Approved February 12, 1990
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Dale Sprague at
Chairperson

3:30 xx a.m./p.m. on February 7, 19 90 in room 531-n of the Capitol.

All members were present except:

Committee staff present: Chris Courtwright, Research Department
Emalene Correll, Research Department
Bill Edds, Revisor of Statutes
Patti Kruggel, Committee Secretary

Conferees appearing before the committee:

see attached list

The meeting was called to order at 3:40 p.m.

Jerry Slaughter, Kansas Medical Society requested that the Committee recommend introduction of a bill (Attachment 1)intended to correct a technical flaw found in SB 18, relating to coverage for self-insured residents.

Representative Helgerson made a motion to introduce the bill. Representative Brown seconded. The motion carried.

The Chairman began the series of Topic Briefings in which the Committee is expected to hear from several conferees knowledgeable in each of their particular areas of health care coverage.

Rich Huncker, Insurance Department gave an overview of the issuance of health insurance coverage and explained the various methods health care protection can be provided to the residents of this state (Attachment 2.)

Joel Frisch, George Lahood and Associates, appeared as a third party administrator which provides administration solely for health care plans and principally in the single employer marketplace. Mr. Frisch stated their role in regard to self-insured groups and some of the characteristics of those groups.

Mike Mattox, Blue Cross/Blue Shield provided testimony (Attachment 3) which explained the four classes of health insurance coverage offered by their company and the background information: eligibility, benefit options, underwriting regulations, and rating methodology for each class.

Written testimony (Attachment 4) was provided by Keith Hawkins, Pyramid Life stating that as a domestic insurer which markets individual health insurance it is a constant struggle to provide "affordable" health insurance to individuals and families not other wise covered by an employer. Mr. Hawkins explained that individual insurance has generally been more expensive than group because of the size of the market and the limited ability to spread the risk.

MINUTES OF THE House COMMITTEE ON Insurance,

room 531-N, Statehouse, at 3:30 xxm./p.m. on February 7, 89.

Cheryl Dillard, Kansas HMO Association provided a brief description of Health maintenance organizations (HMOs) and its operations in Kansas(Attachment 5). Ms. Dillard explained the concept of HMO's is to organize health delivery into a local, efficient system that emphasized prevention and early treatment of disease, and monitoring to assure quality of care and appropriateness of treatment.

Next appearing was Marlin Dauner, Preferred Provider Organizations (PPOs). Mr. Dauner provided testimony (Attachment 6) which explained the entity through which a partnership is developed between providers, health care physicians, hospitals and other providers with an insurer, third party administrator, a union trust or an employer that is self funded. He stated that a PPO basically provides a network of providers who agree to accept discounted prices and utilization management programs to try to restrain the rate of increase in the cost for their group in their benefit programs.

There were no others wishing to testify and the briefings were concluded.

The meeting was adjourned at 5:25 p.m.

GUEST LIST

COMMITTEE: HMO Committee DATE: 2/7/90

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Maggie L Goodman	Kansas City	Kansas HMO Assoc.
Cheryl Dillard	Kansas City	Kaiser Permanente
Robert B. Fisher, Jr.	Overland Park	Prime Health
Allan J. Dinkel	Oakley KS	[illegible]
Keith Hawkins	6201 Johnson Dr, Mission, KS	Pyramid Life
Kelly Waldo	Topeka	KCA
Jerry Leopold	McPherson	Ks. Optometric Assn.
ALAN COBB	WICHITA	KS Respiratory Care Soc.
Marlon Daumen	Wichita	Preferred Health Care
MICHAEL MATTOX	TOPEKA	Blue Cross/Blue Shield KS
Jack Roberts	"	"
William Pitsenberger	"	BC BS
Bob Williams	Topeka	KS Pharmacists Assn
Joe Burmeister	Atchison	
Ron Samuelson	Lawrence	KS Optometric Assn
Mary E. Whitty	Lawrence	KS Pharmacists Assn.
JOEL FISCH	O.P. KS	LAHOOD & ASSOC.
JIM OLIVER	TOPEKA	PIA
Shirley MARKHAM	TOPEKA	MR DRG Programs

Law Review and Bar Journal References:

"Practical and Constitutional Challenges to the 1985 Kansas Medical Malpractice Legislation," Edward J. Guid[illegible]d Keith L. Mark, 25 W.L.J. 304, 306 (1986).

[illegible]s of McGuire vs Sifers," Richard Cordry, Vol. [illegible]1, J.K.T.L.A. 21 (1984).

[illegible]s, 'Crisis,' and Constitutionality—Evaluating the 1986 Kansas Medical Malpractice Legislation," Elizabeth Schartz, 35 K.L.R. 763, 772 (1987).

Attorney General's Opinions:

Self-insurance for residents by university of Kansas Medical Center. 85-73.

Maintenance of insurance as condition to rendering services in state. 85-92.

CASE ANNOTATIONS

4. Cited; ambulance services as professional services and exempt from bidding requirements in home rule statute (19-214) examined. Curtis Ambulance v. Shawnee Cty. Bd. of Cty. Com'rs, 811 F.2d 1371, 1381 (1987).

5. Cited; statutes (60-3407, 60-3409, 60-3411) limiting recovery in medical malpractice actions as unconstitutional examined. Kansas Malpractice Victims Coalition v. Bell, 243 K. 333, 345, 757 P.2d 251 (1988).

40-3403. Health care stabilization fund, e[illegible]blishment and administration; board of g[illegible]nors; liability of fund; payments from fund; qualification of health care provider for coverage under fund, termination; liability of provider for acts of other providers; university of Kansas medical center private practice foundation reserve fund, establishment, transfers from; provider coverage options, election; eligibility of psychiatric hospitals and certain inactive providers for coverage. (a) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall admini[illegible]the fund or contract for the administration o[illegible] fund with an insurance company authorized to do business in this state.

(b) (1) There is hereby created a board of governors. The board of governors shall:

(A) Provide technical assistance with respect to administration of the fund;

(B) provide such expertise as the commissioner may reasonably request with respect to evaluation of claims or potential claims;

(C) provide advice, information and testimony to the appropriate licensing or disciplinary authority regarding the qualifications of a health care provider; and

(D) prepare and publish, on or before October 1 of each year, a summary of the fund's activity during the preceding fiscal year, including but not limited to the amount collected from surcharges, the highest and lowest surcharges assessed, the amount paid from the fund, the number of judgments paid from the fund, the number of settlements paid from the fund and the amount in the fund at the end of the fiscal year.

(2) The board shall consist of 14 persons appointed by the commissioner of insurance, as follows: (A) The commissioner of insurance, or the designee of the commissioner, who shall act as chairperson; (B) two members appointed from the public at large who are not affiliated with any health care provider; (C) three members licensed to practice medicine and surgery in Kansas who are doctors of medicine; (D) three members who are representatives of Kansas hospitals; (E) two members licensed to practice medicine and surgery in Kansas who are doctors of osteopathic medicine; (F) one member licensed to practice chiropractic in Kansas; (G) one member who is a licensed professional nurse authorized to practice as a registered nurse anesthetist; and (H) one member of another category of health care providers. Meetings shall be called by the chairperson or by a written notice signed by three members of the board. The board, in addition to other duties imposed by this act, shall study and evaluate the operation of the fund and make such recommendations to the legislature as may be appropriate to ensure the viability of the fund.

(3) The board shall be attached to the insurance department and shall be within the insurance department as a part thereof. All budgeting, purchasing and related management functions of the board shall be administered under the direction and supervision of the commissioner of insurance. All vouchers for expenditures of the board shall be approved by the commissioner of insurance or a person designated by the commissioner.

(c) Subject to subsections (d), (e), (f), (i), (k) and (m), the fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any personal injury or death arising out of the rendering of or the failure to render professional services within or without this state; (2) subject to the provisions of subsection (m), any amount due

Attachment 1

from a judgment or settlement which is in excess of the basic coverage liability of all liable nonresident health care providers or nonresident self-insurers for any such injury or death arising out of the rendering or the failure to render professional services within this state but in no event shall the fund be obligated for claims against nonresident health care providers or nonresident self-insurers who have not complied with this act or for claims against nonresident health care providers or nonresident self-insurers that arose outside of this state; (3) subject to the provisions of subsection (m), any amount due from a judgment or settlement against a resident inactive health care provider for any such injury or death arising out of the rendering of or failure to render professional services; (4) subject to the provisions of subsection (m), any amount due from a judgment or settlement against a nonresident inactive health care provider for any injury or death arising out of the rendering or failure to render professional services within this state, but in no event shall the fund be obligated for claims against: (A) Nonresident inactive health care providers who have not complied with this act; or (B) nonresident inactive health care providers for claims that arose outside of this state, unless such health care provider was a resident health care provider or resident self-insurer at the time such act occurred; (5) reasonable and necessary expenses for attorney fees incurred in defending the fund against claims; (6) any amounts expended for reinsurance obtained to protect the best interests of the fund purchased by the commissioner, which purchase shall be subject to the provisions of K.S.A. 75-3738 through 75-3744, and amendments thereto, but shall not be subject to the provisions of K.S.A. 75-4101 and amendments thereto; (7) reasonable and necessary actuarial expenses incurred in administering the act, including expenses for any actuarial study contracted for by the legislative coordinating council, which expenditures shall not be subject to the provisions of K.S.A. 75-3738 through 75-3744, and amendments thereto; (8) annually to the plan or plans, any amount due pursuant to subsection (a)(3) of K.S.A. 40-3413 and amendments thereto; (9) reasonable and necessary expenses incurred by the insurance department and the board of governors in the administration of the fund; (10) return of any unearned surcharge; (11) reasonable and necessary expenses for attorney fees and other costs incurred in defending a person engaged or who was engaged in residency training or the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center from claims for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider; (12) notwithstanding the provisions of subsection (m), any amount due from a judgment or settlement for an injury or death arising out of the rendering of or failure to render professional services by a person engaged or who was engaged in residency training or the private practice corporations or foundations and their full-time physician faculty employed by the university of Kansas medical center; (13) reasonable and necessary expenses for the development and promotion of risk management education programs; (14) notwithstanding the provisions of subsection (m), any amount owed pursuant to a judgment or settlement for any injury or death arising out of the rendering of or failure to render professional services by a person, other than a person described in clause (12) of this subsection, who was engaged in a post-graduate program of residency training approved by the state board of healing arts, and but who, at the time the claim was made, was no longer engaged in such residency program.

(d) All amounts for which the fund is liable pursuant to subsection (c) shall be paid promptly and in full except that, if the amount for which the fund is liable is $300,000 or more, it shall be paid, by installment payments of $300,000 or 10% of the amount of the judgment including interest thereon, whichever is greater, per fiscal year, the first installment to be paid within 60 days after the fund becomes liable and each subsequent installment to be paid annually on the same date of the year the first installment was paid, until the claim has been paid in full. Any attorney fees payable from such installment shall be similarly prorated.

(e) In no event shall the fund be liable to pay in excess of $3,000,000 pursuant to any one judgment or settlement against any one health care provider relating to any injury or death arising out of the rendering of or the failure to render professional services on and after July 1, 1984, and before July 1, 1989, subject to an aggregate limitation for all judgments or settlements arising from all claims

, but not less than the required basic coverage limits,

at the time of the occurrence

1-2

Kansas Insurance Department

Testimony Before the

House Insurance Committee

Presented by Rich Huncker

February 7, 1990

Overview of the Issuance of Health Insurance Coverage

The following is the various methods health care protection can be provided to residents of this state.

Generally, health insurance coverage can be obtained on either an individual or group basis. Group insurance is an arrangement for insuring a number of people under a single, "master" insurance policy. The purchaser, usually an employer or association, is the policyholder; group members receive certificates under the policy. Group plans can be written to provide just about any kind of health insurance. Group medical-expense insurance (hospital, medical-surgical, and major medical) is probably most common and accounts for by far the largest premium volume in group insurance. Group benefits vary widely from policy to policy. Most insurers offer several different group plans. If the group is large enough, the group policyholder and the insurer may negotiate a unique package of benefits.

Individual policies of health insurance are generally issued to meet particular insurance needs. Quite often, individual policies are

Attachment 2

purchased to supplement benefits of a group or government plan, or to obtain coverage for a specific type of protection. For instance, the largest market in individual health insurance is that of Medicare Supplement insurance. Also, persons who need primary protection through individual policies are those not covered by group or government plans. Typical of this group are self-employed persons, students no longer covered by their parents' insurance, and persons under age 65 and not in the work force, such as early retirees, divorcees, and persons between jobs.

There are generally five types of insurers which offer health insurance coverage. These include commercial insurance companies, fraternal benefit societies, health maintenance organizations (HMOs), non-profit hospital and medical service corporations which are commonly known as Blue Cross and Blue Shield, and self-insurers. With respect to individual health insurance, companies sell their products by means of an agent and/or by direct mail. Companies offering group health insurance coverage sell their products by means of an agent or through salaried representatives.

Commercial insurance companies traditionally cover medical expenses on a "reimbursement" basis - that is, they reimburse the individual for medical expenses already incurred, up to the limits of the policy. Blue Cross and Blue Shield uses the "service" approach. The person (subscriber) insured by Blue Cross and Blue Shield is promised that, during a given number of days of hospital confinement, the company will provide for certain hospital services. Blue Cross and Blue Shield plans cover the medical and surgical services of participating and non-participating providers. Participating providers who sign up with

the company agree to accept a specific fee for their services. The company pays directly to them for services rendered. Reimbursement for non-participating provider services are made directly to the subscriber and the amount of reimbursement is specified in the subscriber's contract. Blue Cross and Blue Shield writes plans on both an individual and group basis. There are two Blue Cross and Blue Shield plans in Kansas, each of which operates within a certain plan service area. Blue Cross and Blue Shield of Kansas, Inc. serves 103 counties in Kansas, and Blue Cross and Blue Shield of Kansas City serves the counties of Johnson and Wyandotte in Kansas.

Fraternal benefit societies are social organizations that provide insurance for their members. Health insurance coverage provided by fraternal benefit societies is written on an individual basis. Since the insurance offered by fraternal benefit societies is available to only a limited group (members of the society), there are separate laws governing their insurance activities. The purpose of these insurance laws, however, is generally the same as those governing commercial companies: to ensure that the organization has the financial capacity to meet all of its insurance commitments.

A self-insured plan is an alternative to a fully insured group health insurance plans. Section 514 of the 1974 Employees Retirement Income and Security Act (ERISA) preempts all state laws pertaining to employee benefit plans. The courts have interpreted this as exempting self-insurance plans from state regulation. Therefore, some employers seriously consider self-insured plans in order to save premium taxes, improve cash flow through the use of money otherwise held by the insurer as reserves, and avoid providing state mandated benefits. Others see

self-insuring as a way to take advantage of their own good claims experience. The employer considering a self-insured plan must weight these advantages against the cost of additional management and administrative resources required and loss of insurance company expertise in such areas such as claim payment and cost containment.

Health maintenance organizations (HMOS) are organized systems of health care delivery available to individuals residing in a specific geographic area. They provide comprehensive medical care to a group of enrollees for a predetermined, periodic payment. HMOs may be organized in several forms. The main ones are:

1. Staff Model - Physician services are provided through a multi-specialty physician group practice by a salaried staff of full-time HMO physicians.

2. Group Model - Physician services are provided through a multi-specialty group practice that is a separate entity from the HMO with which it contracts to provide physicians' services. Group Model HMOs in Kansas are Prime Health Kansas City and Kaiser Foundation Health Plan of Kansas City.

3. Individual Practice Associations (IPAs) - Physician services are provided by an association of individual physicians (a mixture of solo and group practices) on a negotiated per-capita rate, flat retainer fee, or negotiated fee-for-service basis. All HMOs operating in

Kansas except Prime Health and Kaiser are considered to be IPA models.

In theory, HMOs have a strong incentive to encourage preventative medicine. By keeping their enrollees healthy and detecting illnesses early, more expensive later treatment can be avoided and hospitalization can be reduced.

The newest form of alternative health care delivery system is the preferred provider organization. They are a creation of the current competitive environment in the field of health care. All PPOs in existence today employ the concept of negotiating between the provider community (doctors and hospitals) and the payer community (employers, government and insurers).

The providers which may be involved in a PPO arrangement include a panel of physicians and one or more hospitals. The physicians and hospitals agree with the PPO (1) to charge set fees which may be discounted and (2) to accept certain standards of utilization of medical services to contain costs. The payor agrees to a more favor payment basis, i.e. waiving deductibles or coinsurance, when the employee uses one of the preferred providers. If the employee goes to a non-preferred provider, a portion of his medical expense will not be covered. On May 1, 1985 K.S.A. 40-231 was amended to allow commercial insurance companies to enter into contracts with health care providers and PPO's for a negotiated system of payment.

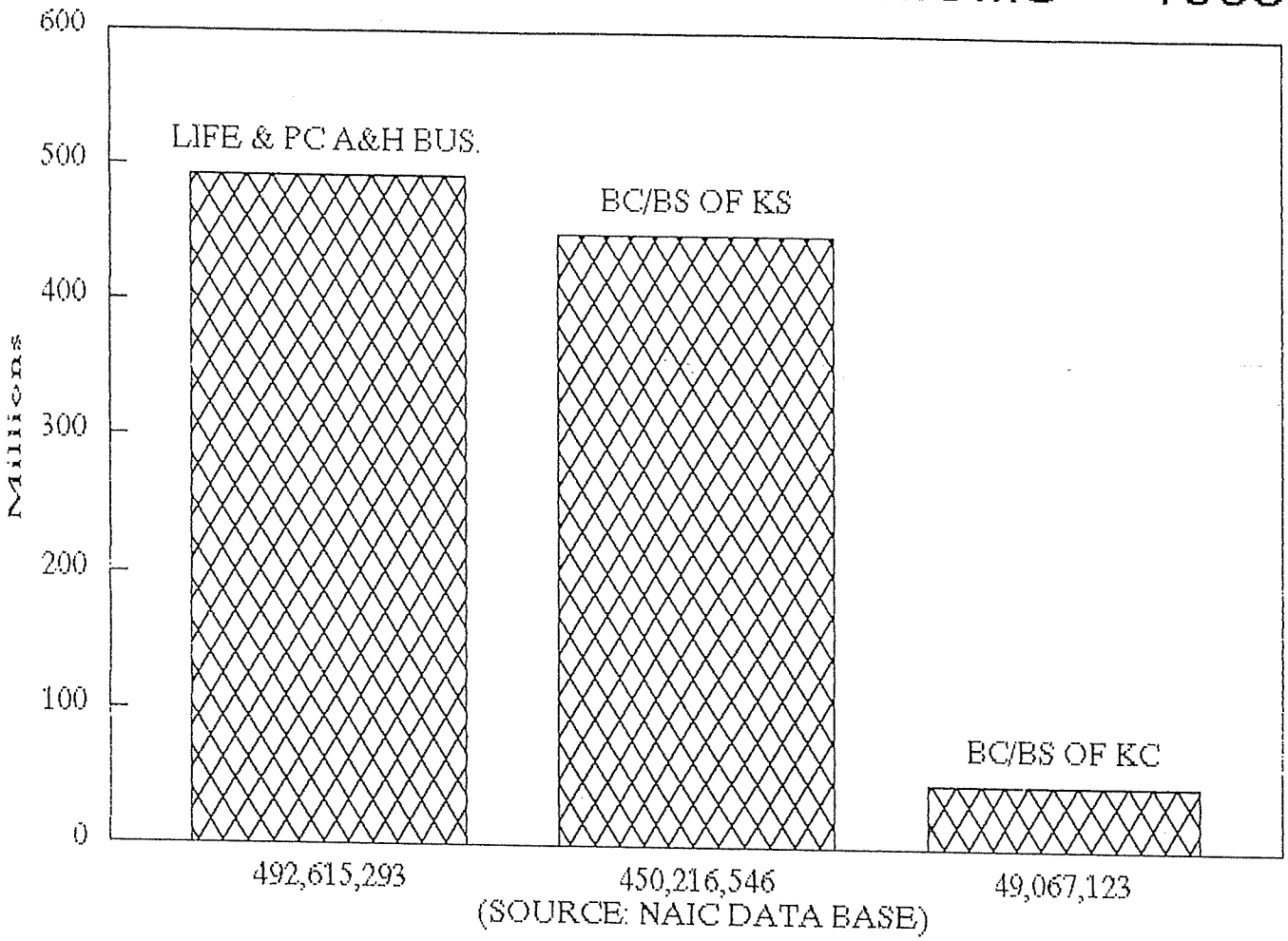
The Insurance Department is charged with the general supervision and regulation of all matters relating to the writing of accident and

sickness insurance by insurance companies, corporations and societies licensed for such business in Kansas. As of December 31, 1989, there were 935 insurance organizations licensed to transact the business of accident and health insurance in Kansas. In addition to commercial insurance companies, we regulate 14 health maintenance organizations, 2 Blue Cross and Blue Shield Organizations, 1 non-profit dental service corporation and 1 non-profit optometric service corporation.

BW:crah

1676/REPOR

HEALTH INSURANCE PREMIUMS – 1988



(SOURCE: NAIC DATA BASE)

HOUSE INSURANCE COMMITTEE MEETING
3:30 p.m., February 7, 1990
Testimony By Blue Cross and Blue Shield of Kansas

Thank you, Mr. Chairman and members of the House Insurance Committee, for extending to me the opportunity to provide comments on traditional health insurance.

My name is Michael Mattox. I serve as the Vice President of Marketing for Blue Cross and Blue Shield of Kansas. Our Plan serves all counties in Kansas with the exception of Johnson and Wyandotte counties who are served by the Kansas City, Missouri Blue Cross and Blue Shield Plan.

Blue Cross and Blue Shield of Kansas has four general classes of traditional health insurance: non-group, group, conversion, and complementary. The following description provides background information (eligibility, benefit options, underwriting regulations, and rating methodology for each class).

NON-GROUP

Eligibility:

Individual contracts are made available to all Kansans under 65 years of age.

Benefit Options:

Benefit options for non-group enrollment consists of two programs; a $500 and a $1,000 deductible comprehensive major medical program.

NON-GROUP (continued)

Underwriting Regulations:

The applicant is required to complete a health statement. Upon the medical department's review of that health statement, pre-existing health conditions are noted and are ridered out for future benefits. Ridered conditions waiting periods consist of two years, five years, or lifetime durations depending on the medical condition. The applicant is then advised of the riders that were placed on their contract so that they can determine whether they want to purchase coverage from our firm. With this procedure we insure that the client knows exactly what benefits they will be entitled to receive.

Rating:

Pool rated; By age.

GROUP

Eligibility:

Blue Cross and Blue Shield of Kansas has two classes of group coverage. The first class is "true" group which means the enrolled group will have five or more subscribing contracts under the age of 65. The second class is association enrollment. If a Kansas based association (professional, trade or chamber of commerce) sponsor Blue Cross and Blue Shield then the association unit (business) is entitled to group benefits that would be otherwise only available to businesses of five or more employees.

Benefit Options:

Multiple

GROUP (continued)

Underwriting Regulations:

The underwriting regulations consist of two classes -- small group (1 through 9 contracts) and large group (10 or more contracts).

° 1-9 Contracts:

For new groups we require a health risk analysis to be completed by all potential applicants of the group. Once the health risk analyses are reviewed for each individual applicant, we establish a risk factor associated with the entire group's health risk. Rates are then produced to reflect this risk. I should mention that Blue Cross and Blue Shield of Kansas does not turn away or refuse coverage for individual employees within a group as a result of their health conditions. This practice is currently widespread in many of the multiple employer trusts operating within the state of Kansas. I should also point out upon assessment of the risk of the entire group that if we determine the risk to be uninsurable, then we would refuse to provide benefits for the entire group not singling out an individual from within the group. An additional underwriting regulation we require is that the employer have 100% participation by eligible employees in their program. We determine eligibility to be all employees who do not have group coverage (Blue Cross and Blue Shield or commercial coverages) elsewhere.

GROUP (continued)

Underwriting Regulations (continued)

° 10 or More Contracts:

We do not require health risk analyses for groups of 10 or more on the basis that the groups typically will be large enough to provide us with a proper cross-section of risk. Our quota guidelines dictate that the employer must have 75% of the eligibile employees participating. Eligible employees, as with the small groups, means that those employees who have group coverage elsewhere do not count against the group's quota.

Rating:

All groups are merit rated. Simply stated this means each individual group's claims utilization experience dictates the premium needed for that respective group. For groups of 1 through 49 contracts, we employ prospective rating; and for groups of 50 or more contracts, we utilize retrospective rating. Large groups are also extended the opportunity to partially self-insure (PSF) or purchase administrative services only (ASO) from our organization.

CONVERSION

Eligibility:

All group subscribers who terminate their group coverage are eligible. Typically we find that when a group subscriber exhausts their entitlements under Senate Bill 704 (extends group coverage at group rates for a period of six months) or COBRA (extends group coverage at group rates for a period of 18 or 36 months depending on the qualifying event), the subscriber then makes the decision of opting for the non-group conversion program which requires no health questionnaires, or the non-group program which requires they complete a health statement.

Benefit Options:

The benefit options that are available for the non-group conversion program are no deductible 80/20 basic Blue Cross and Blue Shield with a supplemental major medical contract, or a $1,000 deductible comprehensive major medical contract.

Underwriting:

No health screenings are required for the non-group conversion contract.

Rating:

Pool rated; By age.

COMPLEMENTARY

Eligibility:

Over age 65 or Medicare disabled.

Benefit Options:

Plan 65 is a Medicare supplemental program. Plan D is a Medicare disability supplemental program. Medicare Exclusion Rider (MER) has multiple options available depending on the subscriber's group benefits. The MER program entitles the subscriber to the same benefits as group participants under age 65.

Underwriting Regulations:

All applicants are eligible when they first reach age 65 or when approved by Medicare for disability with no health screening. For those individuals who do not apply to participate at their 65th birthday, we provide a three-month annual reopening period when these applicants can make application with no health screening.

Rating

Pool rated; By age for Plan 65 and Plan D. MER is pool rated; By type benefit.

Mr. Chairman, two questions were raised at the hearing that I was requested to provide responses to. The first question was directed at what rates were we typically charging groups for their benefit programs? With over 17,000 groups enrolled in Blue Cross and Blue Shield of Kansas and each having different benefits and rates, this request becomes omnibus at best. As a compromise I am providing the most common benefit program and base rates that Blue Cross and Blue Shield of Kansas is utilizing for the 1990 plan year. One must keep in perspective that these are base rates and the actual claims experience of each specific group will dictate the premiums charged for that group.

Benefits: The most common group program offered by Blue Cross and Blue Shield of Kansas is a $200 deductible (single), $400 deductible (family) comprehensive major medical with a coinsurance maximum (out-of-pocket exposure by the subscriber) of $200 single and $400 family per contract year. Taking both components into consideration; that being the deductible and coinsurance, the maximum annual exposure for a single contract would be $400 and for a family contract $800.

Rates: 1990 base rates are $203.00 per month for a single contract; $432.00 per month for a family contract.

The second question was directed at our previous testimony that was given at the Joint House and Senate session. I have been informed by staff that the answers to these questions will be provided to your committee by separate memorandum.

Mr. Chairman, I have also included for the benefit of the committee brochures for our Plan 65, Plan D, non-group Afforda-Care and non-group conversion programs for your review. If I may provide additional information regarding my testimony, please do not hesitate in contacting me. Again, I would like to express my appreciation for having the opportunity to provide comments regarding Blue Cross and Blue Shield of Kansas' traditional insurance programs.

Thank you.

Tried and True — Blue Cross and Blue Shield of Kansas Plan 65.

For most of us, Medicare will be the single most important part of our health care plans.

Since Congress repealed the Medicare Catastrophic Coverage Act in November 1989, a good supplemental health insurance policy, like Plan 65, is essential.

For more than 20 years, Blue Cross and Blue Shield of Kansas has offered Kansans Plan 65 to help cover many expenses Medicare doesn't. Medicare has changed through the years, however, you can be assured today's Plan 65 gives you the up-to-date coverage and peace of mind people have come to expect from Blue Cross and Blue Shield of Kansas.

This booklet is designed to answer many of your questions about Medicare and Plan 65.

What's inside

- What you need to know first
- Care outside the United States
- How to enroll in Plan 65
- Medicare and Plan 65 coverage at a glance
- Limitations of coverage
- How much Plan 65 costs
- How to file a claim
- And, where to get more information

What you need to know first

You need Medicare. There are two parts to Medicare:

- Hospital Insurance (Medicare Part A) is designed to help pay for the cost of hospitalization and related services.

- Medical Insurance (Medicare Part B) is for medical-surgical and outpatient services. Nearly everyone age 65 and over is eligible to receive these benefits and is automatically enrolled.

Then you need Plan 65 offered by Blue Cross and Blue Shield of Kansas.

Plan 65 provides some benefits not included in the hospital and medical insurance programs of Medicare. **Plan 65 does not provide benefits which are available through Medicare, even though the applicant may not be covered under Medicare.** This is why it is important for you to have the medical insurance program of Medicare.

If you are not enrolled in Medicare, we urge you to contact your local Social Security office for the details of Medicare benefits and the rates. Medicare and Plan 65 benefits are described on the following pages of this booklet.

Care received outside the United States

When Medicare coverage is not available outside the United States, Plan 65 hospital coverage is provided for 120 days per spell of illness for covered inpatient care or the hospital's charges for covered outpatient care.

When Medicare coverage is not available outside the United States, Plan 65 medical-surgical coverage is provided up to a maximum payment of $1,000 each calendar year for covered services. Coverage is subject to the limitations shown in your contract.

You must be traveling (not residing) in the foreign country for these benefits to be available.

How to enroll in Plan 65

All Kansans except those in Johnson and Wyandotte counties age 65 and over may enroll in Blue Cross and Blue Shield of Kansas Plan 65.

Existing subscribers:
If you are already enrolled in Plan 65, you do not need to fill out an application card or any other form of communication. If you are presently enrolled in regular Blue Cross and Blue Shield of Kansas coverage, you will be automatically transferred to Plan 65, at age 65, unless you notify us to the contrary or unless your group has a special retiree program.

New applicants:
You may apply for Medicare benefits and Plan 65 anytime during the 60 days prior to your 65th birthday, and for 60 days following your 65th birthday. For those missing their first opportunity to enroll, a Plan 65 open enrollment period is usually held once each year. Call one of the telephone numbers on the back of the booklet to receive an application.

There is no health statement, and no health conditions are excluded for anyone enrolling in Plan 65 when they first become eligible. If both you and your spouse are 65 years of age or over and not presently enrolled, two application cards must be completed.

Dependents under age 65

Existing subscribers:
Your spouse may keep the present coverage on a single membership or a family membership if there are unmarried dependent children. Most Blue Cross and Blue Shield of Kansas contracts currently cover unmarried dependents to age 23. However, be sure to check you contract. Write Blue Cross and Blue Shield of Kansas for rate information.

New subscribers:
Your spouse under age 65 and unmarried children under age 23 can apply for regular Blue Cross and Blue Shield of Kansas coverage when you apply for Plan 65.

Medicare and Plan 65

Hospital benefits (Part A)

Service and supplies	Medicare pays	Plan 65 pays	Your responsibility
Inpatient hospital services including semi-private room and board; and miscellaneous services and supplies, such as drugs, x-rays, lab tests, and operating room services [A **benefit period** begins on the first day of an inpatient hospital stay and ends when you have been out of the hospital or facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days.]	All but $592 for first 60 days/ benefit period All but $148 a day for 61st-90th days/benefit period All but $296 a day for 91st-150th days (if you choose to use 60 days nonrenewable lifetime reserve days) Beyond 150th day — no coverage	First 60 days — $592 per admission 61st-90th days — $148 a day 91st-150th days — $296 a day Beyond 150th day — covered services for an additional 365 days per lifetime after Medicare lifetime reserve days have been used	Only for un-covered services
Blood	All costs except nonreplacement fees for the first 3 pints (blood deductible) in any benefit period	The blood deductible of a 3-pint combined maximum used per calendar year under Part A or B	Only for un-covered services
Skilled nursing facility care (in a facility approved by Medicare)	100% of costs for first 20 days (after a 3-day prior hospital confinement and within 30 days)/ benefit period All but $74 a day for 21st-100th days/benefit period Beyond 100 days — no coverage/benefit period	First 20 days — no coverage needed 21st-100th days — $74 a day Beyond 100 days — no coverage	Only for un-covered services All charges for days beyond 100
Private duty nursing and out-of-hospital prescription drugs	No coverage	No coverage	All charges
Home health services, other than doctor's services	Covers unlimited visits when accompanied by a treatment plan set up and certified by a doctor (not subject to deductible and coinsurance)	No coverage needed	Only for un-covered services

Coverage at a glance

Medical-surgical benefits (Part B)

Service and supplies	Medicare pays	Plan 65 pays	Your responsibility
Doctors' allowed charges, inpatient and outpatient services, allowed cost of ambulance, durable medical equipment and medical supplies	80% of allowable charges (after an annual $75 deductible*)	The remaining 20% of charges accepted by Medicare and the $75 deductible*	Nothing — if your doctor accepts Medicare assignment. You will be responsible for the difference between Medicare allowance and the doctor's charge if your doctor does not accept Medicare assignment.
Outpatient physical therapy	80% of reasonable charges (except a limit of $500 in a calendar year) for services of independent licensed physical therapists in office or patient's home (after $75 deductible*)	The remaining 20% of charges accepted by Medicare and the $75 deductible*	Anything over the $500 amount allowed by Medicare and the difference between the Medicare allowance and the doctor's charge if your doctor does not accept Medicare assignment.
Blood	80% of all costs except nonreplacement fees for first 3 pints (blood deductible) in each benefit period (after $75 deductible*/calendar year)	The blood deductible of a 3-pint combined maximum used per calendar year under Part A or B. The remaining 20% of charges accepted by Medicare (and the $75 deductible*)	Only for uncovered services
Out-of-hospital psychiatric services	80% of the first $1,375 of charges accepted by Medicare (after the $75 deductible*) — a maximum of $1,100 each calendar year	No coverage for outpatient psychiatric services	20% of the first $1,375 of allowable charges, any amount applied to the deductible and any additional expense over these amounts
Home health services, other than doctor's services	Unlimited visits (if not covered by Medicare hospital benefits) when accompanied by a treatment plan	No coverage needed	Only for uncovered services

* Combined deductible

Limitations of coverage

The charts summarizing Medicare benefits in this booklet briefly describe benefits. No coverage is available under either Medicare or Plan 65 for the following:

1. Custodial nursing home care.
2. Intermediate nursing home care costs.
3. Most dental care and hospital admissions for such care. Examples are treatment, filling, removal or replacement of teeth, root canal therapy, surgery for impacted teeth, and other surgical procedures involving the teeth or structures directly supporting teeth.
4. Routine physical examinations and tests, immunizations except injection or pneumococcal vaccine, routine foot care.
5. Hearing aids and examinations for them, or consultations about them.
6. Eyeglasses or contact lenses and examinations about them, or consultations about them, unless for replacement of the lens following cataract surgery.
7. Benefits considered medically unnecessary by a committee of doctors representing Medicare will not be paid by Plan 65.

This coverage is designed to supplement Medicare by covering some hospital, medical and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges, subject to any deductible and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy.

This policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicines. Also, benefits for hospital stays which began before the policy is effective are not covered until six months of coverage have elapsed.

The Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations of Medicare benefits.

What does Plan 65 cost?

The rate for Plan 65 is determined by your age at time of enrollment. If you enroll within 60 days of your 65th birthday or your official date of retirement, your rate will always be the age 65 rate. If you wait, your rate will always be based on your age at the time of your enrollment.

The 1990 monthly rates are:

Age 65	**$56.04**
66 - 69	$58.25
70 - 74	$61.65
75 - 79	$65.00
80 - 84	$66.70
85 and over	$68.90

Blue Cross and Blue Shield of Kansas reserves the right to change subscribers' rates upon proper notification of the subscriber and approval by the State Insurance Department.

How to report Plan 65 claims

You should carry your identification card with you at all times. When you receive a service, show your identification card.

Your Medicare coverage always pays **first**. To collect Medicare benefits, follow the instructions in *Your Medicare Handbook* available at your Social Security office.

The Plan 65 program pays **second.** In most cases your claim will be processed automatically if your Blue Cross and Blue Shield of Kansas identification number is shown on your Medicare claim form, and if your claim is processed by Blue Cross and Blue Shield of Kansas. If your Medicare claim is not processed by Blue Cross and Blue Shield of Kansas, you should send in the *Explanation of Medicare Benefits* form sent to you by Medicare. Be sure to include your Plan 65 identification number when submitting claims.

More information

For additional Plan 65 information or an application, write:

Katy Beard
Blue Cross and Blue Shield
of Kansas
P. O. Box 239
Topeka, Kansas 66601-0239

Or, call:

In Topeka (913) 291-8253
Outside Topeka, toll-free
1-800-752-6650

(Representative's Signature)

(Date)

This booklet provides a brief description of some important features of Plan 65. However, the contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Kansas. **It is important that you read your contract carefully when you receive it.**

Plan 65 contract numbers are 80-1000, 80-1031 and 80-1582.

Blue Cross and Blue Shield of Kansas is not connected with Medicare in its solicitation or issuance of coverage.

Plan 65 may not be cancelled or non-renewed by Blue Cross and Blue Shield of Kansas solely on the ground of deterioration of health.

5-205 1/90

PLAN 65

A plan to supplement your Medicare coverage in 1990

Blue Cross
Blue Shield
of Kansas

3-15

A special plan from Blue Cross and Blue Shield of Kansas — Plan D.

Since Congress repealed the Medicare Catastrophic Coverage Act in November 1989, a good supplemental health insurance policy to Medicare, like Plan D, is essential.

For more than 20 years, Blue Cross and Blue Shield of Kansas has offered Kansans coverage to help cover many expenses Medicare doesn't. Medicare has changed through the years, however, you can be assured today's Plan D gives you the up-to-date coverage and peace of mind people have come to expect from Blue Cross and Blue Shield of Kansas.

This booklet is designed to answer many of your questions about Medicare and Plan D.

What's inside

- What you need to know first
- Care outside the United States
- How to enroll in Plan D
- Medicare and Plan D coverage at a glance
- Limitations of coverage
- How much Plan D costs
- How to file a claim
- And, where to get more information

3-16

What you need to know first

You need Medicare. There are two parts to Medicare:

- Hospital Insurance (Medicare Part A) — This program is available **beginning with the 25th month you have received Social Security checks**. Because you are entitled to disabled benefits, you pay no monthly premium for your Medicare hospital insurance protection.

- Medical Insurance (Medicare Part B) — You are automatically enrolled, unless you return a health insurance card to the Social Security Administration (SSA) office the month prior to the effective date of coverage. (See instructions in the kit you will receive from the SSA office.)

Then you need Plan D offered by Blue Cross and Blue Shield of Kansas.

Plan D provides some benefits not included in the hospital and medical insurance programs of Medicare. **Plan D does not provide benefits which are available through Medicare, even though the applicant may not be covered under Medicare.** This is why it is important for you to have the medical insurance program of Medicare. If you do not get your Medicare health insurance card at least 30 days prior to the effective date (the 25th month of Social Security checks), contact your nearest Social Security office. The benefits of the Medicare program and the Plan D program are briefly described on the inside pages of this booklet.

Care received outside the United States

When Medicare coverage is not available outside the United States, Plan D hospital coverage is provided for 120 days per spell of illness for covered inpatient care or the hospital's charges for covered outpatient care.

When Medicare coverage is not available outside the United States, Plan D medical-surgical coverage is provided up to a maximum payment of $1,000 each calendar year for covered services and subject to the limitations shown in your contract.

You must be traveling (not residing) in the foreign country for these benefits to be available.

How to enroll in Plan D

All Kansans, except those in Johnson and Wyandotte counties, who are disabled and have received Social Security cash benefits for 24 months may enroll in Blue Cross and Blue Shield of Kansas Plan D. Applicants must be able to show their Social Security health insurance membership card which has their name, number and the effective date of Medicare coverage.

To receive an application, write to the address on the back of this booklet.

Existing subscribers:
The effective date will be the first of the month following the date Blue Cross and Blue Shield of Kansas is notified of your eligibilty for health insurance under Social Security.

New applicants:
If you are presently eligible, or whenever you receive your health insurance card from Social Security, your coverage under Blue Cross and Blue Shield of Kansas Plan D will be effective the first of the month following receipt of your application in the Topeka office. It must be received within 60 days from the effective date of your health coverage under Medicare.

Dependents under age 65

Existing subscribers:
Your spouse may keep the present coverage on a single membership or a family membership if there are unmarried dependent children. Most Blue Cross and Blue Shield of Kansas contracts currently cover unmarried dependents to age 23. However, be sure to check your contract. Write Blue Cross and Blue Shield of Kansas for rate information.

New subscribers:
Your spouse under age 65 and unmarried children under age 23 can apply for regular Blue Cross and Blue Shield of Kansas coverage when you apply for Plan D. Blue Cross and Blue Shield of Kansas existing enrollment regulations will apply.

3-18

Medicare and Plan D

Hospital benefits (Part A)

Service and supplies	Medicare pays	Plan D pays	Your responsibility
Inpatient hospital services including semi-private room and board; and miscellaneous services and supplies, such as drugs, x-rays, lab tests, and operating room services [A **benefit period** begins on the first day of an inpatient hospital stay and ends when you have been out of the hospital or facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days.]	All but $592 for first 60 days/ benefit period All but $148 a day for 61st-90th days/benefit period All but $296 a day for 91st-150th days (if you choose to use 60 days nonrenewable lifetime reserve days) Beyond 150th day — no coverage	First 60 days — $592 per admission 61st-90th days — $148 a day 91st-150th days — $296 a day Beyond 150th day — covered services for an additional 365 days per lifetime after Medicare lifetime reserve days have been used	Only for un-covered services
Blood	All costs except nonreplacement fees for the first 3 pints (blood deductible) in any benefit period	The blood deductible of a 3-pint combined maximum used per calendar year under Part A or B	Only for un-covered services
Skilled nursing facility care (in a facility approved by Medicare)	100% of costs for first 20 days (after a 3-day prior hospital confinement and within 30 days)/ benefit period All but $74 a day for 21st-100th days/benefit period Beyond 100 days — no coverage/benefit period	First 20 days — no coverage needed 21st-100th days — $74 a day Beyond 100 days — no coverage	Only for un-covered services All charges for days beyond 100
Private duty nursing and out-of-hospital prescription drugs	No coverage	No coverage	All charges
Home health services, other than doctor's services	Covers unlimited visits when accompanied by a treatment plan set up and certified by a doctor (not subject to deductible and coinsurance)	No coverage needed	Only for un-covered services

Coverage at a glance

Medical-surgical benefits (Part B)			
Service and supplies	Medicare pays	Plan D pays	Your responsibility
Doctors' allowed charges, inpatient and outpatient services, allowed cost of ambulance, durable medical equipment and medical supplies	80% of allowable charges (after an annual $75 deductible*)	The remaining 20% of charges accepted by Medicare and the $75 deductible*	Nothing — if your doctor accepts Medicare assignment. You will be responsible for the difference between Medicare allowance and the doctor's charge if your doctor does not accept Medicare assignment.
Outpatient physical therapy	80% of reasonable charges (except a limit of $500 in a calendar year) for services of independent licensed physical therapists in office or patient's home (after $75 deductible*)	The remaining 20% of charges accepted by Medicare and the $75 deductible*	Anything over the $500 amount allowed by Medicare and the difference between the Medicare allowance and the doctor's charge if your doctor does not accept Medicare assignment.
Blood	80% of all costs except nonreplacement fees for first 3 pints (blood deductible) in each benefit period (after $75 deductible*/calendar year)	The blood deductible of a 3-pint combined maximum used per calendar year under Part A or B. The remaining 20% of charges accepted by Medicare (and the $75 deductible*)	Only for uncovered services
Out-of-hospital psychiatric services	80% of the first $1,375 of charges accepted by Medicare (after the $75 deductible*) — a maximum of $1,100 each calendar year	No coverage for outpatient psychiatric services	20% of the first $1,375 of allowable charges, any amount applied to the deductible and any additional expense over these amounts
Home health services, other than doctor's services	Unlimited visits (if not covered by Medicare hospital benefits) when accompanied by a treatment plan	No coverage needed	Only for uncovered services
* Combined deductible			

Limitations of coverage

The charts summarizing Medicare benefits in this booklet briefly describe benefits. No coverage is available under either Medicare or Plan D for the following:

1. Custodial nursing home care.
2. Intermediate nursing home care costs.
3. Most dental care and hospital admissions for such care. Examples are treatment, filling, removal or replacement of teeth, root canal therapy, surgery for impacted teeth, and other surgical procedures involving the teeth or structures directly supporting teeth.
4. Routine physical examinations and tests, immunizations except injection or pneumococcal vaccine, routine foot care.
5. Hearing aids and examinations for them, or consultations about them.
6. Eyeglasses or contact lenses and examinations about them, or consultations about them, unless for replacement of the lens following cataract surgery.
7. Benefits considered medically unnecessary by a committee of doctors representing Medicare will not be paid by Plan D.

This coverage is designed to supplement Medicare by covering some hospital, medical and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges, subject to any deductible and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy.

This policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicines. Also, benefits for hospital stays which began before the policy is effective are not covered until six months of coverage have elapsed.

The Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations of Medicare benefits.

What does Plan D cost?

The 1990 monthly rate is **$98.03** per person.

Blue Cross and Blue Shield of Kansas reserves the right to change subscribers' rates upon proper notification of the subscriber and approval by the State Insurance Department.

How to report Plan D claims

You should carry your identification card with you at all times. When you receive a service, show your identification card.

Your Medicare coverage always pays **first**. To collect Medicare benefits, follow the instructions in *Your Medicare Handbook* available at your Social Security office.

The Plan D program pays **second**. In most cases your claim will be processed automatically if your Blue Cross and Blue Shield of Kansas identification number is shown on your Medicare claim form, and if your claim is processed by Blue Cross and Blue Shield of Kansas. If your Medicare claim is not processed by Blue Cross and Blue Shield of Kansas, you should send in the *Explanation of Medicare Benefits* form sent to you by Medicare. Be sure to include your Plan D identification number when submitting claims.

More information

For additional Plan D information or an application, write:

Katy Beard
Blue Cross and Blue Shield
of Kansas
P. O. Box 239
Topeka, Kansas 66601-0239

Or, call:

In Topeka (913) 291-8253
Outside Topeka, toll-free
1-800-752-6650

_____

(Representative's Signature)

_____

(Date)

This booklet provides a brief description of some important features of Plan D. However, the contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Kansas. **It is important that you read your contract carefully when you receive it.**

Benefits are paid for hospital or skilled nursing facility services only when confinement begins on or after the effective date of Plan D. Plan D contract numbers are 80-1001, 80-1031 and 80-1582.

Blue Cross and Blue Shield of Kansas is not connected with Medicare in its solicitation or issuance of coverage.

5-12 1/90

PLAN D

A special plan for disabled people under age 65

1990

Blue Cross
Blue Shield
of Kansas

2-23

PYRAMID LIFE SINCE 1913
THE PYRAMID LIFE INSURANCE COMPANY, 6201 JOHNSON DRIVE, SHAWNEE MISSION, KANSAS 66202 (913) 722-1110

M. KEITH HAWKINS
Vice President
Secretary and Counsel

February 7, 1990

Mr. Chairman, Members of the Insurance Committee:

My name is Keith Hawkins and I am Vice President, Secretary and Counsel The Pyramid Life Insurance Company, a domestic insurer which markets individu health insurance. Traditionally, over 75% of our written premium is fr health insurance. We primarily market major medical, Medicare supplemen hospital indemnity and various other health expense coverages. We sell individuals, families, and small businesses not otherwise insured under gro coverage. We are licensed to do business in 40 states and we currently ha 1400 health insurance policyholders in the state of Kansas.

Since marketing health insurance is our "bread and butter" paying the salari of 135 Home office employees in Kansas and 4700 agents in Kansas and acro the nation, we like you, are most concerned with the direction our busine is taking. We fear market shrinkage as premiums rise to cover medical ca cost increases. To demonstrate the seriousness of the situation, a rece editorial in the "National Underwriter" states:

> The Federal government will spend about $150 billion over a period of three or four years to bail out hundreds of insolvent savings and loans. The increased cost of the health care system rises that much every three years (or at the rate of $55 billion per year), and is expected to keep increasing by more than that amount indefinitely. What's more, unlike the health care crises, the savings and loan bailout will be a one-time expenditure and then it will be over.

To focus on where we are headed, it helps to know where we have been. the 1950's and 60's, health insurance products provided very structur benefits: specified daily indemnity for hospitalization, surgical f schedules, a specified dollar benefit per physician visit. By capping limiting benefits in this manner, insurers could price more accurately a claim costs were not subject to medical care inflation. Also, insureds we participating by paying some portion of every bill and, consequently, we more aware of actual medical costs.

As the industry progressed and the idea of comprehensive coverage developed market pressure caused the industry to abandon previous cost containment controls. The end result was major medical coverage with a very small deductible and limited out of pocket for the insured. Take this change in product development and couple it with the cost of new medical technologies cost shifting, mandated benefits, defensive medicine and what do you come up with? A "health insurance crises".

Realizing this, like others in the industry, we have been trying to come up with cost containment features like higher deductibles, greater coinsurance second surgical opinions, 100% coverage for outpatient surgery pre-certification of hospitalization, and even a financial reward to an policyholder who determines an overcharge in his/her hospital claim Unfortunately, our experience has been no better than the industry's, and whatever savings was gained has been overshadowed by a greater increase in medical care costs.

There is an analogy which compares rising health care costs to a balloon Whenever you squeeze on one end (implement a cost containment measure), the balloon bulges somewhere else.

We have come full circle in our product development and just recently introduced a per cause deductible, as opposed to calendar year deductible. Another product contains structured benefits and a surgical fee schedule applicable for the first $25,000 of medical expense. Whether these products will be accepted by the consumer is yet to be seen. The point is we are desperately trying to provide "affordable" health insurance to individuals and families not otherwise covered by an employer. Individual insurance has always been more expensive than group because of the size of the market and the limited ability to spread the risk. One could say with more and more not insured through an employer, our potential market has grown. However, if group insurance is too expensive for employers to provide, chances are the individual insurance available to those employees is also too high.

We commend this Committee for taking the initiative to study the health insurance problem that certainly exists. We pledge our cooperation to work with the Legislature in any way possible to improve this situation. We firmly believe that this problem can only be solved through joint efforts of the Legislature, regulators, industry and consumers.

Respectfully,

K·A·N·S·A·S HMO ASSOCIATION

Testimony Before the House Insurance Committee

February 7, 1990

Mr. Chairman and Committee members, I am Cheryl Dillard, Government an Community Relations Manager for Kaiser Permanente in Kansas City. I am appearin before you today on behalf of the Kansas HMO Association to provide you with a bri description of our industry and its operations in Kansas.

Health maintenance organizations (HMOs) have been operating in Kansas since 197 and were formed as an alternative to the traditional indemnity health insurance plans

HMOs are not insurance companies, although they market their services in competitic with health insurance carriers. The HMO concept is to organize health care delivery int a local, efficient system that emphasizes prevention and early treatment of disease, an provides monitoring to assure quality of care and appropriateness of treatment. HMC take different forms but all have certain things in common.

All HMOs provide direct health care for a predetermined monthly charge, rather tha reimbursement for expenditures. There are no deductibles, although there is sometime a modest copayment for individual services. Most provide substantially mo comprehensive services than indemnity plans, and by their nature share the subscriber interest in maintenance of good health and early detection and treatment of illnesse before they become serious. All of them require subscribers to use selected provide except in emergencies. Their operations are monitored by the State, and those whic are federally qualified or have Medicare contracts are monitored by the Feder Government as well.

They fall into three structural models:

1. INDIVIDUAL PRACTICE ASSOCIATION: IPAs contract with priva physicians, practicing in their own offices, to provide medical care members.

2. STAFF MODEL: Staff Model plans directly employ physicians, nurses, ar other providers and support staff to provide needed health care servic to members.

HMOs encourage members to maintain their health through a variety of programs. The provide physical examinations, prenatal care and other services for well persons services that are usually excluded from insurance coverage. They manage care for th ill and injured to ensure that needed care is rendered in the most appropriate settin

There are 13 health maintenance organizations serving more than **300,000 Kansans**

* HMOs employ more than 700 persons in the state with a total payroll of **ov $10,000,000** per year.

* The plans pay an aggregate of approximately **$750,000** in taxes.

* Residents of 40 counties in Kansas are served by at least one HMO, and 1 counties have two or more. Wyandotte, Leavenworth, Johnson, Douglas, Harve Marion, and McPherson Counties have three or more HMOs from whic employers and employees can select.

Health Maintenance Organizations belonging to the Association are:

CIGNA Health Plan of Kansas City, Inc.
9225 Indian Creek Parkway
Bldg. 32, Suite 700
Overland Park, KS 66210
(913) 451-9388
Contact: Joy Haug, General Manager

EQUICOR Health Plan, Inc.
2959 N. Rock Road
P.O. Box 780008
Wichita, KS 67278
(316) 681-1152
Contact: Robert A. Vohs

Lincoln National Health Care
7300 College Blvd., Suite 100
Overland Park, KS 66210
(913) 345-2240
Contact: Mike Tweedie

Family Health Plan Corporatio
414 North Main, P.O. Box 348
Newton, KS 67114
(316) 283-5880
Contact: Walter D. Roger
President & CEO

HMO Kansas, Inc.
419 West 29th Street
Topeka, KS 66111
(913) 232-3644

Kaiser Permanente
6900 Squibb Road, Suite 201
Shawnee Mission, KS 66202
(913) 722-8484

MedPlan
9200 Glenwood, Suite 101
Overland Park, KS 66212
(913) 648-6670
Contact: Rodney A. Cart

Prime Health
6801 East 117th Street
Kansas City, MO 64134
(816) 765-6200
Contact: Robert E. Eisler, Jr.

Principal Health Care of Kansas City, Inc.
4600 Madison Avenue, Suite 9
Kansas City, MO 64112
(816) 931-8250
Contact: Dave Roberts, Executive Director

Total Health Care
One Pershing Square
Kansas City, MO 64108
(816) 395-3777
Contact: Dennis McCart

PREFERRED PROVIDER ORGANIZATIONS

productive
partnerships
for cost-effective,
quality
health care

American Association of Preferred Provider Organizations

Attachment 6

Marlin Dauner, Pres.
Preferred Health Care
P.O. Box 3015
Wichita, KS 67201
316-268-0345

Testimony for House Ins Committee
2/7/90

CONTENTS

PREFERRED PROVIDER ORGANIZATIONS

productive partnerships for cost-effective, quality health care

AN INTRODUCTION TO THIS PRIMER ON PPOS

This handbook is designed to provide concise, current information on Preferred Provider Organizations to all those individuals and organizations with an interest in providing quality health care at a reasonable, predictable price. It is written for:

Buyers of health care — Employers, unions, health benefits managers, third party administrators, government agencies, consultants and others involved in the selection and purchase of health care services.

Payers for health care — Commercial and not-for-profit carriers, union trusts, multiple employer trusts, self-insured employer programs of all types, and joint purchasing groups such as those formed by business coalitions.

Providers of health care — Physicians, hospitals, pharmacists, nurses, and the whole array of allied professionals who provide some type of health service.

Implementers of health care programs — Utilization management and review specialists, claims processors, data processors and data analysts, quality control and quality assurance specialists, marketers of health care programs, and all of the vendors of services and equipment necessary to the operation of comprehensive health care programs.

This book is written only incidentally for patients, whose employers and/or insurers provide them with information that enables them to use their health care programs. Informed consumers and consumer organizations, however, may find its content helpful in evaluating the various program options available.

In recent years, the health care profession has responded to strong pressures from government, business and industry to cut or hold the line on health care costs by developing new ways of packaging, pricing and selling a quality health care product. These new programs have been evolving at a rapid rate, changing, expanding, maturing, increasing in sophistication. It has not been easy for the buyers, insurers, providers and implementers to follow closely all of these fast-breaking developments.

What is increasingly clear to all who share the goals of developing high quality, cost-effective health care programs is that to do so, an equitable working partnership must be forged among those who provide care, pay for it, and make it available to the public. That is the kind of partnership that a Preferred Provider Organization fosters. In the following pages that partnership — how it develops, how it works, and why it is an important option in health care today — will be described.

MANAGED HEALTH CARE'S FRONT RUNNER

The fastest-growing concept for providing quality health care while containing costs is the PPO. A PPO manages health care, weaving providers, purchasers and patients into an efficient network, with incentives for all to hold down expenditures.

"It is clear that the present direction of the health care marketplace is shifting toward PPOs," says Douglas L. Elden, Esquire, Chicago, Chairman of the Board of the American Association of Preferred Provider Organizations.

Numbers bear out this prediction. PPOs grew at a rate of at least 14% in 1988 while HMOs (Health Maintenance Organizations) experienced a 13.6% growth rate — down from 22% in 1986 and 26% in 1985, according to data from InterStudy, a Minneapolis-based research organization. There are now approximately 660 operating or organizing PPOs in the nation — up from about 570 in 1987.

Blue Cross/Blue Shield reports that in the first six months of 1987, PPO membership increased by 1.5 million — or at approximately a 19% growth rate. BC/BS now says that more than 8 million of its subscribers are enrolled in PPOs.

"No other cost-containment strategy adopted in the past 30 years has gained such quick acceptance," says BC/BS President Bernard R. Tresnowski.

Increasingly, employers are offering a PPO plan. A recent survey conducted by the Health Insurance Association of America, Johns Hopkins University and the University of North Carolina found that in 1987, 17% of employers offered a PPO program, even though this type of managed care has been widely offered only since about 1983.

RAPID GROWTH OF PPOS

Month/year	No. of PPOs
January 1984	73
December 1984	143
October 1985	325
October 1986	369
May 1987	674

PPOs have exploded onto the health care scene in the last few years and now are growing at a faster rate than health maintenance organizations (HMOs) and other types of managed health care plans. In the early 1980s only about 30 PPOs could be identified in the nation. When AAPPO published a survey in January of 1984, the number of PPOs had more than doubled, and in each successive year significant increases occurred. By the end of 1988, it is estimated that there will be approximately 700 PPOs in operation or on the drawing boards.

Source: Directory of Operational PPOs, *American Association of Preferred Provider Organizations, 4th edition, May, 1987.*

WHERE PPOS NOW HAVE BEEN ESTABLISHED IN U.S.

Alabama	17	Louisiana	12	Oklahoma	10
Arizona	21	Maine	1	Oregon	7
Arkansas	4	Maryland	10	Pennsylvania	24
California	117	Massachusetts	16	Puerto Rico	1
Colorado	27	Michigan	18	Rhode Island	1
Connecticut	4	Minnesota	14	South Carolina	3
District of Columbia	8	Missouri	18	Tennessee	14
Florida	41	Mississippi	3	Texas	26
Georgia	21	Nebraska	3	Utah	7
Hawaii	3	Nevada	7	Vermont	1
Illinois	47	New Jersey	5	Virginia	8
Indiana	16	New Mexico	4	Washington	20
Iowa	5	New York	16	West Virginia	4
Kansas	9	North Carolina	10	Wisconsin	11
Kentucky	9	Ohio	50	Wyoming	1

PPOs now are established in all but about half a dozen states. In an early 1987 survey, AAPPO identified operational PPOs in 43 states, the District of Columbia and Puerto Rico. An operational PPO is characterized as a program which has contractual arrangements in place with purchasers and is currently providing health care services to PPO participants. The heaviest concentrations are in densely populated states. California leads the list with 117 PPOs, followed by Ohio with 50, Illinois with 47, and Florida with 41.

Source: Directory of Operational PPOs, *American Association of Preferred Provider Organizations, 4th edition, May, 1987.*

productive partnerships for cost-effective, quality health care

Given an opportunity to enroll in a PPO by their employer, 70% of eligible workers enrolled, the survey found.

In its recent report, InterStudy, the organization which has served as the "godfather" to HMOs and some other managed care concepts, concluded that one of the factors contributing to the slower growth rate of HMOs in 1987 was "the proliferation of PPOs as an alternative."

WHAT IS A PPO?

"PPO" is an acronym for a Preferred Provider Organization. It is an entity through which a partnership is established between a group of "preferred providers" — doctors, hospitals and others — and an insurance company, self-insured employer or its intermediary to provide specified medical and hospital care and sometimes related services at a negotiated price.

"A PPO is an organization separate from the participating provider or purchasing organizations and is marketed on the basis of cost-efficiency. As such, the PPO works as a broker, arranging contracts between purchasers and providers," explains the Clearinghouse on Business Coalitions for Health Action, a project of the U.S. Chamber of Commerce, in its 1986 publication *What Employers Should Know About PPOs.*

Providers negotiate lower fees in anticipation of a greater volume of patients and agree to basic managed care principles — utilization review, with accompanying guidelines for hospital admissions, use of facilities and resources.

Physicians and hospitals tend to think of a PPO as an organization — a separately created unit through which they can negotiate with buyers or middlemen for the buyers to provide health care services to a defined group of patients.

Buyers more often view a PPO as a type of health care product — health services purchased at competitive prices through negotiations with providers which can then be offered to insureds or employees.

In the private sector of the health care marketplace, both providers and insurance companies are marketing the PPO as a product to consumers through their employers. Now the federal government is testing the PPO concept with some Medicare patients as a vehicle for public policy change as well.

Because PPOs are relatively new, the PPO concept and how it differs from other managed care approaches is not understood by everyone. "Right now, the rest of the world isn't quite sure *what* a PPO is," says Lynn Dowling, President of the American Association of Preferred Provider Organizations.

In actuality, a PPO facilitates an arrangement which marries the health care delivery system to the financing system with the goal of containing costs. It is an organization out of which a new way of providing and paying for health care services arises.

WHAT ARE THE SPECIAL HALLMARKS OF A PPO?

Several features characterize a PPO, distinguishing this type of arrangement from others now in existence on the health care scene:

- A PPO retains the concept of fee-for-service medicine. Each physician, hospital or other health care provider who joins the PPO bills for his/her services according to the negotiated fee guidelines established in the contract. Unlike HMOs, PPOs are not capitation plans. PPO providers do not negotiate a set fee per patient for provision of all necessary services for a specified period.
- Free choice of physicians and hospitals is retained in a PPO plan. Patients enrolled in a PPO plan may use the "preferred providers" or go outside this group to other physicians and hospitals for care. However, there are strong financial incentives that motivate patients to use the enrolled preferred providers. Care patients receive from preferred providers is usually reimbursed at 90% to 100%, while care obtained outside the PPO may be reimbursed at 80% or less, meaning that individuals must pay more out of their own pockets.
- Preferred providers render their services at agreed-upon prices — usually discounted from their usual and customary charges. While reimbursement arrangements in PPOs are evolving, the basic premise is that fees are generally lower than those offered by other providers in a given area, making the PPO plan price-competitive.
- Preferred providers accept strict management controls, such as utilization review and other techniques designed to contain costs. At the same time, quality controls are maintained to balance cost constraints with proper care.
- PPOs provide efficient claims payment systems as well as comprehensive data systems that enable buyers to track utilization as well as costs.

"The health care plan characteristics most important to employees in selecting health insurance plans are the ability to choose their own doctors and the amount of the monthly payroll deduction needed to pay for the plan," concludes a 1988 consumer survey conducted by the Life Insurance Marketing and Research Association (LIMRA) and the American Council of Life Insurance (ACLI). Thirty-six percent of the respondents said choosing their own doctor was the most important factor.

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"PPOs contract with employers to manage health care delivery for their traditionally insured employees. It is important to note that an HMO is an option *apart from*, whereas a PPO is an option *within*, the traditional plan. The PPO offers traditionally insured employees the option of cost-effective, quality health care with low out-of-pocket costs and no claims filing."

From What Employers Should Know About PPOs, *Clearinghouse on Business Coalitions for Health Action*

HOW PPOS DIFFER FROM OTHER PROGRAMS

There have been basically three types of health care systems operating in the nation over the past few decades:

- Traditional fee-for-service medicine provided by physicians practicing in their offices coupled with hospital care provided in hospitals chosen by patients with their physicians. Patients then submit claims to their insurers and/or self-insured employers who either reimburse them or pay the physicians and hospitals directly.
- Government programs, such as Medicare, Medicaid, and those of the Veterans Administration and U.S. Public Health Service. There are various criteria to meet to qualify for various federal and state-funded programs, and often care must be provided in specified institutions or by certain providers. These programs are underwritten largely by taxes, but in the case of Medicare, enrollees pay small amounts monthly and often buy supplementary insurance to fill coverage gaps.
- Prepayment programs, such as Health Maintenance Organizations (HMOs), which provide all needed medical and hospital services for a pre-negotiated per capita fee, but with restrictions on which physicians and which hospitals patients may use.

More recently, another model, which combines some desirable features of traditional medicine with the cost-containment features of the prepayment model, has evolved. That is the PPO.

A PPO is *not* a prepayment or capitation program.

It *is* a program in which fees are prospectively negotiated.

A PPO does *not* put providers at risk. Care is provided as needed and providers receive payment for these services.

It *is* a cost-containment program.

A PPO does *not* provide less care or lower quality care to hold down costs.

It *does* review care, monitor care and create tension between providers' educational bias toward providing more care and the need to be cost-conscious in providing services today.

A PPO gives enrollees free choice of physician and hospital.

It does *not* restrict enrollees to panels of physicians or particular hospitals.

A PPO operates within, not apart from the existing health care system.

HOW PPOS EVOLVED

The story of escalating health care costs and efforts to address them over the past two decades is well known to those who provide, package, purchase or pay for health care services and programs. Even the average consumer is well aware of constantly climbing health insurance premiums and the drain they make on his/her paycheck.

The government, which pays for millions of dollars of health services for Medicare recipients and others who receive care through government-sponsored programs, was the first to take a hard line on cost-containment. Initially, the government began cutting back reimbursement to physicians under Medicare — a process which has been ongoing for years. Then physicians' fees were frozen for the period from August, 1971 to May, 1974. Another fee freeze developed out of the Deficit Reduction Act which ran from June 20, 1984 through 1986, despite a voluntarily imposed hold on fees by the nation's physicians themselves in that time period. Subsequently, attempts to reduce physician reimbursement and to lock these providers into lower-level Medicare payment scales as well as into participating agreements that require them to accept Medicare payment as the full fee for services have been continuous. Meanwhile, retrospective payment to hospitals was scrapped and prospective payment by diagnostic groups (DRGs), with a flat fee per diagnosis and circumscribed lengths of stay, was substituted.

These measures, while somewhat helpful in holding down further cost increases, were still insufficient. Casting about for a system revision that would bring further cost savings, the health care policymakers turned to an idea from the past — prepaid or capitated health care.

As far back as the early 1800s, "contract practice," an early form of health insurance that embodied the concept of reimbursing physicians on a fixed annual fee basis, developed in a few isolated places. Prepaid medical practices began to develop more rapidly in the 1920s when the Ross-Loos Medical Clinic in Los Angeles and the Elk City (OK) Cooperative began providing medical care through prepaid health plans. In the 1940s, Kaiser Industries introduced the Kaiser Foundation Medical Care Program (now known as Kaiser-Permanente) to provide health care services for employees and their families. By 1947, such prepaid group practices as the Health Insurance Plan of Greater New York (HIP), Community Health Centers of Two Harbors, MN, and the Group Health Cooperative of Puget Sound were in operation. By 1950, several major labor unions, including the Teamsters, United Mine Workers, and United AutoWorkers, all had set up prepaid health care plans.

The Kaiser-Permanente health plans have expanded greatly, and now are sold on a broad scale to other businesses and industries. Basically, Kaiser-Permanente programs are "in-house," with panels of salaried physicians

and their own hospitals. To combat the inroads Kaiser programs were making in California in the mid-1950s, some medical societies countered with what was called the medical care foundation concept. Basically, a foundation enrolled physicians in the medical society to care for enrolled groups of patients and closely scrutinized their services and fees. The foundations enabled fee-for-service physicians to contract with other businesses and industries to provide medical care.

"What PPOs have done is realign the components in the traditional health insurance equation. That equation consisted of an insurance company designing an insurance product which would be sold by its in-house agents to employers or individuals, who became the patients of physicians and hospitals. PPOs and other forms of alternative delivery systems caused the providers to become an integral part of the product...."

Jerry T. Payne
Vice President Marketing
Preferred Health Network
Monterey Park, CA

In the Nixon years, policymakers took the prepayment/capitation/ foundation concepts a step further, introducing the idea of the HMO. HMOs have experienced major growth in recent years. Today, approximately 30 million Americans receive care through these programs.

The concept of the HMO is to provide a continuum of health care services, including hospital care, for a predetermined set fee per patient per year. The philosophy of the Health Maintenance Organization initially was to focus intensively on so-called wellness care — routine physical examinations, health education programs, and other activities designed to keep patients healthy on the theory that this would greatly reduce costly expenditures for preventable diseases and conditions down the line. Unfortunately, as their own costs went up, many HMOs soon learned that the first services they had to eliminate were the very wellness features they had been promoting.

There are several HMO models. In the staff model HMO, physicians are direct employees of the HMO. In the group model, physicians are members of a group practice which contracts with the HMO. As the cost-containment/HMO wave swept the country, fee-for-service physicians answered with their own variation on the theme — the Individual Practice Association (IPA). In this framework, individual physicians contract with the IPA to provide their services from their own offices. The IPA then negotiates a capitation contract with an HMO for the medical quotient of its services. There are some variations on this theme. There may be an IPA network composed of freestanding multispecialty medical groups which negotiates capitation contracts with HMOs to provide services. IPA physicians generally see prepaid patients and fee-for-service patients side-by-side in their offices.

The PPO is an improvement on the HMO/IPA systems approach. It maintains fee-for-service but provides for prospective negotiation of competitive fees. It assures physicians certain autonomy in their provision of care to patients, but builds in tight — and getting tighter — cost controls via utilization management and review, supervisory measures, and data collection and analysis.

There is general agreement that PPOs as entities started on the west coast in the late 1970s and early 1980s, although examples of some earlier models do exist. Group Health, Inc., in New York City, launched in 1937, calls itself one of the nation's oldest PPOs.

A move by the state of California to control health costs in recent years probably gave PPOs their greatest impetus. There the state's Medi-Cal (Medicaid) program, which some years ago put out hospital care for

enrolled individuals to competitive bid, has expanded this concept to medical care. Thus, not only hospitals, but physicians were thrust into the competitive market, and as a result, PPOs, with their potential for personalized product packaging and cost-containment, proliferated. As competition has increased in other medical markets around the nation, PPOs have emerged as a major force on the health care scene. By the early 1980s, PPOs had gained a significant foothold in Ohio, Florida, Colorado and Illinois. By the mid-80s, PPOs were operational in 43 states.

TYPES OF PPOS

"To be a PPO, an entity must establish and control a managed care network of physicians, hospitals, ancillary providers, ancillary facilities and entities which provide for the health care covered under a benefit plan," AAPPO Chairman Douglas L.Elden has explained.

Generally, but not always, a PPO offers both physician and hospital services. Some PPOs offer only physician services; others only hospital services. In response to increasing market demand, many progressive PPOs are broadening their approach to include ancillary services, such as dental care, vision care, psychiatric care, substance abuse programs, pharmacy services, etc., and are incorporating ancillary facilities, such as freestanding ambulatory care centers and outpatient surgical centers, into their networks. Other providers, such as dentists, podiatrists, chiropractors, psychologists, physical therapists, etc., may be an integral part of this ancillary network or may create their own PPOs which then are plugged into the service network.

The physician component of a PPO may be comprised entirely of primary care providers, or entirely of specialty providers, or may include many types of physicians. In some areas, the philosophy of the PPO is that it is better to include only certain physicians or hospitals in the PPO partnership; here, the theory is that while a smaller panel provides limited patient accessibility to providers, it can select the best quality providers and reward them by directing more patients to them. In other places, it is felt that everyone benefits if all physicians and hospitals participate because there is greater accessibility to more providers and a larger panel is more marketable.

SPONSORSHIP OF PPOS

Type of sponsorship	No.	% of total
Hospital/ physician joint venture	104	18%
Commercial insurance company	99	17%
Physician	70	12%
Hospital	47	8%
Blue Cross/Blue Shield	44	8%
Pharmaceutical	41	7%
Health care corporation	26	5%
Hospital/insurer	19	3%
Blue Cross	18	3%
Entrepreneurial	17	3%
TPA	12	2%
Private	8	1%
Blue Shield	7	1%
Foundation for medical care	7	1%
Employer	5	1%

As the above table shows, PPOs are sponsored by a diverse variety of entities. The largest number are sponsored by hospitals and physicians in joint ventures. The number of PPOs sponsored by commercial insurance companies has grown rapidly as has the number sponsored by Blue Cross/Blue Shield plans.

Source: Directory of Operational PPOs, *American Association of Preferred Provider Organizations, 4th edition, May, 1987.*

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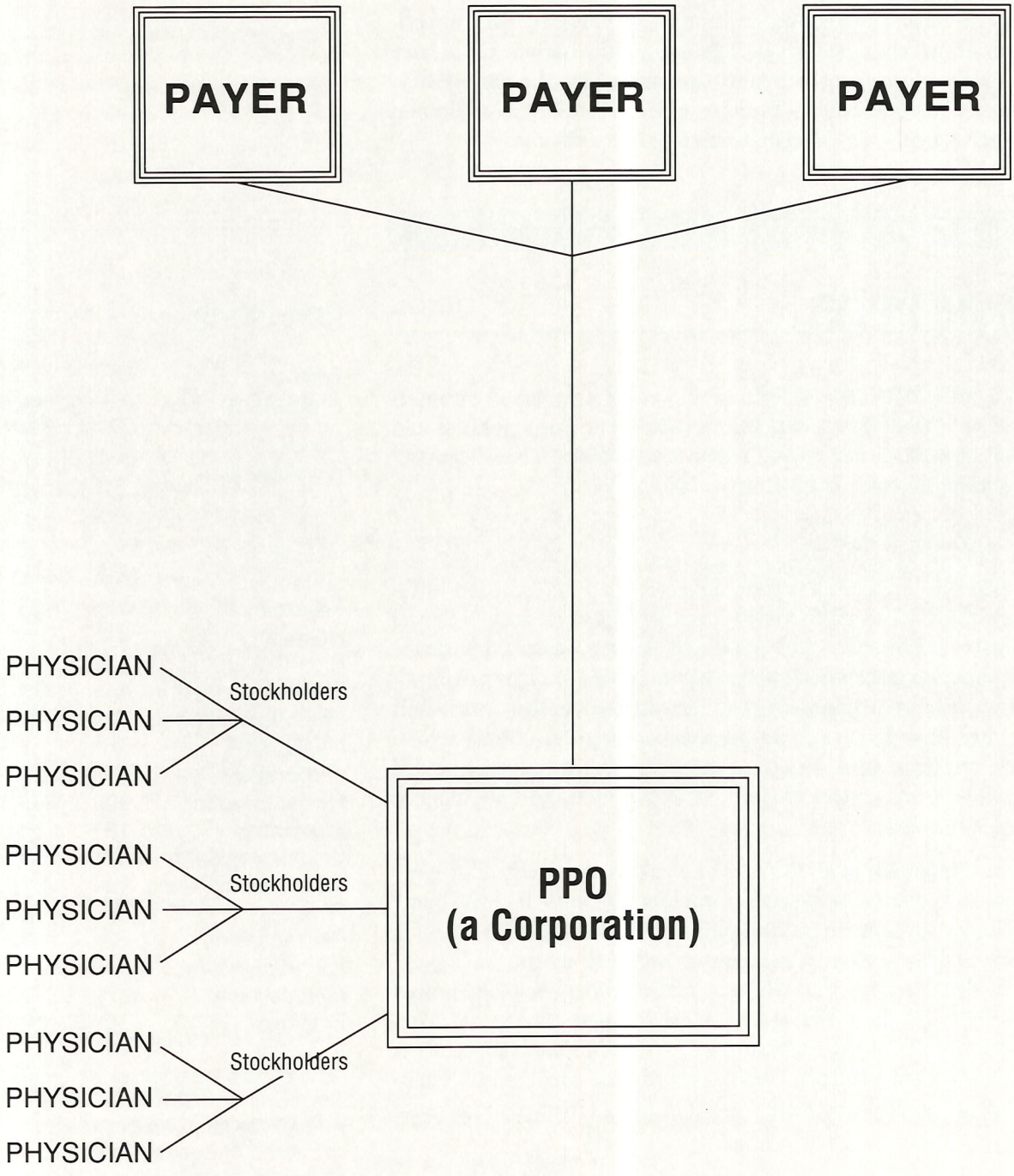
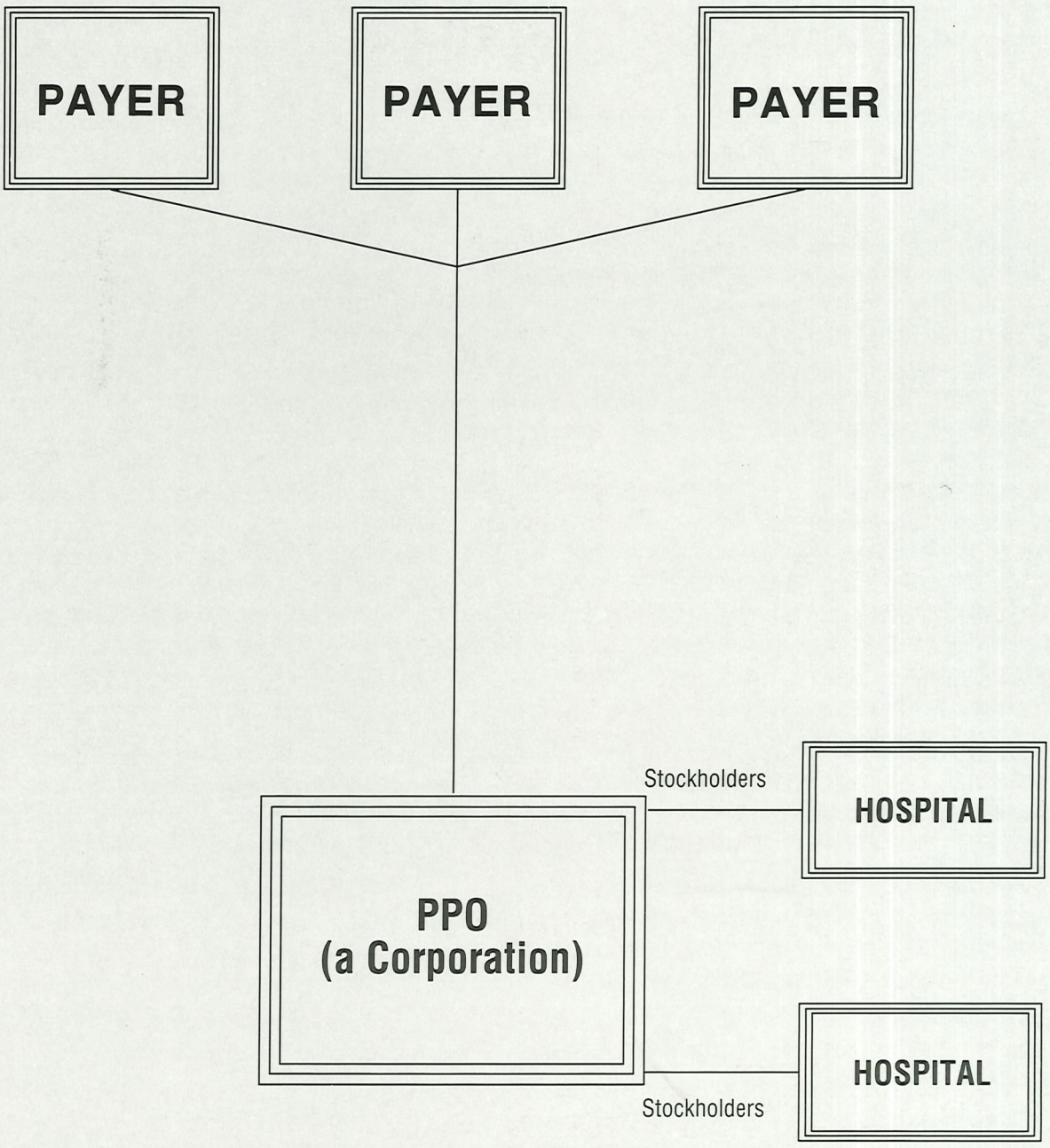
OWNERSHIP CHART OF PHYSICIAN SPONSORED PPO



An ownership diagram of a physician-sponsored PPO in its simplest form might look like this. Physician stockholders form a PPO corporation and then can negotiate contracts with payers to provide medical services.

OWNERSHIP CHART OF HOSPITAL SPONSORED PPO



An ownership diagram of a hospital-sponsored PPO is very similar to that of a physician-sponsored PPO. Hospitals are stockholders who create a PPO corporation as the vehicle for negotiating contracts with payers to provide hospital care.

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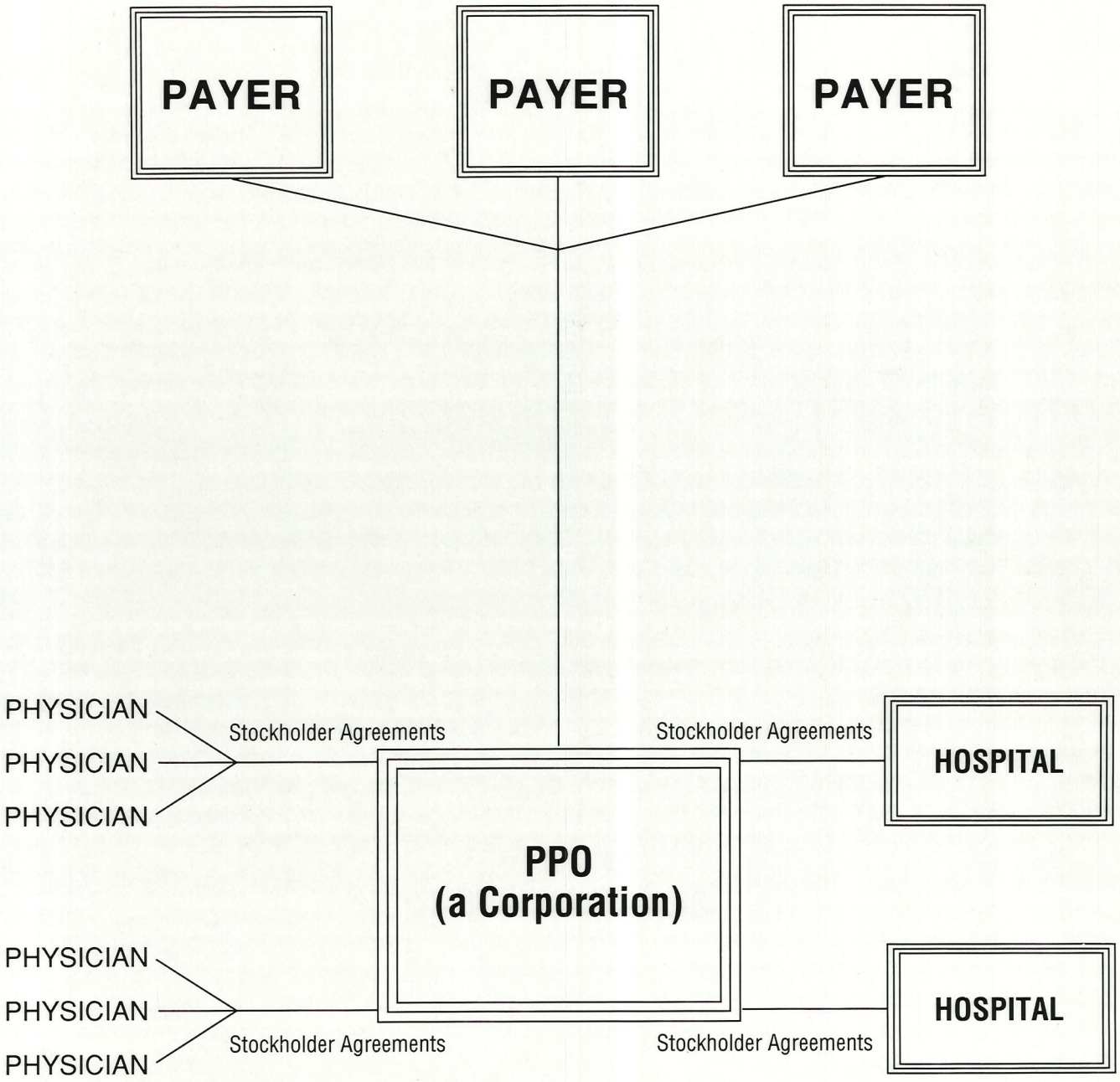
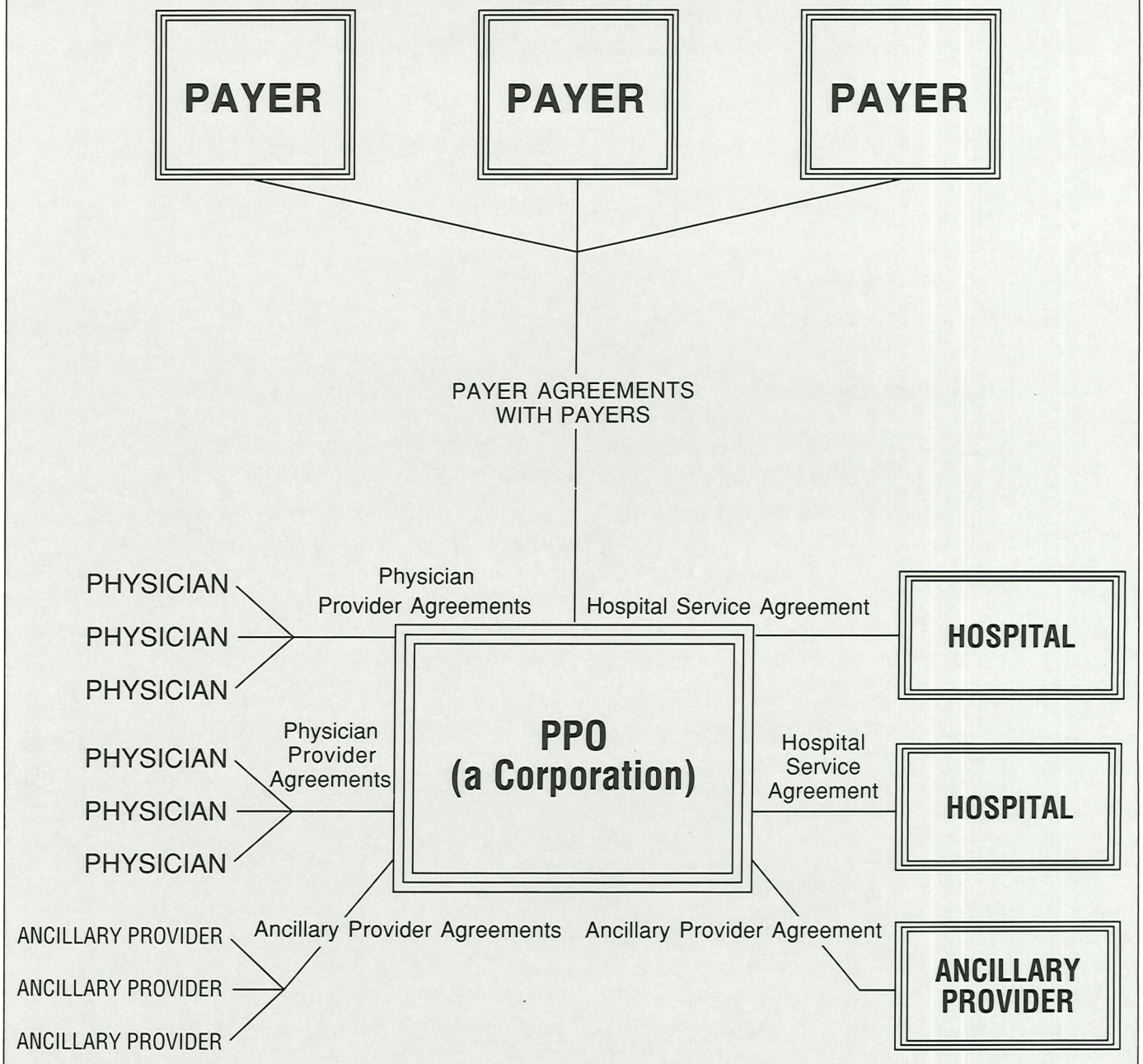
OWNERSHIP CHART OF HOSPITAL-PHYSICIAN JOINT VENTURE PPO



An ownership chart of a PPO created as a joint venture between a hospital and physicians might look like this. Physicians and hospitals negotiate stockholder agreements with the PPO corporation, which then can negotiate contracts with payers for both medical and hospital services.

OPERATIONAL CHART OF PROVIDER PPO



From an operational standpoint, a provider PPO negotiates physician provider agreements, ancillary provider agreements, hospital service agreements, and sometimes other ancillary provider agreements with other facilities in which some types of care are provided in order to negotiate payer agreements for broad-scale hospital, medical and related health care services.

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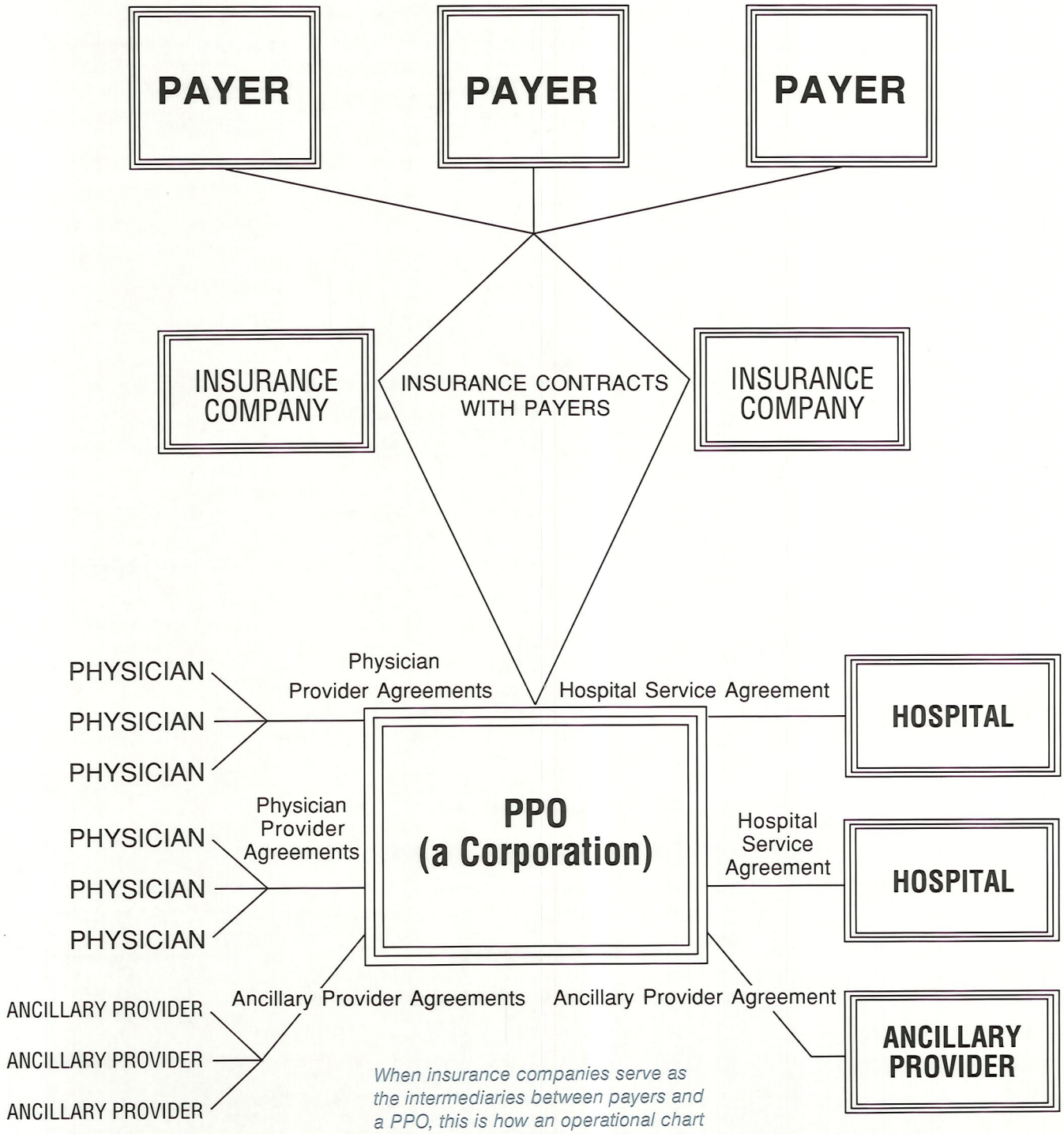
OPERATIONAL CHART OF PPO WITH INSURED PRODUCT (Marketing of Insured Product)



When insurance companies serve as the intermediaries between payers and a PPO, this is how an operational chart might look. The PPO corporation, with agreements with physicians, hospitals, ancillary personnel and facilities, markets its services through insurance companies who negotiate insurance contracts with payers.

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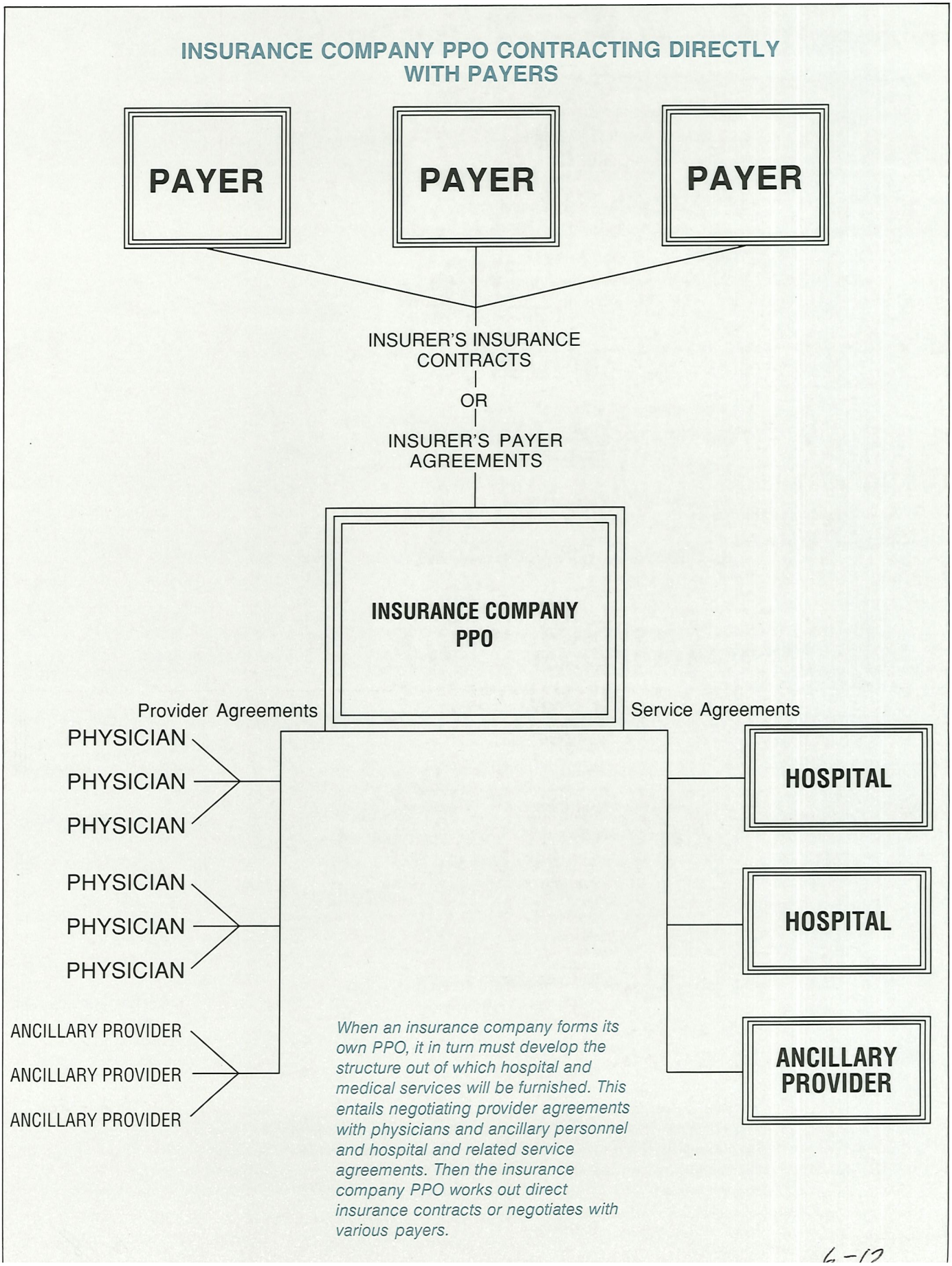
INSURANCE COMPANY PPO CONTRACTING DIRECTLY WITH PAYERS



When an insurance company forms its own PPO, it in turn must develop the structure out of which hospital and medical services will be furnished. This entails negotiating provider agreements with physicians and ancillary personnel and hospital and related service agreements. Then the insurance company PPO works out direct insurance contracts or negotiates with various payers.

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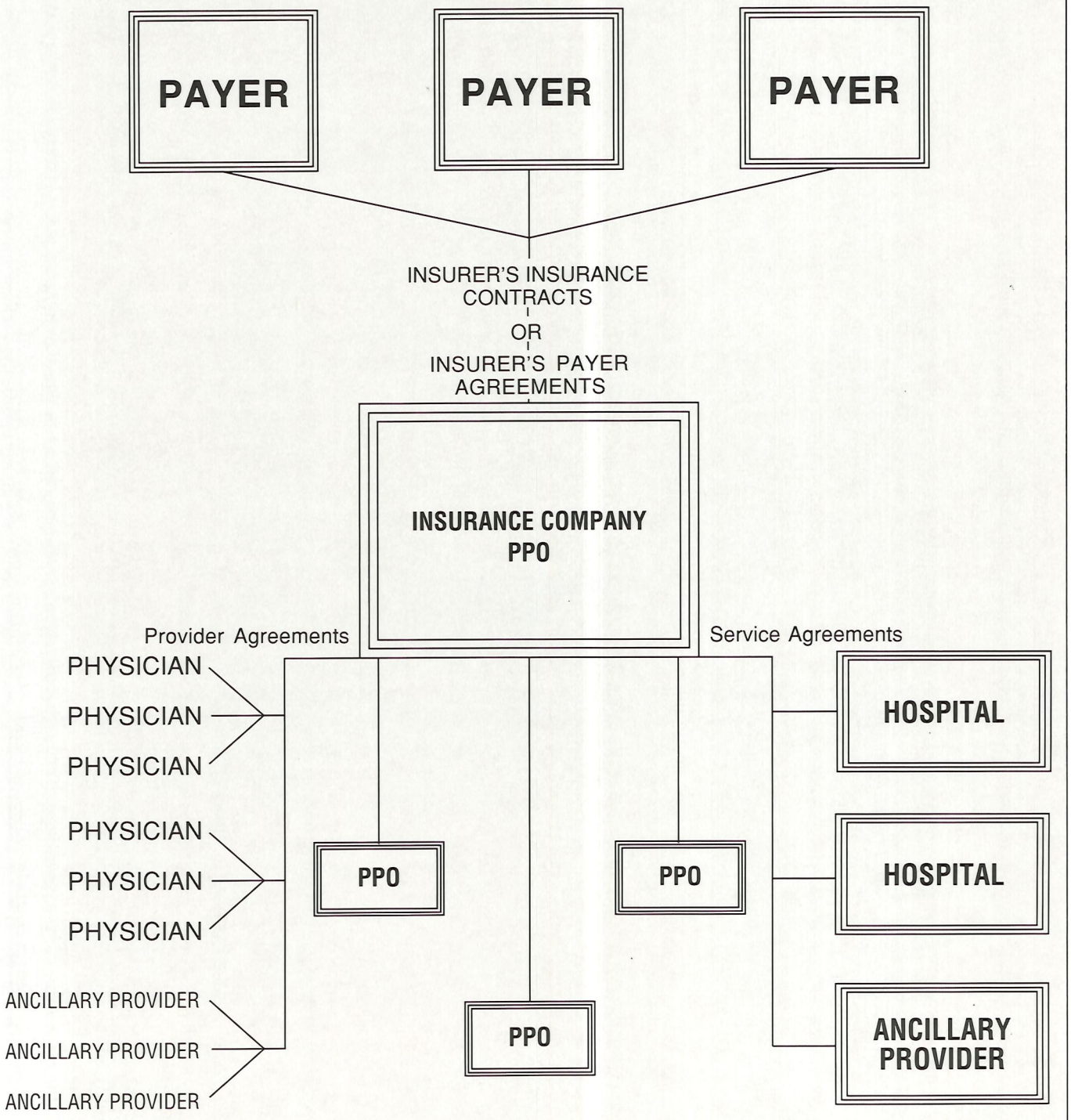
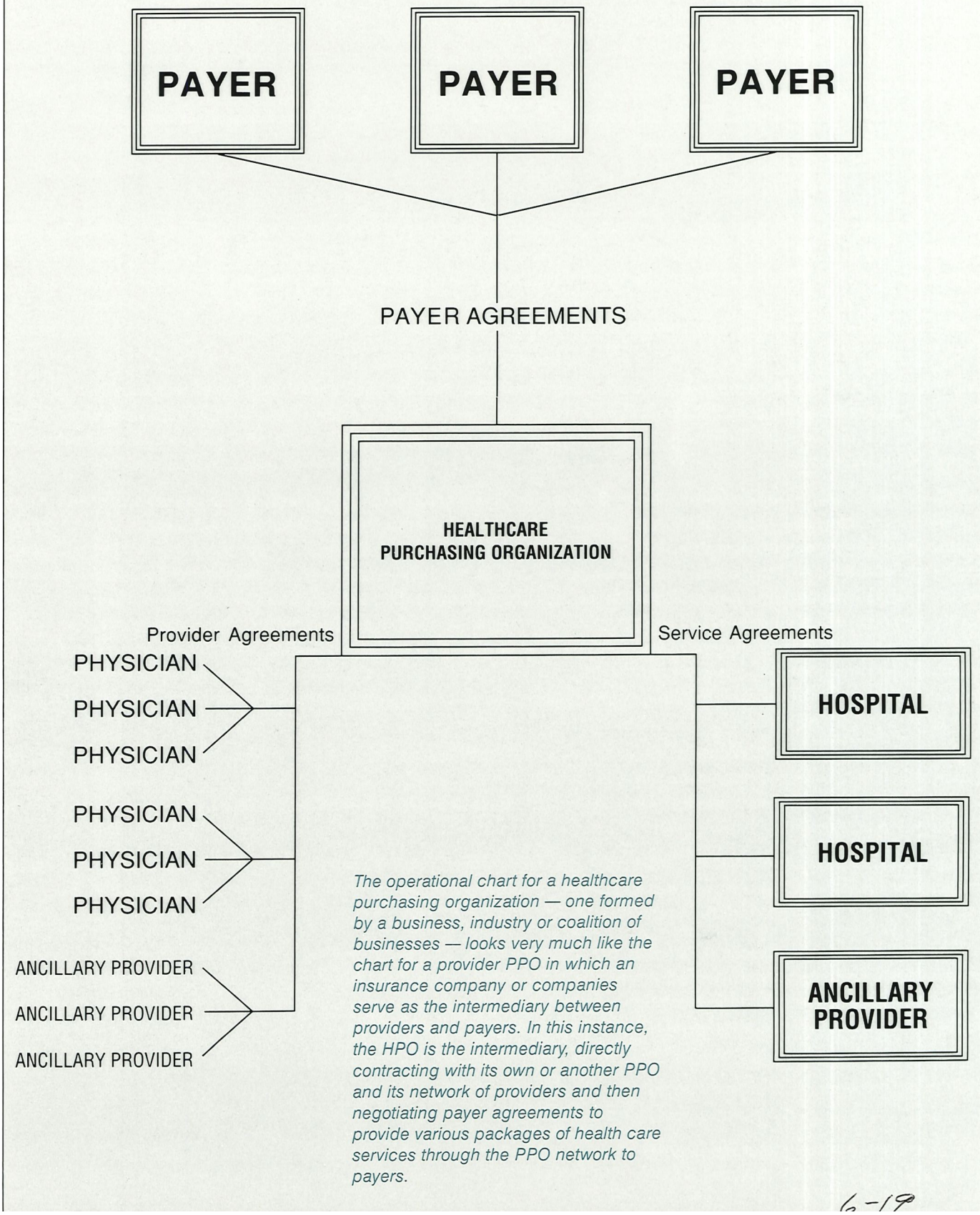
INSURANCE COMPANY PPO CONTRACTING DIRECTLY WITH PAYERS AND PROVIDING HEALTHCARE SERVICES VIA NETWORKING OF NETWORKS



As the insurance company PPO broadens its coverage base, it must expand its service network, drawing in more physicians, hospitals, and other providers. It may spin off additional PPOs from the basic corporation, each involving agreements with other provider networks. The result is a networking of health care networks, integrated into a working arrangement for providing services to payers in different locations and with different service packages.

OPERATIONAL CHART OF HEALTHCARE PURCHASING ORGANIZATION (HPO) CONTRACTING DIRECTLY FOR SERVICES



The operational chart for a healthcare purchasing organization — one formed by a business, industry or coalition of businesses — looks very much like the chart for a provider PPO in which an insurance company or companies serve as the intermediary between providers and payers. In this instance, the HPO is the intermediary, directly contracting with its own or another PPO and its network of providers and then negotiating payer agreements to provide various packages of health care services through the PPO network to payers.

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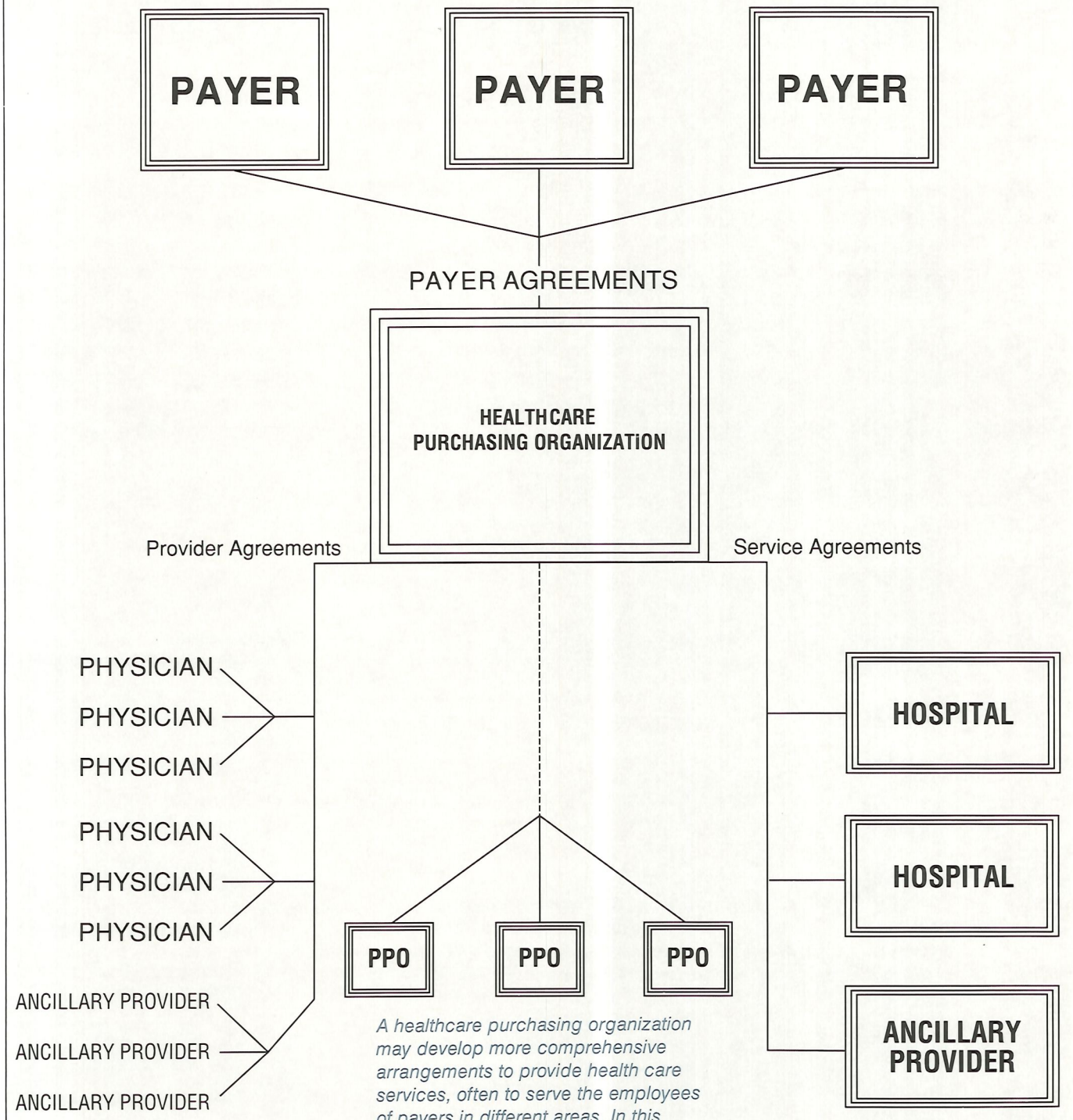
OPERATIONAL CHART OF HEALTHCARE PURCHASING ORGANIZATION (HPO) COMBINING DIRECT CONTRACTING AND A MORE EXTENSIVE HEALTH CARE NETWORK



A healthcare purchasing organization may develop more comprehensive arrangements to provide health care services, often to serve the employees of payers in different areas. In this instance, the HPO contracts directly with payers but establishes linkages with a number of PPOs, expanding its network of physicians, hospitals, and ancillary providers and facilities.

The nine diagrams illustrating various types of PPOs appearing in this section were prepared by Douglas L. Elden, Esq., Altheimer & Gray, Chicago. Elden is Chairman of the American Association of Preferred Provider Organizations.

WHO SPONSORS PPOS?

PPOs have been established by physicians and hospitals (separately or in joint ventures), by medical societies, by insurance companies, by individual purchasers (such as a large business or industry) or by buyers' groups formed for this purpose, and by entrepreneurs (such as brokers, third party administrators, and for-profit management firms).

Initially, providers — either physicians alone or hospitals alone or the two working together in a joint venture — established PPOs, mainly to provide an alternative to the HMO programs that were springing up. More recently, insurance companies have been forming PPOs, as have some self-insured companies or coalitions of businesses and industries. Entrepreneurially-established PPOs are a rather new entry into the field.

While the insurers have moved into the PPO arena in large numbers recently, they often draw upon existing PPOs for services, weaving them into their new networks rather than creating new groups of providers themselves. So while the insurer is the sponsor of the PPO, the physicians and hospitals who provide the services may be the same ones who initially formed their own PPOs. That is because there is nothing to preclude physicians or hospitals from joining as many PPOs in their area as they wish.

HOW PPOS ARE STRUCTURED

How a PPO actually is structured is often a function of sponsorship. On the previous pages, some charts showing typical ownership and organizational arrangements for some types of PPOs are shown. Here is a brief description of some of the structural models.

Provider-sponsored PPOs — In these PPOs, a corporation is established, and either physicians or hospitals or both become stockholders. The PPO then can negotiate payer agreements to provide specified services. A few local and state medical associations have sponsored development of PPOs, often through existing foundations for medical care. About 40% of PPOs now operating fall into the provider-sponsored category.

A note of interest: PPO sponsors also may include IPA (Individual Practice Association)-model HMOs. These entities sometimes offer PPO options to subscribers as well, since the IPA can easily convert its services to the PPO format.

There are nearly 300 such provider-sponsored PPOs operating, ranging from very small, local ones to large networks operating in many regions

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and states. Some typical examples are Florida Health Choice Plan, South Florida; Preferred One, St. Paul, MN; CompMed, Tulsa, OK; and California-based Preferred Health Network.

"PPOs have tended to resemble the legal structures of their sponsoring organizations. If they were created by hospitals or hospital/physician joint ventures, they tend to be nonprofit organizations. Those sponsored by entrepreneurs are for-profit ventures. Those sponsored by insurance companies and Blue Cross/Blue Shield organizations may have a separate legal identity, or they may be created as a division within the sponsoring organization. While legal structure itself has very little to do with the actual success, it consumed an inordinate amount of discussion in the early days."

Marcus Merz
President
Preferred One
St. Paul, MN

Insurer-sponsored PPOs — Blue Cross/Blue Shield plans in many states and a number of commercial insurance companies have been moving into the PPO market, putting together their own product — but not necessarily their own PPO network — for marketing purposes. Some insurance-sponsored plans are those offered by Metropolitan Life, The Travelers Companies, and American General. A consortium of carriers operates Private Health Care Systems, and Partners National Health Plan is a joint venture of Aetna and Voluntary Hospitals of America.

Buyer-sponsored PPOs — Recently, self-insured employers — individually, through multi-employer trust funds or business coalitions — and union trust funds have created their own PPOs in an effort to get a direct handle on health care cost-containment for their employees and memberships. The vehicle through which buyer-sponsored PPOs develop is termed a Healthcare Purchasing Organization (HPO). Some examples include The Florida Health Alliance Corp., established by a coalition of 19 companies in the Jacksonville, FL area; Teamcare, a national network of PPOs sponsored by The International Brotherhood of Teamsters; and Community Care Network (CCN), launched by a San Diego, CA business coalition.

There are some product differentiations related to the PPO mechanism and terms that buyers and payers will encounter. The term sometimes used by a carrier such as Blue Cross/Blue Shield when setting up its own PPO or negotiating a marketing arrangement with an existing one so that it can broaden its available options to clients is "Insured Product Option (IPO)." This is an arrangement worked out between the insurer and provider to deliver PPO-type services covered by the Blue plan to employers or union trusts.

Sometimes purchasers negotiate direct contracts with providers in what is termed Preferred Provider Arrangements (PPAs). Other employers negotiate selective contracts with certain providers on the basis of competitive bidding. Or, business coalitions publish lists of providers who are known to be cost-conscious in managing care. These direct contracts and other arrangements all are cost-containment attempts and arrangements but are not truly PPOs.

Entrepreneurial or vendor-sponsored PPOs — Some PPOs are for-profit enterprises established by brokers, third party administrators (TPAs), utilization management firms, or other vendors peripheral to the operation of a successful PPO program. Med Network in California, sponsored by Admar Corporation, a third party administrator, and Benefit Panel Services are two examples of profit-minded PPOs. Health Care COMPARE , Downers Grove, IL, a utilization management firm, recently purchased Affordable Health Care Concepts, a large California PPO. As more third

party administrators develop extensive computer, claims processing and management networks, it is possible that they, too, will become PPO owners as well as operators.

HOW A PPO OPERATES: THE HEALTH CONNECTION

A PPO is a mechanism for integrating a number of services and facilities into a working, cost-effective health care program which can then be marketed in a variety of ways to any number of buyers. Inherent in its success are continuing efforts to monitor quality and cost — in other words, to manage care.

A PPO links buyers or payers and providers into a network. Negotiations and agreements are the elements which weave this intricate network together. The more extensive and comprehensive the eventual PPO network, the more numerous and complex are the steps which must be taken to put all the pieces in place. Regardless of the complexity of the PPO, however, there are some basic agreements that must be hammered out. These are either direct contracts or subcontract arrangements.

- The PPO must negotiate individual physician provider agreements in which the doctors agree to accept certain fees or fee schedules for their services, and at the same time agree to abide by the management controls of the PPO.
- Hospital services, usually offered by PPOs, must be assured via payment and coverage arrangements in service agreements with each participating hospital.
- Similar agreements about services and fees and acceptance of management controls must be worked out with any ancillary providers — individuals, groups and facilities.

These contractual arrangements assemble the particular services that a given PPO will offer to buyers.

HOW PPO SERVICES ARE FUNDED AND DISTRIBUTED

Funding mechanism	Distribution system
Fully insured payer	Through broker, employed agent of insurer
Self-insured payer	Through consultant, third party administrator (TPA), or stop loss carrier

The buyers of PPO services either are fully or self-insured. They purchase health care services through a PPO in different ways, depending on how they fund these benefits.

Source: Jerry T. Payne, Vice President, Marketing, Preferred Health Network, Los Angeles, CA

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Next, payer agreements must be negotiated between the PPO and the purchaser for the particular package of services offered. Sometimes these agreements are made directly; in other instances, an insurance carrier is the middleman in the negotiations.

Now the links between the purchasers and the providers have been established. These links can become extremely complex as the size and type of PPO expands. A large regional PPO, for example, might negotiate agreements with a number of other smaller PPOs in different areas. This may be accomplished by dealing with local groups one by one or via contracting or licensing arrangements.

"It is no longer accurate to say, as the old adage, that 'Once you've seen one PPO, you've seen one PPO.' There *are* basic components which the marketplace requires to meet the criteria of a successful PPO."

Douglas L. Elden
Chairman
AAPPO

Here is an instance in which a PPO network can be specifically designed to provide for the needs of an employer whose employees are scattered throughout a region or state. The primary PPO network may be able to provide services to the majority of employees, but it must link with at least one or even several other PPOs in areas where other workers of that employer are located. The specific details will vary as will the networks themselves. What is important is that these contracts and arrangements lay the foundation for a comprehensive arrangement for providing health care services — one that becomes more marketable as its coverage expands.

Cost is a key consideration but so is quality. No PPO can operate, remain cost-efficient, and keep quality of care high without the support of a number of important functions. These include provider selection, claims processing, utilization management, with a lengthy array of cost-containment techniques, data collection and analysis, marketing and quality assurance. Consequently, all of these functions must be provided for, either in-house or by other organizations and firms.

PPO networks are developed in a variety of ways, with two types representing both ends of the spectrum — the collaborative and the fully integrated versions. In the collaborative PPO, all health plan services are present, but different entities bring together the individual components. For example,

HOW DISTRIBUTION SYSTEMS VARY BY GROUP SIZE

Funding mechanism	Group size	Distribution system
Fully insured	1000+ employees	Via national brokerages
	100-999 employees	Via regional brokerages
	1-99 employees	Via independent brokers networked by general agents
Self-insured	1000+ employees	Via national consultants
	100-999 employees	Via regional consultants
Partially self-insured	1-99 employees	Via independent brokers networked by general agents

The chart shows the different distribution systems for PPO services. The distribution systems vary according to group size.

Source: Jerry T. Payne, Vice President, Marketing, Preferred Health Network, Monterey Park, CA.

utilization review and quality assurance functions may be performed as an outside service rather than performed by the PPO network itself. More of the related but important functions are subcontracted out to other firms and organizations.

In the fully integrated PPO, all health plan functions, including utilization review and quality assurance, management information systems, third party administration, marketing, insurance agency functions, health plan administration, and related legal regulatory capabilities, are assembled into one overall network. The collaborative style is most common today, but there are many different combinations and types on the scene.

Whatever its particular structure, the PPO provider network reaches out to establish relationships that could produce payers and patients. These might include relationships with health benefits underwriters, insurance companies, HMOs, self-funded employers, union trusts, government programs, third party administrators, insurance brokers and agencies, health care consultants, and others. Some, but not all, of these relationships may require formal codification in legally binding agreements.

Today, most purchasers of health care want a network which at the minimum includes both physician and hospital components, and there are increasing requests for "full service" comprehensive networks. "Purchasers are learning that to engage only one component... eliminates those areas which are capable of saving the most dollars, that is, the appropriate use of an entire network of health care providers to manage care," emphasizes AAPPO Chairman Douglas L. Elden.

Substantial savings do not arise by constantly cutting back physicians' fees or bargaining down hospital charges, Elden says. Health care in the managed setting is high volume/low margin. Initial savings generated by various health care programs in the first year or two come mainly from reducing inpatient admissions. From that point on, the real savings come from effective management of the network itself.

The PPO partnership extracts provider loyalty in anticipation of a larger patient volume. That loyalty must translate into provider cooperation in utilization management programs, provider agreement to fee schedules, provider provision of data and records. Without providers who will deliver high quality care, the PPO cannot meet its obligations to its buyers and payers. Interdependence is the glue that holds the network together.

Elements in a PPO

- A financial incentive to deliver services, tempered by controls assuring their medical necessity
- Freedom on the part of patients to choose health providers
- An established, controlled managed care network of providers
- Established and enforced criteria for provider selection
- Established, effectively operating utilization management systems to monitor quality of treatment rendered, identify inappropriate use of services, and assist in the redesign of benefit plans

- Sophisticated data systems to retrieve and analyze information about providers, care provided, quality and cost as well as to conduct the business operations of the PPO efficiently
- Adequate capitalization and administrative sophistication to assure the financial viability of the PPO

THE PPO GOAL: EVERYBODY WINS, NOBODY LOSES

As the health care delivery and financing systems have undergone change in response to cost-containment pressures and a shifting picture with regard to physician supply and hospital occupancy, new combinations of the two elements have rearranged the way that Americans pay for and obtain their medical care.

The first wave of enthusiasm has been for the HMOs — which did effectively reduce outlays for health care by cutting hospitalization drastically. Per head sums were negotiated to cover all costs of caring for individuals enrolled in these plans, and the HMO physicians went on risk for any cost overruns.

Chafing at the push to reduce care and limit patients' free choice of physicians, as well as their own professional autonomy, a number of physicians and hospitals then countered with a different kind of cost-containment approach — the PPO.

WHAT EMPLOYERS SEEK IN HEALTHCARE PURCHASING ORGANIZATIONS

1. Leverage to negotiate better financial arrangements with their providers
2. A direct voice in the structure and operation of the HPO
3. Local control and development of an HPO that targets area-specific issues
4. To treat health care costs like any other costs of doing business in seeking quality care at more reasonable price
5. Direct access to health care data
6. Control over monitoring the effectiveness of the HPO
7. Ability to revise structure of the HPO and add modules if desired
8. An HPO option without breaking relations with current insurance company or third party administrator
9. To provide employees with information and direction to access care from providers who have been screened to meet certain criteria

Employers list these nine reasons why they might create Healthcare Purchasing Organizations (HPOs) to create their own PPOs to provide health care to employees.

Source: Ralph S. Pollock, President, Connecticut Business Coalition on Health.

The PPO promises cost savings without threatening to undertreat. It preserves, to a large degree, free choice of provider, except for those economic pressures built into the programs to make it more attractive to use the "preferred providers."

Initially, PPOs negotiated discounted fees with health care providers in order to offer a cost-competitive package to buyers. Now the philosophy is changing. It is becoming increasingly obvious that it is more cost-effective in the long run to bring high quality providers into the PPO network and to pay them at or close to their usual fees.

"Good doctors save money and sometimes a PPO will pay them close to their full fees to get them into the network. That really is the direction in which we are moving now," says Lynn Dowling, President, American Association of Preferred Provider Organizations. The point, Dowling said, is that in the PPO setting, everybody wins — the providers, the payers and, of course, the patients.

"In the increasingly mature HMO markets, providers are becoming anti-capitation and anti-risk sharing."

Marcus Merz
President
Preferred One
St. Paul, MN

What providers like about PPOs

- PPOs retain fee-for-service
- Physicians retain autonomy in treating patients
- Physicians can anticipate a larger patient volume
- The PPO markets their services
- Physicians are not at risk if a plan has cost overruns

What patients like about PPOs

- Freedom to go outside the system to providers of choice even though it costs more
- Minimal fears of being undertreated
- Lower health insurance premiums
- Sometimes expanded benefits
- No claims to file

Since the PPO plan falls somewhere between a traditional indemnity plan and other types of managed care plans, it is often a more acceptable approach for many patients. It can be overlaid onto an indemnity plan easily and its provisions are not overly restrictive or difficult to understand. The patient decides when he or she wants to use other providers not in the plan.

What buyers like about PPOs

In this era of the "triple option" health care plan for many employees, a PPO brings yet another choice. There is little doubt that the PPO arose as an alternative to the HMO. It conforms to many of the expressed desires of health care purchasers, including:

- Flexibility
- Predictability of costs
- "One-stop" shopping
- Provision of data on care provided and related costs
- Assurance of good providers

productive partnerships for cost-effective, quality health care

- Ease of facilitation
- Acceptability to employees and/or insureds

Many Americans, including a lot of employers and unions, still favor the traditional fee-for-service medical system. The PPO preserves much of this philosophy but builds in cost-containment features. Savings from a well-managed plan flow back to employers.

PPO plans can be tailored easily to a given employer's preferences and needs. It is not an all-or-nothing program. It is an approach that provides purchasers with more say in system planning and design. Also, there may be fewer regulations and requirements to meet with a PPO than with other managed care programs, like HMOs.

"A PPO removes the nagging concern that there is an incentive not to treat in a health plan like an HMO. In a PPO, there is an incentive to give care. However, that makes employers worry about the presence of very strong utilization review to guard against providing too much care."

Ralph L. Pollock
President
Connecticut Business Coalition on Health

Ralph Pollock, President of the Connecticut Business Coalition on Health, Hartford, CT, says one thing employers like in particular about PPOs is their flexibility. "HMOs had to meet legislative regulations to get started and that took away some flexibility. As a result, employers who initially had great hopes for HMOs are now becoming more cynical about their ability to continually provide cost-effective quality care."

PPOs preserve some freedom of choice for those who enroll, because patients can decide at point of service which providers to use — a PPO member or nonmember. Because a PPO can be grafted onto an existing indemnity plan, a beneficiary can participate in a PPO without changing a relationship with an existing carrier, Pollock said.

Buyers of health care want to purchase the highest quality of care possible to save money, Pollock emphasized. His own coalition, which is comprised of 42 area companies, is establishing a Healthcare Purchasing Organization (HPO), or PPO, for its own members. The PPO is expected to be in place by mid-1989.

Pollock believes the Connecticut PPO will give employers what they have said they want, namely: (1) a direct voice and stake in their organization; (2) local control and development; (3) the opportunity to treat health care costs like any other costs of doing business; (4) aggregated, statistically meaningful, comparable health care data not now available from other health plans; and (5) continual monitoring of the effectiveness of the PPO. Finally, employers will have flexibility to add or subtract various service modules from the plan as they see fit.

EMPLOYER GOALS FOR A PPO

These are five specific goals which employers have defined for PPOs with which they negotiate.

Source: Ralph S. Pollock, President, Connecticut Business Coalition on Health.

1. Establish accountability for *quality* of care among providers.
2. Reduce ambulatory health care use and claims costs.
3. Reduce hospital use and claims costs.
4. Establish recognition as important health care clients and develop a rapport with providers.
5. Encourage employers to use cost-effective, quality health care providers.

"Employers have felt more and more helpless about what they can do about health care costs," says Pollock. "This holds out the next promise of something they can do."

HOW PROVIDERS ARE PAID IN A PPO

PPOs were able to offer competitively priced health services because they initially required that providers signing on with them discount their fees substantially. Both physicians and hospitals and other ancillary providers and facilities agreed to these discounts.

The question purchasers sought to answer was: from what is the fee discounted? "If a hospital, for example, jacks up its fees and then negotiates a 20% discount to a PPO, little is gained. If a physician sees a patient twice instead of once in order to recoup the loss of discounted fees, any financial advantage in the PPO is lost," says Molly Miceli, Executive Director, Humana Health Care Plan, Itasca, IL.

Typically, physicians in PPOs have been reimbursed in one of four different ways:

- On a percentage of the usual, customary and reasonable (UCR) fees for certain services and procedures in the geographical area in which the PPO is located. "Payment at the 90th percentile of UCR at first may appear to be a 10% discount. In reality, the use of the 90th percentile may actually increase some physicians' fees," The Clearinghouse on Business Coalitions for Health Care pointed out in *What Employers Should Know About PPOs*. Thus, purchasers must guard against physicians skewing or hiking UCR rates to push up UCR levels.
- On the basis of a straight discount, i.e., 90% of a physician's fees. Since individual physicians' fees differ, each participating PPO doctor might receive a different fee for the same procedure. AAPPO leaders say this approach is falling out of favor.
- On the basis of a fee schedule developed with the application of a relative value scale. A relative value scale is not a fee schedule in and of itself. It is merely a method for weighting various procedures and services in relation to one another. If an appendectomy, for example, rates five units on a scale, then a triple bypass might rate 20. When a per-unit dollar conversion factor is applied to a scale, then a fee schedule can result. There is considerable interest in the new relative value scales being developed by an investigative team at Harvard University since these scales may try to account more equitably for so-called cognitive medical services, i.e., ongoing counseling and treatment for degenerative diseases, and other nonsurgical procedures, which traditionally have commanded a higher fee.
- On the basis of a negotiated fee freeze during the first fiscal year of the

PPO plan operation, with subsequent increases tied to the fluctuations in the Consumer Price Index.

Today, as selection of high quality, cost-conscious providers becomes increasingly important, the trend is away from flat discounting to negotiations that reimburse physicians according to fee schedules that often approach their usual and customary fees.

On the hospital side, it is now more typical for a PPO to negotiate a per diem or a DRG-type reimbursement. As with physicians, there have been three typical ways of reimbursing hospitals:

- On the basis of first-dollar discounts of a given percentage. "The employer should compare the discount with the cost of competing hospitals. In fact, it would be best if the discount was taken from a preestablished, set base...or schedule of charges...based on daily room and board, daily service, radiology, laboratory and all other ancillary charges," suggested the authors of *What Employers Should Know About PPOs*. These schedules of charges should hold for a specified period of time and subsequent increases should be pegged to changes in the Consumer Price Index. A related discount approach provides a volume discount after a certain number of patient days or admissions, or after a total of dollars billed by an employer or PPO purchaser have been reached.

- On the basis of per diem or per case fee schedules. Usually, various per diems will be negotiated for different categories of care, such as medical/surgical, obstetrics, or intensive care, because of the wide spread in costs among these services.

- On the basis of a case mix reimbursement, according to Diagnosis Related Groups (DRGs), as in Medicare.

Reimbursement systems differ for providers and hospitals. Physician providers most often are reimbursed on the basis of a relative value system or fee schedule. Fee-for-service is the third most prevalent method. Other ways of reimbursing providers include capped fee-for-service, preestablished discounts, a percentage of charges, capitation, usual/customary/reasonable (UCR), billed charges, volume pricing, gatekeeper, negotiated fees, contract rates and contracted fees. Hospitals most commonly are reimbursed on the basis of discounts on billed charges and per diems, with modified diagnosis related groups (DRGs) less prevalent.

Source: Directory of Operational PPOs, *American Association of Preferred Provider Organizations, 4th edition, May, 1987.*

REIMBURSEMENT SYSTEMS USED IN PPOS

For Providers

Reimbursement mechanism	No.	% of total
Relative value system	138	24%
Fee schedule	130	22%
Fee-for-service	101	17%

For Hospitals

Reimbursement mechanism	No.	% of total
Discounts on billed charges	129	34%
Per diems	118	31%
Modified DRGs	51	14%

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HOW CAN A PPO CONTROL COST WITHOUT SACRIFICING QUALITY?

PPOs do not put providers at risk for cost overruns, as do HMOs, but because there are fewer incentives not to treat, this must be counterbalanced by close scrutiny of utilization and by incorporation of a number of important utilization management controls. Central to these efforts are such processes as careful selection of providers, utilization management, data collection and analysis, and ongoing cost analysis. These processes are described in greater detail on the following pages.

"In the long term, PPO success will be based upon selection of cost-effective, efficient providers."

Marcus Merz
President
Preferred One
St. Paul, MN

PROVIDER SELECTION: THE KEY TO PPO GOALS

The process of utilization management begins with the careful selection and credentialing of good providers. "To be a PPO, an entity must establish and enforce selection criteria for *all* of the providers in its network," emphasizes AAPPO Chairman Douglas L. Elden.

The concept upon which a PPO's cost-containing approach is based is that good providers practice good medicine and operate good, efficient facilities. The physicians perform no unnecessary surgeries, monitor patients' medical conditions and recoveries carefully to avoid complications and/or readmissions, use diagnostic and therapeutic tests and tools judiciously and appropriately, and are not profligate with costly resources.

"The provider selection process cannot be an arbitrary one. Nor can it rely on the 'good old boy' methodology. Rather, definite criteria must be established and implemented during the selection process and maintained during the term of the agreement."

Edward Zalta, MD
Chairman of the Board
CAPP CARE
Fountain Valley, CA

Credentialing and accreditation are two criteria used by PPOs in selecting providers. Peer review and continued monitoring of performance assure that selected providers retain their skills, reputations for excellence, and concern for cost-effectiveness. Providers themselves establish the selection criteria and administer the selection/oversight process.

Utilization review, and concurrent and retrospective monitoring programs soon identify providers who game the system, unbundling charges excessively, running up costs for their own gain. PPO leaders have learned that rather than changing reimbursement systems, it is more important to identify such physicians, hospitals, and ancillary professionals and to weed them out.

"Remember, inappropriate services, that is, those not necessary, are not cost-effective, no matter how well performed."

Charles M. Jacobs
President
InterQual, Inc.
Westborough, MA

Because the initial PPOs were largely doctor- and hospital-sponsored, there were few efforts to impose rigid selection criteria for panelists. Political reality required that every medical staff member who wished to do so be permitted to join the PPO panel. The rationalization was that "we'll get rid

of the bad ones later." The accept-everyone theory is fast fading.

Today, say AAPPO leaders, buyers are specifying that quality, cost-conscious providers be selected, and they are increasingly asking to examine the selection criteria.

Selecting cost-effective, quality-conscious providers from among the hundreds of thousands in the U.S. to be PPO members is not an easy task, says Edward Zalta, MD, Chairman of the Board, CAPP CARE, Fountain Valley, CA. The problem is compounded when not only physicians but the full range of health care professionals are included. "It is, however, a process that must be undertaken if the PPO is to provide its users with a degree of certainty that quality care is the objective," he says.

"All medical professionals agree that the highest quality providers are also the most cost-effective. They make fewer mistakes in diagnosing illnesses, know how to treat conditions properly, avoiding traumatic and expensive procedures when there is a less intensive but equally effective alternative. They perform operations skillfully and successfully the first time. Quality care is more cost-effective in the long run."

Charles M. Jacobs
President
InterQual, Inc.
Westborough, MA

CAPP CARE has established uniform criteria for its selection process and membership retention, "assuring objectivity while giving true meaning to 'preferred,' " says Dr. Zalta. This plan maintains a comprehensive physician data base, uses extensive claims data files from payers to develop practice profiles, compares specialty-specific standards to detect aberrances in volume and intensity of services, and tracks how providers care for patients and bill for these services, using a computerized audit program.

"The entire provider listing... is further reviewed to identify those with known hospital disciplinary problems....and every applicant...undergoes a review of his/her professional liability record to make certain that each has an acceptable record and maintains professional liability coverage," Dr. Zalta explains.

"Good providers not only save purchasers, payers and patients money, but they have good clinical outcomes," says AAPPO's Lynn Dowling. "Since doctors determine treatment, doctors are the key to what that treatment should be and what it will cost."

One problem which every managed care program faces is that how physicians practice is a direct result of how they were trained. That is why the emerging guidelines and treatment protocols of PPOs serve an important educational function in demonstrating to the physicians the parameters that define good medicine, but do not contribute to unnecessary tests and procedures or over-long hospital stays.

"Any fundamental, lasting change in fee-for-service practice styles involves lengthy, time-consuming gathering of data; generating a consensus around appropriate practice patterns; disseminating information to physicians; and accomplishing incremental changes in practice patterns over a long period of time."

Marcus Merz
President
Preferred One
St. Paul, MN

UTILIZATION MANAGEMENT MAKES QUALITY CONTROL POSSIBLE

Utilization management is as critical to the success of a PPO as is the selection of the preferred providers. "Properly operated, effective utilization management programs can ensure quality medicine delivered at a reasonable and predictable cost," says Douglas L. Elden, AAPPO Chairman. PPOs with effective utilization management systems will:

- Identify quality and cost-efficient providers
- Monitor quality and cost-effectiveness of treatment rendered to patients
- Modify provider and patient behavior
- Assist in the design of benefit plans that channel patients to good, cost-efficient providers and to the most appropriate level of care
- Encourage cost-consciousness among patients
- Promote the use of preventive health habits and lifestyles

The critical element of utilization management is information and education. Patients and providers must be guided toward properly accessing and using the health care system.

Some specific processes that must be conducted, in addition to development and enforcement of provider selection criteria, include:

- **Prior authorization procedures** — to determine the need for a hospital admission, the appropriateness of the intended procedure or care, and the completeness of the preadmission evaluation. The purpose is to assure that care is needed and appropriate, that it is being provided in the appropriate type of facility, and that overutilization does not occur.
- **Preadmission certification** — to obtain prior approval for a given admission on the basis of sound medical criteria and to establish an expected length of stay. When these steps have been completed, the admission is certified. This program meshes with prior authorization procedures, using previously acquired patient data to set parameters for lengths of stay.
- **Second opinion programs** — to verify a legitimate need for surgery and to prevent unnecessary operations.
- **Concurrent review of care** — to monitor a patient's care while admitted or undergoing treatment. This is an ongoing process intended to assure that a patient receives optimal care, but that the hospital stay is kept to the minimum. Because review is concurrent, if circumstances dictate, earlier certified lengths of stay can be approved. Such review facilitates most effective use of personnel, facilities and other resources.

"Physicians and hospitals must never lose sight of the fact that patients are their primary customers and that protecting the quality of care should be their most important goal. However, the reality of the health care marketplace is that the quality of care must be protected while working within the boundaries of cost-effectiveness."

William L. Amos, Jr., MD
President
Preferred Health Options
Columbus, GA

"Referral patterns, friendships, and many other personal factors bind practicing physicians into a network of mutual obligations and courtesies. Review processes are inevitably influenced, and sometimes regrettably compromised, by these informal and personal arrangements and relationships."

Robert J. Becker, MD
Chairman of the Board
Healthcare COMPARE
Downers Grove, IL

- **Discharge planning** — to determine the appropriate time when a patient is ready to leave a hospital and the next level of care appropriate for the patient, i.e., skilled nursing facility, custodial care facility, rehabilitation facility, or home. Discharge planning evolves from concurrent review of care.
- **Retrospective review of care** — to monitor claims after a patient is discharged for indications of unnecessary use of ancillary services and procedures, such as tests, consultations, etc.

"A retrospective review may be initiated if a disturbing trend is noticed — an unusual pattern of emergency admissions is one example," says AAPPO in its publication *What Is a PPO?* Some PPOs use retrospective review to develop a profile of practice patterns of individual physicians and hospitals. Retrospective review can be a PPO's most important diagnostic tool — it pinpoints problems in the system. The information can be used to educate providers whose treatment patterns are outside of the norm or patients who are using the system improperly. Utilization management data can be invaluable in the redesign of benefit plans."

In the future, retrospective review of care may expand further to include ambulatory review. As more care moves out of hospitals and institutions and into the outpatient setting, various functions of PPO utilization management will follow, so that costs cut in one place do not escalate in another setting.

One other aspect of utilization management merits comment here. A directional shift in utilization review seems to be taking place. Some PPOs are moving away from reliance upon traditional local utilization review systems operated by local physicians. Some have been successful in assessing and enforcing quality and reducing utilization, but many purchasers of health care look upon these systems as "the fox guarding the henhouse." Purchasers fear that referral patterns and friendships among physicians compromise utilization review. There have been instances in which performance of the utilization review function by conscientious physicians has cost them referrals. So PPOs are looking to outside utilization management companies to avoid the pitfalls of traditional peer review, suggest several AAPPO leaders.

"The essence of the PPO's task is to control the charge per case, in terms of both quality and proper use of resources."

Linda L. Kloss
Senior Vice President
MediQual
Westborough, MA

Not only are PPOs seeking to introduce more objectivity into utilization review, they are watching closely as new methods for measuring quality evolve. As they do, these, too, will be incorporated into their concurrent and retrospective review processes.

Utilization management is a delicate balancing of appropriateness, efficacy and effectiveness of care with ongoing efforts to hold down the costs of that care. It should and must be at the heart of every successful PPO system.

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DATA COLLECTION AND ANALYSIS: AN ESSENTIAL INGREDIENT FOR A PPO

When a health care delivery system is meshed with a health care financing system, then information systems must be developed to assure a steady flow of current data in both directions. The payers/purchasers must know what their outlays for the health care product will be, and the providers must bill and be paid for their services. The exchange, while not always like a true insurance plan, will require many of the same types of data:

- Actuarial studies upon which proper prices can be set for purchase of care (premiums)
- Underwriting activities which lead to assumption of the liability for providing care at a specified price to a designated group of people (insurance)
- Claims processing for billing and payment purposes (claims administration)

Payers and purchasers today factor price into their decision-making about how, where, and from whom they obtain health care services. So managed health care plans must carefully calculate what the projected medical and health care costs for a defined group of covered individuals may be and then do two things: (1) determine a price for this package of services for the potential buyer; and (2) find ways to keep these costs as low as possible while still providing quality care.

PPOs that negotiate directly for services with purchasers must develop this kind of information themselves or with the assistance of outside experts. PPOs that utilize insurance carriers or third party administrators (TPAs) as the middlemen between purchasers and providers may rely partially, but not completely, on the insurers' in-house staff for this information.

While claims are the instruments which trigger payments for participating providers, these forms also give insight into important aspects of utilization review and management. That is why every PPO, from the smallest to the largest, generates some data of its own spinning out of claims and claims handling.

"When PPOs first began, utilization review activities were delegated to participating providers and performed by existing hospital personnel or were done by purchasers themselves," said Marcus Merz, Preferred One, St. Paul, MN. Subsequently, as data needs grew, some PPOs began preprocessing claims submitted by providers to them, repricing, performing necessary utilization review activities, and generating encounter and utilization data before submitting the claims to the payer. Other PPOs did retrospective review on claims after processing by payers.

"No carrier, to our knowledge, has as yet invested the considerable amount of capital needed to capture the full range of data required to perform all the functions of managed care. Because of this large capital outlay, the only programs that come nearest to the ideal are those run by the federal government and several state Medicaid programs. Unfortunately, these programs frequently have separate data bases for inpatient and outpatient services."

Edward Zalta, MD
Chairman of the Board
CAPP CARE
Fountain Valley, CA

"There are two keys for data: data capture and the ability of a PPO to integrate claims data with utilization review and management."

Mark Jasper
President
Benefit Panel Services
Los Angeles, CA

It is true that, usually, insurance carriers do not provide physician-specific utilization review data and that is a dilemma for PPOs, points out Mark Jasper, President of Benefit Panel Services, Los Angeles. This large California PPO has put its own computerized data system in place for claims processing and payment, as well as utilization management. "PPOs do not need to handle claims, although we do," Jasper says. "Insurers don't have the necessary data for UM and cost-control. One way to get it is via claims. Since many insurers require PPOs to do some claims processing, even if only preprocessing and repricing, you might as well abstract the information. It is in your best interests to do so."

As PPOs have matured and become increasingly conscious of the vital importance of utilization management, data has assumed greater importance in their operation. Many are expanding their own data capabilities or are working out arrangements with vendors to obtain it.

"I do not know if we will see more TPAs getting into the PPO business or more PPOs moving into TPAs' areas. What is happening is that this whole shift is being reviewed. If it is going to happen, it will start happening soon."

David Pynn
Executive Vice President
Compmed
Tulsa, OK

It is the fact that many TPAs handle claims processing that has led some of them to get into the PPO business. At the same time, a PPO is *not* an insurance company, yet to provide its services, it must assure that claims are processed and administered. Large self-insured companies negotiating with PPOs may handle this function themselves; others contract with a TPA for claims processing functions. Where insurance carriers are involved, much of the claims-related duties are handled by the carriers themselves.

"There is a lot of overlap in the services that PPOs and TPAs provide today," says David Pynn, Executive Vice President, Compmed, Tulsa, OK. "TPAs have needed PPOs for marketing and other purposes. They have contracted with them, and found that by having their own, they have more flexibility and a more comprehensive marketing tool. PPOs, on the other hand, are having to reprice claims for many large insurance carriers, using systems similar to those of some TPAs. Generating these reviews is one way that PPOs get into the TPA business. There is some money to be made on the claims processing side. Furthermore, many of the people who have been brought into the PPO movement are familiar with claims processing functions. There is something to be said for having all services in-house so you need not depend on others."

A key aspect of data analysis for every PPO is provider cost information review. This is a more involved process in the PPO setting than in other types of managed care programs because rather than just inputting purchased computer tapes with provider fees at specific percentiles already calculated, often individual physician fee schedules must be incorporated. Preferred providers and nonparticipating providers must be identified at claims-processing time so that appropriate reimbursements are made to both providers and patients, depending on which providers were used.

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Data systems must demonstrate that a PPO is performing properly. AAPPO suggests that a PPO's data capabilities should:

- Provide a variety of data necessary for effective utilization management
- Measure quality
- Measure cost savings
- Demonstrate actual savings to the health care purchasers
- Provide useful management tools to assure the financial viability of the organization

"PPOs need good data systems and good computer people, and that costs money. That's why I think many local PPO networks will be acquired by larger companies who will feed their claims into centralized computers for sophisticated analysis."

Lynn Dowling
President
AAPPO

"There are many component parts of the management of health care services which are data-dependent," says Dr. Zalta of CAPP CARE. "Among these are eligibility determination, performance reports, management information controls, quality assurance, data transfer for claims administration, cost-savings reports, and the full spectrum of utilization management. Automation and timely execution of these functions require payers to capture far more data than in the past. In addition, health care management companies must capture other data elements in order to perform additional tasks necessary for the complete management of the entire medical encounter."

As PPOs have been developing, purchasers and payers themselves have been becoming more sophisticated about the operations of the health care delivery system and the various financing options that have emerged. They are asking hard questions and they want to know "How much did you save us?" and "How did you save it?" It is becoming increasingly necessary for PPOs to be able to demonstrate those savings, and comprehensive data is essential for this purpose.

As Ralph Pollock, President of the Connecticut Business Coalition on Health emphasized earlier, purchasers want aggregated, statistically meaningful, comparable data from managed health care plans, and from many such programs, that data is just not available.

So in the future, PPOs will expand in-house or obtain outside sophisticated data-generating capabilities. It is essential in order to market services to new clients and to retain old ones.

HOW COST ANALYSIS PROVIDES INSIGHTS INTO QUALITY OF CARE

Just as every businessman wants information from all departments so that each one's effects on the company's bottom line can be assessed and adjusted if necessary, each operating PPO must conduct similar ongoing analyses.

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Plans can be altered, benefits packages reshaped, but ultimately, PPOs' ability to manage costs lies in their ability to manage people — those who provide medical and health care services and those who use them.

That is why AAPPO leaders emphasize that a critical element of utilization management is education. Patients and providers must learn to access and use the health care system properly.

"As price and access become standardized variables, competition increasingly will turn on quality and clinical outcome performance."

Marcus Merz
President
Preferred One
St.Paul, MN

What consequently must be monitored is behavior — how physicians practice medicine, what tests and procedures they use to treat various illnesses and conditions, how long they typically hospitalize for certain problems.

PPOs seek to differentiate between medically necessary and unnecessary care and maximize efficient care. Prior authorization requirements, preadmission certification, second opinion programs, and concurrent and retrospective review of care all are techniques for this purpose. Probably the most important, however, is the crafting of individual physician practice profiles.

Granted that every patient is different, there are still basic guiding precepts which all physicians follow. As Peter Boland, Boland Healthcare Consultants, Berkeley, CA, puts it: "A physician's curative powers are the same, whether he practices in New York or California."

Development of profiles of PPO physicians suggests which ones practice most efficiently and yet still produce the best outcomes. A physician's charges for certain procedures, as indicated by CPT or ICD-9 codes on claim forms, as compared to the charges of other physicians in the same specialty in the same area furnishes one indicator of cost-effective practice. The number of tests and consultations on physician orders as compared with the numbers of other similar physicians is another indication. Specified lengths of stay for given conditions, use of appropriate facilities, numbers of follow-up visits all can be tracked and compared, and outliers found.

"Utilization review — the methods and mechanisms for controlling costs — makes or breaks a PPO. It is what managed care is all about."

Jim Kent
Regional Director
CAPP CARE of Texas
Houston, TX
Chairman-Elect
AAPPO

These are confidential reports with each doctor identified only by his/her provider number. As the PPO data base grows, the amount of meaningful information about what constitutes typical *good* medical practice — neither underutilization nor overutilization — emerges.

CPT and ICD-9 codes are excellent indicators of just what medical services were performed. They are far more precise and specific than other measurements in use today.

As PPOs refine utilization management techniques, more of them are expanding the scope of their scrutiny to include review of aberrant practice patterns. This review in some plans, such as CAPP CARE, extends beyond the hospital into physicians' offices for study of practice patterns.

Once a PPO does identify a physician or other provider who upon utilization review appears to deviate from typical practice patterns and charges in the area, what can be done?

"With a physician who is a member of the PPO, you can go back and educate him/her — or you can kick him/her out. With a non-PPO physi-

cian, you can sometimes inform the third party payers that what you are picking up with your data analysis is that this doctor is providing medically unnecessary services. No payer is required to reimburse for such care," says Kent.

Managed care, like that provided by a PPO, requires development of certain protocols for care, i.e., normal parameters for length of stay, accepted tests and procedures for treating given medical problems, even appropriate medications for certain conditions. Because review is concurrent, any physician can deviate from these guidelines when he or she demonstrates that it is necessary and appropriate. And, in fact, it is incumbent upon every PPO physician to do so since the physician bears the ultimate responsibility for patient care.

PPO treatment protocols sometimes can give physicians a broader perspective. Often, when a PPO doctor sits down with another to discuss his deviation from the normal practice patterns, it is truly an educational experience. A physician may be unaware that his approaches — length of stay for given conditions and procedures, number of tests ordered, etc. — differ significantly from those of his colleagues.

There is little doubt that as the managed care concept, as epitomized in a PPO, becomes more prevalent in the nation, treatment protocols will be refined. Who will develop those protocols and on what basis are the main questions. In a PPO, it is representatives of the physician providers or their MD counterparts in the plan who ultimately set these guidelines for appropriate care and its cost.

Cost will necessarily figure into the development of these protocols. Since managed health care systems achieve their biggest cost-savings by keeping people out of hospitals and limiting access to specialists, many of these plans "encourage drug therapy in the primary setting," says an article, "Making a Match with Managed Health Care," in the August, 1988 *Pharmaceutical Executive.*

A survey by *Drug Topics* magazine and a large pharmaceutical company recently revealed that 88% of HMOs and more than 50% of PPOs provide their members with a medication benefit. To keep costs of drugs for patients down, managed health care plans are establishing formularies, relying more heavily on generic products, and conducting careful drug utilization review.

Already, for example, some PPOs are working out volume purchasing arrangements for drugs and related supplies and equipment used in the practice of medicine. Increasingly, buying through a purchasing group is becoming more attractive to managed health care plans. Others are negotiating contracts with pharmacies to furnish drugs at a discount or are picking up a larger share of the cost when generic drugs are used. Some are establishing their own in-house pharmacies.

There is little doubt that as pharmacology plays a greater role in treatment of conditions that once required surgery, managed health care systems will have to determine which medications should be incorporated into treatment protocols.

"Nurses aren't saying, 'No, Doctor, you can't do that with this patient.' The doctors themselves develop the objective, relevant medical criteria. That is the difference. When a surgeon visited our plan and looked at our control mechanisms, he said, 'These are doctor-friendly.' "

Jim Kent
Regional Director
CAPP CARE of Texas
Houston, TX
Chairman-Elect
AAPPO

"Protocols definitely will be developed by managed care systems and I believe they will be developed faster in the PPO industry, mainly because PPOs do not put providers at financial risk for the care they provide. A tight utilization management treatment protocol, therefore, assumes great importance in a PPO."

Lynn Dowling
President
AAPPO

productive partnerships for cost-effective, quality health care

CAN QUALITY REALLY BE MEASURED?

"'Quality assurance' is the current buzzword. It is what all health plan operators want to hear. There will be much more emphasis on this aspect, but we are not there yet. There is not a functional health plan that can really demonstrate quality. We haven't yet developed the tools or software."

Peter Boland, PhD
President
Boland Healthcare Consultants
Berkeley, CA

"Quality assurance is probably the most important aspect of managed care and the most troublesome to implement from a practical standpoint. Done properly, it involves tracking each episode from inception to conclusion, aggregating that data by individual provider and by class of provider, comparing the individuals and classes to norms, and assessing the efficacy of the treatment."

Jerry T. Payne
Vice President, Marketing
Preferred Health Network
Los Angeles, CA

Frankly, nobody in the nation can answer that question with a definitive "Yes." In the PPO, while protocols are developing that offer certain treatment/cost guidelines, physicians still largely are free to practice medicine according to their best training and instincts. There are no financial incentives *not* to treat. Consequently, good medicine is more likely to result.

Purchasers and payers give top priority to quality care. There is considerable talk in the nation right now about the importance of measuring quality.

Experiments with computer software are laying the groundwork for programs that may someday represent true quality *assurance* activities. The first step is to document medical outcomes from a clinical perspective.

There is, however, more action on the quality *control* side, especially among HMOs, in response to expressed concern by government agencies and payers that underutilization could potentially result because of the way that financial incentives for providers are structured.

"'Quality control' is a management term, but 'quality assurance' relates to clinical judgment and criteria," explained Boland. "PPOs and other managed care plans must place more emphasis on designing and collecting the kind of data it takes to get a handle on quality assurance. It is expensive, time-consuming and no quick fix. We're going to be talking about it and working on it because buyers want to talk about it."

One PPO spokesperson warns that quality and value in health care should not be confused. "Quality is a delivery system parameter and value is a benefits dollar parameter," says Wayne Iverson, MD, President of Managed Care Technology, San Diego, CA. "Quality connotes the essential characteristics of the services carried out, whereas value reflects the fairness of return in the exchange of money for services."

HOW A PPO IS MARKETED

A decade or two ago, the payers of health care benefits mainly were insurance companies and government entities. In recent years, partly because health care costs have risen so fast, many more employers are self-funding health benefits. As a result, the categories of payers have broad-

ened to include ERISA (Employee Retirement Income Security Act) trusts for employers, Taft-Hartley trusts for unions, third party administrators (TPAs) which administer benefit plans for self-funded entities, workers' compensation carriers, and federal programs, such as Medicare, Medicaid, Champus and others. Most recently, business coalitions and self-funded employers have pooled their efforts to form PPOs through Healthcare Purchasing Organizations (HPOs), whose purpose is to negotiate benefits programs.

Payers

Insurers

Self-insured employers (ERISA)

Unions (Taft-Hartley)

Federal government

Third party administrators (TPAs)

Workers' compensation carriers

Healthcare Purchasing Organizations (HPOs)

PPO services may be marketed directly, as by a group of physicians and/or hospitals, by a PPO network or networks aligned for this purpose, or through entities which serve as gatekeepers for their clients. Today there are many "marriage brokers" who help establish partnerships between providers and payers, including brokers, consultants, third party administrators, and utilization review and/or management companies. Business coalitions, too, may fulfill this role.

When a managed health care program is marketed to a prospective buyer, it should be able to speak for the quality of its providers because the providers are the key to its product. "Knowing what amount of cost-savings was achieved is not enough; knowing how it was done *is*," emphasizes Jerry Payne.

A potential client evaluating a PPO may self-insure or fund health care benefits by paying a carrier for coverage. Here, distribution systems differ. A fully insured purchaser uses a broker or employed agent of an insurer to obtain the necessary benefits package. A self-insured purchaser may rely on any one of several entities for its distribution system — consultants, TPAs, or others.

Flexibility is a hallmark of a PPO. Because it can be overlaid on an existing indemnity insurance plan, the product design process can involve the purchaser. The product developed can range from very simple to comprehensive services:

- Network contracting services
- Hospital-only network
- Hospital and physician network
- Network plus utilization management
- Network plus UM and information system
- Network plus UM and information system which can be unbundled

"Assuming PPOs become increasingly effective at managing inpatient and ambulatory care, the emphasis will shift more towards prevention. At this point, the challenge will be to develop programs that not only detect problems and prescribe remedies, but also build in compliance mechanisms to ensure that prevention programs are completed and the results maintained."

Jerry T. Payne
Vice President, Marketing
Preferred Health Network
Los Angeles, CA

"If a PPO is truly market-driven, it will bundle or unbundle its products, depending on the needs of the prospective client. For example, a network capable of unbundling could offer as little as a hospital-only network," says Payne. The point is that the availability of a PPO's services, whether very comprehensive or less so, enables purchasers to choose those features that suit their needs and to offer insureds and/or employees yet another benefit option. "Demand now is growing for wellness products and services," says Payne.

ISSUES FOR BUYERS AND PAYERS: SOUNDNESS AND SOLVENCY

Because PPOs are relatively new, potential purchasers of health care from these programs seek to assure that the provider networks will remain intact and that the financial underpinnings of the operations are solid.

A potential client should evaluate a PPO as it would any other new supplier with whom it may do business. Its solvency and credit-worthiness should be investigated. Although this has not been the case in the past, it has become increasingly clear that programs that seek to provide quality health care while controlling costs must be run in a businesslike manner. Two elements should be present in any PPO:

- Adequate capitalization
- Administrative sophistication

It takes capital to employ good personnel and to obtain utilization management systems, state-of-the-art data systems, marketing expertise, and the related services needed to make a PPO a successful business operation.

It also requires administrative sophistication — the know-how necessary to link a highly professional health care delivery system with its consumers in a network that will provide comprehensive, quality services. It thus becomes very important to know who is running a PPO and what the health care and business backgrounds of the key team members are.

"It is clear that undercapitalized and failing businesses cut corners in the delivery of their products. In the delivery of health care products, such practices are not permissible. If a PPO fails, a purchaser of health care may lose its network because the PPO becomes bankrupt. If this occurs after it has printed lists of providers, educated its employees or insureds and generally promoted the PPO, the purchaser will suffer the expense, embarrassment, and in the case of insurance companies, the potential loss of business as a result. So purchasers should evaluate a PPO... as they do other suppliers."

Douglas L. Elden
Chairman
AAPPO

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ARE THERE LEGAL ISSUES TO RECOGNIZE WITH PPOS?

Despite the fact that PPOs were created to help reduce health care costs — a move which the nation has agreed is necessary — there has been a continuing question about whether antitrust actions might materialize in connection with these and other managed health care plans.

The basic concept of federal antitrust laws is to foster and protect market forces that encourage and contribute to competition in the sale of goods and services. Thus, various antitrust statutes, such as the Sherman Act, the Federal Trade Commission Act, the Clayton Act and the Robinson-Patman amendment to the Clayton Act, prohibit activities that inhibit competition.

The laws are aimed at preventing restraint of trade that limits competition, and they specifically prohibit such activities as price-fixing, division of market, customer allocation, exclusive dealing and tying arrangements, boycotts, monopolization or attempts or conspiracies to monopolize, and unfair or deceptive methods of competing.

Contracts, agreements and arrangements among providers, payers, purchasers and intermediaries who may handle such activities as claims processing or utilization review are an integral part of any managed care system. The PPO is no exception. Thus, "there is potential antitrust liability for the groups, and sometimes the individuals, who enter into these arrangements," points out Richard A. Hinden, Esquire, Altheimer & Gray, Chicago. "So do it right. Obtain guidance from competent legal counsel about any aspects of a PPO or other managed care arrangement that could lead to possible antitrust violation."

Brant Kelch, President of Health Alternatives, Leesburg, VA, echoes the same warning to buyers and payers. "When contracting with PPOs or developing your own plan, it is important to involve expert legal assistance. Find legal counsel who are experienced in the field. Build in the proper organizational structures and make it flexible enough to accommodate change — because these plans will change."

In its *Physician's Guide to Preferred Provider Organizations*, the American Medical Association points out that "whenever there is collaboration or cooperation among natural competitors or individuals engaged in the same business, there exists a potential for antitrust implications...and questions may be raised. The effect of such questioning, however, will depend upon how the PPO is organized, who negotiates what with whom, the size of the market share involved and whether the pro-competitive effect of the arrangement outweighs the anti-competitive results."

"Not every constituted restraint of trade is necessarily prohibited, only those that are deemed by the courts to be unreasonable or to constitute per

se violations," says the AMA publication. Everyone is seeking "competitive solutions" to rising health care costs, the AMA says, but one of the difficulties in applying antitrust law in the health care field is that no one knows what these competitive solutions will look like.

As these new programs have evolved, "the threat of antitrust prosecution has lessened over time," says Hinden. In his view, the new managed health care plans may be given more leeway by the antitrust prosecutors because, although there may be some anti-competitive aspects to some of their activities, the overall result is pro-competitive and benefits the consumer.

"Single employers do not have many antitrust worries because few employers today fully control a health care market. Actually, when it comes to price-fixing, employer-purchasers are permitted to go out and set prices, where, on the other hand, the providers must worry when they get into this area. Nor do employers need to worry much if they organize an entity — a network or coalition — even if they represent everybody in town. Here my greatest concern would be that because the entity has so much purchasing power, it dictates prices so low that quality of care falls."

Brant Kelch
President
Health Alternatives
Leesburg, VA

Few substantive antitrust decisions directly affecting PPOs have arisen to date. There have been some cases in the managed health care field. One in Tulsa *(FTC v. Preferred Physicians Inc.)* made it clear that individual providers in a plan must be permitted to deal individually with payers and may not be restricted to negotiating only through the managed care entity, or liability may arise. Early in 1988, a federal jury awarded a $102 million verdict in favor of 1,800 Cincinnati-area physicians who sued a doctor-controlled HMO on grounds that it was guilty of antitrust violations for price-fixing, creation of a monopoly, racketeering and fraud *(Thompson v. Midwest Foundation Independent Physicians Association)*. The price-fixing violation arose out of allegations that the HMO failed to return funds withheld from its participating MDs and that it unlawfully set maximum fee levels at a much lower than agreed-upon usual-customary-reasonable methodology. However, the case involved other considerations — mainly a for-profit conversion of the HMO surrounded by a degree of acrimony. Whether the case will be overturned on appeal is uncertain.

There are two far more pressing legal concerns for PPOs and other managed care plans — liability for the negligence of PPO providers for commission of medical malpractice of some sort, even though this liability may be only indirect, and liability for utilization review activities.

Should a provider be sued for malpractice, it is possible that the PPO itself might also be named. Judgments today can be incredibly large, and consequently, providers and the PPOs themselves must obtain costly liability insurance, whether purchased in the marketplace or through self-insurance.

Expanding doctrines of liability have heightened hospitals' exposure to malpractice suits for the activities of physicians who practice within their walls. AAPPO Chairman Douglas Elden points out that "the underlying theories of these doctrines indicate a potential application to alternate delivery systems."

As hospitals increasingly have been held liable under the doctrine of *respondeat superior* for their agents or employees, so might a PPO similarly be deemed liable. Hospitals' exposure to suit has expanded on grounds they violated their duties to patients by failure to properly survey quality of patient care services, by failure to properly review and investigate the credentials and expertise of medical staff applicants, and by failure to protect patients from malpractice by its medical staff members. The parallels with care provided by and through a PPO immediately become clear.

PPOs' emphasis upon careful provider selection minimizes exposure considerably, although no provider, no matter how excellent, is immune from suit today. Whether meritorious or not, such a legal action generates costly defense bills and drains precious time from providers' schedules.

Utilization review activities add a new area of liability exposure. "Buyers and payers are exhibiting a great deal of anxiety, nervousness and misunderstanding about some of the issues associated with utilization review and quality assurance activities. These functions can influence the care that people receive. They [buyers and payers] are consequently uneasy philosophically and financially about potential liability," says Brant Kelch of Health Alternatives. "They want to know what their risks are and how to minimize them."

A 1986 landmark California case *(Wickline v. State of California)* arose out of such utilization review activities. A woman was admitted for surgery to correct circulatory problems in her legs. Since the woman was a Medi-Cal (Medicaid) patient, her care required utilization review, approval of surgery, and specification of the appropriate length of stay, which was set at 10 days. However, prior to her discharge, her physician requested an additional eight-day extension because of developing complications. Only four days were authorized by the Medi-Cal consultant. Later, she was readmitted to the hospital and her right leg required amputation. She sued Medi-Cal, claiming it was negligent in failing to grant the extended stay requested by her physician.

A lower court judgment against Medi-Cal was overturned by the California appeals court, which ruled that the decision to discharge a patient from the hospital is the sole responsibility of the patient's treating physician and not that of the third party payer. Physicians were advised to protest adherence to length of stay and treatment guidelines when individual circumstances indicate that they should be altered. The court warned that while "cost-consciousness has become a permanent feature of the health care system, it is essential that cost-limitation programs not be permitted to corrupt medical judgment."

Points out AAPPO's Elden: "The court stressed, however, that a third party payer could be found liable for injuries resulting from an arbitrary or unreasonable decision to disapprove requests for medical care."

Currently in process is a case in Saginaw County (MI) Circuit Court *(Bush v. Dake)*. In this case, not utilization review but gatekeeper protocols in an HMO are being challenged. Sharon Bush is suing her family physician, an obstetrician-gynecologist to whom she eventually was referred, the doctors' medical group, and the HMO, alleging that their gatekeeper arrangement was "a significant causative factor" in the failure of her family doctor to order tests and make an appropriate and timely referral to the OB/GYN to diagnose what has developed into metastatic cervical cancer. Another issue raised in the case is that the HMO did not obtain Bush's informed consent to the physician payment system. Should this case succeed, some experts are suggesting that, in the future, managed health care plans like HMOs may be required to obtain such informed consent as a protection from liability actions.

The ultimate decision-maker about medical care in a PPO is the physician. He or she must serve as the patient's advocate, and as the courts so explicitly stated in *Wickline*, that physician must protest vehemently when guidelines designed to reduce health care costs get in the way of good medicine. In a PPO, the physician and hospital do not profit from not treating, and that is a consideration to bear in mind when thinking through possible liability related to reduced quality of care, suggest AAPPO leaders.

"Every PPO has a grievance process — usually a panel of physicians — or the plan's medical director, if time is of the essence — which any participating physician can use to recommend changes or modifications in any treatment guidelines. Furthermore, a doctor still can do what he or she thinks should be done in a given situation — still follow his or her own best judgment — and the payment issues will be discussed later," says Diane D. Dailacis, Director, Flex Plans, Pacific Mutual Life Insurance Company, Fountain Valley, CA.

"Many PPOs perform their own utilization review and make recommendations to payers regarding whether or not somebody should be paid. In other cases, payers perform this function themselves. In both instances, there is potential liability if harm results to a patient as a result of these decisions."

Richard A. Hinden, Esq.
Altheimer & Gray
Chicago, IL

As for peer review activities by managed health care plans, these activities, when performed in good faith, are given immunity under the Health Care Quality Improvement Act, passed by Congress in 1986. Even though the U.S. Supreme Court reinstated a jury verdict in favor of Timothy A. Patrick, MD, last May on his claim that physicians in his hospital violated antitrust laws during peer review proceedings to consider terminating his hospital privileges, few in the health care field consider this a case that will have broad application. The defendant physicians involved were unable to document fully and effectively the fairness of their activities which led to Dr. Patrick's dismissal from the hospital staff.

Restricting employees' freedom of choice of providers is a related area that can generate liability, suggests Kelch of Health Alternatives. "It is not so much a problem for employers but an employee relations problem. An employer should have a good reason for selecting providers available to employees in a plan, and it should be based on considerations other than the fact it is cheaper. The decisions made about provider selection carry liability potential — employees can sue and providers can sue."

The advice from AAPPO leaders on the subject of liability is to get the best guidance before making decisions or finalizing them on paper when it comes to provision of health care.

There is a final note on legal issues that should be mentioned. One start-up hurdle for PPOs has been eliminated, or at least minimized, in many states. For a time, as many as 40 states had statutes on the books precluding or making it difficult to develop PPOs. Many of these barriers have since fallen. At last count, almost half of the states have enabling provisions for PPOs, and only a few states expressly prohibit the selective contracting and channeling activities essential to PPOs. Provisions in the new enabling measures coupled with preexisting consumer protection regulations protect PPO consumers. As a result of these legislative changes, the doors now have been opened to PPO formation in most areas.

At the same time, PPOs retain greater freedom from regulations and

restrictions imposed by statute on other managed health care plans, such as HMOs. "The HMO movement was shaped by federal legislation. Through the qualification process, the structure and functions of HMOs became more or less standardized. At the present time, however, no such process exists for PPOs," says John L. Miller, John L. Miller & Associates, Westlake Village, CA.

"With respect to the PPO, a significant issue is whether the PPO is subject to regulation and/or state licensure, either as an indemnity plan or as a Health Maintenance Organization (HMO). The current wisdom holds that significant loopholes in the statutes and regulatory requirements of most states allow operation of nonregulated systems, such as the PPO," say authors Samuel J. Tibbitts and Allan J. Manzano in *PPOs — an Executive's Guide*.

These writers point out that depending upon the circumstances of its organization and administration and its geographic locale, the PPO may be subject to qualification and/or licensure under state and federal securities laws and under state insurance or prepaid health plan laws. They add that "if the organization is at risk in any way, compliance with insurance or prepaid health plan laws and regulations may also be required."

WHAT IS THE FUTURE OUTLOOK FOR PPOS?

The growth momentum demonstrated in recent years by PPOs will continue. PPOs were the fastest-growing health care plans in 1987, and there are no indications that this growth will slow. PPOs may soon be the dominant force in the managed health care field.

Without question, managed health care is not only the wave of the future — it is the wave of the present. Already, managed health care, which has been growing at a "feverish" pace in recent years according to analysts, predominates in the health insurance arena. A recent Health Insurance Association of America survey revealed that 60% of those individuals with employer-sponsored health insurance were enrolled in some form of managed care plan.

Although traditional fee-for-service medicine still is the most prevalent means of caring for Americans, HMOs and PPOs represent a larger segment of the health services market with each passing year. PPOs, which retain free choice of provider but build in cost controls, preserve the best of both the fee-for-service and managed care systems.

As managed health care plans increase, traditional indemnity insurance programs decrease. "Indemnity plans won't be around in the future. They are already dying," says AAPPO Chairman-Elect Jim Kent, Regional Director, CAPP CARE of Texas.

"There will be substantial and continued growth of PPOs in the top 20 U.S. cities and accelerated growth will continue in secondary cities. This trend will continue indefinitely — and certainly for the next two or three years."

Peter Boland, PhD
President
Boland Healthcare Consultants
Berkeley, CA

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"The marketplace has selected the PPO as the model for the transition to managed health care. Those in the PPO industry seeking to participate in this transition from first-generation to more sophisticated PPOs recognize that the PPO as a managed health care system cannot continue to serve merely as a marketing agent, a negotiator, an administrator or a device to fill physician offices and hospital beds. The leaders in the industry understand that the purchasers of health care perceive that these objectives conflict with actual management of health care."

Douglas L. Elden
Chairman
AAPPO

Insurers' market share has declined as more and more businesses and industries have begun to self-insure their health care costs. Blue Cross/Blue Shield, for example, lost ground in 1987 to commercial insurers, employer self-insurance, and third party administrators, dropping to a 25% market share. Savvy insurers are developing several products and taking them to their customers — HMO and PPO options as well as their traditional indemnity products. That is easy to do with a PPO; it can merely be welded onto the chassis of an existing indemnity policy.

Others are launching bold experiments to assure quality and the best dollar-for-dollar purchase of health care. Just recently, for example, The Prudential Insurance Company of America, the nation's largest private health insurer, announced a new program to channel heart, kidney and liver transplant patients to certain selected hospitals which have better track records for these surgical procedures and are willing to negotiate 25% to 30% discounts. Prudential used certain Medicare criteria to target those hospitals with the best surgical outcomes. Prudential will continue to pay for these procedures in other institutions, but will tell subscribers that their chances of recovering are greater in those institutions on the selected list. The company also will pay for transportation for the patient and transportation and housing for one other individual accompanying the patient.

Nationwide programs of this type will operate best when they can plug into existing networks whose providers can demonstrate that they are quality-conscious as well as cost-conscious.

New product development

In the transition period, new products and variations on the managed health care theme will be introduced. Hybrids will be developed and tried as the different plan developers jockey for position in the marketplace and respond to buyers', payers' and consumers' perceived preferences. Already on the scene are:

- Specialty PPOs
- EPOs (Exclusive Provider Organizations)
- Point-of-service HMO plans

Specialty PPOs — The services of allied fields, such as mental health, chiropractic, vision care, rehabilitation, and an array of outpatient facilities, initially were not incorporated into structured managed care programs. Now these areas are being covered in specialty PPOs, which can market their own services directly, but more often do so through alignments with existing PPO networks. Eventually, larger hospital/physician PPOs may absorb specialty networks by purchase or merger, suggest some AAPPO leaders.

EPOs (Exclusive Provider Organizations) — Falling somewhere between a PPO and an HMO is the EPO. John L. Miller, John L. Miller and Associates, sees a strong cost-controlling potential for this hybrid, which he defines as "a managed care system that limits the patient's selection of providers to a defined panel and reimburses these providers not on the basis

of capitation, as in an HMO, but on a modified fee-for-service method. Reimbursement may be based on UCR (Usual/Customary/Reasonable), discounts, fee schedules or some other formula, such as a relative value scale. Reimbursement to contracted hospitals usually is based on a negotiated discount or per diem," says Miller. The advantage of the EPO, in Miller's view, is that it lends itself to various forms of provider incentive systems which, like HMOs, seek to reward providers for controlling costs.

Point-of-service HMO plans — This HMO version introduces some of the free choice of provider that PPO plans offer by making it possible for a patient to determine which provider to use at the time of service. There are financial disincentives to go outside the HMO in the form of lower reimbursement levels, but some free choice is introduced.

Enter the Medicare PPO

A significant development on the PPO front is that the government — the "ultimate purchaser of health care for the Medicare consumer" — is beginning to introduce the Medicare PPO on a trial basis.

The Health Care Financing Administration (HCFA) is setting up demonstration programs to test the PPO concept and is offering Medicare beneficiaries the choice of enrolling in a PPO or staying in traditional Medicare. HCFA indicates that it will use existing private-sector PPOs instead of organizing its own provider panels. AAPPO supports use of the existing PPO panels and has testified against government-created programs.

The Medicare PPO experiments are efforts to control rising Part B costs covering physicians' services and ambulatory services. Some health care economists believe that cost-savings could be achieved using the PPO model.

Paul Ginsburg, PhD, Executive Director of the Physician Payment Review Commission, which advises HCFA, believes that Medicare PPOs are more likely to save money by managing utilization than through price discounts from providers. Ginsburg says Medicare already has forced down prices paid to providers but has not done an effective job of utilization management.

AAPPO has been assisting various branches of the government in thinking through and formulating the Medicare PPO program. AAPPO, while expressing its support for use of existing PPOs rather than newly created government PPOs, has voiced three additional recommendations:

- That HCFA institute a mechanism to encourage Medicare beneficiaries to use PPO providers
- That the government evaluate and select, not regulate, PPOs
- That evaluation be based upon realistic operating criteria rather than regulation which would change the way that PPOs function

To provide payers, purchasers and government agencies such as HCFA with methods of evaluating various PPOs, the American Association of Preferred Provider Organizations has developed a set of basic, general

"We have been fearful throughout this Medicare PPO process that the government would, through regulation, transform the actual working, operating, successful PPO into something else and that this 'something else' would not work. If such a situation were to occur, the entire Medicare PPO process could cause severe and possibly fatal damage to the PPO industry and managed care generally."

Douglas L. Elden
Chairman, AAPPO
Statement to Health Care Financing Administration
March 11, 1988

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"At some point, more efficient management and operating systems must be developed to handle the interface between payers, providers and patients. For instance, some managed care organizations already are experimenting with health care credit cards, 'paperless' claims, and are capturing encounter and utilization data on a real-time basis. Products of the future will need to incorporate these newer, more sophisticated processes."

John L. Miller
President
John L. Miller & Associates
Westlake Village, CA

criteria which must be present in any successful PPO. These elements are listed in the chapter entitled "How a PPO Operates: The Health Connection."

PPOs expand services

As new PPO and managed care models and hybrids develop, PPO networks will become more integrated and more comprehensive. The reason is, says John Miller, that "new products will require a better integration of managed care services that will facilitate the entire system."

So far, says Miller, many managed care organizations have developed a limited level of operational support activities, i.e., customer and provider service, data collection and reporting, submission of prepriced provider bills, etc. Such services support the overall effectiveness of the program and help different elements of the system — provider, payer and patient — fit together.

PPO accreditation program formulated

More recently, in July, 1988, AAPPO announced that its board of directors had approved preliminary guidelines that will serve as a basis for voluntary PPO accreditation standards. The final guidelines were distributed in August, 1988. Accreditation survey activity begins early in 1989.

"The AAPPO guidelines are an important first step in a program that health care purchasers nationwide have asked us to pursue," says AAPPO Chairman Douglas L. Elden. "For many purchasers, health care costs continue to rise despite cost-containment efforts. They have studied the industry and are convinced there is a difference between so-called 'first generation' discount-only PPOs and those that truly *manage* care. Purchasers want to avoid health care marketing organizations; they are demanding *managed care* organizations."

ADDITIONAL BENEFITS AND SERVICES OFFERED BY SOME PPOS

Additional benefit	No.	% of total
Home health care	174	38%
Mental health benefits	156	37%
Pharmacy discounts	154	33%
Chemical dependency programs	132	28%
Wellness/health promotion	82	18%
Dental	80	17%
Lab/ x-ray	75	16%
Eye exams/vision care	75	16%
Office visits	23	5%
Chiropractic services	16	3%
Hospice	6	1%
Podiatric services	5	1%
Surgical	4	1%

As competition among managed health care plans increases, more PPOs are offering increased additional benefits and specialized services. Sixty-eight percent of the respondents included in the May, 1987 AAPPO Directory listed at least one additional benefit or specialized service offered by their programs.

Source: Directory of Operational PPOs, *American Association of Preferred Provider Organizations, 4th edition, May, 1987.*

"Because the PPO industry is still so new, the accreditation plan will establish multiple levels of accreditation to accommodate start-up and mature PPOs alike," says Brant Kelch, President, Health Alternatives, and Chairman of the AAPPO's Accreditation Committee.

Growth and change ahead

So the PPO outlook is for continued growth but, at the same time, for continued refinement of the product and more comprehensive packages of services. Already, a certain market shake-out is beginning to materialize, suggests Peter Boland, as consolidation and expansion of the PPO product takes place. However, this realignment in the marketplace will not be as major as that which has characterized HMOs in recent years. "The reason is that PPOs generally are less expensive systems to capitalize. PPOs do not 'own' the lives of those they care for because free choice remains an essential ingredient. There are not the same kind of assets to acquire when a PPO changes hands as there are in the case of an HMO."

Boland's prediction: PPOs will experience continued growth, but they will change in response to changed demands in the marketplace.

Among the major changes AAPPO leaders suggest are that PPO networks will expand and offer more products and more support services, whether these services are in-house or obtained outside. Ultimately, networks will network with other networks to broaden the provider base.

Says AAPPO's Chairman-Elect Jim Kent: "PPOs will go from 30% to 40% and as much as 50% of the market in the next few years."

"PPOs will continue to grow and improve, particularly with the input of their client-partners: the employers, insurance companies, union trust funds and third party administrators who pay for health care on behalf of employees. Now even Medicare is pursuing a plan to develop PPOs."

"What Is a PPO?"
American Association
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productive partnerships for cost-effective, quality health care

A PPO CHECKLIST FOR EMPLOYERS

Here are some key questions for employers to ask when evaluating a PPO for possible linkages. This is only a partial list. Other questions may come to mind as the discussion progresses.

- ☐ **Physicians:** Who are the physicians in the plan? How were they selected? What arrangements exist between the primary care physicians and the specialists? Are the primary care physicians gatekeepers for the specialists and hospitalizations?
- ☐ **Hospitals:** What hospitals participate in the PPO? How were they selected? What data and other information are available to prove that these hospitals are cost-effective and that they remain that way?
- ☐ **Reimbursement:** What incentives exist for employees to use the PPO providers? Are the copayments and deductibles waived? Are the total out-of-pocket payments by employees less than those of the regular health insurance plan? Do the reimbursement incentives provided to employees also result in net savings to the employers?
- ☐ **Payment:** Will hospital payments merely be discount arrangements or will they involve per diems or DRG reimbursements? Will the payments to physicians be on a usual-and-customary percentage basis or on a fixed-fee schedule? To what extent will the PPO assure that initial rates will be maintained?
- ☐ **Plan Redesign:** Will an employer be required to install different levels of copayments and deductibles in the PPO? Will the premium structure be altered in any way? How limited will employees be to certain providers? Can employees drop out of the PPO and select another option?
- ☐ **PPO Selection/Formation:** Should an employer choose a specific PPO in one geographic area or should it consider selecting hospitals and physicians from several PPOs? Should an employer create its own PPO, customized for its employees and their dependents? What are the start-up and ongoing administrative costs? Should the employer attempt to operate the PPO itself or should it contract with a third party?
- ☐ **Utilization Review:** Is utilization review (UR) specifically incorporated into the PPO? Who provides the UR? What are the criteria for determining issues such as medical necessity? Does the UR program include preadmission, concurrent and retrospective review? How is UR documented, i.e., what reports are issued relative to the UR? What are the penalties to PPO providers for noncompliance?
- ☐ **Geographic Distribution:** What happens if an employer has multiple sites where PPOs differ in structure and quality? How are these variations reconciled with employee needs, especially when benefits are negotiated through collective bargaining? Is there a network of PPOs with uniform standards available or capable of being established?
- ☐ **Assumption of Risk:** How much of the risk for the PPO will be assumed by the PPO itself, by the individual provider hospitals and physicians, and by the employer and/or employee? Are these risks clarified in the PPO-employer agreement?
- ☐ **Administrative and Legal Issues:** How will the administration of the existing employer indemnity plan be integrated with the PPO? How will the PPO insure that the employer is protected from antitrust and other liability issues?
- ☐ **Performance Measurements:** In addition to UR reports, how will consumer satisfaction with PPO service be measured? What kind of analysis will be performed to monitor and evaluate the overall operation of the PPO? Can the PPO performance be compared with other PPOs? Can the employee withdraw from the PPO and convert to another plan?

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Preferred Provider Organizations... productive partnerships for cost-effective quality health care is available from the American Association of Preferred Provider Organizations (AAPPO) for $11.95. Quantity discounts are available. Call or write AAPPO for more information: AAPPO, 111 East Wacker Drive, Suite 600, Chicago, Illinois 60601; (312) 644-6610, ext. 271.

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American Association of Preferred Provider Organizations

An Independent National Trade Association Representing PPOs and Their Partners in Managed Healthcare Systems

The Evolving PPO System

The nation's healthcare system, under competitive pressures, continues to evolve rapidly. PPO Administrators, Corporate Benefit Managers, Insurance Carriers, Hospital Executives, Trustees, Group Practice Administrators; all who are associated with the healthcare field must understand the changing economics and regulatory climate of this fastest-growing of all managed care systems. How should a Preferred Provider Organization best be structured? What are the benefits of systems administered by hospitals, physicians, insurance carriers, or healthcare payors? What types of compensation plans are working best to reduce healthcare costs without impairing quality and patient satisfaction? How can provider selection, utilization management, and quality assurance be structured to control total healthcare costs without the rigidity and loss of beneficiary satisfaction which comes with "gatekeeper" systems of healthcare management? What objective criteria exist for evaluating and selecting PPOs?

Through national conferences, regional meetings, its monthly newsletter, and other publications, the AAPPO helps PPOs and their healthcare partners find the answers to these and other critical questions which are best suited to their own organizations and their clients.

State and Federal Government Relations

The regulatory climate in which PPOs operate is still in its early stage of development. Without our coordinated action, changes in insurance regulations would have closed down PPOs in some states. On the federal level, the AAPPO is working with the Health Care Financing Administration to develop the framework with which Medicare will utilize PPO networks. As proposals for new "competitive" programs are considered, AAPPO reports regularly to its members. Mandatory health insurance (for both Medicare and private healthcare plans), and the changes in physician reimbursement which are expected under a Resource-Based Relative Value Scale (RVS) are among the forthcoming developments which will change the healthcare environment.

The American Association of Preferred Provider Organizations is your source of information and your voice in Washington and state capitals when action is needed.

Principal Activities and Benefits of the AAPPO

- National and Regional Educational Conferences
- Liaison and Advocacy for PPOs with the Health Care Financing Administration and other Federal or State Governmental Agencies
- Congressional Liaison
- Summary of State Laws with Respect to PPOs
- Monthly Newsletter on PPO Development and the Managed Healthcare Climate
- Targeted Information Packages on PPO-Specific Issues
- Annual Directory of Operational PPOs
- Development of State/Regional AAPPO Chapters
- Executive Salary and Operation Survey

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