the HMO products. Does that mean that the HMO versus the indemnity carrier needs to be in compliance with the small group reform laws?

Ms. Jensen: The total product must comply with the small group laws, but what I meant is deciding which company will be responsible for that compliance and certify that. Because that product probably is going to have to be written consistently with one or the other carrier's product, it usually makes sense to have the product underwritten and priced consistently with the HMO. Then the HMO

would do the underwriting on the product and certify after the fact that the product is in compliance. That usually makes the most sense.

From the Floor: Then do we need to fit into the HMO's rating corridors?

Ms. Jensen: Yes. If, for example, the factors have to be applied consistently and the HMO is using one age/gender table and the indemnity carrier is using a different table on its other products in the state, you'd want to use the HMO's age/gender table for the POS product and rate it consistently. If the HMO is doing other adjustments, you'd want to apply those adjustments consistently to all of the HMO business and the POS business.