

STATUS OF THE MEDICARE PPO DEMONSTRATION
EARLY IMPLEMENTATION EXPERIENCE OF:

CAPP CARE
FAMILY HEALTH **PLAN**
HEALTHLINK
CAREMARK

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EXECUTIVE SUMMARY

Preferred Provider Organizations (**PPOs**) are designed to curtail health care costs by combining the cost containment Features of Health Maintenance Organizations (**HMOs**) with more Freedom of choice in providers. Common approaches to containing costs include selective contracting with **cost-effective** providers, negotiating price discounts with those providers, controlling patterns of use within the network of providers, and channeling beneficiaries to those providers through such financial incentives **as** reduced deductibles or coinsurance.

Despite the rapid growth of **PPOs** in the **1980s** and the widespread belief that **PPOs** can contain costs, there is little, evidence about their effects on **costs**, quality of care, or patient satisfaction. To assess the Feasibility of **PPOs** for Medicare the Health Care Financing Administration (HCFA) engaged **Mathematica** Policy Research, Inc. to evaluate a pilot Medicare physician PPO demonstration, with a focus on ambulatory care. **Two** of the five **PPOs** selected for the demonstration are now operating and one may be operating soon (depending on the **PPO's** ability to attract employers and develop a benefit design that is consistent with the basic Medicare structure). The other two **PPOs** have withdrawn from the demonstration.

PPO MODELS

Three PPO models emerged among the five pilot demonstration sites: the individual enrollment Medigap model, the nonenrollment model, and the mixed enrollment model. The **First two** of these have shown the most prospects For success so Far:

The individual **enrollment Medigap model** PPO was adopted by Blue Cross and Blue Shield of Arizona (**BCBS/AZ**). **BCBS/AZ's** early experiences are described in Nelson and others (submitted to HCFA on August **8, 1990**); the experiences of the other **PPOs** are **described** in this report. 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 incorporates the PPO into 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.

The **nonenrollment model** PPO was adopted by CAPP **CARE** in Orange County, California. This model is also relatively simple to implement. Its chief advantage is that beneficiaries can be brought into a managed care system and receive **services** from cost-effective providers without formal enrollment-which can be difficult and **time-consuming**. This model is based on the belief that service use and thus Medicare costs can be reduced **without** enrolling beneficiaries in the PPO. Enrollment incentives do not have **to** be offered as beneficiaries enter the PPO whenever they visit a network physician. Beneficiaries have two **incentives to** use network providers, **First**, network providers accept **assignment on all** Medicare claims, **so beneficiaries** are guaranteed no balance billing. Second, CAPP CARE physicians agree to adhere to CAPP CARE's utilization management program and they have been **pre-screened** or malpractice history, medical qualifications, and past disciplinary actions by government agencies, licensing boards, and physician and hospital review committees.

The mixed enrollment model PPO was adopted by Family Health Plan in the Twin Cities of Minneapolis and St. Paul, by **HealthLink** in St. Louis, and by **CareMark** in Portland, Oregon. The latter two **PPOs** have withdrawn from the demonstration. Family Health Plan hopes to implement its plan as soon as it has **HCFA's** approval and financial commitment. In this model the PPO enrolls both individual beneficiaries and retiree groups, but marketing to individuals has not been tried and marketing to groups has had limited success so far. Because these **PPOs** proposed changing the Medicare benefit structure, operational difficulties have also presented a formidable challenge.

EARLY EXPERIENCE OF DEMONSTRATION PPOS

CAPP CARE's Medicare demonstration began on April 1, 1990. Through September CAPP CARE had performed over 5,400 preadmission and preprocedure reviews. In the **first** quarter of operation CAPP CARE physicians had about 329,000 **office** visits by Medicare beneficiaries, generating \$32 million **in** claims. CAPP CARE currently has 881 physicians, about 7 percent of Orange County's Physicians. CAPP CARE selects physicians using a highly automated system with an extensive physician database and detailed physician profiles. CAPP CARE's automated utilization review activities--including **preauthorization** and retrospective review--are designed to detect unnecessary or inappropriate care. CAPP CARE's utilization review functions include quality assurance components that compare patterns of service to industry standards.

Integrating the CAPP CARE demonstration into the Medicare payment system was quite simple. The arrangement with the carrier and the two fiscal intermediaries is simply that the three organizations are to provide CAPP CARE with all claims submitted by its member physicians. The arrangement with the Peer Review Organization (PRO) is that, to avoid duplication of effort, PRO activities for CAPP CARE physicians are now performed by CAPP CARE, although the PRO continues its mandated quality assurance functions.

As the CAPP CARE demonstration continues, two issues have been raised. One of these, and the most pressing to CAPP CARE, involves data HCFA is not providing data on non-network use to CAPP CARE to protect the confidentiality of physicians and beneficiaries. CAPP CARE maintains that these data are needed to identify referrals made by its physicians and thus monitor and modify the behavior of CAPP CARE physicians. The second issue is whether the demonstration provides adequate incentives for beneficiaries to use network providers. Guaranteed assignment may not be a strong enough incentive to channel beneficiaries to network providers, especially in a state where **84** percent of Medicare claims are already accepted on assignment (U.S. House of Representatives, 1991). This second issue ties directly to whether **CAPP** CARE is generating savings to the Medicare program, a question we will attempt to answer in future research.

Family Health Plan has been trying to obtain commitments from employers in Minneapolis/St Paul to enroll their retiree, groups into the PPO. While it feels ready to implement, HCFA wants **final** benefits packages and firmer employer commitment before it signs off on implementation. Family Health Plan has **developed** three models of benefit packages for each of three major client groups. The **first** model package is for self-insured employers already offering health benefits. Incentives offered enrollees probably will include **full** coverage of services when network providers are used, with a coinsurance or copayment required for out-of-network use. The second model package is for employers currently offering no supplemental insurance. It includes no balance billing, elimination of the Part B deductible, and only 10 percent coinsurance or, preferably, a \$10 copayment. The third model package is a PPO combined with existing Medigap insurance. It is still being investigated. All packages may include such additional benefits as free physical examinations

and blood pressure tests. Cash rebates to users of network providers may also be provided in the self-insured employer and Medigap insurance packages if projected savings are **sufficient**.

Family Health Plan chooses its physicians for their commitment to cost containment and utilization management, among other criteria. So far 280 primary care physicians and more than 100 specialists have agreed to participate in the demonstration. Family Health Plan's utilization review program will include preadmission certification, retrospective review, second surgical opinions, outpatient management, and case management. For quality assurance, the PPO has an established patient grievance process, patient satisfaction surveys, and evaluations of medical records for appropriateness and quality of care.

Family Health Plan has letters of intent **from** three **firms**, but has not developed **final** benefit packages nor binding agreements for any employer. Family Health Plan is optimistic that agreements can be reached with employers on the specific benefit packages and that once agreement with initial employers is achieved, recruitment of other **employers** will be much easier. HCFA is reluctant to approve funding without agreements on the final benefit packages.

Family Health Plan and HCFA have not yet begun discussions with the carrier, fiscal intermediary, and PRO, so the start-up date may be some time away. The foremost factor in the potential success of Family Health Plan as a demonstration site is whether it can come up with a benefit package that could attract employers, receive HCFA approval, and be incorporated by the carrier.

HealthLink withdrew **from** the demonstration because it could not design a benefits package that was both attractive to employers and consistent with the basic Medicare structure. A major reason for **HealthLink's** inability to develop a suitable benefits package was a misunderstanding by **HealthLink** about the basic conditions of the demonstration. **HealthLink** was under the assumption that **employers could** not reap savings from the demonstration under any circumstances--all employer savings would have to be returned to beneficiaries in the form of increased benefits. HCFA maintains that employers could accrue savings if HCFA paid its standard 80 percent of allowed charges instead of the 90 percent that **HealthLink** proposed. However, paying the standard 80 percent was never discussed as an alternative. **HealthLink** concluded that employers--who were suspicious of government programs after the Medicare Catastrophic Coverage Act was rescinded by Congress--were not interested in an experimental demonstration which provided no direct opportunity for savings as opposed to savings generated through lower utilization rates.

HealthLink had planned to market to individual Medicare beneficiaries, including those with Medigap policies, and to employers with retiree groups, but soon focused solely on employers. The benefits package it proposed included a stiff 30 percent (rather than 20 percent) penalty for using non-network physicians along with 10 percent coinsurance for **users** of network physicians. But, **HealthLink** later dropped the 30 percent penalty due to difficulties incorporating it into the Medicare payment system by the carrier and **HCFA's** lack of support for the penalty. Before deciding to leave the demonstration **HealthLink** had recruited most of the physicians needed for its Medicare network--'only three specialties needed boosting, **HealthLink's** proposed utilization review program included preadmission review and retrospective review of inpatient and ambulatory services, as well as second opinions on surgery and discharge planning. It also wanted to conduct concurrent review which was not approved by HCFA **HealthLink's** quality assurance program was to focus on patient grievances and patient satisfaction studies, and the **PPO** planned ongoing review and feedback.

HealthLink, which was to serve beneficiaries in two states, had begun what turned out to be lengthy, complicated negotiations between the Illinois and Missouri carriers about coordinating changes in the claims processing system. **HealthLink** soon found that the problem of the interface between two states each with its own carrier, **fiscal** intermediary, and PRO was overwhelming. It finally decided that focusing on its existing thriving business was a better use of its resources than remaining in the demonstration.

CareMark dropped out of the demonstration shortly after three key staff persons left, due to lack of interest by the new management and the physicians. It had intended to market three alternative benefit packages to three major client groups in three Portland counties--an area known for its high penetration of managed care systems. In one package, individuals would pay an enrollment fee and copayments would replace **deductibles** and coinsurance for physician visits. The same benefits were available in the second package, for enrollees in a Blue Cross/Blue Shield **Medigap** plan. The third package was for members of the Public Employees Retirement System who had chosen a supplemental coverage **option**. **These** members would not pay the Part B deductible or the coinsurance when using network physicians. All three packages included free health screenings and discounted drugs, eyeglasses, and hearing aids.

Physician interest in the demonstration waned as the demonstration progressed. In a 1988 survey of all PPO physicians 67 percent indicated interest. In a March, 1990 survey 29 percent of primary care physicians responding expressed interest in the demonstration. **CareMark** attributed this drop to network primary care physicians realizing they would have significant administrative duties (as gatekeepers) for which they would not be compensated, and to the perception of limited increased volume--the physicians already had access to the Medicare market through an HMO and felt the benefit package proposed would not bring in many new patients. **CareMark's** utilization review was to include preadmission, concurrent, and retrospective review. Quality of care was to be monitored through the patient grievance process and patient satisfaction surveys.

CareMark and HCFA had managed to find ways to incorporate **CareMark's** benefit structure into the Medicare payment system, although it was a long and arduous process. This shows that alternative **benefit** packages can be incorporated, but at a substantial cost in money and effort. **CareMark** feels that the Medicare system is too inflexible to allow a competitive PPO benefit package, at least in Portland.

EMERGING LESSONS

With only two physician **PPOs** operational, conclusions about what approaches can be successfully implemented are necessarily very tentative and some are likely to be overturned with more extensive experience in different environments. Nevertheless, with Congress, HCFA, and providers extending managed care options to Medicare beneficiaries through new initiatives such as Medicare Select, even tentative conclusions may provide important guidance. Congress recently authorized a **15** state demonstration of Medicare Select, a proposal allowing **PPOs** to offer Medicare supplemental insurance.

PPO Incentives. All of the demonstration **PPOs** joined the demonstration to expand their own and their physicians' volume of business. Other reasons they gave for joining included maintaining fee-for-service medicine for Medicare, **influencing** future changes in the Medicare program, to reduce their Medicare spending, and responding to local requests from employers and providers for a

managed care Medicare product. Two of the **PPOs** thus far have found the complexities involved in developing a Medicare PPO product greater than the perceived benefits.

Benefit Design. Successful benefit package designs provide sufficient incentives (1) to enroll beneficiaries in the PPO, and (2) to use **PPO** providers once enrolled. Designing viable benefit packages within the Medicare context has proven to be a very challenging task with three of the demonstration **PPOs** having difficulty defining a viable benefit package. Indeed this difficulty is a **key** reason three of the five **PPOs** are currently not operational.

Lower premiums were effective in attracting enrollees in **BCBS/AZ's** Medigap PPO. CAPP CARE's nonenrollment model side steps the entire enrollment decision. With employer group enrollment models there is no beneficiary decision to enroll; rather the issue is providing sufficient incentives to employers to enroll their Medicare retirees. While there would appear to be more scope for **PPOs** to provide these incentives to employers than to individuals, none of the **PPOs** has yet developed and implemented a group model benefits package.

To provide incentives for beneficiaries to use network providers, all the **PPOs** have guaranteed that the beneficiaries will not be balance billed when network providers are used. Penalizing **out-of-network** use with higher coinsurance than in-network use--as proposed by **CareMark**, Family Health Plan, and HealthLink--has a potentially higher monetary impact and thus may be stronger. However, no PPO has implemented these penalties yet. Waiving the Part A deductible when network hospitals are used as implemented by **BCBS/AZ** (independently of the demonstration) also provides a larger financial incentive.

Marketing. Once a benefit package has been designed that will attract beneficiaries and direct them toward network providers, it must be presented to beneficiaries or those making enrollment decisions, such as employers who provide retiree **health** benefits. Marketing to individuals was conducted by **BCBS/AZ** and CAPP CARE. **BCBS/AZ** marketed through direct mail, presentations, and other methods, to subscribers of its standard Medigap product and to the general Medicare population. Although 7 percent of those targeted responded, requesting more information, few enrolled. **BCBS/AZ's** letter to its standard Medigap subscribers informing them of a premium increase and of the lower premiums of **the** Medigap PPO was the key to increased enrollment. The marketing done by CAPP CARE for its nonenrollment model PPO was simple, consisting only of mailing a directory of network physicians to all Orange County beneficiaries. It **is** too soon to tell if CAPP CARE's provider directory has **successfully** channeled beneficiaries to network providers. The other three **PPOs** originally all planned to market to individuals, but **CareMark** was the only one **that took** steps towards it--it dropped out **of** the demonstration before marketing began.

CareMark hoped to enroll beneficiaries from Oregon's Public Employees Retirement System and an area Medigap insurer, but as the demonstration, and discussions with these groups went on enrollment projections diminished. Family Health Plan and **HealthLink** kept to their private-sector strength and targeted employers who provide retiree health benefits, keeping an eye out for interested Medigap insurers as **well**. **They** both made presentations to employers and found employers interested in the PPO concept in the hope that **PPOs** would curb their rapidly rising retiree health benefit costs. **HealthLink**, however, could not provide a product that provided adequate incentives for **employers** to sign **up**. Family Health Plan has found more **definite** interest from employers--three have signed letters of intent to join the demonstration.

Physician Network. The size, quality, specialty mix, and practice patterns of the physician network are all important for a PPO in 'attracting enrollees and containing costs. Physician interest

is necessary for the **PPOs'** success, and the main incentive for physicians to submit to the **PPOs'** requirements is the potential for more patients. All five demonstration sites were to draw their Medicare physician network from their private-sector networks in the demonstration areas. Physician requirements in all sites were to accept Medicare assignment on all PPO claims and to abide by PPO utilization review/control procedures, including practicing conservative medicine. The CAPP CARE demonstration went one step further and required demonstration physicians to sign up for Medicare Participating Physician and Supplier Program

BCBS/AZ and CAPP CARE were able to put together Medicare networks of adequate size and specialty mix rather easily, although CAPP CARE felt its network could have been larger if it were not for a few complicating factors. Family **Health Plan** has succeeded in building an adequate number of primary care physicians and is in the process of filling gaps in several specialties. **HealthLink** had also pulled together a network of primary care physicians and was lacking in only a few specialties. **CareMark** did encounter resistance from primary care physicians who were skeptical of the **PPOs'** ability to bring new patients to the physicians. Thus it seems that physicians are receptive to Medicare **PPOs** and will join a network if the benefits in increased patient load outweighs the costs of accepting Medicare assignment. If state assignment rates are an indicator, **CareMark** and Family Health Plan physicians would give up the most to join these demonstrations.

Utilization Review. The main purpose of the Medicare PPO demonstration is to control Part B costs. HCFA is unlikely to obtain price discounts from providers, given current Medicare reimbursement rates. Thus, the primary method for generating savings is through reducing the use of services. The demonstration **PPOs** seek to control the use of services through a variety of means. **BCBS/AZ's** Medigap PPO has no utilization review mechanisms. Instead it relies on physician practice profiles generated for its private-sector PPO to identify physicians who practice conservative medicine. These are the physicians **BCBS/AZ** wants in its Medicare network, as they are less costly.

The other four **PPOs** use, or proposed to use, more aggressive utilization review mechanisms for their Medicare **PPOs**. These mechanisms include **preauthorization** of admissions and selected procedures and retrospective review of inpatient and ambulatory services. Some of the **PPOs** also require **second** opinions for surgery, perform concurrent review of inpatient stays, and have active case management programs. CAPP CARE has shown that traditional PPO utilization review procedures can be integrated with Medicare fairly easily. The only substantial change in Medicare review in the CAPP CARE demonstration is that the PRO has delegated its utilization review functions, including preadmission review, for network physicians to CAPP CARE.

Operational Issues. Implementing a physician PPO for Medicare beneficiaries involves integrating a PPO network plan with the existing Medicare program. **This** integration is relatively straightforward if the PPO design does not change the existing Medicare benefit or utilization review structure. **BCBS/AZ** did not change either and, hence, did not face significant implementation problems. CAPP CARE did not change the Medicare benefit structure, but did change the location and nature of utilization review, and is fully **operational**. However, there are outstanding issues regarding CAPP CARE access to **data**. CAPP CARE says it needs data on referrals to non-network physicians to monitor network physician practice profiles, while HCFA considers these data confidential and has not supplied them.

This integration becomes much more problematic with PPO benefit packages that change the structure of the standard Medicare benefit structure. The claims processing systems maintained by the carriers and **FIs** are large complex computer processing systems that, in general are difficult to modify to integrate the types of incentives for in-network use proposed by Family Health Plan,

HealthLink, and **CareMark**. Since none of these **PPOs** is operational, the difficulties and costs of full implementation have not been observed. However, it is clear that carrier changes generally will be complex and expensive. This is doubly true when **two** or more carriers serve a single PPO.

OBSERVATIONS

Now that two **PPOs** are in operation, another hopes to be, and two have withdrawn from the demonstration, we have several observations regarding this and future PPO demonstration programs.

Adding demonstration sites. Each of the three remaining sites in the demonstration represents a different PPO model and a unique set of circumstances in terms of such factors as benefit structure, marketing, and utilization review. To provide a **firm** basis for policy decisions Medicare **PPOs** with similar characteristics, particularly enrollment models, should be tested in several sites. Thus, HCFA should either (1) add at least two more **sites** per PPO model of interest to allow for more generalizable results or (2) **field** additional Medicare PPO demonstrations.

Including Medicare Part A benefits. All **five PPOs** in the demonstration are interested in including management of Part A use. **The** main reasons cited for the inclusion of Part A benefits were: 1) Part B **services** for inpatient stays could be more effectively managed and thus increase savings, 2) additional savings could be realized through inpatient utilization management and through discounts with hospitals and, 3) it would offer a product that is more marketable to individuals, employers, and other private-sector payers.

Supporting group enrollment. Group enrollment through either employers or Medigap insurers offers a potentially easier avenue for bringing large numbers of Medicare beneficiaries into **PPOs** than individual enrollment. Incentives for the employer group model, in particular, might be easier to design. Employer-paid retiree benefits are not regulated as strictly as Medigap insurance, and thus employers may have an easier time using strong incentives for network use. Employers also would have virtually no marketing costs and thus could realize the full impact of savings from managed care. HCFA may want to **require that** employers keep the standard Medicare benefits to avoid the high costs of changes in benefits and of associated changes in carrier systems. HCFA must ensure the flow of claims data to the **PPOs** so they can perform adequate utilization management. It must also assure employers and **PPOs** of its long-term support of employer-group PPO operations and the longevity of any incentives the **provide**.

I. INTRODUCTION

A. MEDICARE APPLICATIONS OF THE PPO CONCEPT

Preferred Provider Organizations (**PPOs**) are an innovative approach to the organization and financing of health care. They have proliferated in recent years because of their perceived potential for cost containment. A PPO is created through contractual arrangements between an insurer and a group of health care providers. The objective is to create a network of cost-effective providers and to channel patients to these providers through such financial incentives as reduced deductibles or coinsurance. **PPOs** differ in their specific method of controlling costs, but commonly used approaches include selective contracting with low-cost providers, negotiating price discounts with providers, and applying utilization control mechanisms within the network. The main incentive for providers to participate in a PPO is the potential for increased patient volume. **PPOs** combine some of the **cost** containment features of health maintenance organizations (**HMOs**) with the features of traditional fee-for-service insurance plans. Like **HMOs**, **PPOs** try to control **costs** through selective contracting with cost-effective providers and, in most cases, through utilization management. **PPOs** offer consumers more freedom of choice than **HMOs**, however, because **PPOs** provide coverage for services received outside the network--although enrollees often pay a higher share of **costs** for using out-of-network **services**. Unlike HMO enrollees, PPO enrollees are not "locked in" to network providers. **PPOs** also differ from **HMOs** in their provider reimbursement arrangements. Physician **capitation** and other forms of provider risk-sharing are now **common** in the HMO industry but rare among **PPOs**, which typically pay physicians on a discounted fee-for-service basis.

In the initial stages of PPO development, **PPOs** sought to control **costs** primarily by getting price discounts from providers. But price discounts alone did not yield the expected level of wst savings, so most **PPOs** now employ utilization management procedures to control the volume of service use (Boland 1987). The utilization management programs of most **PPOs** concentrate on

reducing unnecessary or inappropriate hospital care. A survey of **PPOs** conducted by the American Managed Care and Review Association (AMCRA) in 1989 found that 97 percent of responding **PPOs** require preadmission **certification** for nonemergency inpatient care, 94 percent **employ** concurrent review, 85 percent employ retrospective review of inpatient stays, and 74 percent require second opinions for surgery (**AMCRA 1990**).

The number of **PPOs** operating in the United States increased dramatically in the **1980s--** from **25** in 1981 to 802 as of January 1, 1990 (**AMCRA 1990**). The earliest **PPOs** were sponsored primarily by providers, including hospitals, **physicians**, and joint ventures between hospitals and physicians. Provider-sponsored **PPOs** market their services to payers such as insurers or self-insured employers, offering to discount their services or submit to utilization management in return for an expected increase in patient volume. PPO sponsorship by commercial insurance companies and Blue Cross/Blue Shield plans has increased substantially. In 1989, nearly 40 percent of all **PPOs** were sponsored by commercial insurers or **Blue Cross/Blue Shield** plans, 32 percent by providers, and the rest by such entities as private investors, third-party administrators, **HMOs**, and self-insured employers (**AMCRA 1990**).¹

The rapid growth of **PPOs** in the private sector **reflects** the widespread belief among insurers and employers that **PPOs** might be able to contain costs. **PPOs** are a recent innovation in the health care market, however, so there is **little** evidence about their effects on health care costs, the **quality** of care, or patient satisfaction. Previous studies have found that hospital use and total medical spending are reduced by utilization management in conventional fee-for-service insurance plans (Feldstein and others 1988, **Wickizer** and others 1989, and Institute of Medicine 1989) and in the managed care environment of **HMOs** (Manning and others 1984, **Luft** 1981). **PPOs** typically seek to channel patients into managed care, so these findings lend support to the expectation that **PPOs**

¹The **PPOs** classified as being sponsored by commercial insurers and the “Blues” include some that are joint ventures with utilization management companies and providers.

will reduce costs. But the effectiveness of a given PPO is likely to depend heavily on the benefit design and the extent to which it induces patients to select providers from within the PPO network.

The growth of **PPOs** in the private sector and the widespread expectation that **PPOs** will prove to be effective at cost containment have prompted interest in PPO applications to the Medicare program. 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 including a PPO option under Medicare. This demonstration was designed to control the volume of services performed and ordered by physicians. The announcement of the planned demonstration was mailed to all **PPOs** operating in the United States in June **1988**, and 116 **PPOs** submitted preapplication forms expressing interest*. Twenty of those **PPOs** were invited to submit formal applications and in January 1989 HCFA announced the selection of five **PPOs** to participate in the demonstration.

The **PPOs** were given much latitude in designing their Medicare component. The preapplication package imposed few requirements. Those imposed were:

- Physicians had to accept assignment for all PPO enrollees
- **PPOs** could not negotiate with hospitals or provide lists of hospitals to enrollees
- Utilization review and prior authorization could be performed for **physician-**performed or physician-ordered services
- Utilization review had to include ambulatory procedures

Two of the five **PPOs** selected for the demonstration are now operational: Blue Cross and Blue Shield of Arizona (**BCBS/AZ**) and CAPP CARE in Orange County, California. Of the remaining three, **CareMark**³ in Portland, Oregon, and **HealthLink** in St. Louis, Missouri, will not participate;

*Operational **PPOs** were identified from the Directory of Operational PPOs published by the **American** Association of Preferred Provider Organizations (AAPPO) for 1987.

³**CareMark** merged with another PPO and changed its name to Managed **HealthCare** Northwest. For this report we use **CareMark** when discussing this PPO.

Family Health Plan in Minneapolis, Minnesota continues to work on developmental issues and hopes to implement the demonstration soon. **BCBS/AZ** has implemented a PPO combined with a Medicare supplemental insurance, or Medigap, plan. CAPP CARE has implemented a **nonenrollment** PPO model, not linked to Medigap insurance. CAPP CARE does not enroll beneficiaries but **applies** utilization management procedures whenever beneficiaries obtain care from a network physician. Family Health **Plan** is pursuing an **enrollment** model PPO focused on **enrolling** groups of beneficiaries through employers and insurers.

B. OVERVIEW OF THE MEDICARE PPO DEMONSTRATION SITES

BCBS/AZ has introduced a Medicare PPO linked with a Medigap insurance plan in two metropolitan counties in Arizona. Enrollees in this plan receive the extra 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 covers additional services such as vision and hearing care. Enrollment in **BCBS/AZ's** Medigap PPO climbed from 836 at the end of 1989 to 5,443 in April 1990. The **BCBS/AZ** demonstration was fully described in a previous status report (Nelson and others 1990).

CAPP CARE is a **nonenrollment** PPO operating in Orange County, California. 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 Medicare costs reduced without beneficiaries formally enrolling in the PPO. 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 formally **enrolling**. **BCBS/AZ's** slow enrollment-836 in its first year of operation--shows getting Medicare beneficiaries to formally enroll in a PPO is difficult and time-consuming and requires substantial incentives. Another advantage of CAPP CARE's model is that, like **BCBS/AZ**, it does

not alter the basic Medicare benefit structure. So the Medicare carrier and **fiscal** intermediaries⁴ serving Orange County have not had to alter their systems, except to provide data tapes to CAPP CAPE. CAPP CARE is now fully operational. Orange County beneficiaries have been seeing demonstration physicians since April 1, 1990.

Family Health Plan, Inc., proposed an employer group model PPO in the Minneapolis/St. Paul area. This Medicare PPO will focus on enrolling Medicare beneficiaries through employer retiree benefit plans. Family Health Plan has letters of intent from three area employers to serve the retiree populations of these companies--a total of **about 850** Medicare beneficiaries. Negotiations have begun with other **employers** and with groups that do not provide **health** benefits 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 existing Medigap or group retirement plans. Enrollment projections in July were 1,900 by January 1991, and 3,425 by July 1991. Family Health Plan feels it is ready to implement and is awaiting the signal--funding--from HCFA to do so. HCFA, however, wants firm commitments from employers and a final benefit design before proceeding with funding.

HealthLink will not participate further in the Medicare PPO demonstration. **HealthLink** found working within the Medicare system difficult and was not able to define a benefits package that was both attractive to employers and compatible with Medicare's benefit structure. **HealthLink** had planned to market to individual Medicare beneficiaries, employers with retiree groups, and individuals with Medigap policies in the St. Louis metropolitan area.

CareMark also will not participate in the demonstration. **CareMark** management said there is not enough provider interest in the Medicare PPO. A recent change in leadership was also a major factor in the decision to withdraw from the demonstration. **CareMark** had **planned** to offer its demonstration PPO in three Portland area counties (**Multnomah, Clackamas**, and Washington).

⁴**Medicare** carriers process claims for most Part B services--physician services (including those provided in a hospital), and various other medical services and supplies. Fiscal intermediaries process claims for Part A services--inpatient hospital care, skilled nursing facility care, and hospice care--and for Part B outpatient hospital services.

CareMark intended to target individual Medicare beneficiaries and groups such as Blue Cross and Blue Shield of Oregon Medigap policy holders, and members of the Public Employees Retirement System.

C. OBJECTIVES AND ORGANIZATION OF THIS REPORT

This report has two objectives. The first is to describe in detail the nature of the **pre-implementation** experience of four of the five **PPOs** in the Medicare Physician PPO demonstration. (The fifth, **BCBS/AZ**, was described and assessed in an earlier report--Nelson and others 1990). We describe each PPO, its market area, **history**, and reasons for developing a Medicare PPO. Our description of each PPO covers:

- Design of the **PPO's** benefit package, including incentives to enroll and to use network providers
- Marketing approaches
- Criteria and process for selecting network providers
- Utilization management procedures
- Quality assurance procedures

Our analysis is based mainly on information obtained through on-site interviews and telephone **follow-up** with PPO management.

The second objective of this report is to give a preliminary assessment of the early **implementation** experience of the demonstration as a whole.

This report was prepared in the early stages of a **42-month** evaluation of the Medicare PPO Demonstration by **Mathematica** Policy Research, Inc. The evaluation is to conclude in December 1992. The conclusions presented here are preliminary. Issues to be analyzed later include the full implementation and operational experience of the demonstration **PPOs**, beneficiary choice and biased selection, and the impact of the demonstration **PPOs** on the use and costs of services. A schedule for reports on this research can be found at the end of Chapter VI.

Chapters II through V describe the experience of CAPP CARE, Family Health Plan, **HealthLink**, and **CareMark**, and the models they have developed. Chapter VI provides a comparative analysis of their early implementation experience and emerging lessons. Chapter VII presents our observation regarding three demonstration issues for **HCFA's** consideration.

II. CAPP CARE

A. BACKGROUND

CAPP CARE is one of the oldest and largest **PPOs** in the United States. Founded by physicians in 1982, CAPP CARE is a national organization operating in 32 states, with its hugest operations in California. It contracts with more than 38,000 physicians--few, if any, **PPOs** have **more--** and provides utilization review services for about 1.3 million people, one-third of whom (430,000) are enrolled in the PPO.

In its early years CAPP CARE's main clients were the six insurance carriers with equity positions in the company. One of these carriers, Allstate, withdrew from the **health** insurance market, taking with it 24 percent of CAPP CARE's enrollees. In making up for this loss CAPP CARE has diversified its clients and now has 88 different payers. Non-owner, that is, non-stockholder, business has increased 61 percent since Allstate's departure in 1989. A recently considered merger that would have greatly increased CAPP CARE's size failed to materialize.

CAPP CARE originally proposed a large demonstration covering nine southern California counties with 1.3 million Medicare beneficiaries. A demonstration of that scale was far larger than needed to test the CAPP CARE approach and the administrative costs **would** have been expensive. Consequently, the scope was scaled back to include only Orange County. The demonstration covering Orange County is budgeted to cost HCFA more than \$2 million the first year, with 64 percent of the money going to fund utilization review activities.

CAPP CARE is now fully operational. The nonenrollment model allowed for rapid operations **once** the start date was determined and data exchanges were worked out. Orange County beneficiaries have been seeing CAPP CARE physicians since April 1 and their admissions and surgeries began to be reviewed at once. Retrospective review of claims began in June, after the first data arrived from the carrier. **CAPP** CARE reports one major setback; it is not receiving the data

it says it needs to adequately review entire episodes of care. Data on referrals to non-PPO physicians made by CAPP CARE physicians have not been supplied to CAPP CARE because HCFA considers these data to be confidential.

CAPP CARE is highly optimistic about the success of this demonstration. Orange County has a large Medicare population with high Medicare costs. To serve these beneficiaries CAPP CARE has assembled a large panel of physicians, although smaller than originally expected. To reduce Medicare costs **CAPP** CARE has a sophisticated utilization review system that can identify aberrant billing patterns and unnecessary medical procedures.

1. The Market Area

The Medicare market in the demonstration area is sizable. Orange County has a population of about 2.2 million, of whom 214,000 (or 9.6 percent) are Medicare beneficiaries.' This compares to **13** percent of Medicare beneficiaries across all large metropolitan counties in the United States (see Appendix A for a comparison of PPO market characteristics).

Average Medicare reimbursements are higher in Orange County than in other large metropolitan counties. The average Part A reimbursement in Orange County in 1987 was \$1,760, which is 15 percent higher than the average for all large metropolitan counties (\$1,525). But the hospital admission rate for the Medicare population in Orange County is 24 percent lower than the average for large metropolitan counties. The average Part B reimbursement in Orange County in 1987 was \$1,333, which is **51** percent higher than the average for large metropolitan counties (**\$881**). The high reimbursement levels in Orange County indicate a potential for cost savings from managed care. The **hospital** use rate (admissions) is lower than for **large** metropolitan counties, but it is still higher than in areas such as Minneapolis, **signifying** potential for savings.

*Data in this section are from the Bureau of **Health** Professions Area Resource File (**ARF**). Most of the data are for 1988. The large-county comparison group comprises the largest county (by population) in each metropolitan area in the United States.

Residents of Orange County have higher average incomes than residents of other large metropolitan counties. Per capita income in Orange County in 1987 was \$21,444, which was 45 percent higher than the average for large metropolitan counties (\$14,773). These data reflect averages for all age groups, but CAPP CARE management reports that the Orange County Medicare population is relatively wealthy, yet still on fixed incomes and thus cost-conscious. CAPP CARE estimates that more than 80 percent of Orange County Medicare beneficiaries have Medicare supplemental insurance.

The California market is experienced with managed care, but largely as a private-sector product. According to **AMCRA (1990)**, as of January 1, 1990, the PPO option was available to 12.8 million Californians.* **PPOs** continue to thrive in California, where they originated. Currently 119 **PPOs** are operating in California, more than twice the number in any other state.

Success in the private-sector PPO market does not guarantee success in the Medicare market, but the ability of several Medicare **HMOs** in the area to attract enrollees suggests that at least part of the Medicare market is receptive to managed care. Total Medicare HMO enrollment in Orange County is about **42,000--20** percent of **all** beneficiaries in Orange County? All of the Medicare **HMOs** operating in Orange County require copayments for basic care. Most do not charge a premium.

CAPP CARE has a large pool of physicians from which to draw in Orange County. There are 2.53 physicians for each 1,000 residents of Orange County, 10 percent more than the 2.30 average for all large metropolitan counties. Statewide data show that these physicians are very receptive to **PPOs**; 56 percent of California physicians have a PPO contract; compared with 48 percent nationally.

²**This** figure includes (1) individuals whose employers have incorporated a PPO into the company's **existing** insurance plan, and so do not face an enrollment choice, and (2) individuals who have explicitly chosen a PPO as a separate insurance plan. It is slightly inflated since nationwide **PPOs** based in California may not have separated their enrollment by state when reporting to **AMCRA**.

³**Data** on HMO enrollment are from the Group Health Plan Operations (GHPO) file and from **HCFA's** private health plan option operational reports.

California physicians also have high assignment and Medicare participation rates. Assignment is accepted on 84 percent of physician claims--the national rate is **83--and** 58 percent of California physicians and limited licensed practitioners participate in Medicare, compared with 44 percent nationally (U.S. House of Representatives, 1991). **The** large number of Medicare participating physicians helped CAPP CARE put together a demonstration network (Medicare participation was a requirement), but the high assignment rate makes it **less** likely that CAPP CARE will draw beneficiaries to its physicians simply because they accept assignment.

2. **Incentives for CAPP CARE**

CAPP CARE management expressed interest in **PPOs** for Medicare even before: the first solicitations went out. Dr. Ed Zalta, CAPP CARE's chief executive officer and chairman of the board, personally, and through his position on the American Association of Preferred Provider Organizations' (AAPPO) board of directors, encouraged HCFA to pursue this option. Dr. Zalta's interest in seeing what **PPOs** could do for Medicare was a major factor in CAPP CARE's decision to create a Medicare PPO. Of course, CAPP CARE also entered the demonstration for business reasons. By channeling a new population to member physicians, CAPP CARE sought to attract more area physicians to its network. But this is a longer-term incentive, dependent on expanding the demonstration area, since CAPP CARE is satisfied with the size of its Orange County network. (CAPP CARE has over 50 percent of CAPP CARE-eligible Orange County physicians in its private sector network) CAPP CARE was also interested in supplementing CAPP CARE data with Medicare data to develop richer profiles of provider practice patterns. Medicare claims data contain much more information than data from private sector payers so, when used properly and supplied adequately, allow for a more detailed analysis of the practice patterns of providers.

B. EARLY EXPERIENCE WITH THE **CAPP** CARE MODEL

CAPP CARE is a nonenrollment PPO. With **this** model, beneficiaries do not formally enroll **in** the PPO but enter it whenever they visit a network physician. The main advantage of CAPP CARE's nonenrollment model is that, without their formally enrolling, beneficiaries can be brought into a managed care system and receive services from a provider network that is supposed to practice more conservative medicine. (**BCBS/AZ** had difficulty developing incentives strong enough to attract beneficiaries to its Medigap PPO.) Another advantage of CAPP CARE's model is its relatively small impact on the operations of the Medicare payment system. CAPP CARE did not alter Medicare benefits, so the Medicare carrier and fiscal intermediaries serving Orange County did not have to alter their systems, except to provide data tapes to CAPP CARE.

As of the end of July the CAPP CARE Medicare network had provided about 329,000 **office** visits to Medicare beneficiaries with physician charges of \$32 million (about \$95 per visit). These visits were provided to 71,000 individual beneficiaries signifying a potentially high CAPP CARE penetration rate. Many of these beneficiaries could, however, reside outside of Orange County.

1. Attracting Beneficiaries

Since beneficiaries do not enroll in CAPP CARE there are no enrollment incentives. But there are incentives to use network physicians. Initial discussions of incentives focused on variations in the coinsurance rate, reducing it to 10 percent in the demonstration area, and waiving the Part B deductible in two of the original nine counties. When the demonstration was scaled back to Orange County, HCFA and CAPP CARE agreed on an incentive package that simply guaranteed assignment--and thus no balance billing--when CAPP CARE physicians are used. One factor in the decision to not alter the coinsurance was that **80** percent of Orange County beneficiaries have Medigap insurance, and thus would not likely be influenced by reduced coinsurance.

CAPP **CARE's** proposed marketing plan was also scaled back CAPP CARE proposed an extensive marketing program, with both mass media and targeted marketing efforts. It ended up with

the simple step of sending a provider directory to all Medicare beneficiaries in Orange County. That directory went out in July, so it is too soon to know how it affected the use of network providers (only two months of post-directory claims data are available).

2. **The Physician Network**

CAPP CARE uses a highly automated system to select its physicians. First it identifies physicians to screen, such as those on the **staffs** of selected hospitals or those who send in unsolicited applications. Those physicians are then matched against CAPP CARE's extensive physician database to establish a physician profile. This physician database contains information on medical education, licensure, board certification (for the second opinion program), and sanctions on the physician. Physicians not meeting minimum criteria are excluded from further consideration,, those with professional board sanctions, for example. The database on remaining physician candidates is then merged with claims data, when available, to determine patterns of practice. Physicians whose practice patterns differ from the norm are eliminated. The candidate physicians who remain are sent an application form. Information from the application forms is then entered into the physician database and checked for accuracy, and if all the data meet CAPP CARE's standards the physician is accepted into the network CAPP CARE then notifies the physician of the decision. An appeals process is available for those not selected.

Through this process about 43 percent of southern California's eligible **physicians**⁴ were solicited for membership in CAPP CARE's private-sector network. Of these, nine percent were later rejected for failure to satisfy standards of quality. In Orange County CAPP CARE has not solicited new physicians for six years. It accepts new physicians who apply on their own, but has closed the network for some specialties. There are currently 2,761 physicians in the Orange County network,

⁴Not eligible for CAPP CARE are physicians who are excluded by automated physician profiling or who are retired or in administrative medicine, residency or internship, full-time prepaid practice, or the military service. The initial physician solicitation was made to all of southern California.

48 percent of all eligible physicians in the county. Of these, 73 percent are board certified in their specialty.

For the Medicare demonstration CAPP CARE currently has **881** physicians, about 36 percent of all CAPP CARE physicians in Orange County. About half of these are primary care physicians. As of October **1990, 19** physicians had left the demonstration. The last 7 departures occurred when a group practice dissolved--the individual physicians chose not to continue participating. Most disliked the **preauthorization** requirements for Medicare or decided that the demonstration was of no benefit to them.

Generally CAPP CARE was pleased with physician response to the demonstration. Physicians were asked to join the demonstration in two solicitations, both of which were sent only to physicians in CAPP CARE's private-sector network. The first solicitation was sent to the 883 Medicare participating physicians in the CAPP CARE network in February **1990.**⁵ Of these 883 physicians 90 percent (795) signed up for the demonstration. In March 1990 a second solicitation was sent to non-participating physicians in the CAPP CARE network whose specialty was needed for the demonstration. The solicitation asked the physicians to join the Medicare network, telling them of the requirement to become Medicare participating physicians. This solicitation netted another 93 physicians, about 6 percent of non-participating physicians in CAPP CARE's Orange County network, only a fraction of whom were sent solicitation letters. After the demonstration started 12 chiropractors were added to the network, keeping the network size 888 after the initial 12 departures.

Prior to the solicitation CAPP CARE had concluded that a panel of 500 physicians in a suitable mix of specialties would be adequate to serve the Medicare beneficiaries in Orange County. Thus, CAPP **CARE** is satisfied with the results of its physician solicitations. But, participation could have been higher if it were not for several factors:

⁵The Medicare Participating Physician and Supplier Program provides incentives for physicians to agree in advance to accept assignment on all Medicare claims. Medicare participation is a requirement for participation in the CAPP CARE demonstration network.

- The time available to sign up for Medicare participation was moved from October 1989 to March 1990, drastically reducing the time which physicians could sign participation agreements before the demonstration began.
- The solicitation was made during a period of “physician revolt” toward the Medicare program as a result of legislative actions (repeal of the Catastrophic Coverage Act and imposition of prohibition on balance billing, for example).
- Delays in demonstration start-up led to rumors that the demonstration had failed, even though it had actually not started.
- The agreement between **HCFA** and CAPP CARE to solicit only CAPP CARE members in good standing limited the pool of physicians from which to draw.

CAPP CARE expects that more **currently** non-participating physicians will apply in further solicitations during upcoming open periods for Medicare participation.

CAPP CARE plans to review all provider profiles for the demonstration and its private-sector network Member physicians will be asked to update information in CAPP CARE’s database. Physicians who are identified as having new liability claims, professional society complaints, hospital committee actions, or other disciplinary actions will be singled out for further review by the CAPP CARE medical director. Physicians can be dismissed for failure to comply with their contracts--failure to comply with prior authorization, for example. Nationwide about 1,300 physicians have been dismissed in the past four years. The rate of physician dismissal continues to slow as CAPP CARE ages and its physicians become more accustomed to what **is** expected of them.

Incentives for physicians to conform to CAPP CARE service use standards are weak. The reason for this weakness lies in the nonenrollment model and beneficiary incentives for this PPO. If a physician chooses not to practice conservatively and CAPP CARE threatens to dismiss him or her, the physician may leave the panel and continue to treat the beneficiary who **will** continue to incur the Medicare-allowed charge. In CAPP CARE’s private sector PPO, a physician who resigns would not be able to treat a CAPP CARE patient, unless the patient is willing to incur the extra charges for using an out-of-network physician.

Since this demonstration focuses on Part B services, CAPP CARE is not allowed to negotiate contracts with hospitals for this demonstration, nor is it allowed to channel beneficiaries to particular hospitals. So CAPP CARE cannot make financial arrangements with hospitals for the Medicare demonstration. For its private-sector payers, CAPP CARE has contracts with 18 hospitals and medical centers in Orange County. These facilities are located such that a patient can reach a participating hospital in 20 minutes or less.

3. Utilization Review Provided by Medicare

The idea of controlling inappropriate or unnecessary services is not a new one to Medicare. Medicare currently incorporates utilization review procedures into its **payment** system, **although** the main thrust is on identifying noncovered services. Medicare utilization review is provided through contracts with carriers, **fiscal** intermediaries (**FI**s), and Peer Review Organizations (PROs).

Carrier Review. Medicare carriers, as part of their contracts to process Part B claims, are required by HCFA to conduct both prepayment and postpayment reviews. Carrier prepayment reviews are performed by applying three categories of screens to incoming claims. Category I screens are designed to flag, for payment denial, claims for services not covered by Medicare. Category II screens select, for review, claims for services that are potentially unnecessary, inappropriate, or fraudulent. These screens, designed by the carriers, reflect a minimum level mandated by HCFA. How carriers implement the HCFA-mandated screens and how many screens they use varies widely. The General Accounting Office (GAO **1988b**) reports that carriers use from 5 to 177 optional screens--and four carriers also use diagnosis codes to determine whether such services as electrocardiograms are necessary, given the diagnosis. Category III screens are designed to **flag** for review all claims of providers who have been identified as having abnormal practice or billing patterns.

Carrier postpayment review is designed to analyze aggregated claims data for physicians and suppliers. Physicians and suppliers who are in the upper three percent of utilization norms for the

most categories are selected for further review. The carrier discusses with these providers how their practice or billing patterns differ from those of their peers. When this fails or when more serious cases are discovered, the carrier may flag the provider for full review under the Category III prepayment screens, perform an integrity review in which past claims are further examined and medical records might be reviewed, or, in cases of suspected fraud, refer the case to the Inspector General of the Department of Health and Human **Services for** further investigation. Carrier reviews result in denied payment for about 9 percent of annual Part B claims (GAO 1988b).

Fiscal Intermediary Review. The **FI**s perform utilization review in processing claims for Part A benefits and Part B services under their authority. To avoid duplicating PRO review, **FI** hospital review is limited to questions of coverage, diagnostic coding, and verification of eligibility and copayments. **Like** carrier review, **FI** review is fully automated, with screens for unacceptable diagnoses (which do not fully characterize a patient's current illness or injury) and questionable diagnoses (which could indicate unnecessary admission to the hospital). Unacceptable claims are returned to the hospital for correction and resubmission. Questionable claims are processed but referred to the PRO for possible postpayment review. Similar screens are used to detect invalid codes, procedures not covered, and procedures for outpatient surgery claims for which coverage is questionable. **FI**s may institute optional **UR** screens, but a GAO study (1988b) found that 77 percent of **FI**s do not use optional screens and that the most optional screens used was seven. FI review of other services includes:

- Skilled nursing facilities (**SNFs**). The **FI** review for **SNFs** is more in-depth than the review of hospital claims. Each admission to hospital-based **SNFs** and at least 30 percent of non-hospital-based **SNF** admissions are reviewed for medical necessity and appropriate level of care. To make these determinations, this review requires examination of medical records and all claims.
- Home health. **FI**s review about 52 percent of home health bills to ensure that the services are covered under Medicare's limited home health coverage. Medical records are requested when this information is needed. Each year the **FI**s randomly select and review medical records of 20 beneficiaries per home

health provider to determine the accuracy of the information reported to **HCFA**

- **Comprehensive outpatient rehabilitation facilities.** All claims that are identified as being provided by a comprehensive outpatient rehabilitation facility are reviewed for coverage and necessity of treatment.
- **Outpatient physical therapy.** **HCFA** has developed screens for **FIs** to use in their review of outpatient physical therapy **claims**. These screens--based on diagnostic codes, duration and frequency of treatment, and date of onset of illness or symptoms--are used to identify unnecessary and noncovered services. **Claims** failing these screens are forwarded to the **FI's** medical review staff.
- **Hospice.** **FI** review of hospice services focuses **on** the necessity and adequacy of the care provided and on the accuracy of hospice billing. **In** their review, **FIs** examine hospice claims as well as medical records and plans of care. All hospital admissions for hospice patients and care for beneficiaries who leave the hospice program are reviewed for necessity, coverage, and **potential** provider abuse.

These review activities all tend to focus on questions of coverage and medical necessity, with particularly close attention paid to services with strictly limited coverage under Medicare.

Peer Review Organizations. The Medicare **PROs** provide utilization and quality-of-care review for inpatient hospital services. PRO review encompasses both prospective and retrospective review procedures. To determine the appropriateness of an admission or procedure, preadmission and preprocedure reviews are performed for selected diagnoses. The determination of which diagnoses receive **precertification** is made based on findings from retrospective reviews and services targeted by HCFA

PRO retrospective review examines cases again for the appropriateness of services provided. Cases are selected for review based on a three-percent random sample of discharges and a series of screens that may indicate problems, such as readmissions, day and cost outliers (long-term or high-cost patients as **defined** under the prospective payment system), and cases referred by the **FI**. For these cases the **PROs** review the medical records, paying attention to coverage, correct DRG coding, and the necessity and appropriateness of the admission and discharge.

The data collected in PRO reviews is also used to profile individual physicians and hospitals. Profiles are used to identify providers with abnormal billing and treatment practices and problems with quality of care. Specific utilization issues that **PROs** examine include admission denial rates, claims denial rates, and, for hospitals, **incorrect DRG coding**. Providers shown to be above the norm for these **criteria** may receive more intensive review on future claims filed. A GAO survey (1988a) of **PROs** found that most **PROs** view retrospective review and profiling to be more effective than preadmission and preprocedure reviews for identifying utilization problems. In this demonstration the PRO activities for services provided by CAPP CARE physicians have largely been assigned to CAPP CARE to avoid unnecessary overlap, but the PRO is continuing its mandated quality assurance functions.

4. CAPP CARE Utilization Review

The major premise of the Medicare PPO demonstration is that the PPO will be able to reduce the volume of services through utilization review (UR) procedures, thus reducing costs to Medicare. So demonstration **PPOs** must have a **UR** program to control services that will enhance the procedures already in place. This demonstration is focused on reducing the volume of Part B services, so UR mechanisms to manage physician utilization effectively are crucial, especially in an ambulatory setting. UR is especially important for CAPP **CARE** because beneficiaries have little incentive to switch to CAPP CARE physicians so most savings must **come from** managing care provided by physicians proven to practice conservatively in the private sector.

CAPP CARE's **UR** activities rely heavily on the use of sophisticated computer programs used by clinically trained staff. Primary UR activities are **preauthorization** and retrospective review of services. Concurrent review (during a hospital stay) is not **being** performed under the Medicare demonstration. According to CAPP CARE, concurrent review would not be cost-effective under Medicare's diagnosis-related groups (DRG) hospital payment system. The DRG payment system reimburses hospitals a set amount for most admissions. Reducing the length of stay or level of care

in the hospital for admissions on the DRG schedule would reduce **HCFA's** costs only to the extent that Part B services associated with the admission are reduced.

Preauthorization review is **largely** telephone based. Providers must **call** in on CAPP CARE's toll-free number to request an admission for a **beneficiary**.⁶ Nurse clinicians screen using Appropriateness Evaluation Criteria (**AEC**) to approve admissions and determine an appropriate level of care and length of the stay. The AEC is a CAPP CARE-developed system that invokes **computer-**based clinical algorithms to determine medical necessity using diagnostic information supplied by the admitting physician. **All** surgery (inpatient, outpatient, ambulatory) except for emergencies must have preauthorization. Second opinions are required for those requests failing the AEC screen. These second opinions are paid for by Medicare but are expected to result in net savings through reducing unnecessary surgeries. The AEC criteria were reviewed for relevance to Medicare prior to demonstration startup and were found to be appropriate for the Medicare population. New criteria are incorporated into the computer system as medical information becomes available, often as a result of CAPP CARE research--findings showing that outpatient care is appropriate for a given condition, for example. In May through September 1990 CAPP CARE performed 1,858 preadmission reviews, and did not approve 22 hospital admissions (1.2 percent); of 3,588 preprocedure reviews, CAPP CARE did not approve 61 (1.7 percent).

Retrospective review is used to determine contract compliance by physicians and, in the **private-**sector PPO, by hospitals. CAPP CARE has a sophisticated data system for conducting this compliance review. For inpatient care, hospital claims are compared to the median of a set of normative standards for **similar** procedures. Physician procedures are also checked with CAPP CARE's utilization **norms** by a completely automated system. Potential coding errors are also checked--such as the transposition of numbers by carriers--a **common** problem, according to CAPP CARE

⁶**Preauthorization** is the sole responsibility of the provider. Beneficiaries have no part in the preauthorization process and are not liable if preauthorization is not **obtained**.

Retrospective review also extends to the ambulatory setting. CAPP CARE's ambulatory review program is also completely automated. Claims data from the carrier is compared to normative values developed from many years of claims data and evolving appropriateness of care criteria, such as use of assistant surgeons **in** ambulatory surgeries. This comparison is available for a wide range of ambulatory **services**, with criteria for additional services being added constantly. Current categories of Medicare ambulatory review at CAPP CARE are:

- **Upcoding** of services
- Frequency of **consultations**
- Frequency of use of ancillary services, injections, and consultants
- Misuse of procedure or service codes
- Billing errors
- Fragmented billing
- Quality issues
- Noncompliance issues

In addition to checking procedures against norms, CAPP CARE also checks for miswded or fraudulently **coded** claims. Procedures that are commonly **miscoded** are screened and examined more **closely**. If a procedure is not **reasonable--given** information on the patient and on the physician's specialty--the examination is extended to determine the probable cause of the mismatch. To support this computer-intensive review of Medicare **services** CAPP CARE upgraded its hardware to an IBM **AS400** mainframe processor and increased its disk storage capacity. Access to the computer center is limited to ensure data security.

Of the 329,000 visits to CAPP CARE physicians from May through June 1990, CAPP CARE's retrospective review flagged 3,426 claims (1.2 percent) totaling \$2 million, for further examination. These included:

- **168** for possible misuse of new patient code
- 613 for possible misuse of global surgical fee
- 1,907 for possible misuse of **followup** visit code
- 176 for possible unbundling of surgical procedure codes
- 184 for hospital or office visits within the **followup** period
- 441 for admitting patients to the hospital without prior authorization.’

There is no information as of yet on how many of these flagged claims were actually **problems**. Savings to Medicare also cannot be **determined** at this point since information on Medicare beneficiaries not seeing CAPP CARE physicians has not been examined. Whenever problems arise, CAPP CARE immediately gives feedback to its physicians. This feedback can be 1) the reason for denying an admission, 2) a warning letter for overuse of a particular procedure, or 3) a request for a refund on a **miscoded** or inappropriate procedure. Requests for refunds are generally honored.

CAPP CARE reports that its utilization management and review of physician compliance under the demonstration is hampered because CAPP CARE does not have adequate data on referrals from CAPP CARE physicians. Claims data received from the carrier and **fiscal** intermediaries are those that pertain directly to CAPP CARE physicians. CAPP CARE asserts that for its UR to work effectively, it must be able to track out-of-network referrals by CAPP CARE physicians to other physicians and for lab services. These referrals are an indication of a physician’s practice patterns. Without this information CAPP CARE believes that accurate management of service use for an episode of care cannot be performed. A physician who has a hospital admission denied, for example, could refer the patient to a non-network physician for admittance.

‘Many of these are thought to be in error due to physicians admitting out of non-Orange County offices for which they do not have to have prior authorization. This problem is due to the **FI’s** inability to select claims based on office address.

5. Quality Assurance

The primary goal of the Medicare **PPOs** is to control utilization and thus reduce Medicare payments, but the quality of care must not be compromised. To this end, the Medicare PPO demonstration sites are required to maintain a structured quality assurance (QA) program that complements the Medicare quality review.

a. Medicare Quality Review

The main review organizations in the Medicare program--carriers, **FI**s, and **PROs--all** review quality of care as well as utilization and payments. Carrier and **FI** quality assurance activities are largely reviews of cases that are identified in the claims review procedures outlined above. Cases involving potential quality-of-care problems are referred to medical directors or medical review committees for further investigation. The **FI**s are also mandated to conduct quality assurance visits to beneficiaries in the hospice program.

Medicare quality assurance activities are carried out mainly by the Medicare PROs, based on retrospective reviews. Hospital cases under review are screened for potential quality-of-care problems based on **HCFA's** six "generic" quality screens:

- Adequacy of discharge planning
- The patient's medical stability at discharge
- Deaths
- Nosocomial (hospital-contracted) infections
- Unscheduled return to surgery (for the same condition or to correct problems with the initial operation)
- Trauma suffered in the hospital

Cases that fail any of these screens are referred to PRO physician advisors for further quality-of-care assessments. Individual **PROs** may implement additional screens designed to further identify

premature discharges and other quality issues. Provider-specific quality review is also performed as a result of PRO provider profiling (discussed earlier). Hospitals and physicians with excessive rates of screen failure or patient mortality, and those that fail to meet PRO quality objectives, may be selected as the focus of more intensive PRO review activity.

b. CAPP CARE Quality Review

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 at modifying physician behavior. CAPP **CARE** is also setting up a beneficiary grievance system based on both informal and formal complaints. All anonymous complaints will also be investigated. To date no grievances have been filed.

CAPP CARE now has a full-time quality assurance manager. The standing QA committee consists of representatives from all departments. Dr. **Zalta** reports QA issues to the board of directors at all board meetings.

C. IMPLEMENTATION EXPERIENCES

Implementation of the CAPP CARE demonstration generally proceeded smoothly and CAPP CARE had generally positive comments about its interactions with the Medicare system in implementing the demonstration.

1. Startup and Implementation

CAPP CARE found the demonstration application process straightforward but wished that the initial instructions were more specific. For example, no constraints on beneficiary incentives were spelled out in the application materials, but it later became apparent that HCFA did have limitations on what incentives it would approve.

Throughout implementation, CAPP CARE has been pleased with **HCFA's** support, especially the Office of Research and Demonstrations. One area for improvement, however, is for HCFA to structure implementation so as to minimize delays. CAPP CARE had planned on a March 1989 implementation schedule, about the same time-frame as the demonstration design optimistically outlined. But delays, primarily for funding decisions, pushed the start date to April **1, 1990**. Funding delays led to CAPP CARE missing the window for physicians to sign participation agreements with Medicare, possibly resulting in fewer demonstration physicians. The provider directory was also held up for several weeks, it was mailed in mid-July, 1990.

2. Arrangements with the Carrier, FIs, and PRO

Once HCFA and CAPP CARE agreed upon a benefit design for the demonstration, integrating the demonstration with the Medicare payment system was quite simple. The only requirements of the carrier and **FIs** in the demonstration area are to provide CAPP CARE with claims data for services provided by network physicians, although identifying demonstration physicians has proven to be **difficult** for the **FIs**.

Integrating the CAPP CARE demonstration with PRO review required a more elaborate arrangement between the two parties and HCFA. CAPP CARE is conducting preadmission review of hospital admissions for its physicians. To avoid confusion and overlap of responsibilities, the PRO screens preadmission authorization requests, directing all requests from network physicians to CAPP CARE. The PRO will not include admission denial statistics for network physicians in physician profiles or adjustment information sent to the **FIs** and carriers, and will refer all beneficiary inquiries regarding utilization issues to CAPP CARE. The PRO will continue to perform all quality-related reviews and **followup** on quality-related beneficiary inquiries.

CAPP CARE started the demonstration without formal memoranda of understanding with the carrier, **FIs**, or PRO--something CAPP CARE was not entirely comfortable **with**. They now have signed memoranda with all parties. Throughout the implementation process CAPP CARE has been

concerned that the California PRO feels it is in competition with CAPP CARE and therefore has no incentive to see the demonstration succeed. The PRO's concern may increase if CAPP CARE's review proves more effective than its own.

3. Data Exchange

Since CAPP CARE cannot receive claims data on non-network physicians, the carrier and **FLs** must **screen incoming** claims and send to CAPP CARE only those claims from network physicians. This process is complicated by physicians who have offices in Orange County and other offices elsewhere. In these cases, claims originating in the physicians' Orange County offices are deemed in-network and those claims originating from non-Orange County offices are out-of-network claims. CAPP CARE is satisfied that the carrier is accurately identifying network physician claims through the office address of the physician. But, the **FLs** are not adequately identifying network physicians who admit patients to the hospital. The **FLs** cannot select claims data based on office location (Orange County) of physicians. Thus, CAPP CARE is not receiving all claims **from** its physicians in Orange County and is receiving claims from physicians with offices outside of Orange County. This has led to incorrectly identifying physicians not complying with preadmission certification requirements.

4. CAPP CARE Recommendations

In future PPO contracting, CAPP CARE suggested that HCFA bring together all relevant parties including parts of **HCFA**, carriers, **FLs**, and **PROs** early in the planning stage. A HCFA and CAPP CARE team met with the other three organizations separately in their early meetings (April 1989). CAPP CARE also suggested that a one-year implementation period be planned for similar PPO demonstrations in the future. It sees one year as the minimum amount of **time** needed to implement a similar demonstration.

In summary, CAPP CARE is fully operational. The physician network is strong and there is substantial network provider use. CAPP CARE feels the key unresolved issue is incomplete data. Without data on out-of-network referrals from the carrier and correct identification of physicians by the **FI**, CAPP CARE says its ability to monitor and modify physician behavior **is** restricted.

III. FAMILY HEALTH PLAN

A. BACKGROUND

Incorporated as a for-profit company in **1982**, Family Health Plan of Minnesota was one of the first **PPOs** in the country. In its first five years of operations, Family Health Plan evolved from a PPO to a managed care corporation with a **PPO** component. Other components include a case management service and a Centers of Excellence Program that develops standard treatment patterns for specific procedures and diagnoses, particularly chronic conditions such as diabetes.

The original funding for Family Health Plan came from sponsoring hospitals and physicians. These development funds were used to cover startup costs for three years until a break even point was reached, then funds were returned to the original investors. Now Family Health Plan operates independently and is fully supported by administrative fees paid by clients. Family Health Plan is owned by a national company, Metrocare National, which has established similar entities in 15 additional markets throughout the United States, including Detroit, Portland, Philadelphia, and Charlotte, North Carolina.

At the time of its original proposal, Family Health Plan had 700 contracts with such payers as insurers, private self-funded employers, public employers, multiple-employer trusts, and union welfare plans. In 1984, Family Health Plan had 5,605 enrollees; by 1988, the number had grown to **86,321**. Today, Family Health Plan of Minnesota serves about 100,000 enrollees.

Concerned about employer interest and benefit design, HCFA requested and funded a feasibility study, which Family Health Plan submitted on July 27, 1990. Family Health Plan stated in this report that it would target its efforts entirely to employers and not pursue individual enrollment of beneficiaries. It reported significant employer interest including letters of intent (a commitment to action on the part of the employer) from three **firms**, and promising developments with several others. Family Health Plan did not detail a final benefit package for any employer, which **HCFA**

requires before going forth with implementation. But, it did outline alternative products to market to employers.

Family Health Plan also reported considerable progress in recruiting physicians into the demonstration and improving its ambulatory utilization review system. The company would like a definite commitment to proceed from HCFA before entering final negotiations with employers. HCFA, on the other hand, wants to **see** agreement on a final benefit package before it approves **proceeding** with implementation.

Too many issues remain unresolved to speculate on **Family** Health Plan's prospects for success. It is in a market that has major employers who offer retiree benefits that are not yet subject to managed care. Also in this market are about 20,000 beneficiaries with no supplemental insurance, some of whom are represented by unions or employers interested in purchasing health benefits for their retirees. This market offers promise of PPO enrollees, but Medicare reimbursement patterns are low in the area. It is not yet clear whether a benefit package can be designed that both saves employers money on their retiree health costs and competes well with Medigap insurance plans, the major local source of competition for this PPO product.

1. The Market Area

Family Health Plan's geographic area of operation spans the metropolitan area of Minneapolis and St. Paul. Of the 2.2 million people living in the Twin Cities, 227,000 are Medicare beneficiaries, or **10.5** percent--lower than the 13 percent average for large metropolitan counties. Residents of this area are wealthier than **those** elsewhere--per capita income is 29 percent higher in the Twin Cities than the average in large metropolitan counties.

The Twin Cities are low in all indicators for Medicare spending. Part A reimbursement per beneficiary is \$1,016, which is 33 percent lower than for all large metropolitan counties. Medicare hospital admissions are 34 percent lower and Medicare hospital days 46 percent lower than those for large metropolitan counties. Per capita Part B expenditures in the Twin Cities area are 47 percent

lower than large metropolitan counties. These low use and cost rates may indicate less potential for savings from managed care than is possible for the other demonstration sites. But there may be room for reductions in this site as well as the others, and the nation as a whole.

Managed care is popular in Minnesota. **The 15 PPOs** operating in the state cover about 1 million people or 23 percent of the population (**AMCRA** 1990). Medicare **HMOs** have had phenomenal success, boasting **42-percent** penetration in the Twin Cities, the highest Medicare HMO penetration rate in the nation. A market with this kind of HMO acceptance may be hard for a PPO to penetrate, but the Medicare **HMOs charge** relatively high monthly premiums (\$35\$54). By providing the right incentives, **PPOs** could draw from both the HMO and the fee-for-service markets.

Twin Cities physicians are numerous and receptive to managed care. There are 289 physicians for each 1,000 residents, 26 percent more than the average for large metropolitan counties. In Minnesota, 84 percent of the physicians are in one or more PPO networks compared with 48 percent for the nation. But these physicians are not receptive to Medicare fees. **Only** 46 percent of Minnesota Medicare claims are assigned claims and only **25** percent of Minnesota's physicians are Medicare participating physicians. **The** national assignment rate is 81 percent and 41 percent of the nation's physicians are Medicare participating physicians.

2. Incentives for Family Health Plan

For five years, Family Health Plan has been repeatedly approached by employers and providers requesting a viable managed care product for the Medicare population as an alternative to the traditional fee-for-service and HMO options currently available in the Twin Cities. Employers are interested because they have benefitted from managed care for their younger employees and are convinced that they can reduce the costs of their retirees' health benefits. Physicians are interested because they want to increase their market share in a highly competitive **environment**. Hospitals are interested because a managed care product may help them shorten the beneficiaries' hospital stays, thus improving the hospitals' financial performance under Medicare's Prospective Payment System.

Family Health Plan believes that enrollment in Medicare **HMOs** has peaked, and sees an opportunity to capture a part of the Medicare market that is not in managed care systems. In developing a Medicare PPO, Family Health Plan aims to bring more patients to its current provider network and to attract more business for itself from current and future clients, primarily employers and unions.

Family Health Plan also sees the demonstration as a way to test the viability of its policies and procedures on the high utilization pattern of Medicare beneficiaries. If the results of this test are promising, Family Health Plan hopes to **offer the** Medicare PPO in other Metrocare National **PPOs**. Some of the employers being recruited in Minneapolis expressed an interest in enrolling retirees in other parts of the country.

B. THE PLANNED FAMILY **HEALTH** PLAN MODEL

1. Attracting Beneficiaries and Employer Groups

Family Health Plan's marketing efforts have focused almost exclusively on employers. In Family Health Plan's view, targeting employers has several advantages over targeting individual beneficiaries. **First**, the marketing costs are lower. **Second**, it can speed up the enrollment process since, conceivably, large groups of beneficiaries can be enrolled quickly. **Third**, given a previous relationship between the PPO and the employer, the working relationship under the PPO is likely to be smooth. **Finally**, this approach gives HCFA a chance to test the effectiveness of a group enrollment model,

Many large corporations in the Twin Cities are attuned to managed care systems. They are aware of the impending regulations drafted by the Financial Accounting Standards Board (**FASB**) that will require companies to include estimated liability for future retiree health benefits in their financial statements. These corporations will soon be required to demonstrate that they have set aside enough reserves to cover these benefits, so they are more concerned than ever about the rising costs of retiree **health** care benefits. Hence their renewed interest in managing retiree benefits.

To implement its employer targeted marketing strategy, Family Health Plan surveyed its current clients to determine their interest in participating in the demonstration. Employers who expressed an interest were visited by Family Health Plan staff members who gave a formal presentation about the demonstration and solicited ideas about benefit structures that might be incorporated into existing retiree benefit programs. Family Health Plan also met with insurance companies to determine their interest in an insured product that could be offered to groups that do not have Medicare supplemental insurance.

It soon became evident that several alternative model benefit structures should be developed to maintain client interest. So Family Health Plan developed three models which have generated interest among a variety of employers and a union of retirees with no supplemental coverage. These models correspond to the three major client groups: self-insured employers, unions without health benefits, and Medigap insurers.

The first model benefit structure, the “classic employer model,” is suited for self-insured employers that already offer health benefits to their retirees. In this model, the employer pays the entire cost of health benefits that Medicare does not cover, or shares these costs with the beneficiary. Once the employer makes the decision to enter the PPO, the retirees are “enrolled,” so no incentives to enroll are required. Enrollees are enticed to use PPO physicians with better benefits, the type and value of which would depend on how much the employer is expected to save through the PPO. One option is for the employer to offer cash rebates that encourage enrollees to use PPO physicians. For example, an enrollee would receive \$50 if PPO physicians were used **50** percent of the time or \$100 if they were used all of the time. Family Health Plan uses these kinds of incentives in its commercial plans and they have proven effective in diverting enrollees to PPO providers. Possibly a more effective way to channel enrollees to PPO providers, however, would be for the employer to adjust the amount of coinsurance it **covers**. A package covering all costs when PPO providers are used, but leaving 20 percent for the beneficiary to pick up when non-PPO providers are used should

create strong incentives for network provider use. This package is possible since no benefit design under consideration has HCFA paying more than 80 percent of allowed charges.

The second type of benefit package, the “employer or group sponsored model,” is designed for unions, trust funds, or employers who do not currently offer their retirees health benefits. This is an individual enrollment model. Beneficiaries using PPO physicians do not pay the Part B deductible, pay only 10-percent coinsurance, and are guaranteed no balance billing. Those who do not use PPO physicians pay the \$75 deductible, **20-percent** coinsurance, and are not protected from balance billing. One option suggested by **Family** Health Plan is to charge a \$10 a visit copayment instead of any coinsurance. This option is beneficiary-friendly because it is easier to calculate and more predictable. It is also provider-friendly because it is easier to handle administratively. But this approach may be difficult for carriers to implement since it requires substantial programming changes in the carriers’ claims processing system.

The employer or group sponsored model also offers free preventive services such as comprehensive physical examinations, vision screening, blood pressure screening, and hearing tests. Family Health Plan’s network physicians will provide these preventive services through a coupon redemption program offered by Family Health Plan’s network hospitals. The physical examination provides an enrollment incentive and baseline data for identification of beneficiaries who could benefit from the Centers of Excellence program in which care for high-cost cases such as transplants and cancer treatment is contracted out. The Centers of Excellence Program will not be ready in the initial stages of the Medicare PPO.

Family Health Plan is still investigating a third model benefit structure—a PPO product combined with Medigap insurance. This product would be similar to the classic employer model, with a **Medigap** insurer assuming the role of employer. It would offer enrollees one **or** more of the following incentives: cash benefits, no paperwork, free physicals, and free dental **services**.

As of the end of July **1990**, Family Health Plan has received letters of intent from three major employers, Northwest Airlines, the Metropolitan Airport Commission, and Ecolab, that together have 850 retirees who are Medicare beneficiaries and thus would be eligible for the demonstration. Two additional employers with 450 retirees have expressed a strong interest in joining the demonstration; their letters of intent are expected soon. A sixth employer with 1,000 retirees has also shown an interest in the demonstration. Family Health Plan also has promising contacts with eight other major groups with a total of **4,750** retirees. Should all 14 employers join the demonstration, Family Health Plan would have a pool of 7,050 enrollees to draw on.

Most of the employers approached so far offer some health benefits to their retirees. In the Twin Cities area about 20,000 beneficiaries have no supplemental insurance, and some of them belong to unions or other groups. Family Health Plan has begun discussions with some of these groups that have expressed interest in joining the demonstration.

Family Health Plan projects an enrollment of 1,900 by January 1, 1991, barring any delays in implementation of the demonstration. Six months later, Family Health Plan expects this number to rise to 3,425. By May **1992**, Family Health Plan projects an enrollment of 4,475 in the demonstration.

2. The Physician Network

Family Health Plan selects its physicians based on location, specialty, hospital affiliation, malpractice coverage, status with the state board of examiners and with board certification, commitment to cost containment and utilization management, acceptance of Family Health Plan's fee schedule as payment in full, and commitment to Family Health Plan's policies and procedures. Physicians are reviewed annually in terms of these criteria, their practice patterns, and the incidence of complaints about them from patients and other physicians. Physicians whose practice patterns are outside of norms are counseled. If this counseling proves to be ineffective, the physician is subject to a succession of sanctions, beginning with warning letters, denial of fees, and eventually separation from the network

To recruit physicians for the demonstration, Family Health Plan staff conducted on-site presentations in primary care clinics and the offices of physicians who are already network providers and are located in areas deemed accessible to the **Twin** Cities' elderly population.

So far, **280** primary care physicians have agreed to participate in the demonstration, or 37 percent of Family Health Plan's total primary care network. More than 100 specialists, or **17 percent** of the network, are also available. Both the primary care physicians and the specialists are geographically well dispersed.

Family Health Plan is satisfied with the number of primary care physicians recruited, but sees gaps in some specialties. Should Family Health Plan receive a go-ahead to begin implementation, its recruitment will continue with an aggressive focus on these specialties. Having set goals for the number of physicians needed in each specialty, Family Health Plan will identify potential candidates in the desired geographic locations and recruit them the same way it recruited all of the network's physicians.

3. Utilization Review and Quality Assurance

Family Health Plan's utilization management program, the Value Assurance Plan, includes preadmission certification, concurrent review, retrospective review, second surgical opinion, outpatient management protocol, and case management.

Preadmission review is a telephone certification process required for all nonemergency admissions. Elective surgery is confined to morning admission on the day of surgery. Admissions before the day of surgery are allowed only in extenuating circumstances. Certain procedures must be done on an ambulatory basis, except in extenuating circumstances. There is mandatory triage for all chemical dependency and psychiatric admissions.

Concurrent review **will** be conducted for all admissions, no less than every five days of confinement. Every effort is made to discharge patients, even if **followup** care must be arranged in

the home or in an alternative institution. Case management services are offered to potentially **high-**cost patients.

Family Health Plan plans to conduct concurrent review because it believes these reviews to be necessary for effective discharge planning and case management. This is also a service that stands to generate significant savings for hospitals, if not for the payers. Concurrent review is not encouraged by HCFA, which sees minimal Part B savings from inpatient concurrent review. Family Health Plan can conduct this review, but it cannot expect to be reimbursed by HCFA for its costs in this demonstration.

At the time the initial proposal was submitted, Family Health Plan's ambulatory UR was largely retrospective, except for surgical procedures. Retrospective review includes periodic audits of selected claims and comparison of physician utilization patterns with average patterns within specialties. For the ten most common diagnoses, Family Health Plan has developed the Centers of Excellence program that designs optimum treatment protocols, to which physicians must **conform**. This program is being expanded to include the diagnoses most common to elderly patients.

Since it first submitted its proposal, Family Health Plan has also developed a comprehensive pretreatment approval program for outpatient services. As delineated in Family Health Plan's final report of the feasibility study, this improved ambulatory UR system authorizes outpatient treatment in the following areas:

- Ambulatory surgery
- Home health care
- Speech, physical, and occupational' therapies
- Durable medical equipment
- Chiropractic care
- Biofeedback

The medical appropriateness of care is established on the basis of the following types of information required of the provider:

- Diagnosis and severity of condition
- The estimated risk of deterioration without treatment
- A measure of functional impairment
- A treatment plan that includes proposed treatment modalities, measurable results, and expected duration of treatment

Family Health Plan enjoys a unique relationship with its employer clients who provide full access to all claims made by employees and encourage efforts to educate employees. Family Health Plan is in a position to monitor and shape the behavior of physicians and employees. When an enrollee seeks care outside the provider panel, Family Health Plan tries to determine whether this was because of a conscious choice or lack of understanding about the PPO system. In the latter case, the enrollee is encouraged to use network providers, if they can meet the enrollee's needs. If claims data allow, Family Health Plan proposes to apply this practice to the Medicare demonstration.

To monitor quality of care, Family Health Plan has an established patient grievance process and conducts patient satisfaction **surveys**, in addition to evaluating medical records for appropriateness and quality of care in the Value Assurance Plan.

C. IMPLEMENTATION EXPERIENCES

Family Health Plan is the only PPO left in the demonstration that is not operating. It has been working towards implementation for two years and is optimistic about proceeding to implementation.

1. Startup and Implementation

Family Health Plan has been generally satisfied with the implementation process and its relationship with HCFA. As indicated earlier, it would have liked earlier approval **from HCFA** for

implementation. However, HCFA did not think it was prudent to approve funding for implementation before Family Health Plan had a specific benefit package.

There was also some understandable tension between **HCFA's** desire to encourage PPO innovation by not specifying the allowable **benefit** packages and Family Health Plan's feeling that they would have liked clearer instructions.

2. **Arrangements with the Carrier, FI, and PRO**

Discussions have not been held with the Part B carrier, FI, or the PRO. HCFA instructed Family Health Plan to wait until the **results of** the feasibility study were known and a clear benefit design was in place to begin negotiations. HCFA thought discussions with the carrier and the FI could not accomplish much until a concrete benefit package was defined. As indicated earlier, work is still proceeding on a **final** benefit package. Judging by the complications of **CareMark's** carrier negotiations, discussed in Chapter V, the time and cost burdens on the carrier may be considerable. On the other hand, the benefit designs currently under consideration have Medicare paying 80 percent of allowed charges and the closer conformity may make carrier changes simpler.

3. Family Health Plan Recommendations

In its feasibility report, Family Health Plan made the following recommendations about the design of **this** and future demonstrations:

- Include Part A benefits, to take full advantage of potential savings and to make the Medicare PPO easier to market to employers
- In the benefit package, institute the option of a \$10 copayment instead of the 10-percent coinsurance option
- Consider exempting the PRO **from** all UR activities related to demonstration enrollees

Family Health Plan also recommends that HCFA consider the relative value scale payment system in the future. While not possible in this demonstration, they feel the system would be easier to **sell** to employers and physicians in future PPO contracting.

In summary, Family Health Plan feels it is ready to implement the demonstration. It has letters of intent from several area employers and has met its goal for primary care physicians. But the benefits package is not fully defined and discussions with the carrier have not yet begun, so the start date may be some time away.

IV. HEALTHLINK

A. BACKGROUND

Established in 1985, **HealthLink** is a for-profit PPO that offers mainly utilization review services. In 1987, **HealthLink** affiliated with the University of Missouri Hospital and Clinics and with Preferred Health Professionals, creating a statewide network of providers. Incorporated separately from its sponsoring hospitals, **HealthLink** is governed by a board of directors composed of hospital executives, participating physicians, and employer and union representatives.

HealthLink is growing fast and plans to expand its product line to include an HMO and other risk management services. At the time of its initial proposal, **HealthLink** had more than 186,000 enrollees, about 9,300 or five percent of whom were eligible for Medicare. In the two years since then, **HealthLink** has added 50,000 enrollees a year. If the five-percent ratio holds true for the new enrollees, about 14,300 of **HealthLink's** current enrollees are eligible for Medicare. This could represent a larger target population than at other demonstration sites.

HealthLink planned to create a Medicare Demonstration Department to be headed by a **full-time** project director reporting directly to the chief executive officer. This department would have its own marketing and member services staff and would coordinate UR, QA, finance, and other activities with other departments. **HealthLink** hired a new vice president for special projects. He **was** responsible for overseeing the feasibility analysis HCFA requested and launching the demonstration. But once the feasibility study was completed it was decided that **HealthLink** would not continue in the demonstration.

HealthLink's market was promising for **PPOs**. St. Louis has many major employers who are concerned about retiree benefits that are largely unmanaged, and local Medicare expenditures are high. But the demonstration was not attractive to employers in the St. Louis area. They were reported to be leery of government programs, especially experimental programs, but they would have

considered joining the demonstration if they could have received a larger share of the savings to Medicare.

The employers' share of any savings the PPO could generate was the basis for a major misunderstanding by Heal&Link regarding how employers could share in any savings from the demonstration. To attract employers, **HealthLink** developed a benefit package that had Medicare paying 90 percent of Medicare allowed charges and the employer paying the remaining 10 percent. HCFA said that under this model that had HCFA paying an additional 10 percent of allowed charges, no savings could accrue to the employer--all must be applied to the Medicare Trust fund or returned to the beneficiaries through enhanced benefits. HCFA's rationale was that since it was paying a larger share (more than the standard 80 percent plus administrative costs) any savings should accrue to the government.

HealthLink assumed, that this meant no savings could accrue to employers under any circumstances. This was not **HCFA's** intention. Employers could reap utilization review-generated savings on the portion of Medicare allowed charges that HCFA does not cover (20 percent) as long as the basic Medicare benefit structure did not change. That is, if HCFA would continue to pay 80 percent of allowed charges. **HealthLink** did not understand this option and thus it was not presented to employers. So, employers were offered a package that added to their **costs** of benefit administration without the opportunity of savings and one that was short-term, leaving them to **cover** the costs of a richer benefit package after the demonstration ended--not an attractive alternative.

Since **HealthLink's** benefit package differed from Medicare's standard Part B benefit structure, changes would have been required in the carrier's **claims** processing systems. **HealthLink's** enrollees would have had to be flagged and processed differently. Making these changes is always a **formidable** challenge, but was more difficult for **HealthLink** because the site spans two states (Missouri and Illinois), and thus two carriers, two intermediaries, and two PROs. However, implementation did not

proceed far enough to ascertain how difficult it would have been to adopt the carrier processing systems.

1. The Market Area

The **HealthLink** demonstration was to encompass the St. Louis area. The total population in this area is 2.2 **million** people, of whom 327,600 or 126 percent are Medicare beneficiaries. Per capita income in St. Louis is three percent higher than in all large metropolitan counties.

Medicare Part A reimbursements per beneficiary in St. Louis are \$1,905, which is 25 percent higher than average for large metropolitan counties, but Medicare hospital use rates are lower than average. Medicare admissions are **28** percent lower and Medicare hospital days 20 percent lower in St. Louis than the average for large metropolitan counties. Per capita Part B reimbursements are also lower in St. Louis than the average in large metropolitan counties, although only three percent lower. The HMO penetration rate in the Medicare market is less than one percent.

The physician population in St. Louis is low. There are 1.86 physicians per 1,000 persons in St. Louis, 19 percent below average for large metropolitan counties. The average assignment and participation rates are about 72 percent and 50 percent, respectively for **Illinois** and Missouri.

HealthLink saw the main competition for the Medicare PPO in its market area as the supplemental insurance plans offered to individuals by the American Association for Retired Persons and to retirees groups by such companies as Anheuser-Busch and Laclede Steel. These plans range widely in comprehensiveness, from full coverage of all Medicare unreimbursed expenses to only the Part A deductible and Part B **coinsurance**.

St. Louis is rich in Fortune 500 Corporations. Among the corporations to which **HealthLink** marketed the demonstration were McDonnell Douglas, Union Electric, Ralston Purina, and Mercantile Banwrporation. Many of these employers have significant health benefit commitments to **retirees**, and are concerned that the new **FASB** requirements to set aside reserves for these retirees will wreak havoc with their balance sheets. There is a sense of urgency about managing these

health benefits, which at the moment are virtually unmanaged. So, a managed care product promising savings would presumably be attractive to them.

2. Incentives for **HealthLink**

HealthLink chose to participate in the demonstration for two reasons. **First, in** keeping with its corporate strategy to grow and expand its services, **HealthLink** wanted to develop a new product line that would be attractive to current and potential clients, most of whom are employers and unions with retirees. Gaining experience with **retiree groups**, **HealthLink** would be poised to develop additional services designed for the elderly.

Second, **HealthLink** wished to increase its physicians' share of the Medicare market. The added business would keep the physicians satisfied and thus strengthen their already positive relationship with **HealthLink**. **HealthLink** reasoned that if the physicians benefitted from more business, eventually the hospitals these physicians use would, too.

B. THE PLANNED HEALTHLINK MODEL

1. Attracting Beneficiaries and Employer Groups

HealthLink planned to target three types of Medicare beneficiaries: 1) individual beneficiaries who have purchased Medigap insurance, 2) individual beneficiaries without Medigap, and 3) retirees of locally-based employers and unions. **HealthLink** had no experience marketing to any of these groups, but has had considerable experience working with employers and unions through which retirees are accessible.

To attract individual beneficiaries, **HealthLink** requested marketing funds which were not approved for the **feasibility** study. Therefore, the two target groups of individual beneficiaries were not pursued, with one exception. **HealthLink** surveyed a group of insurance companies to elicit interest in developing a Medigap insurance product. The result was a "lukewarm" response by one

insurer whom **HealthLink** did not actively pursue because of the discouraging signals the PPO was getting from its major target group, retiree groups of locally-based employers.

HealthLink approached these employers through the St. Louis Business Health Coalition, which includes most major employers in the St. Louis area. On behalf of **HealthLink**, the coalition sent a mailing to its members describing the PPO demonstration and inviting interested corporations to a coalition-sponsored meeting. Seven companies replied but only three attended the meeting, and of these, only one, Mercantile Bancorporation, expressed an interest at the end of the meeting.

A second try resulted in face-to-face **meetings** with representatives of six more companies, including McDonnell Douglas, Lincoln, Olin, Monsanto, Union Electric, and Ralston Purina. Of these, only Monsanto and McDonnell Douglas were willing to explore participation in the demonstration. Later, one-on-one meetings were held with each of the three interested employers.

HealthLink proposed a benefits package that would include a stiff penalty for using **non-network** physicians. Enrollees using services outside the network would be liable for 30-percent coinsurance and the Part B deductible, with no protection from balance billing. Those who stayed within the physician network would pay only 10-percent coinsurance and would not be subject to the Part B deductible or to balance billing by physicians.

HealthLink was convinced that a penalty approach was necessary to create significant incentives for beneficiaries and employers. But, due to the major system changes required by the carriers to administer the penalty and issues that needed to be resolved to proceed with the penalty approach, **HealthLink** dropped the 30 percent coinsurance for out-of-network provider use.

In meetings, the three interested employers eventually revealed what the other companies had expressed: a need to better manage the benefits of retirees tempered by **concern** about the longevity of, and savings from, the PPO demonstration. The employers were looking for long-term solutions to the burden of retiree benefits and felt their share of potential savings in the demonstration was too small. They **could** not justify making what they saw as burdensome administrative changes to

their benefits programs without the promise of a larger share in savings. According to **HealthLink**, these employers are leery about government programs--especially short-term, experimental programs. "This attitude was reinforced when the Medicare Catastrophic Coverage Act (of **1988**) was rescinded by Congress--at about the time **HealthLink** approached them. Throughout their discussions with **HealthLink**, these employers reiterated their need to **find** a long-term solution to the problem of retiree benefits and their reluctance to get involved in a program that might be of limited duration.

Despite repeated attempts, **HealthLink** found no employers seriously interested in the demonstration. Employers cited the following reasons:

- It offered no clear benefits for the corporate employer
- The demonstration would be "short-term," for an indefinite period
- Employers would not want the extra administrative burden of offering more options
- Retiree benefits have been "tampered with" many times in the last several years and employers could not take the "heat" of any more changes or offerings

As a result, **HealthLink** concluded in its feasibility report that it would be unable to get the necessary support from the corporate community in St. Louis.

2. **The Physician Network**

HealthLink's physician network includes 1,450 physicians who are selected and retained on the basis of their:

- Having staff privileges in at least one participating hospital
- Being board-certified or eligible for board certification
- Carrying professional liability insurance
- Having good standing in the community
- Being geographically accessible to members

- Practicing in a needed specialty area
- Having passed recredentialing according to JCAHO standards

The physicians agree to abide by **HealthLink's UR/QA** program, administrative procedures, and private-sector fee schedule, which is based on a relative value scale. Physicians are also prohibited from balance billing.

HealthLink planned no additions to its current provider network, except for orthopedists, physiatrists, and podiatrists. They also considered contracts with nursing homes, hospices, home health agencies, and durable medical equipment suppliers.

The key incentive for physicians to join **HealthLink's** provider network is the promise of increased volume, a promise that has been fulfilled, if **HealthLink's** dramatic growth in recent years is any indication.

To attract its current physicians into the demonstration, **HealthLink** felt that it would be necessary to promise relief from the administrative burdens of PRO review activities. According to **HealthLink**, its physicians would rather be subject to the **PPO's** reviews than to the **PRO's**. One feature that would attract physicians is a clear delineation of the difference between PRO and PPO responsibilities, so physicians would not face duplicate monitoring and sanctions.

3. Utilization Review and Quality Assurance

HealthLink's commercial UR program includes preadmission, concurrent, ambulatory surgery, and retrospective reviews, second surgical opinions, and discharge planning. For the demonstration, **HealthLink** proposed ambulatory review controls, **precertification** of admissions, concurrent review and discharge planning, retrospective review, and case management for high-risk patients.

Since January of 1989, **HealthLink** has been developing an ambulatory utilization review system that was offered to clients as a new product on September 1, 1990. This UR system includes selective

precertification of specific high-cost procedures, retrospective review of selected diagnoses that tend to show high utilization patterns, and retrospective physician profiling.

HealthLink understood that it could not conduct concurrent review while HCFA allowed other demonstration sites to conduct concurrent review, although in the case of Family Health Plan, at their own expense. **HealthLink** concluded that separating Part A and Part B utilization reviews would create gaps and unnecessary overlap. Most important, **Part B services** associated with inpatient stays would not be monitored, so related savings would not be realized.

Three additional reasons for conducting concurrent review on Part A services given were: 1) it would help identify discharges appropriate for case management, 2) network hospitals would benefit from **HealthLink's** concurrent UR program, 3) employers would be more attracted to a total UR product for their retirees than the “fragmented” product that results from separating Parts A and B. HCFA was concerned that insufficient Part B savings would be generated to cover the **costs** of concurrent review and that pressure would be placed on physicians to refer to **HealthLink** hospitals. The second point was of particular concern since **HealthLink** owns its member hospitals and thus the potential existed for substantial rewards by channeling beneficiaries to its hospitals.

Both the absence of concurrent review and the inflexibility of Medicare benefits were seen as barriers to a successful case management program. The object of case management is to substitute less expensive services for more expensive services, so it is necessary to make as many of these less expensive services available as possible. Under Medicare, many of these services are not readily **accessible** for a case manager to recommend.

HealthLink's QA program focuses on the patient grievance process. **HealthLink** was to add patient satisfaction studies and ongoing review and feedback to providers for both inpatient and outpatient care. For inpatient care, **HealthLink** planned to develop a review of randomly selected records and selected procedures deemed potentially inappropriate. For outpatient services, **HealthLink** was to **review** randomly selected records at physicians' offices, including a review of

selected procedures and physician care prior to inpatient care that repeatedly resulted in complications.

The continuum of feedback for physicians begins with a letter educating the physician about the review findings, followed by a series of warning letters, and finally dismissal from the panel, if necessary.

C. IMPLEMENTATION EXPERIENCES

When the demonstration ended, **HealthLink** was in many areas further down the road to implementation than Family Health Plan.

1. Startup and Implementation

Working within the constraints of the Medicare benefit structure and claims payment systems is inherently difficult. These difficulties may have been compounded in **HealthLink's** case by their lack of experience with Medicare, and **HealthLink** found implementing a Medicare PPO frustrating and difficult. HCFA intentionally left the demonstration design flexible in order to encourage innovation from the private sector **PPOs**. This flexibility was interpreted by **HealthLink's** as HCFA not providing clear direction. **Finally, HealthLink** complained that the costs of the feasibility study were much higher than the HCFA budget. **HealthLink** estimated they assumed \$50,000 in costs not reimbursed by HCFA

2. Arrangements with the Carriers, FIs, and PROs

HealthLink met several times with the Part B carrier in Missouri, General American, to discuss the flow of claims in the demonstration. After studying the situation, the carrier representatives concluded that the system changes required for the demonstration would be **costly** and would have to be closely coordinated with the Illinois carrier. **HealthLink** and General American came up with two options for resolving the problem: **1) have both carriers make the same costly** changes in their

claims processing systems, and 2) have the Illinois carrier make only the minimal changes required to separate out the claims, and send those claims to General American.

The second option was less costly but required full cooperation between the two carriers, which had not worked together before. This was a complicated task, and **HealthLink** dropped out of the demonstration before the problem could be resolved

In its original proposal, **HealthLink** expressed concern about PRO resistance to the demonstration. Indeed, the PRO did express fear that it would lose revenues if part of its workload was assigned to **HealthLink**. However, HCFA reassured the PRO that it would not lose out financially, and discussions focused usefully on the coordination of claims processing and the interface with physicians. Progress was made, but **HealthLink** still felt some issues remained **unsolved**, including the following:

- Would the PRO receive a waiver of responsibility for the beneficiaries enrolled in the PPO?
- How would the PRO be compensated for “lost revenue” because of the reduced workload?
- If **HealthLink** were solely responsible for the review of PPO enrollees, how would the PRO be able to include those cases in the sample taken for the mandated quality monitoring and oversight?
- How would the PRO be able to **fulfill** its obligation of answering through its outreach hotline inquiries made by PPO enrollees?
- How would the data flow and system changes be conducted and paid for?
- How would retrospective denials be handled?

HealthLink received a copy of the PRO modification for CAPP CARE but said it was difficult to interpret and did not resolve the issue of final authority.

3. **HealthLink** Recommendations

To facilitate future PPO interactions, **HealthLink** recommended that **HCFA**:

- Document major decisions and instructions in writing
- Consider an integrated UR system combining Part A and Part B
- Allow more flexibility in the benefit package so it is possible to create stronger incentives for beneficiaries
- Consider options for stronger employer and PPO incentives
- Set aside considerable funds for amending carrier systems
- Provide a more assertive presence and clear direction when negotiating with carriers and **PROs**

In summary, **HealthLink** is no longer part of the demonstration, It was not able to develop a viable benefit package, within the constraints of Medicare and **HealthLink's** understanding of the demonstration requirements. While it expressed frustration about several issues, the lack of a viable benefit package appears to be the key factor leading to **HealthLink** dropping out of the demonstration.

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V. CAREMARK

A. BACKGROUND

CareMark was incorporated in 1984 as a nonprofit organization, and became operational in 1985. At the time, **CareMark** was a joint venture between **HealthLink**¹--Portland's largest health care delivery system--and member physicians. **HealthLink's** system included four hospitals and a home health agency. **HealthLink** provided the startup funds that were used until **CareMark** reached a **breakeven** point in 1988, exactly three years after beginning operations. In those three years, enrollment reached 33,000 enrollees.

At the time of its original proposal, **CareMark** was governed by a ten-member Board of Directors, five of whom were nominated by the **HealthLink** hospitals, and five by physicians. From the start, **CareMark** has been controlled by providers.

In December 1988, **CareMark** merged with another leading PPO in the Portland area, Northwest Health, Inc. (NHI). NHI was a for-profit PPO sponsored by **two** hospitals and two physician organizations. Established in 1986, **NHI** had 21,200 enrollees by 1988. The new, combined organization was called Managed **HealthCare** Northwest, Inc.--but for this report we will call the PPO **CareMark**. In December 1988 it had about 54,000 enrollees, eight hospitals and 1,000 physicians.

The **CareMark** PPO seemed ready for implementation sooner than the other sites, except for **BCBS/AZ**. But after an extensive preimplementation development process, **CareMark** withdrew from the demonstration. The current **CareMark** leadership has stated that the reason for leaving the demonstration was lack of physician interest. A major factor in **CareMark's** decision to withdraw was a complete change in leadership in early 1990. The new management took a fresh look at the 63 demonstration's prospects and decided not to proceed.

¹To our knowledge, the **HealthLink** hospital chain in Portland is in no way related to the **HealthLink** PPO in St. Louis.

1. The Market Area

CareMark's demonstration service area was to consist of three counties in the Portland area (Multnomah, Washington, and Clackamas). The Portland area has a population of 1.4 million, with 143,630 Medicare beneficiaries, or 13 percent of the population.

Medicare use and expenditures in the Portland area are below average. Medicare Part B reimbursement per beneficiary is \$613, which is 30 percent lower than **the** average in large metropolitan counties. The average expenditure per beneficiary for Medicare Part A is \$1,175, which is 33 percent lower than average for large metropolitan counties. Hospital admissions of Medicare beneficiaries are 25 percent fewer and Medicare hospital days 45 percent fewer in Portland than the average for large metropolitan counties.

Like the Twin Cities, Portland is very receptive to managed care. Private sector **PPOs** cover half a million people in Oregon, or 18 percent of the population (AMCRA 1990). In the Medicare market, **HMOs** have received a warm welcome. In Portland, 28 percent of the beneficiaries are in risk contract **HMOs** and another 14 percent in other Medicare **HMOs**. Like the Minnesota **HMOs**, Portland's **HMOs** all charge premiums (\$19 to \$49) and require copayments for office visits.

Portland also has the highest physician-to-population ratio of all the demonstration areas. There are 3.36 physicians for every 1,000 people in Portland, which is 46 percent higher than average for large metropolitan counties. These physicians have proven receptive to **PPOs--48** percent of Oregon physicians are in one or more **PPOs** (AMCRA 1990). But these physicians are less likely than others to accept Medicare fees. The assignment rate in Oregon is 58 percent, 22 percent below the national average. The Medicare participation rate among physicians **is** 37 percent, 9 percent below the national average.

2. Incentives for **CareMark**

CareMark had two reasons for joining the demonstration. First, it had a strong interest in growing and saw the Medicare PPO as a vehicle for gaining market share for itself and its physicians.

Second, it was convinced that the PPO structure would be effective **in** reducing Medicare expenditures, while maintaining or improving the quality of care.

B. THE PLANNED CAREMARK MODEL

1. Attracting Beneficiaries and Employer Groups

CareMark planned to market its demonstration PPO to three groups of Medicare **beneficiaries**: individual Medicare beneficiaries, beneficiaries who had selected the intermediate option of Blue Cross and Blue Shield of Oregon's supplemental insurance plan, and Public Employees Retirement Systems (PERS) beneficiaries. Under the benefits package designed for individual beneficiaries, enrollees would pay an annual \$20 enrollment fee, and their benefits would include a \$10 copayment for PPO physician visits and a **15-percent** coinsurance on PPO physician surgery. **The** \$75 Part B deductible would be waived and all radiology and pathology services, and therapeutic injections during an office visit would be fully reimbursed. **CareMark** physicians would accept assignment, so PPO members would not be subject to balance billing when they visited network physicians.

Beneficiaries could also enroll in the demonstration PPO by selecting the intermediate option of the supplemental insurance plan offered by Blue Cross and Blue Shield of Oregon (BCBSO). Essentially, BCBSO would rent **CareMark's** PPO. Beneficiaries enrolled in this plan would pay a premium to BCBSO but would pay no enrollment fee to **CareMark**. When these enrollees used **CareMark** demonstration PPO physicians, they would pay a \$4 to \$6 copayment and no deductible, coinsurance, or balance bill amounts.*

Finally, **CareMark** was to offer a benefit package to PERS members who had selected a supplemental insurance option. All PERS members with the supplemental option would be

²**The** benefit design for BCBSO was in a very preliminary stage. The proposed copayments are inconsistent with the Medigap guidelines of the National Association of Insurance Commissioners (NAIC). Under these guidelines, Medigap plans are required to cover the full coinsurance amount (generally 20 percent) for Medicare Part B expenses after the patient meets the annual Part B deductible. Further investigation and clearer definition of the benefits would have to have been made to determine the legality of the copayment in Oregon.

automatically enrolled in the demonstration. The benefit structure would apply only when members used PPO physicians. When PPO physicians were used, the Part B deductible would be waived; when PPO physicians were not used, the member would be responsible for payment of the Part B deductible.

All three benefit packages included free health screenings and discounted drugs, hearing aids, and eyeglasses.

In its original proposal, **CareMark** projected a total enrollment of 16,800 after two years, 10,400 of whom would come primarily through PERS. After initial marketing efforts, **CareMark** officials revised this projection to **3,100** PERS enrollees. The prospects for individual enrollment and enrollment through BCBSO also began to look discouraging. The benefits **CareMark** could offer to individuals were seen as insufficient to even attempt marketing and an actuarial analysis revealed that low BCBSO premiums **would** not attract many beneficiaries. In the end, **CareMark** concluded that the benefit packages, as originally conceived, would not yield sufficient enrollments, and that there was not enough flexibility in the demonstration to design a benefit package that would succeed against the local competition.

2. The **Physician** Network

In **1988** when **CareMark** was developing its proposal for the Medicare PPO demonstration, it conducted a survey of its physicians to assess their interest in the demonstration PPO. The survey asked both primary care physicians and specialists to indicate their interest in participating in the demonstration PPO and their views on a gatekeeper model PPO. The results indicated that 67 percent of the physicians were either very or somewhat interested in serving as a Medicare network provider. **CareMark** did not have much time to develop its proposal (the preapplication forms were due in July **1988** and the proposal in October **1988**), so it did not devote many resources to educating the physicians about the demonstration before the survey. As a result, the physicians knew little about the demonstration when they responded.

In February and March 1990, a survey of just primary care physicians was conducted. In this survey, only **29** percent of the 400 primary care physicians **surveyed** expressed interest in the demonstration PPO. **This** dramatic change in physician interest was partly due the fact that primary care physicians knew more about the demonstration in 1990. Also, by then **CareMark** physicians had gained, as a result of a merger, access to the Medicare managed care market through an HMO.

The more **CareMark's** primary care physicians learned about the demonstration, the **less** interested they became in participating. **CareMark had proposed** a gatekeeper model PPO **even** though it did not use a gatekeeper model in **its** commercial PPO. This meant that all demonstration PPO enrollees were to select a primary care physician who would be responsible for managing their health care. For in-plan use, enrollees would have to consult with their assigned primary care physician before seeking care from other PPO providers. With the gatekeeper model, PPO primary care physicians would have more administrative duties than specialists would, but they would not be compensated for their gatekeeper responsibilities. They were told that, unlike physicians in the HMO, they would not receive a **capitated** administrative fee. So, interest among primary care physicians waned

Before the merger of **CareMark** and Northwest Health, Inc., in December **1988**, **CareMark** physicians had not had access to the Medicare managed care market. After the merger, they were offered participation in a Medicare HMO, which gave them access as a group to the managed care Medicare market for the **first** time. Other physicians in the Portland market had reaped rich financial benefits from participating in risk-sharing managed care systems, so the **CareMark** physicians viewed the new HMO opportunity favorably.

The **CareMark** physicians now saw that the Medicare HMO had more to offer them than the Medicare PPO did. And, they saw a risk in the Medicare PPO because it required Medicare participation--which to these physicians meant accepting reimbursement rates below what they usually charge Medicare beneficiaries. (The ratio of assigned charges to total charges is lower in Oregon

than in all but 7 states.) Once the HMO option was available, the Medicare PPO option was less attractive.

According to the new **CareMark** leadership, the physicians were also deterred by the benefit package that would be offered to enrollees in the demonstration. The physicians felt this package was not attractive enough to draw beneficiaries away from their current providers, so it would not generate significant new business for the physicians.

An article by Jane Bryant Quinn in the Oregonian (Portland's major newspaper) on the repeal of the Medicare Catastrophic Coverage Act of 1988 also affected **CareMark's** assessment of potential PPO enrollment. Quinn advised Medicare beneficiaries enrolled in **HMOs** to remain where they were after the act's repeal. **CareMark's** chief executive officer wondered, after reading this article, how many beneficiaries would make any kind of a move away from their current health care providers. As it had in St. Louis, the Act's repeal reinforced suspicion of government programs.

Faced with a discouraging market assessment, the results of the physician survey, and the complications of the carrier interface, **CareMark's** new leaders became less optimistic about the demonstration. They began discussing withdrawal from the demonstration after receiving the results of the physician telephone survey conducted in February-March 1990. In May 1990 **CareMark** decided to withdraw from the demonstration.

3. Utilization Review and Quality Assurance

The utilization review process **CareMark** proposed for the demonstration was to include the following:

- **Preauthorization** of all elective hospital-based surgery, elective inpatient admissions, and use of such specialized **services** as rehabilitation
- Concurrent review of inpatient utilization that would focus on selected services (because of the ambulatory focus of the demonstration and prospective inpatient reimbursement)

- Retrospective review of nonelective hospital use and of patients **requiring** admission after the ambulatory procedure
- **Preauthorization** of selected ambulatory “focused” procedures such as bronchoscopy, EEG, and cancer chemotherapy
- Retrospective review of nonelective “focused” procedures and of facility requests for day/cost outliers
- Triage screening for mental health services

CareMark contracts with the Oregon Medical Professional Review Organization (OMPRO) to provide case management services. This **contract** was to be applied to the demonstration (OMPRO is also the Medicare PRO in Oregon). **CareMark** was uncomfortable with **HCFA’s** decision to separate Part A review from the demonstration, believing that many savings opportunities would thus be lost.

CareMark proposed using a patient grievance process and medical record reviews to detect any deviations in quality of care.

C. IMPLEMENTATION EXPERIENCES

When **CareMark** withdrew from the demonstration in May/June 1990, it had made more progress toward implementation than **HealthLink** and Family Health Plan had. HCFA had already negotiated intensively with the carrier and the PRO. Those negotiations produced some lessons and solutions, as well as the sobering finding that the interface between the PPO and the carrier and PRO can cost considerable time and money.

1. Startup **and** Implementation

CareMark received more attention from HCFA than any other site. Members of the PPO staff, both current and former, thought implementation of the PPO was going relatively well, given the complexities of integrating the proposed benefit package into the Medicare payment system.

2. Arrangements with the Carrier, FI, and PRO

HCFA entered into formal discussions with the carrier, Aetna, early in this demonstration. Eventually meetings *were* held at Aetna's regional office in Portland and in Aetna's national office in Hartford, Connecticut. In these discussions, it became clear that changing Aetna's claims processing system to handle the PPO would be very costly, in both time and money.

Aetna needed to work closely with **CareMark** and HCFA because **CareMark's** PPO demonstration benefit **design** included changes to Medicare's **Part B** benefit structure--waiving the Part B deductible and instituting a copayment instead of coinsurance. This change in benefit structure meant that claims of **CareMark** enrollees would have to be flagged and processed differently than the claims of nondemonstration enrollees, necessitating modifications in Aetna's claims processing system.

Accommodating the PPO benefit package was all the more difficult because Aetna was struggling with a **15-year-old** information system which was outdated and inflexible. Considerable resources were needed just to maintain this system, so demanding new projects were rarely approved, unless there was a projected payback period of two years or less. Aetna did not refuse to participate in the demonstration, but was very reluctant to do so. According to an official at Aetna's Connecticut headquarters, the demonstration would have involved about one percent of Aetna's total claims, and less than one percent of its revenues--but the system changes would have been "enormous" and very **costly**.

The preferred way to implement changes in the claims flow system was to have Aetna initially handle **all** claims and perform **eligibility** checks. Start-up costs for this approach were estimated to be \$316,000 to \$523,000, with annual operating costs of \$44,000 to \$86,000. **CareMark**, Aetna and **HCFA** decided to **implement** a less expensive approach, which involved moving the **initial** claims review from Aetna to **CareMark**. The estimated costs to **CareMark** to develop the software for the less expensive approach were estimated to be **\$25,000** to \$50,000.

In the less expensive approach that was going to be **implemented**, demonstration PPO network providers would send all **CareMark** PPO enrollee Medicare claims to **CareMark**. **CareMark** would enter the relevant claims information in their system to verify the patient's eligibility and the primary care physician's network membership. If the patient is enrolled in the demonstration PPO, and if the primary care physician is in the network, the relevant information **is** entered into a separate computer terminal connected to Aetna in Portland. When processing these claims data for **CareMark** enrollees, Aetna would flag the specific batch number and not bill the patient for the deductible.

Under the proposed **approach**, **both CareMark** and Aetna were concerned about processing errors because Aetna did not have the editing capacity to detect errors. Two basic types of errors could occur. The first type of error occurs when a claim for a PPO enrollee is initially sent to Aetna instead of **CareMark** because the network physician does not know that the patient is enrolled in the PPO. When Aetna receives the claim, its system has no way of knowing that the patient is a PPO enrollee. Thus the enrollee's claim will be treated as a nonenrollee claim; the physician will be paid, and the physician will bill the patient for the deductible. If the patient complains about the error, **CareMark** would have to initiate a complicated process to refund the patient's deductible.

The second **type** of error would occur if the physician and the claims processor at **CareMark** are unaware that a particular beneficiary disenrolled from **CareMark**. The **CareMark** claims processor and Aetna would process the affected beneficiary as an enrollee, so the beneficiary would not be billed for the deductible. If the error is detected after the claim has been processed, **CareMark** will have to bill the patient for the deductible if **CareMark** wants to recover the deductible amount.

OMPRO was very cooperative in its negotiations with HCFA and the PPO. From the start, it agreed to forgo its current review of the PPO enrollees, to avoid duplication of effort. OMPRO suggested that it should not maintain an eligibility file, if the FI and the carrier were already doing

so. OMPRO suggested that the FI determine eligibility and flag eligible **cases**, and that OMPRO make changes for exceptions.

CareMark proposed **preauthorizing** 31 surgical procedures. Ten of these 31 procedures, absent the demonstration, would be preauthorized by OMPRO. OMRO agreed not to conduct preauthorization reviews on these procedures, if there was no penalty in lost revenues. **HCFA** assured OMPRO that it would not lose revenues under the demonstration. To **offset** any losses, **HCFA** was to increase **OMPRO's** validation sample. (Validation of preauthorization is a **process** of determining whether the information obtained on the telephone is consistent with hospital records.)

HCFA's negotiations with the OMPRO produced satisfactory solutions, according to the OMPRO representative, but the process itself was not totally satisfactory. Although OMPRO staff were pleased with their early involvement in the demonstration, and felt they contributed, they were not kept as well-informed as they would have liked. The only thing they received in writing was **CareMark's** withdrawal letter.

3. **CareMark** Recommendations

CareMark recommended only that **HCFA** begin meeting in person with the carrier earlier, combine Part A and Part B UR, and allow more flexibility in the benefit package.

In summary, **CareMark** has withdrawn from the demonstration. Its reason for withdrawing was lack of interest on the part of physicians and the **PPO's** new leadership. Also contributing to the decision was the perceived unattractiveness of the benefits package to beneficiaries.

VI. CROSS SITE EXPERIENCES

The Eve demonstration sites have designed **PPOs** that differ greatly in their benefit design, beneficiary enrollment incentives, approaches to utilization review, and success in recruiting network physicians. In this chapter we describe the three enrollment models that emerged; compare such design features as incentives, benefits, physician network, and utilization review; discuss PPO interactions with HCFA, the carriers, and the **PROs**; and list forthcoming research reports. Throughout our discussion we identify **lessons** that have emerged from experience so far.

A. ALTERNATIVE PPO MODELS

From the five demonstration sites, three PPO models emerged: the nonenrollment PPO (CAPP CARE), the Medigap PPO (**BCBS/AZ**) and the mixed enrollment model PPO (Family Health Plan, **HealthLink**, and **CareMark**).

1. Nonenrollment Model PPO

The **nonenrollment** model PPO (CAPP CARE) is simple to operationalize, compared to enrollment model **PPOs**, because formal enrollment is unnecessary. A nonenrollment model PPO does not enroll beneficiaries, but applies utilization management procedures whenever beneficiaries visit a network provider. A nonenrollment model PPO need not provide incentives for beneficiaries to **enroll**. But to effectively manage care, however, it must provide incentives for beneficiaries to use PPO providers. CAPP CARE tries to attract beneficiaries to its PPO physicians by eliminating balance billing payments when beneficiaries visit PPO physicians. Since this incentive did not involve changing the basic Medicare benefit structure, carrier interaction was less of an implementation problem than in **PPOs** that modify the benefit structure.

2. Individual Enrollment Medigap-PPO

The **BCBS/AZ** demonstration is a Medigap PPO-that is, a Medicare PPO linked with a Medigap insurance plan. Enrollees in this plan receive the financial protection provided by Medigap insurance but, unlike enrollees in standard Medigap plans, have financial incentives to select providers from within a specified provider network. **BCBS/AZ** has marketed its **Medigap** PPO strictly to individual enrollees.

As an approach to introducing a PPO option under Medicare, **BCBS/AZ's** Medigap PPO model has several features that, made for a smooth implementation. **First**, it relies on private sector innovation to develop and implement the PPO, with no government decisions required. Second, it incorporates the PPO into an existing product (Medigap insurance) that is familiar to most Medicare beneficiaries. Third, like CAPP CARE the model does not impose extra administrative burdens on the carriers or intermediaries, since the incentives used to channel enrollees to network providers do not involve changing in the basic Medicare benefit structure.

3. Mixed Enrollment Model PPO

The three other **PPOs--Family** Health Plan, **HealthLink**, and CareMark-are mixed model **PPOs**. These **PPOs** originally planned to enroll both individual beneficiaries and retiree groups. But, they soon turned to focus primarily on the retiree groups. Since they planned to serve two or more groups of beneficiaries (individuals and one or more retiree groups), they planned to offer two or more benefit packages. **CareMark**, for example, had planned to offer three different benefit packages to three different beneficiary groups-individuals, enrollees in Blue Cross and Blue Shield of Oregon's intermediate option Medigap plan, and PERS members who had selected a supplemental insurance option.

Mixed model **PPOs** must develop separate marketing strategies for individual beneficiaries and retiree groups. Individual beneficiaries must be reached one by one through such costly marketing approaches as multimedia advertising, direct mail, or presentations at health fairs. Marketing to a

retiree group involves only negotiating with the representative who is responsible for providing health insurance coverage for the group. It requires fewer marketing dollars per beneficiary than does marketing to individual beneficiaries.

The incentives proposed by the three mixed enrollment model **PPOs** would change the Medicare benefit structure, necessitating carrier programming changes. Early experience indicates these system changes are generally difficult and expensive to implement.

B. **STRUCTURING MEDICARE PPOs**

1. **Incentives for Joining the Demonstration**

All of the sites joined the demonstration for the same basic business reason--expanding their market--but their other reasons for participating differ somewhat. All the sites viewed the demonstration as a way for the PPO and its physicians to gain a share of the Medicare market. They also felt that the PPO structure could reduce Medicare expenditures. Two of the **PPOs--BCBS/AZ** and CAPP CARE--had actively pursued the Medicare PPO concept before the demonstration sites were announced in January 1989.

In the late **1980s**, the **BCBS/AZ** management saw that its position in the Medigap insurance market was threatened, as enrollees in its standard Medigap plan (Senior Security) were getting progressively older and incurring higher claims costs. It saw the lower premiums possible through a PPO as a way to increase **BCBS/AZ's** market share and improve its competitive position in the Medigap industry. Senior Preferred, its Medigap PPO, was introduced without formal support from **HCFA**. **BCBS/AZ** does not advertise that Senior Preferred is a Medicare PPO demonstration site in its marketing campaigns, and **BCBS/AZ** is not receiving financial support from HCFA. So its incentive to be part of the Medicare PPO demonstration is not federal subsidies in the form of administrative costs or support for the Senior Preferred product. Instead, **BCBS/AZ** wants to generate empirical evidence to prove its proposition that the PPO model is a credible alternative for

Medicare beneficiaries and that a radical departure from the traditional fee-for-service health care system is not necessary to control the use of physician services.

Dr. **Zalta**, CAPP CARE's chief executive **officer**, expressed interest in **PPOs** for Medicare before the first solicitations went out. His personal interest and the potential for doubling its enrollment were the driving force behind CAPP **CARE's** decision to develop a Medicare PPO. Dr. **Zalta** and others at CAPP CARE were also interested in the access to Medicare data that participation in the demonstration would provide. With these data his organization would be in a better position to analyze the practice patterns of CAPP **CARE** physicians.

Family Health Plan viewed participation in the demonstration as an opportunity to respond to local requests from employers and providers for a Medicare managed care product. The demonstration was also a way to test their UR policies and procedures on a high-use population (Medicare beneficiaries). **HealthLink** perceived the demonstration as an opportunity to grow. Through the demonstration **HealthLink** would gain experience with retiree groups, enabling it to better develop additional **services** for the elderly. **CareMark** viewed the demonstration as an opportunity to grow and to provide lower-cost health care, while maintaining or improving the quality of care.

2. **Attracting Beneficiaries and Employer Groups**

a. Marketing

The marketing approach used by the demonstration sites depends largely on the **PPO's** model **type**. **Nonenrollment** model **PPOs** (CAPP CARE) do not market to enroll beneficiaries but they must: (1) inform beneficiaries about the PPO option and its benefits, (2) distribute a directory of the network physicians, and (3) provide incentives for beneficiaries to use network providers. CAPP CARE sent a provider directory to all Medicare beneficiaries in Orange County.

Medigap and mixed model **PPOs** must develop strategies to entice beneficiaries to enroll in the plan. Mixed model **PPOs** must also develop strategies to entice employers to bring their retirees into the plan. Marketing to individual beneficiaries can be costly. **BCBS/AZ**, which markets exclusively to individuals, has done more marketing than any of the other demonstration sites. Its marketing efforts have included: two direct-mail campaigns (December 1988 and May 1989), one **direct-response** campaign (July 1989), and the use of agents to market the PPO.

All of the mixed model **PPOs** had planned to market to individual beneficiaries and retiree groups. But marketing to individuals, as **BCBS/AZ's** experience shows, may require many approaches and substantial resources. To date none of the mixed model **PPOs** has tried marketing to individuals. Whether mixed model **PPOs** can successfully negotiate contracts with a few large retiree groups will determine whether they can enroll enough beneficiaries to be viable.

The two **PPOs** that withdrew from the demonstration (**HealthLink** and **CareMark**) were unsuccessful at group enrollment. **CareMark's** projected group enrollment (more than 80 percent of its projected enrollment was to be from groups) declined by more than half one and a half years after its proposal was submitted, which was a factor in its decision to withdraw. Family Health Plan is optimistic about its ability to enroll retiree groups, but prospects for concluding these negotiations are uncertain.

b. **Benefits** Package

Benefits packages, for the demonstration sites are designed to provide incentives for beneficiaries (1) to enroll in the demonstration PPO and (2) to use PPO providers once enrolled'. The two main approaches the demonstration sites have used to entice beneficiaries to enroll are lower premiums and additional services such as free or discounted health screening, vision exams,

¹The benefit package for the nonenrollment model PPO and the group part of mixed model **PPOs**, provide incentives only for beneficiaries to use PPO providers since beneficiaries do not enroll in this type of PPO.

hearing exams, and drugs. **BCBS/AZ** has used both of these approaches and found that lower premiums were much more effective.

Lower premiums, more than any other incentives, attracted most of the enrollees in Senior Preferred, **BCBS/AZ's** Medigap PPO. In response to the repeal of the Medicare Catastrophic Coverage Act and trends in claims costs, **BCBS/AZ** increased the premium for Senior Security, its standard Medigap plan 44 percent, while increasing the premium for Senior Preferred only 24 percent. This created in a 30-percent price **difference** between the two plans and prompted the influx of more than 4,000 enrollees, most of whom switched from Senior Security to Senior Preferred.

To provide incentives for beneficiaries to use network providers, all the **PPOs** have guaranteed that the beneficiaries will not be balance billed when network providers are used (a demonstration requirement). The demonstration **PPOs** have also considered the following benefit provisions:

- Waiving the \$75 Part B deductible (all three benefit packages proposed by **CareMark**, and Family Health Plan's group-sponsored model)
- Replacing deductibles and coinsurance rates with copayments for physician visits (**CareMark's** individual benefit package, the **CareMark** and BCBSO supplemental plan package, and Family Health Plan's group-sponsored model)
- Offering annual cash rebates of \$50 or \$100 to encourage enrollees to use PPO physicians (Family Health Plan's classic employer model and proposed Medigap PPO model)
- Lowering the coinsurance rate when network providers are used (Family Health Plan's group-sponsored model and **HealthLink's** proposed benefit package)
- Waiving the Part A deductible when network hospitals are used (**BCBS/AZ only**)²

Although these incentives have not been thoroughly tested, it would seem that the first three provisions do not provide strong incentives to use network providers because they do not save the

²The other four demonstration sites received funds for HCFA, so they were not allowed to form a preferred hospital network. Since **BCBS/AZ** developed its plan independently of the demonstration and did not receive HCFA funds, it is able to offer a hospital network.

beneficiary much money. When the only incentive beneficiaries have to use network physicians **is** the guarantee that they will not be balance billed (as is true for CAPP CARE and **BCBS/AZ's** Senior Preferred), non-network physicians who also accept assignment may be equally attractive to beneficiaries.

The last two provisions--penalizing out-of-network use with a higher coinsurance rate and waiving the Part A deductible when network hospitals are used--have potentially higher monetary impact and thus may be more effective. Penalizing beneficiaries with higher coinsurance rates for out-of-network use can involve substantial sums of money for expensive Part B services such as **some** outpatient hospital surgical services. **HealthLink** initially proposed a stiff penalty (coinsurance of 10 percent for in-network use but 30 percent for out-of-network use), but withdrew this proposal after encountering **difficulties**. Waiver of the Part A deductible provides a strong incentive to use network hospitals, because the beneficiary can save the \$560 deductible for each hospital stay. Employers in a mixed model PPO may be able to more readily use these strong incentives. They are in **full** command of the benefits they offer to retirees and can alter their payment of the 20-percent of allowed charges that Medicare does not cover to create sufficient differences in the **costs** of services for which the beneficiary is liable to channel beneficiaries to network providers.

3. The **Physician Network**

To be viable the demonstration sites must not only attract enough enrollees but must put together a network of physicians large enough, and covering enough specialties, to attract and serve those enrollees. To contain costs, those physicians must practice conservative medicine.

Physicians generally agree to participate in the demonstration because they believe their patient volume and revenues will increase. To join the demonstration they must agree to do the following:

- Accept assignment
- Practice conservatively, the definition of which is usually determined by analyzing physicians practice patterns

- Comply with any utilization review requirements indicated by the PPO

So far, only **BCBS/AZ** and CAPP CARE have successfully organized a full network of demonstration physicians. Family Health Plan has met its goal of primary care physicians but is still recruiting some specialists. **HealthLink** had not begun actively recruiting physicians when it withdrew from the demonstration. **CareMark** found that its primary care physicians were not very interested in participating, which was one reason **CareMark** withdrew from the demonstration.

BCBS/AZ emphasizes having an efficient physician panel, which means carefully screening physician applicants and promptly **removing** high-cost physicians. The primary incentives for physicians to join the **BCBS/AZ** panel include the potential for increased business and direct payment of claims to the physician. Physicians who want to remain in the network have an incentive to practice conservative medicine because **BCBS/AZ** can terminate a physician contract at will with no waiting period. Senior Preferred has been successful in recruiting and maintaining its physician network--indeed, it has a waiting list of providers in most specialties.

Like **BCBS/AZ**, CAPP CARE has successfully recruited an adequate physician panel. In its first physician solicitation, 90 percent (795) of the Medicare participating physicians in CAPP CARE's private sector network signed up for the demonstration. A second solicitation to non-participating physicians yielded 93 more physicians during a short sign-up period. **CareMark's** primary care physicians apparently lost interest in the demonstration because they did not think its prospects for channeling beneficiaries to network physicians were good and did not **expect** to increase their earnings **significantly** by participating.

Physician recruitment in the demonstration will be successful if physicians believe that the demonstration will be viable and that their revenues (through increased patient volume) will increase. The **experiences** of **BCBS/AZ** and CAPP CARE as well as the early **experience** of Family Health Plan indicate that for a PPO with an **existing** network, recruiting physicians is not difficult as long as the PPO can offer a viable benefit package. To assess physician interest accurately it is important

at an early stage to educate the physicians fully about the demonstration and then to assess their interest, particularly the interest of primary care physicians since they usually manage the overall care of the patient.

4. Utilization Review

Except for **BCBS/AZ**, all the demonstration sites are using or have proposed using traditional UR mechanisms such as preadmission certification, and retrospective review for inpatient and ambulatory services. Family Health Plan, **HealthLink, and CareMark** have proposed using concurrent review; CAPP CARE, decided concurrent review would not be cost-effective for Medicare.

To support its UR approach, CAPP CARE relies heavily on sophisticated computer programs. Its retrospective reviews are completely automated.

BCBS/AZ relies on physician **profiling** from its private sector PPO to maintain cost-effective providers in Senior Preferred. **BCBS/AZ** maintains a database on physician activity, closely scrutinizes patterns of use and quality measures, establishes financial parameters for each specialty and dismisses from its panel any physician with large, unexplained, uncorrected deviations from the norm for health care **costs** for that specialty. Periodically, claims data for each physician are examined and those with particularly high aggregate claims costs (twice the average for that specialty) are investigated and sent a warning letter. So far in **1990, 30** warning letters about claims **costs** have been sent to physicians. Medicare claims are not used in **BCBS/AZ's** profiling.

The private-sector PPO industry tends to rely on aggressive day-today management of **UR**, particularly preadmission review. Langwell, **Carlton**, and Swearingen (1989) report that 78 percent of the **PPOs** that responded to the original Medicare PPO solicitation use preadmission certification as a UR mechanism, 51 percent perform concurrent inpatient reviews, 55 percent use retrospective inpatient review, and 44 percent require second opinions for selected surgical procedures. Only 23 percent make use of physician profiling in their UR programs. **AMCRA** (1990) does not provide data on physician profiling but points out the greater use of **hands-on** UR mechanisms in **PPO**

operations: 97 percent of the 183 **PPOs** responding use preadmission **certification** as a UR mechanism, 95 percent perform concurrent inpatient reviews, 85 percent use retrospective inpatient review, and 74 percent use mandatory second opinions for surgery. Table 1 displays the utilization management program components of the demonstration **PPOs** and the percent of **PPOs responding** to the Medicare PPO solicitation that employ the utilization management component in **their private-sector** PPO operations. Ambulatory review is a requirement of the demonstration and thus all **PPOs**, except **BCBS/AZ** which developed its PPO outside of, the demonstration, employ ambulatory utilization management.

5. Quality Assurance

All the demonstration sites are using or have proposed using patient grievance programs and reviews of medical records for quality assurance. Some also proposed patient satisfaction surveys. And CAPP CARE and **BCBS/AZ** have taken their programs a step further. **CAPP CARE** compares the pattern of services rendered by its network physicians on the top 20 Medicare diagnosis-related groups to industry standards. All of CAPP CARE's utilization review components have quality assurance components.

BCBS/AZ has supplemented its QA program with site visits to office and laboratory facilities. The adequacy of office staff is evaluated by a count of the number of employees and their professional backgrounds and the number of patients seen per hour. Laboratory facilities are reviewed for quality and inventoried for necessary equipment and supplies.

The **QA** programs at CAPP CARE and **BCBS/AZ** have similar objectives, which include giving physicians feedback on where they stand relative to a standard. Physicians are encouraged to modify their behavior, and **outliers** may be expelled **from** the panel.

TABLE 1

UTILIZATION MANAGEMENT PROGRAM COMPONENTS OF DEMONSTRATION PPOS

Component	BCBS/AZ	CAPPCARE	Family Health Plan ¹	HealthLink ¹	Care Mark ¹	PPOs responding to Medicare solicitation (percent)
Preadmission certification	No	Yes	Yes	Yes	Yes	78
Concurrent Inpatient Review	No	No	Yes	Yes	Yes²	51
Retrospective Inpatient Review	No	Yes	Yes	Yes	Yes	55
Mandatory Second Surgical Opinion	No	Yes	Yes	No	No	44
Discharge Planning	No	No	Yes	Yes	No	31
Case Management	No	No	Yes	Yes	Yes	N/A
Physician Profiling	Yes³	Yes	No	No	No	23
Preauthorization of Selected Ambulatory Procedures ⁴	No	Yes	Yes	Yes	Yes	29
Other Ambulatory Review ⁴	No	Yes	Yes	Yes	Yes	17

SOURCE OF ALL, PPOs: Langwell, Carlton, and Swearingen 1989.

¹Proposed

*Selected Services only

³Conducted as part of BCBS/AZ's private-sector PPO operations. No Medicare data is used.

⁴Demonstration requirement

C. IMPLEMENTATION EXPERIENCES

1. **Interface** with HCFA

Except for **HealthLink**, the **PPOs** were generally satisfied with their working relationship with HCFA. Despite a positive working experience, some frustration was expressed by most of the **PPOs**. Part of this frustration appeared to arise from different expectations between HCFA and the **PPOs**. HCFA was purposely not **specific** on benefit packages and other PPO components in order to encourage private sector creativity. This was sometimes viewed by the **PPOs** as HCFA not giving clear directions. It is noteworthy that **these** large **complex** institutions were able to proceed with these PPO innovations with minimal problems among the key factors.

2. Interface with the Carrier

When the demonstration PPO benefit design includes changes in the Medicare benefit structure, claims for demonstration enrollees must be flagged and processed differently than the other claims--and the demonstration PPO, carrier, and HCFA **must** cooperate closely to implement the claims processing. If the demonstration benefit package does not alter the Medicare benefit structure and if all demonstration network physicians are accepting assignment for demonstration enrollees, no major changes in the claims processing procedure are needed and implementation goes more smoothly.

Family Health Plan, Health Link, and **CareMark** proposed benefit packages that would change the Medicare Part B benefit structure. Only **CareMark**, HCFA, and Aetna (**CareMark's** carrier) actually worked through many of the processing changes that would have been required, however--because **CareMark** had made much earlier progress toward implementation than had Family Health Plan and **HealthLink**, both of which had to do feasibility studies before proceeding to implementation.

CareMark proposed an individual enrollee benefit package that replaced Medicare Part B deductible and coinsurance payments with a \$10 copayment. Cost estimates to modify Aetna's information system to process demonstration claims under the beat design approach ranged from **\$360,000** to **\$609,000**. A less expensive, but **trouble-prone** approach was to be implemented at **a cost** of **\$25,000** to **\$50,000**. The estimates would have been lower if the carrier's system had been newer and more flexible. **CareMark's** experience suggests that:

- The carrier must **modify** its information system when the demonstration benefit package changes the Medicare Part B benefit structure.
- Modifying the carrier's information system will be expensive and complicated if the system is inflexible. If the information system is new and flexible, the changes can be made much more easily.
- **HCFA**, the carrier, and the PPO should begin discussing any changes needed in the processing system as soon as the benefit design is defined. Prior to this the carrier should be consulted to estimate potential costs of benefit designs under consideration.
- An immediate, strong presence from **HCFA** is essential in these discussions if the carrier is reluctant *to* participate.

The broader **lesson** learned from comparing **CareMark's** experience to the experiences of **BCBS/AZ** and CAPP **CARE** is that carrier modifications require a substantial investment in time and effort. This **time** and effort may be better spent designing and marketing a benefits package that does not require carrier modification.

3. Interface **with** the PRO

A common concern among the 3 **PROs** that negotiated with the sites was possible **loss** of revenue from a reduction in their workload **once** the demonstrations began operations. The PRO often views the PPO as a competitor that is taking away some of its business. **In** Portland this concern was addressed to the PRO's satisfaction by increasing the PRO's revenues **from** another source--an increase in its validation sample. Another PRO-related issue was avoiding duplication of

work. These issues seem easier to resolve once the PRO no longer feels threatened about giving up some of its review responsibilities to the demonstration PPO. PRO issues were resolved both at CAPP CARE and at **CareMark**, although **CareMark** withdrew before final PRO modifications were completed.

D. FUTURE RESEARCH

Future research to be conducted under this evaluation will yield far more information about the viability and effectiveness of Medicare **PPOs**. Subsequent analyses **will** examine a broad range of issues for participants in the Medicare **PPO** demonstration. These analyses **will** include an examination of the beneficiaries' decision to **enroll** in the PPO and use network providers, whether **enrollees** are representative of all **beneficiaries**, and the impact of the PPO on the use and cost of services to Medicare beneficiaries. Preliminary results of these analyses will be available in April 1991 and **final** results in October **1992**. An analysis of the **feasibility** of **PPOs** for Medicare will be prepared in September 1992. Reports we will prepare under the evaluation contract include:

<u>Research Area</u>	<u>Date of Draft</u>
Status of the demonstration sites	Semi-annually (July and January)
Implementation of the demonstration (Final Report)	October 1991
Beneficiary choice and biased selection in enrollment	November 1991 (interim) October 1992 (final)
Impact of the PPO on the use and cost of services	November 1991 (interim) October 1992 (final)
Feasibility of PPOs for Medicare	September 1992
Summary of research findings	December 1992

VII. OBSERVATIONS

So far, the Medicare PPO demonstration has been a partial success. **Two PPOs** in the demonstration are operating and another hopes to start operations **soon**. This early **success** with implementation indicates that it is **possible** to incorporate **PPOs** into Medicare, thus adding another managed care option for Medicare beneficiaries. On the other hand, two **PPOs** have left the demonstration, giving reasons that show that implementing **PPOs** for Medicare can be a difficult task. It is an appropriate time to rethink some issues related to the PPO demonstration. We pose three issues for **HCFA's** consideration: 1) adding demonstration sites, 2) including Part A benefits, and 3) supporting employer group model **PPOs**.

Adding demonstration sites. For the Medicare PPO demonstration to provide reliable information about the program's effectiveness and **serve** as a guide for policy development, more sites or additional demonstrations are needed. Of the three sites remaining in the demonstration, two are operational and one could become so. Each of these sites represents a different enrollment model for potential replication in a national Medicare PPO program. Each site also represents unique circumstances in terms of marketing, benefit package, and other factors--and a single site cannot provide generalizable results. Each approach (enrollment model) should be tested in several sites to provide a sound basis for evaluating the effects of each PPO approach for Medicare and making future policy decisions. If HCFA is interested in the policy implications of one or more of these models, it should consider adding at least two more sites per model of interest or initiating **further** demonstrations. This demonstration was intended as a pilot phase with a decision to be made about whether to expand the demonstration. Now that two **PPOs** are operational, it may be time to make that decision.

Including Part **A benefits**. **AU** of the PPO personnel we interviewed asked to include both Part A and Part B services in the demonstration. (**BCBS/AZ** implicitly supports this **inclusion** by

contracting with hospitals.) The advantage of **including** all Medicare services, according to the **PPOs**, is that they can:

- More effectively manage Part B services for inpatient stays. Physician **services** related to hospital admissions are covered under Part B. Two **PPOs** want to perform concurrent review to manage these **services**.
- **Realize** savings on Part **A services** beyond those **realized** through the Prospective Payment System. Including Part A services in the demonstration could generate savings through 1) potential **discounts** on hospital services, 2) reduced **costs** for DRG **outliers** (about 6 **percent** of hospital expenditures (Ways and Means **1990**)), and 3) lower **DRG reimbursement** levels through lower-cost hospital stays in the long term.
- Provide a more attractive and marketable cost-containment package to any private-sector payers involved in the demonstration. Including Part A services may make savings more certain. Discounts and added benefits provided by the hospitals--such as **BCBS/AZ** hospitals waiving the Part A deductible may make the benefit package more attractive.

Whether through adding demonstration sites, initiating new demonstrations, or allowing the current demonstration sites to revise their package, HCFA should consider allowing **PPOs** to include Part A benefits.

Supporting employer group enrollment In the early design period of this demonstration, the target enrollee group was individual beneficiaries. But so far no PPO has marketed to individual beneficiaries, except for **BCBS/AZ's** Medigap-linked product. **CareMark, HealthLink, and Family Health Plan all** planned to enroll individuals but soon **focussed** on employer and insurer group enrollments. **The** main problem with an individual **enrollment** model PPO is developing a benefits package that is attractive to beneficiaries. Medicare beneficiaries who have already passed up Medigap insurance and **HMOs** are not likely to join a PPO without substantial incentives--such as lower monthly premiums. Marketing costs of individual enrollment would also be high.

HCFA may want to look more closely at the possibility of enrolling groups of beneficiaries through either employers or Medigap insurers. Incentives that HCFA could offer potential Medigap **PPOs** were examined in the recent **BCBS/AZ** status report (Nelson and others 1990). Medigap

industry representatives indicated interest in the Medigap PPO concept, according to that report, but said the current financial incentives to enter the market are small, since most of the savings generated **by** a Medigap PPO would accrue to the Medicare **program**. Industry representatives expressed the view that any savings captured by the Medigap insurer would be largely, if not totally, **offset** by the lower premiums and other incentives needed to attract enrollees. These industry representativea **identified** several steps the government could take to make **Medigap PPOs** more viable and effective.

These included:

- providing the Medigap insurer **with** easier, cheaper access to the claims data required for utilization management and quality assurance
- clarifying whether Medigap **PPOs** are allowed to negotiate with hospitals to obtain waivers or reductions in deductibles and coinsurance
- modifying the National Association of Insurance Commissioners (**NAIC**) model regulations so it is easier for Medigap **PPOs** to penalize enrollees for receiving care outside the network
- covering part of the Medigap **PPO's** administrative costs
- paying more than 80 percent of allowed charges when enrollees obtain care from a network physician

In addition, some insurers have expressed interest in a risk-sharing arrangement with HCFA, in which the larger share of any savings or losses generated would accrue to the Medigap PPO. In return for its investment in these incentives, **HCFA** would benefit from **the** utilization review of the Medigap **PPOs**. Since HCFA pays the bulk of health care costs for beneficiaries, it would also save the most if **service** use is reduced.

For employer group model **PPOs**, the incentives may be different and easier for HCFA to support. In light of rapidly increasing health care costs and the new FASB regulations, employers are concerned about cutting their health care costs for retirees. The demonstration experience so far has shown that employers are interested in managed care for their retirees. Unlike Medigap insurance companies—which value competitiveness, profits, and the like when considering a Medicare

PPO--employers are concerned only with providing adequate benefits to their retirees at the lowest cost. Insurance is not their business. These employers would realize the full impact of savings from managed care. They have no need to return the savings to beneficiaries, unless retirees are paying for part of the premiums. Since they have a captured population they have no expenses for enrollment incentives. So for employer groups potential PPO savings may be sufficient to cover administrative costs.

Generating savings in an employer group model may be easier than in a Medigap PPO. Employers are in a much better position **than** Medigap insurers to channel **beneficiaries** to PPO providers. Employers and labor organizations are exempt from **NAIC** model regulations, so they can institute penalties for non-network use. According to analyses done by the **PPOs**, a benefits package that covers all coinsurance for network use but asks for **20-percent** coinsurance from the beneficiary for non-network providers would be strong enough to channel beneficiaries to network providers. The one incentive HCFA may want to shy away from is adjusting the standard Medicare benefits-for example, paying more than 80 percent of allowed charges. Such incentives are attractive to insurers and employers, but the costs in benefits and in changes in carrier systems may be prohibitive.

If HCFA assumes the costs of PPO operations for demonstration sites, the costs to employers would be minimal. HCFA may continue to bear the costs of PPO operations in this demonstration or an expanded demonstration, or it **could** shift these **costs** to the employers, which would be desirable if a national policy were adopted. But, savings to employers would have to be well documented to justify funding Medicare **PPOs** entirely. One thing HCFA must do to support employer group **PPOs** is ensure the flow of claims data to the **PPOs**. Without these data adequate utilization management is impossible. HCFA must also assure employers (and **PPOs**) of its long-term support for employer group PPO operations and the longevity of any **incentives** it provides. Again, for its expenditures on incentives, HCFA would reap the majority of any savings through utilization review.

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APPENDIX A

CHARACTERISTICS OF THE PPO MARKET

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CHARACTERISTICS OF THE PPO MARKET

Characteristic	BCBS/AZ	CAPP CARE	CareMark Family	Health Plan	HealthLink	Large Metropolitan Counties (Mean) N=306
Total population	2,579,000	2,219,100	1,109,000	2,167,300	2,437,400	417,700
Total percentage of the population who are Medicare beneficiaries	13.2	9.6	13.0	10.5	13.3	13.0
Per capita income^a	\$15,519	\$21,444	\$15,817	\$18,992	\$15,239	\$14,773
Active physicians per 1,000 persons^a	2.36	2.53	3.36	2.89	1.86	2.30
Inpatient surgeries per 1,000 persons^a	48.99	37.22	69.23	57.86	42.92	65.30
Outpatient surgeries per 1,000 persons^a	37.93	31.85	76.92	52.37	41.70	57.46
Medicare hospital admissions per 1,000 beneficiaries ^a	349	321	320	279	308	428
Medicare hospital days Per 1,000 beneficiaries ^a	2,594	2,429	2,069	2,020	2,986	3,745
Medicare part A reimbursements per beneficiary^a	\$1,490	\$1,760	\$1,175	\$1,016	\$1,905	\$1,525
Medicare part B reimbursements per beneficiary^a	\$1,001	\$1,333	\$613	\$465	\$852	\$881

SOURCE: March 1990 Bureau of Health Professions Area Resource File (ARF).

NOTE: Data for the PPO market areas are the mean of each county in the demonstration, weighted by expected enrollment. Population is the sum of county populations; **this** and percent Medicare beneficiaries are not weighted. All counties in the **HealthLink** market area are weighted equally because enrollment was not broken down by county. Large metropolitan counties are the largest county in each metropolitan area in the U.S.

^a Weighted

APPENDIX B

LIST OF ACRONYMS

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AAPPO	American Association of Preferred Provider Organizations
AMCRA	American Managed Care and Review Association
ARF	Area Resource File
BCBS/AZ	Blue Cross and Blue Shield of Arizona
BCBSO	Blue Cross and Blue Shield of Oregon
DRG	Diagnosis Related Group
FASB	Financial Accounting Standards Board
FI	Fiscal Intermediary
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
NAIC	National Association of Insurance Commissioners
NHI	Northwest Health, Inc.
OMPRO	Oregon Medical Professions Review Organization
PERS	Public Employees Retirement System
PPO	Preferred Provider Organization
PRO	Peer Review Organization
QA	Quality Assurance
SNF	Skilled Nursing Facility
UR	Utilization Review