

# Issue Brief

Findings from HSC



## PREFERRED PROVIDER ORGANIZATIONS AND MEDICARE: IS THERE AN ADVANTAGE?

by Robert E. Hurley, Bradley C. Strunk and Joy M. Grossman

*A key component of the new Medicare reform law is an overhaul of Medicare managed care, including a strong emphasis on recruiting private plans—especially preferred provider organizations (PPOs)—to participate in the new Medicare Advantage program. Citing the popularity of PPOs for privately insured Americans, proponents have touted PPOs as critical to injecting more and better competition into Medicare. This study, based on findings from the Center for Studying Health System Change’s (HSC) site visits to 12 nationally representative communities, explores the reasons for the strong growth in commercial PPO enrollment and examines whether PPOs—as currently structured—can add value to Medicare. The available evidence suggests that the PPO model will face challenges in achieving the policy goals set forth in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), including increasing benefits, improving quality and slowing cost growth.*

### The PPO as Product of Choice

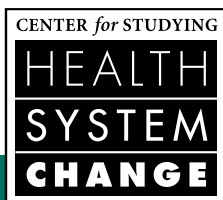
**S** spurred by consumer and provider disenchantment with tightly managed care in the form of health maintenance organizations (HMOs), PPO enrollment jumped to more than 110 million Americans in 2003.<sup>1</sup> PPOs typically offer patients a broad choice of physicians and hospitals and place fewer requirements on providers than HMOs. The ascendancy of PPOs among the privately insured has sparked a great deal of interest in encouraging PPOs as an alternative to traditional Medicare. The revamped Medicare managed care program, now known as Medicare Advantage, will rely heavily on PPOs to address some of the shortcomings

of earlier attempts to introduce private plans to Medicare. Policy makers expect Medicare Advantage PPOs to:

- offer beneficiaries sustainable coverage options with more benefits or lower out-of-pocket costs than traditional Medicare;
- develop broad provider networks with substantial price discounts;
- expand private plan options across geographic areas, particularly rural areas;
- employ care management techniques that contain costs and improve quality; and,

- ultimately, contribute to a slowing of Medicare cost trends.

In the short run, substantial payment increases to private plans as a result of the Medicare reform legislation will help retain many Medicare HMOs and draw in new health plans, including PPOs. This could lead to significant enrollment growth, similar to the pattern displayed in the Medicare managed care program in the mid-1990s prior to the Balanced Budget Act (BBA) of 1997. Available evidence suggests, however, that over the longer term the PPO model will face many challenges to achieving policy goals set forth in the reform legislation, according to HSC’s 2002-03





## Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. HSC researchers interviewed representatives of health plans, providers, employers, policy makers and other stakeholders about the role of PPOs in local health care markets.

### HSC Alerts

Keep up to date on the latest information about health care market trends. Sign up today at [www.hschange.org/alert](http://www.hschange.org/alert) to receive e-mail notification of new HSC studies and publications.

site visits to 12 nationally representative communities (see Data Source).

## What is a PPO, Anyway?

Despite its growth and popularity, the PPO offering is not well understood.<sup>2</sup> At the core of the PPO design is the provider network, assembled through contract and rate negotiation. In addition to the contracting function, the network organizer carries out a credentialing process to establish that the contracted providers meet clinical and other criteria. Many network developers also perform claims re-pricing, the process by which negotiated discounts are applied prior to payment.

In the narrowest sense, the provider network is the PPO. Network developers rent access to third-party administrators acting on behalf of self-insured employers or to insurers wishing to offer network-based products. Networks may include claims administration capability and carry out medical management, or these services may be acquired from other vendors and offered in tandem with the provider network.

Large health insurance carriers typically develop their own networks to exert more influence on contract terms. By owning their own networks, such carriers are well positioned to meet the preferences of a broad array of purchasers, ranging from small to large and fully to self-insured employers. Blue Cross and Blue Shield plans, the leading carriers in nine of the 12 HSC communities, owe much of their dominance to the strength of their PPO options. By parlaying their distinctive history and local market focus, Blue plans usually have the broadest provider networks and the best available discounts, giving them a major competitive advantage.

## How PPOs Add Value

In the private health insurance market, the PPO design has offered several advantages over HMO plans to employers seeking value in health benefits purchasing. Like HMOs, PPOs arrange a network of providers and negotiate discounted payment rates. Unlike traditional HMOs, however, PPOs allow

employers to customize benefits and product designs, give employees a clearer picture of the cost savings associated with using a restricted network of providers and offer more modest administrative costs.

**Access to provider networks and discounts.** The network allows employers to offer employees access to providers who agree to make price concessions to gain access to additional patients. In the absence of a network, self-insured employers would have to negotiate discounts directly with providers or pay full charges. Network developers obtain discounts from a broader set of providers than most individual employers could assemble, and because network developers represent many purchasers, they have greater negotiating leverage to extract larger provider discounts.

**Customized design and cost transparency.** Employers see the flexibility found in PPO options as much more suitable for assembling the customized product designs they are currently offering their workers. As employers seek ways to reduce their financial commitment for benefits, PPO designs easily allow them to add more cost sharing for employees. In HMOs, even making simple changes like adding deductibles may require legislative or regulatory changes. Likewise, state benefit mandates fall most heavily on HMO products because of their risk-bearing design in contrast to PPOs, which in most states are not regulated risk-bearing entities.

**Low administrative expense.** PPOs have lower administrative costs relative to HMOs, reflecting more modest efforts to manage care and costs. Fees for administrative services and network access may be as low as half what HMOs include as administrative expenses in their premiums. Most PPOs have far less performance reporting and monitoring capability than HMOs and make limited efforts to influence provider behavior or enhance quality.

## What PPOs Don't Deliver

PPO networks struggle to get favorable rates or even desirable payment terms. Network developers interviewed during the HSC site visits reported fierce contracting pushback from hospitals, and, in a number of instances,

hospitals have demanded a return to percent-of-charges contracts from fixed-payment methods like case rates or per diems. Both hospitals and plan network contracting executives acknowledged that discounts off charges are not very meaningful if there are no upper limits on the charges or the rates of increases in charges.

PPOs appear to have been somewhat more successful obtaining discounts from physicians; but this too has been an area where PPO networks have faced increasing pressure. The principal exception to this general picture is the experience of Blue plans, which have been more successful in using their large membership and broad product portfolio to extract considerably deeper discounts than their competitors.

Commitment to medical management techniques like gatekeeping and pre-service authorization is typically limited in PPOs. This contributes to provider acceptance but does little to control utilization and cost trends. The more intensive medical management techniques found in HMOs are available from many PPOs but are more likely to be employed with less vigor and purchased more selectively on an *a la carte* basis at an added cost. Disease management is a good example of this, as many carriers and plans have invested in these programs and tout their value but are struggling to accumulate the evidence to persuade employers to pay an additional fee for them.<sup>3</sup>

Because PPO participants are not enrolled per se in a health plan, but use network providers on a voluntary basis in return for lower out-of-pocket costs, the PPO platform is limited in collecting, monitoring and reporting on the experience of patients or promoting quality improvement among network providers. In fact, many PPOs do not see themselves as actually managing care, but only arranging access to it.

## PPOs as Public Policy Option

Given the robust growth of PPOs in the commercial sector, the appeal of PPOs to Medicare reformers is not surprising. But significant challenges exist to adapting PPOs to meet policy makers' goal of increased competition in Medicare, raising

questions about whether PPOs can succeed as a credible alternative to traditional Medicare.

### Attractive, sustainable alternatives.

To attract beneficiaries from traditional Medicare, Medicare Advantage plans will have to offer richer benefit packages or lower out-of-pocket costs to offset beneficiary concerns about restricted provider choice. This was the strategy of HMOs in the mid-1990s that ultimately proved unsustainable after the BBA of 1997. Many providers and beneficiaries are likely to be anxious about a possible repeat of this experience.

In the private sector, much of the appeal of the PPO lies in the fact that it is not an HMO and offers more provider choice and fewer restrictions on access to services—albeit typically for a higher price than an HMO. The appeal is less clear for Medicare beneficiaries evaluating Medicare Advantage PPOs against traditional Medicare. The key will be enhancing benefits, both in the initial phase when Medicare Advantage payments exceed traditional Medicare payments, and during the later stages of Medicare reform when competitive bidding is expected to slow growth in payment rates. Or, if this fails, when the government makes downward payment adjustments as it has done in the past.

**Broad provider networks.** Policy makers believe PPOs are attractive options because they can offer broad provider networks to beneficiaries. Most private sector PPO developers are not very selective when assembling provider networks, and they typically pay providers more than Medicare. PPO networks are expected to be broader than HMOs, given the emphasis they place on provider choice. Likewise, PPOs are more limited than HMOs in steering patients to some providers and away from others, weakening PPOs' ability to win substantial price discounts from providers. How much leverage Medicare PPO plans will command in price negotiations with providers will depend on the number of enrollees and whether providers believe they must join a network to continue seeing current Medicare patients.

The fact that traditional Medicare will remain an option for all providers and beneficiaries will undermine the potential

leverage of PPO plans. It is possible that some providers would consider payments below traditional Medicare if they could expand market share, but experience to date—such as in the Medicare Select program that since 1998 has tried to encourage beneficiaries to use restricted hospital networks to enhance the value of private supplemental coverage—has been disappointing.<sup>4</sup>

**Expanded geographic coverage.** A major attraction of the PPO option to policy makers is its broad geographic coverage. PPO options are widely available in the private sector, particularly beyond major metropolitan markets, and seem better positioned to serve Medicare beneficiaries in rural areas than did HMOs in the Medicare+Choice program. But discounts will be harder to obtain in rural areas because of a general lack of competition in the provider market. Therefore, PPOs will have less leverage with providers relative to traditional Medicare in these areas.

Under the Medicare reform legislation, additional funds have been allocated for plans to facilitate network development in markets where difficult negotiations are expected, so it is possible that plans will be able to enrich benefit packages and still pay providers enough to draw them into networks. The floor payments in many of these markets create opportunities for plans to pay the same as or even more than the traditional Medicare program to deliver Medicare benefits and still make a profit. Whether this occurs depends on the extent of beneficiary participation, provider attitudes toward private plans and confidence in whether these plans will be long-term Medicare participants.

**Care and quality management.** The Medicare reform legislation imposes requirements on Medicare Advantage plans to offer quality improvement and chronic care management programs. Sponsors of many commercial PPO offerings are not strongly invested in care management and quality improvement techniques, and accreditation and licensure standards that require or promote these activities are often not seen as important.

To meet new Medicare requirements, many current PPOs would have to increase



**Given the modest  
price discounts of  
most PPO networks  
and their limited  
commitment to care  
management, lack  
of traction in cost  
containment is  
not surprising.**

care management and information technology capacity—investments they may be reluctant to make in light of the history of private plan instability in Medicare. In the commercial sector, most care and disease management programs are purchased from specialized vendors. They can be launched from the PPO network platform or grafted onto product designs, but typically at an added cost. It is unclear if linking such programs to a PPO network in Medicare Advantage will be any more effective than just overlaying them on standard fee-for-service arrangements with providers as outlined under the Medicare reform legislation for chronic care improvement in traditional Medicare.

**Slowing cost growth trends.** Premium trends for PPO-based products have closely tracked those of other products, though recent evidence suggests PPO purchasers have bought down benefits significantly by increasing patient cost sharing, which may be a response to higher underlying cost trends for the PPO compared with other products.<sup>5</sup>

Given the modest price discounts of most PPO networks and their limited commitment to care management, lack of traction in cost containment is not surprising. Moreover, despite low administrative costs relative to HMOs that make PPOs attractive in the commercial sector, PPO developers cannot approach the levels of traditional Medicare. Discounts could grow if a substantial number of beneficiaries shift from traditional Medicare to Medicare Advantage plans, but that will only happen if benefits are significantly enhanced or out-of-pocket costs sharply reduced.

Initial higher payments to private plans may jump start this migration but will not produce savings to Medicare if the payment rates are set above costs in the traditional Medicare program. When cost containment concerns in Medicare are reasserted, as they inevitably will be, payments to private plans will be targeted for reconsideration and refinement, potentially triggering a new round of instability that discredited Medicare private plan options in the late 1990s.<sup>6</sup> ●

## Notes

1. American Association of Preferred Provider Organizations Web site, <http://www.aappo.org/about.html> (accessed on April 12, 2004).
2. Hurley, Robert E., Bradley C. Strunk and Justin White, “The Puzzling Popularity of the PPO,” *Health Affairs*, Vol. 23, No. 2 (March/April 2004).
3. Short, Ashley C., Glen P. Mays and Jessica Mittler, *Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care*, Issue Brief No. 69, Center for Studying Health System Change, Washington, D.C. (October 2003).
4. Medicare Payment Advisory Commission, *Report to Congress, Medicare Payment Policy* (March 2003).
5. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2003 Annual Survey* (September 2003).
6. Berenson, Robert A., “Medicare+Choice: Doubling or Disappearing?” *Health Affairs*, Web exclusive, [www.healthaffairs.org](http://www.healthaffairs.org) (Nov. 28, 2001).

**ISSUE BRIEFS** are published by the Center for Studying Health System Change.

600 Maryland Avenue, SW, Suite 550  
Washington, DC 20024-2512  
Tel: (202) 484-5261  
Fax: (202) 484-9258  
[www.hschange.org](http://www.hschange.org)

President: Paul B. Ginsburg  
Vice President: Len M. Nichols  
Director of Site Visits: Cara S. Lesser