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DESIGN OF A MEDICARE PHYSICIAN PREFERRED  
PROVIDER ORGANIZATION DEMONSTRATION

PLANNING THROUGH INITIAL IMPLEMENTATION:  
A FINAL, REPORT

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## I. INTRODUCTION

In the spring of 1988, the Health Care Financing Administration (**HCFA**) **announced** its intention to design and implement a demonstration to test the feasibility and desirability of a Medicare physician preferred provider organization (**PPO**) option. **HCFA's** primary impetus for **this** demonstration was to improve utilization management of physicians' **services** and associated **expenditures under the Medicare program**.

Under a HCFA Research Center cooperative agreement, **Mathematica** Policy Research, Inc. (MPR) and the University of Minnesota provided support in designing and implementing the Medicare physician PPO demonstration. This demonstration was to be on a "fast track" with the sites to be chosen by the following December and enrollment beginning in March 1990. The initial design process included:

- **Identification** of design issues and potential approaches to address these design issues by HCFA working groups.
- Development of background papers, discussing alternative approaches to resolving each issue **identified** by the working group.
- Review and discussion of the feasibility of the demonstration design and identification of further operational and implementation issues by a technical advisory panel of PPO industry representatives.

The outcome of this process was the Demonstration Design, Implementation and Monitoring Plan prepared by MPR and the University of Minnesota on June 1, 1988.<sup>1</sup>

An announcement of **HCFA's** intentions to proceed with its PPO demonstration was mailed to over 700 **PPOs identified** by the American Association of **PPOs** (AAPPO), the Blue Cross and Blue Shield Association of America, and industry and government representatives.

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<sup>1</sup>Due to the fast-paced nature of this effort, the Demonstration Design, Implementation, and Monitoring Plan was prepared in draft form only.

This announcement included a pre-application form to be returned to MPR by interested PPOs and the following background materials:

- A brief summary of the objectives and key elements of the demonstration
- A hypothetical example of a Medicare PPO
- An overview of demonstration design considerations that may affect a PPO's interest in participating
- Guidelines for participation in the demonstration
- A schedule for application activities

The response to this solicitation was greater than anticipated. While HCFA expected 40 to 50 PPOs to express interest in the demonstration, 116 PPOs submitted pre-application forms and letters of interest. HCFA narrowed this list to 20 and invited these PPOs to submit full applications. Ten PPOs submitted demonstration proposals including one PPO which was not among the 20 PPOs invited (no PPOs were excluded from applying).

HCFA selected five finalists to participate in the demonstration, based on recommendations of a grant panel:

- Blue Cross and Blue Shield of Arizona (Phoenix)
- CAPP CARE (Los Angeles, California)
- Family Health Plan (Bloomington, Minnesota)
- CareMark<sup>2</sup> (Portland, Oregon)
- HealthLink (St. Louis, Missouri)

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<sup>2</sup>CareMark later merged with another PPO and changed its name to Managed HealthCare Northwest. For this report we will use CareMark when discussing this PPO.

HCFA and **MPR** staff conducted site visits to ail of these **PPOs**. In January 1989, Dr. Wiiam Roper, Administrator of **HCFA**, formally announced the participation of these **PPOs** and negotiations were begun to develop **final** operational plans and budgets. It was during these negotiations that HCFA realized its March 1989 implementation goal would not be met, except perhaps by Blue Cross and Blue Shield of Arizona (**BCBS/AZ**). **BCBS/AZ** was wholly a **private**-sector initiative and had begun marketing its PPO before being accepted into the demonstration.

**BCBS/AZ** and CAPP CARE are now fully operational and Family Health Plan has completed the planning phase of the demonstration with hopes of enrolling beneficiaries **soon**. **CareMark** and **HealthLink** have withdrawn **from** the demonstration. The **following** chapter is composed of summaries of the status of the five demonstration sites.

An evaluation of the Medicare Physician PPO demonstration is being performed by **MPR** under HCFA contract number **500-87-0028(13)**. Work on the evaluation is underway and **will** include analyses of demonstration implementation, beneficiary choice and biased selection, impacts on the use- and cost of **services** provided to beneficiaries by the **PPOs**, and the feasibility of **PPOs** for Medicare. We have already produced a status report on Blue Cross and **Blue** Shield of Arizona (June 1990). The next report produced will be the first Status Report for the other four **PPOs**. This report **will** be drafted in August 1990. Other reports we **will** prepare under the evaluation contract include:

<u>Research Area</u>	<u>Date</u>
Status of the demonstration sites	Semi-annually (August and <b>January</b> )
Implementation of the demonstration	Late summer 1990 (preliminary), winter 1991 ( <b>final</b> )
Beneficiary choice and biased selection in enrollment	Early summer 1991 (preliminary), winter 1992 ( <b>final</b> )

Impact on the use and cost of **services**

Early summer **1991**  
(**preliminary**), winter 1992  
(**final**)

Feasibility of **PPOs** for Medicare

**Winter** 1992

Summary of research findings

Winter 1992

## II. DEMONSTRATION SITES

### A. BLUE CROSS AND BLUE SHIELD OF ARIZONA

In November 1988 Blue Cross and Blue Shield of Arizona (BCBS/AZ) began preliminary marketing of a Medicare PPO linked with a Medigaap insurance plan. The Medigap product, Senior Preferred, required no approval from HCFA and received no funding for implementation.

Enrollees in this plan receive the additional financial protection provided by Medigap insurance but, unlike enrollees in standard Medigap plans, have financial incentives to select providers from within a specified network. To attract enrollees to its Medigap PPO, BCBS/AZ charges a lower premium than it charges for its standard Medigap plan and provides coverage for additional services such as vision and hearing care.

The BCBS/AZ model offers several important advantages as an approach to introducing a PPO option under Medicare. First, it relies on private sector innovation to develop and implement the PPO, with minimal government involvement. Second, it builds the PPO onto an existing product (Medigap insurance) which most Medicare beneficiaries currently purchase. Third, the model does not impose additional administrative burdens on the carriers or intermediaries, since the incentives used to channel enrollees to network providers do not involve any changes in the basic Medicare benefit structure.

BCBS/AZ views its Medigap PPO as a way to increase its market share and to be more competitive in the Medigap industry. Offering a Medigap PPO product was a relatively low-cost and natural step for the company as it already offered both a private sector PPO and a standard Medigap plan. An existing provider network and established utilization review and quality assurance programs were available through the existing private sector PPO, and the company was already experienced in dealing with the Medicare population through its standard Medigap plan. BCBS/AZ currently offers its Medigap PPO in the two most populous Arizona counties,

Maricopa and **Pima**. The **Arizona** market **overall** is quite experienced with managed care products in the private sector, and in recent years has experienced a proliferation of **PPOs** and an influx of **enrollees** from indemnity **plans** into **PPOs**.

A major challenge in the Medicare context, where incentives are limited and **established relationships** with a current physician are often strong, is designing an **economically** viable Medigap PPO product that will entice Medicare beneficiaries to **enroll** and provide incentives for **enrollees** to use network **providers**. The **main incentive offered to attract enrollees to BCBS/AZ's** Medigap PPO is a lower premium than that of the standard Medigap plan. The price difference between the two plans increased **significantly** in early 1990 when **BCBS/AZ** raised the premium for its standard Medigap plan due to repeal of the Medicare Catastrophic Coverage Act and trends in the cost of **claims**. The premium for the PPO product was **also** raised but not as much, creating a price difference of about 30 percent between the two products.

Following the price increases, enrollment in **BCBS/AZ's** Medigap PPO climbed from 836 at the end of 1989 to 5,443 in April 1990. It is likely that most of the beneficiaries who enrolled in the Medigap PPO in early 1990 switched from **BCBS/AZ's** standard Medigap plan, since the Medigap PPO was not being widely marketed to other **beneficiaries** during that period

Unlike enrollees of the standard Medigap plan, **enrollees** of the PPO are offered financial incentives to **select** network providers. The incentive to obtain physician services within the network **is** that enrollees will not be balance billed if they see network physicians since these physicians have agreed to accept Medicare approved charges as payment in **full**. If enrollees obtain care outside the network **from** a physician who does not accept assignment, they are **billed** for the balance of charges above the Medicare approved charge. The incentive to obtain hospital care within the network is that the plan fully covers the Part A deductible only if care is received at a network hospital, the deductible is not covered if care is received at a non-network hospital,

except in the case of an accident or medical emergency. This differs from the standard Medigap plan, which always pays the Part A deductible.

The **BCBS/AZ** Medigap PPO tries to generate cost savings through more **cost** effective treatment **patterns of** their **network providers**. **BCBS/AZ** emphasizes careful selection of network physicians and physician **profiling** in containing **costs**: a database on physician activity is maintained, utilization patterns and quality measures are closely **scrutinized**, financial **parameters** are established for each specialty with penalties for **outliers**, and physicians with large and uncorrected deviations **from** the norm are dropped from the network. The incentives for physicians to join the PPO network include the potential for increased patient volume, and direct payment of claims. These incentives are **sufficient** to maintain the network and generate a waiting list of providers in all specialties. In addition to physician **profiling**, **BCBS/AZ** performs other utilization review activities such as concurrent review of all hospital admissions and random retrospective review through the facilities review and evaluation (**F.R.E.**) program. But, the F.RE program is not currently part of the Medicare product.

The introduction of managed care involving utilization review and selection of physicians with conservative practice patterns has raised concerns regarding the quality of care provided by **PPOs**. Therefore, quality assurance monitoring activities are an important component of all the demonstration **PPOs**, including **BCBS/AZ**. A key component of **BCBS/AZ's** quality assurance program is the **medical** office review and evaluation (**M.O.R.E.**) program. The **M.O.R.E.** program provides, through claims review and **onsite** visits, a detailed examination of: (1) the content of medical records and claims (2) general office facilities, safety, and hygiene, and (3) laboratory and x-ray facilities and procedures. The quality of inpatient hospital care is reviewed under the **F.R.E.** program. **BCBS/AZ's** quality assurance and utilization review programs are in addition to the quality and utilization review functions performed by the Medicare program **carriers**, **fiscal** intermediaries, and peer review organizations.

**BCBS/AZ** has drawn the physicians for its Senior Preferred network **from** the network for its existing commercial PPO, Preferred Care. Statewide **BCBS/AZ** has 2,600 providers in its Preferred Care network. In Maricopa County about one out of ten physicians is in the Senior Preferred Network and in **Pima** County the number is about one out of five. Some specialties are not relevant for the elderly and that partly **explains** why the ratio of Senior **Preferred** physicians **is** not larger. **BCBS/AZ** reports that there is a waiting list of physicians **anxious** to join the Senior Care network in most **specialties**. Senior Preferred has 15 hospitals in its network representing between a quarter and a third of all the hospitals in the two counties.

B. **CAPP CARE**

CAPP CARE is a nonenrollment model PPO. In this model, beneficiaries do not formally enroll **in** the PPO, but enter the PPO whenever they visit a network physician. The underlying concept of this model is that physician behavior could be modified and thus Medicare costs could be reduced without the formal enrollment of beneficiaries in the PPO.

The service area originally proposed by CAPP **CARE** was 9 southern California counties with 1.3 million Medicare beneficiaries. However, the demonstration was scaled back to include only Orange county, with CAPP CARE hoping to expand the demonstration area in the future.

The main advantage of CAPP CARE's **nonenrollment** model is that beneficiaries can be brought into a managed care system and receive services from a provider network that practices more conservative medicine without necessitating the formal enrollment of the beneficiaries. **As BCBS/AZ's** early enrollment experience shows-836 **in** their first year of operation-influencing Medicare beneficiaries to switch physicians is **difficult**, time consuming, and requires substantial incentives. It was not until the premium difference of **BCBS/AZ's two** Medigap products widened to 30 percent that substantial enrollment occurred. Another advantage of CAPP **CARE's** model is its minor impact on the Medicare payment system. Since CAPP CARE did not alter Medicare

benefits, the Medicare carrier and **fiscal** intermediaries serving Orange county have **not had** to alter their systems, other than to provide data tapes to CAPP CARE.

CAPP CARE's utilization review and utilization management activities rely heavily on **the** use of sophisticated computer programs employed by **clinically** trained **staff**. Primary utilization review activities include:

- Prospective review
- Retrospective review
- Ambulatory review

Concurrent review is not being performed under the Medicare demonstration.

Prospective review is **largely** telephone based with providers calling in on CAPP CARE's toll-free number. Nurse clinicians screen admissions and determine an appropriate level of care and anticipated length of stay using Appropriateness Evaluation Criteria (AEC). Surgical procedures in all settings--inpatient, outpatient, ambulatory--except for emergencies, must have prior authorization. Second opinions are mandatory for **selected surgical** procedures. The AEC criteria were reviewed prior to demonstration start up for relevance to Medicare. New criteria are constantly being incorporated into the computer system.

Retrospective review is used to determine contract compliance by physicians and, in the private-sector PPO, by hospitals. CAPP CARE employs a sophisticated data system that checks all claims submitted by CAPP CARE physicians. This system checks that prior authorization was obtained, the beneficiary was not balanced billed, the physician accepted assignment, an unnecessary **assistant** surgeon was not used, and charges were not submitted for cosmetic or archaic procedures. Retrospective review also extends to ambulatory services. For ambulatory review, claims data from payers are merged and then compared to normative values. When this

review shows that a physician is providing services, such as injections or laboratory tests. at a higher rate than is standard, the physician is sent a warning letter.

To ensure quality, CAPP CARE compares patterns of services rendered to industry standards. All of the utilization review functions have quality assurance components. Under the demonstration, CAPP CARE has extended its quality review to focus on the top 20 Medicare diagnosis related groups (DRGs). Feedback to providers is aimed toward education to modify physician behavior. CAPP CARE is also setting up a beneficiary grievance system based on both informal and formal complaint processes. All anonymous complaints will also be investigated

CAPP CARE has 2,761 physicians in its private sector Orange county network 48 percent of all eligible physicians in the county.<sup>3</sup> Seventy-three percent are board certified in their specialty. Demonstration physicians are a subset of CAPP CARE's private-sector network CAPP CARE's Medicare demonstration network currently has 847 physicians representing 1,142 offices. About half of these are primary care physicians.

CAPP CARE was pleased with the response of its physicians to the demonstration. Network physicians were asked to join the demonstration in two solicitations. In February 1990, the first solicitation was sent to Medicare PAR physicians in the CAPP CARE network with 90 percent of these physicians signing up for the demonstration. In March, the second solicitation was sent to the non-PAR physicians in the network. This second group of physicians was required to participate in Medicare before they could join the CAPP CARE demonstration network

Under the demonstration CAPP CARE is not allowed to negotiate contracts with hospitals or channel beneficiaries to particular hospitals. For its private-sector payers, CAPP CARE has contracts with 82 hospitals in southern California, most of which have over 100 beds.

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<sup>3</sup>Ineligible physicians include those in administrative medicine, residency/internship, full-time prepaid practice, military service, and physicians who are retired or deceased.

The incentive for beneficiaries to use CAPP **CARE** physicians is the guarantee that these physicians will accept assignment. **CAPP CARE** is mailing a **directory** of its **physicians** to **all Medicare beneficiaries** in Orange county. This directory may serve **as a way** to **channel beneficiaries** to CAPP CARE physicians, **especially** for those **beneficiaries** without a **regular source** of care,

### C. **FAMILY HEALTHPLAN**

**Family Health Plan, Inc.** proposed an enrollment model PPO in the **Minneapolis/St. Paul** area. The Medicare PPO will include individual enrollment of Medicare beneficiaries and enrollment through employer retiree benefit plans.

Family Health Plan has letters of intent with the Metropolitan Airport Commission and Northwest Airlines to serve the retiree populations of these companies--a total of about 400 Medicare beneficiaries. Negotiations have begun with other employers and with groups that do not provide supplemental insurance but may serve as an access point for individual enrollment. Family Health Plan is also looking into a product that would link its PPO with **Medigap** or group retirement plans in place. **Enrollment** projections are 690 by January 1, 1991 and 5,940 by July 1991.

**Family Health Plan's** utilization review/utilization control program, the Value Assurance, Plan, is most heavily focused on controlling utilization through the following:

- Pre-admission **certification** and concurrent review
- Morning admissions for elective surgery
- Mandatory second **opinions** for many **procedures**
- Heavy reliance on outpatient surgery when **possible**
- "Triage" for **chemical** dependence **cases**
- Home care as cost-saving alternative

- Case **management--especially** for high **risk clients**

**Retrospective** review at Family Health **Plan includes** routine review of **billings** and periodic audits of selected claims, but this review is not as **comprehensive** as that of **CAPP CARE**. **Family Health Plan's** retrospective review provides provider feedback by way of non-compliance warning **letters** and **penalties**.

Quality assurance at Family Health Plan falls under the umbrella of the Value Assurance **Plan**. For its quality assurance activities, Family Health Plan conducts patient/enrollee satisfaction surveys, has an established grievance resolution process, and evaluates medical records for appropriateness and quality of care.

Family Health Plan has a **Medicare** network of 254 physicians and is contacting other providers. Providers must accept assignment and are not **allowed** to **bill** patients for charges deemed medically unnecessary by Family Health Plan.

Family **Health Plan contracts with** 16 hospitals **with** 4,569 beds in its private-sector network. Hospitals are selected based upon criteria including productivity, debt service, management structure, location, scope of services, mission statement, and acceptance of Family Health Plan payments, policies, and **procedures**.

For the demonstration Family Health Plan proposed a cooperative effort between the providers, employers, and HCFA with specific incentives to be negotiated among these actors. Possible incentives include reduced Part B deductible and additional benefits such as discounts for eyewear.

#### D . **CAREMARK**

**CareMark** has officially dropped out of the Medicare PPO demonstration. **CareMark** said there was now not **enough** provider **interest** in the Medicare PPO. Recent turnover in key staff also contributed to the decision to withdraw from the demonstration.

CareMark had planned to offer its demonstration PPO in three Portland area counties (Multnomah, Clackamas, and Washington). CareMark characterized the Portland area as having an oversupply of providers who compete intensely. Approximately 50 percent of Medicare beneficiaries are enrolled in HMOs—an HMO penetration rate that is among the highest in the nation. An additional 40 percent of Medicare beneficiaries currently have some form of supplemental Medigap coverage or Medicaid.

Despite the competition, CareMark's network physicians are reluctant to lock themselves into Medicare participation for three reasons. First, they perceive the Medicare reimbursement rates to be too low, barely covering their costs. Second, the physician's doubt that they would benefit from large volumes of PPO enrollees because the benefit package does not create sufficient incentives to attract beneficiaries. Third, the experimental nature of the demonstration implies a limited time period, which diminishes their willingness to make changes in their practice.

CareMark intended to target three types Medicare beneficiaries:

- Individuals
- Blue Cross-Blue Shield of Oregon's (BCBSO) Medigap policy holders
- Members of the Public Employees Retirement System (PERS)

Negotiations had been underway for quite some time with BCBSO and PERS representatives.

For all three beneficiary groups, incentives to enroll in the CareMark PPO included:

- Waiver of the \$75 Part B deductible when PPO physicians are used
- Fixed copayments instead of coinsurance
- A guarantee that PPO physicians will accept assignment
- Free health screening and discounted drugs, hearing aids, and eyeglasses through the Senior HealthLink program

Beneficiaries **who** enrolled under the individual plan had **two additional** incentives to **enroll**. When individual enrollees visit PPO physicians, they would not pay the 20 **percent coinsurance**, and for PPO physician surgical services they would pay a **lower** coinsurance rate (15 percent). For physician visits, individual **enrollees** were to pay a \$10 copayment instead of Medicare's 20 percent **coinsurance**. Individual enrollees were to be 'locked into' the PPO program for a full year, unless they choose to **disenroll** within the **first** two months following **enrollment**.

**CareMark's** utilization review process for the demonstration included the following features:

- Pre-authorization of all elective hospital-based surgery, elective inpatient admissions, and use of specialized services such as rehabilitation services
- Pre-authorization of selected ambulatory "focused" procedures such as bronchoscopy, **EEG**, and cancer chemotherapy
- Concurrent review of inpatient utilization focused on select services
- Retrospective **review** of non-elective hospital use and of ambulatory service patients requiring admission following the procedure
- Retrospective review of non-elective "focused" procedures and of facility **requests** for day/cost **outliers**
- Triage screening for the provision of **mental** health services\_

Quality review was to be incorporated in **CareMark's** utilization review **process**. In addition, **CareMark** was to incorporate a primary care physician gatekeeper into the demonstration program whereby **all PPO enrollees would** select a primary physician who will be **responsible** for managing the enrollee's health **care**. For in-plan use, **enrollees** were to consult with the primary care physician before seeking care from other PPO providers.

## E. HEALTHLINK

HealthLink has also dropped out of the Medicare PPO demonstration. Initial indications are that HealthLink found working within the Medicare system difficult and could not offer a benefits package that was both attractive to employers and met HCFA's requirements of no "windfall" savings to employers.

HealthLink had planned to market to individual Medicare beneficiaries, employers with retiree groups, and to individuals with Medigap policies in the St. Louis metropolitan area. Incentives that HealthLink considered were a waiver of the Part B deductible for enrollees and a 10 percent coinsurance rate for use of network providers and a 30 percent coinsurance rate for use of non-network providers. They also were to guarantee no balance billing by network providers. Since they were not allowed to use a disincentive of 30 percent coinsurance, HealthLink officials concluded that the benefit package was not strong enough to attract sufficient numbers of beneficiaries. Employers concurred and thus did not agree to participate in the demonstration.

HealthLink's proposed utilization review program is designed to ensure that medical services are rendered only when necessary and in the most cost effective environment. The basic utilization review program includes pre-admission review, concurrent review, a second surgical opinion program, ambulatory surgery and procedures review, discharge planning, and retrospective review.

The pre-admission and concurrent review programs are telephone based with nurse review specialists using an area modified version of the InterQual ISD-A Criteria System. The number of certified days is in accordance with the Professional Activity Study (PAS) normative data set. On-site concurrent review is made of all admissions. An appeals process is available for physicians who wish to contest a decision.

The discharge planning program has been designed so that patients can be discharged **from** the hospital earlier than **normal** and placed into a less costly setting, such as home health care.

**HealthLink's** private sector quality assurance program focuses on the patient grievance **process** but was to be expanded under the demonstration. The inpatient program was to **include** a **review** of random records and review of **selected procedures** deemed potentially problematic particularly with respect to their **appropriateness**. Outpatient care review was to include random review of records from physicians' offices, **review** of selected procedures, and review of prior care for problem inpatient diagnoses. **HealthLink** was also planning to conduct its own patient satisfaction survey.

**HealthLink** has 1,479 physicians in its private sector network, with a good geographic and specialty spread. Physician selection and retention criteria **include staff** privileges at a participating hospital, board certification, professional liability insurance, good standing in the community, **accessible** geographic area for members, and a **needed** clinical specialty. **Re-credentialing** is in accordance with JCAHO standards.

The **HealthLink** hospital network is comprised of 27 hospitals with 6,701 beds. **HealthLink** also has access to four freestanding outpatient clinics in the St. Louis network.

### III. SUMMARY AND PRELIMINARY CONCLUSIONS

Out of the **five PPOs selected** for the Medicare Physician PPO Demonstration **two are fully operational—BCBS/AZ and CAPP CARE. A third PPO—Family Health Plan—has** agreements with two employers to serve their retirees and there is hope that this PPO **will** enroll enough **beneficiaries** to make for a viable demonstration site. The other two **PPOs** have left the demonstration.

**BCBS/AZ** has been enrolling beneficiaries into its Medigap PPO for a year and a half **with** a current enrollment of over 5,000. Implementation was relatively easy for **BCBS/AZ** since they required no interaction with the Medicare system **CAPP CARE** has been serving beneficiaries with its nonenrollment model PPO for **only** a few months Implementation was smooth, although delayed a year due to funding issues. Family Health Plan is actively marketing to employers with retirees and is looking for individual **enrollment** and Medigap insurer support. **CareMark** and **HealthLink** encountered problems which caused them to leave the demonstration; **CareMark's** network primary care physicians resisted the Medicare PPO, and **HealthLink** found that working within the Medicare system made it difficult to offer a benefit package that was attractive to employers,

The experiences of the demonstration **PPOs** are diverse and will be fully explored under the Medicare PPO **evaluation** project, There is at this point, however, enough information to make a few **preliminary** observations:

- The conversion from a standard Medigap product to a Medicare PPO is **attractive** to beneficiaries if the price **difference** between 'the **two** is **sizable**.
- The **nonenrollment** model is relatively **simple** to implement, since it does not require the prolonged and expensive **process** of beneficiary **enrollment**.

- **Aside from Medigap buyers, a second target group that may yield success is retirees, if there is sufficient interest on the part of employers.**
- **Physicians recruitment is easier where there are sufficient concentrations of PAR physicians and where there is physician perception that the benefit package can attract large numbers of beneficiaries.**

**We will continue to look at the role of PPOs for Medicare in the evaluation of the Medicare Physician Preferred Provider Organization Demonstration, a separately funded project from the cooperative agreement which funded this work. A list of analyses to be performed was included in the introduction to this report.**