

Point-of-Service Plans

Overview

These products are designed to capture the best features of the HMO without its rigidity. The expanded participant choices and ease of plan design are assets with the point-of-service product.

The point-of-service product is currently enjoying a great popularity because it is positioned somewhat centrally in the continuum of benefits and freedom of choice.

Description of Product

The reason for the name is simple: participants have the freedom to choose the level of benefit they receive each and every time they seek medical services. There is not just one point-of-service product, but rather several:

- *One.* HMO-oriented (dual option of HMO or indemnity).
- *Two.* Self-funded plan oriented (triple option of HMO, PPO or indemnity).

Regardless of the variations, all point-of-service products have the following characteristics in common:

- HMO-type enrollment with a primary care physician assigned. This is the so-called gatekeeper.
- Plan design aimed at curbing or punishing out-of-network care and encouraging in-network care.
- Choice by participants whenever care is sought.

The point-of-service plan is similar to the traditional HMO with these important differences:

- A Point-of-service plan has a *gatekeeper* physician who controls access to the plan's provider network. The doctors in the plan are generally paid on a capitation basis, which means they get a set fee per person regardless of the amount of service they perform. This exposes them to some financial risk for the services rendered, thus giving them an incentive to control utilization.
- Employees are permitted to use non-network physicians or hospitals, but are exposed to higher co-payments and deductibles, with participants responsible for as much as 30% of the charges they incur. But when care is obtained through the gatekeeper and network providers, no deductibles and lesser co-payments apply.

Point-of-service plans are offered by insurers that have developed networks of physicians and hospitals, as well as by HMOs that have existing provider networks. Insurers have an advantage in that they are better equipped to pay claims for non-network care, an important feature of point-of-service plans.

There is insufficient experience with point-of-service plans to know if they represent a real breakthrough or not. Companies considering such plans should be aware of problems that can develop in the following areas:

- Network that is not adequate for territory to be covered.
- Difficult claims administration problems.
- Need for special education and training on everyone's part.

Why Product Created

Employer-plan sponsor cared about over-restricting the patient's choices. Too little choice with too much savings was rejected by the employer. The point-of-service product gives a more balanced product than the alternatives.

The single precipitating issue that created point-of-service was the HMO practice of permitting no benefits if the HMO primary physician was bypassed.

Advantages of the Product

- Primary care physician continues to play a critical role in health care; the presence of the gatekeeper reduces costs by 5-15%.
- The steering is consonant with both quality of care and freedom of choice.

Typical Goals of the Product

The state goals of a large employer with such a plan were as follows:

- Emphasize quality and family values.
- Establish one plan for all employees.
- Include wellness and behavior programs.
- *Beat* inflation in matters of cost control.
- Achieve effective communications.

Popularity of Product

Point-of-service plans with less restrictive coverage than that offered by standard HMOs are the fastest growing segment of the HMO market.

Nearly 40% of HMOs currently offer an open-ended option, up from 30% a few years ago. During the same period, the number of plans with point-of-service options climbed from one in five to one in three. Both options resemble indemnity insurance with deductibles and co-payments and allow the patient to choose either a participating or nonparticipating provider.

Cost Effectiveness of Product

The point-of-service plans will be at least 10% more expensive as well as less comprehensive in their coverage than are the prepaid plans. Many prepaid plans are adding point-of-service products for competitive reasons and not specifically because of membership trends.

Status of Pure Hmos

Approximately 80% of all HMOs offer an open-ended option: Enrollees may receive services outside the provider network without referral authorization, at the cost of an additional deductible and/or copayment. Approximately 20% have point-of-service coverage. Patients may consult a nonparticipating provider at any time, but coverage has limits like those on indemnity insurance, such as usual and customary ceilings on reimbursement.

Point-of-Service Plan Trends

New types of risk-sharing are being required by employers of providers:

- More comprehensive standards than the traditional claim accuracy standard; broader performance guarantees such as good provider relations and timely service.
- More subtle guarantees that may extend 2-3 years into the future.
- Hold harmless agreements that take employees *off the financial hook* if the provider malpractices.

Also, employers are carving out special areas of care for managed care. Examples include: prescription drugs, mental/nervous, substance abuse, special procedures (transplants, e.g.).

Carrier Trends

Carriers are retrenching in their creation of managed care networks.

HMO Trends

Point-of-Service Plans

HMOs are attempting to be more profitable; to this end, they are offering a broader array of products:

- Point-of-service and indemnity plans
- Self-funded HMO plans.

Participant Trends

Participants have become much more comfortable with point-of-service plans.

Point-of-Service and EPO Battle

Originally, HMOs would pay nothing when a person went out-of-network for care. As a marketing advantage, the HMOs modified their service to permit members to get care out-of-network but at reduced benefits.

There are some obstacles to such a modification by the HMO.

Consider:

- State laws vary on whether an HMO can pay for out-of-network claims on their own. Some allow it, while others require HMOs to contract with a traditional insurer to handle this activity.
- Nonprofit HMOs that pay for their own point-of-service out-of-network claims might find their tax-exempt status in jeopardy. This is due to the release of three *General Counsel Memos* from the Internal Revenue Service. The effect of the memos is to suggest that, if an HMO/point-of-service plan covers a lot of out-of-network claims, it might be considered an insurance company for tax purposes. If the out-of-network claims were only incidental, however, the plan might be treated as a non-profit HMO.
- The competitors of the HMOs, primarily the PPOs, will not let their accounts be *ravaged* by point-of-service plans without a fight. Some PPOs are already fighting back by developing a new HMO rival, the *exclusive provider organization*. *EPOs*, as these contenders are called, feature a more restrictive network, more monitoring and more managed care than found in traditional PPOs. Result: More savings, and greater competitiveness with the highly managed traditional HMOs.

Agony of Conversion – Indemnity to Point-of-Service

In General

The attractive features of the point-of-service plan are:

- Participants are free to obtain medical care when they need it -- but there is a financial incentive for them to stay with the network and seek referrals through the network and not directly.
- The indemnity or basic plan is *sweetened* with preventive and/or wellness benefits.
- Participants, usually reluctant to join an IPA HMO, are attracted to the point-of-service plan.
- The point-of-service plan results in greater provider accountability.
- The financial rewards are significant.

Running the Network

Such networks are sponsored by diverse parties who assume the role of network managers:

- Insurers
- HMOs
- TPAs.

As inducements to employers to *buy on* to such networks, guarantees are offered by the network manager to the prospective employer:

- Quality of service
- Participant satisfaction
- Practice standards up to clinical protocols
- Financial results subject to penalties and/or bonuses.

One of the challenges to the employer with the point-of-service plan is the fairly arduous start-up work:

- Initial planning
- Selecting the network and the manager
- Participant education
- Getting used to period.

To be successful, the management and the employer must work together.

Designing the Plan

While in the network, participants enjoy small co-payments, assigned benefits and preventive care. While free to seek care out of the network, the participants suffer these penalties:

- Regular (or reduced plan benefits)
- Benefits are not assigned (usually)
- Lost benefits (preventive, e.g.) from out-of-network physicians.

The overall goal of the point-of-service is this: Steer covered persons into the network but provide them with reasonable options if they choose to go on their own. Harsh penalties are neither effective nor wise, (30% is too high, 10-20% is reasonable); simplicity and ease of administering and understandability are important; the quality of the network is important.

Accessing the Network

The number and scope of physicians is a balancing act:

- 50% is too high a percent to be cost effective.
- 20-25% is close to being reasonable.
- Toughest part is to get primary physicians to enroll – there are too few and they are too busy.
- There must be a reasonable geographic spread.
- What to do with ancillary providers:

Laboratory	Pharmacy	Medical Equipment
Radiology	Home Health	

These have become, collectively, large-ticket items approaching 30% of the total health care bill.

Administrative Considerations

The difficulties with multi-state plans must be cited:

- Where plan is insured, state-mandated benefits must be provided.
- With HMOs, state HMO statutes must be met.
- With PPO and utilization firms, varying state statutes and regulations must be met.
- Medicine is practiced differently by geography.

Introducing the Point-of-Service Plan

The core administrative challenge is this: benefits differ when treatment is in network or out-of network. Certain practical questions arise which might be handled as follows:

- Participants with serious medical conditions are allowed to continue with a non-network physician without penalty.

- Pregnant covered persons may continue care with their present obstetrician.
- Waivers are available for COBRAs who have moved away and students away at school, also for persons away at work or on vacation.

Customer-Service Issues. Customer service deals with these types of questions:

- What are qualifications of the providers?
- What are penalties for out-of-network care?
- What are claims procedures?
- Are ID cards clear as to where to file?

Dealing with these, and similar questions is critical to the success of the point-of-service plans. To support the customer service, an aggressive program of communication is vital. These points must be reinforced: What is point-of-service? Why was it adopted? What must participants do to comply? Why is going through a gatekeeper important? Communication is a continuing challenge and not a one-time challenge; the message must be repeated and reinforced. The communication message must go to the providers as well as to the participants.

A major goal of communications will always be, with a point-of-service plan, to have the participant understand why a primary care physician has to interfere with the traditional access of the participant to a specialist or alternative care provider.

Medical Management. The manager of the point-of-service network has a great responsibility to see that costs are contained, that quality care is delivered and that access is sufficiently broad. In the area of quality management, oversight reviews by the network manager must be done. This oversight takes these forms:

- Provider credentialing
- Precertification and ongoing review
- Quality assurance reviews (where appropriate).

Critical with medical management is to overcome the common perception that:

- Limiting access is the same as lowering quality.
- Any cost containing is the same as lowering quality.

Financial Results

Financial results of point-of-service plans have been encouraging; savings in the 15-25% range have been reported. Factors that will affect the savings are these:

- Actuarially-determined plan design, which can be heavy or light as regards

steerage

- Age-sex-dependent composition of group.
- Ability of manager operating the arrangement.

Point-of-service plans give an economic edge not because they *beat on the physician* for discounts, but rather:

- Guarding from expensive-exotic-needless care by the gatekeeper doing its job.
- Selecting the physicians who are *virtuous* as regards quality, efficiency and charges to begin with.
- Cutbacks due to rules not being followed.

Administrative Costs of Point-of-Service Plans

It has been reported that while 10% of costs under an indemnity plan are administrative, approximately 16% is the comparable number for point-of-service plans. The largest expense is network management, which includes the initial cost to create the network; other additional costs include more intensive utilization review and extended member services, particularly involving use of non-network physicians. Other added costs include more involved communication and education of participants.

Conclusion: point-of-service plans are labor intense but are cost-effective. Ways of controlling the added costs with point-of-service plans are as follows:

- Keep the program as simple as possible.
- Monitor expenses carefully.
- Tie claims and administrative costs into a single contract.
- Put the physician on the risk as much as possible.