

Preferred Provider Organization

In General. PPOs have strengthened and become more sophisticated. PPOs have graduated from touting discounts to showing the capacity to truly manage costs. The PPO shakeout leaves most PPOs being insurer-owned. PPOs have expanded their scope; most cover a wide area, some are statewide or regional and a few are national. The need for a national PPO is rare, or nonexistent. What is significant is that the PPOs have their hands full being successful statewide, let alone nationally. The methodology of PPOs to multiply geographically is to network with other PPOs or alliances.

PPO Services. The hallmark of PPO services is diversification (outpatient, ambulatory and inpatient):

- Good utilization review
- Sophisticated data analysis
- New service components (workers' compensation, disability management, home care, substance abuse, e.g.)
- Use of gatekeeper and putting the providers at risk.

Plan Design. PPOs traditionally have used only weak steerage to get participants to use network physicians. The benefit spread between the network and out-of-network has been 10-20%. In these plans the PPO option has been, to a considerable extent, ignored. The poor PPO acceptance has also been the result of poor participant education. Employers have been reluctant to push for a greater spread than the usual 20%. It is expected that employers will be changing their views and pushing for greater spreads.

Exclusive Provider Organization (EPO). The EPO may be likened to a hybrid of the HMO and PPO. The EPO came into being as a means by which a PPO may compete with an HMO. The option works as follows:

- Participant may opt for the standard PPO option being able to use any in-network physician at 90% or any out-of-network physician at 70%.
- Participant may opt for the EPO option, meaning such participant uses a single physician or a narrow panel of physicians. Initially, results in no benefits or substantially reduced benefits.

The EPO option demands good utilization review, effective data management and good administrative support. Administrative fees tend to be twice for the EPO what they are for the PPO.

Reimbursement. To *plug-in* or use a PPO network, there is typically a per

participant *use fee* of \$X (\$X is in the \$1 to \$3 range) plus an additional fee of \$Y (XY is in the \$0.50 to \$2 range) for all utilization review services. Two other services are often provided:

- *One.* Case management priced as an hourly cost.
 - *Two.* Claims repricing (negotiating) on a per transaction basis.
- Variations in PPO fees that are being seen include:
- Percent of savings
 - Percent of claims
 - Other guarantees (savings exceed fees; actual fees will overall be less than 10% of market).

Carve out or Ancillary Care. Because of the specialty nature of certain ancillary care services (mental, substance abuse, chiropractic, podiatric and rehabilitation care) these services are carved out. This carveout has been a regular practice of the PPO for many years with dental, vision, hearing and prescription drug care. Specialty firms handle these ancillary services. There are several reasons, however, why the carveout trend may not continue:

- Multiplicity of vendors is becoming complicated.
- Insurer-dominated PPO has ability to offer all service care.
- Specialty vendors are often undercapitalized and too local to be effective.

PPO and Workers' Compensation. As states amend their statutes affecting workers' compensation, PPOs specializing in occupational medicine are being formed. A new managed care world has been opened up and involves both medical and disability. The development is well-timed; workers' compensation claims are increasing at a high rate. The typical workers' compensation PPO is characterized as follows:

- Emphasis on discounts (15-25%).
- Non-aggressive utilization review.
- Minimal quality assurance.
- PPO reimbursement as a percent of savings.

The workers' compensation PPO is presently lagging behind the non-occupational variety for these reasons:

- Management is less skilled.
- Emphasis is on claims turnaround (not sophisticated services).
- Employers tend to take the short and not the long view to claims control.
- States have rigid statutes that control the extent to which managed care can practice steerage.
- Providers and employees find it easier to scam workers' compensation carriers than health care plans.

That workers' compensation PPOs must handle both medical and disability
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claims is a challenge to many firms that know the medical claims area. That is, the PPO doesn't understand disability. It is not uncommon to find the employer's internal policies contribute to and do not serve to control workers' compensation costs. In large companies, there is often split responsibility:

- Workers' Compensation – Risk Manager.
- Health Care Plan – Benefit Manger.

Network Criteria. Selecting the correct physicians to join the PPO network is the Number-one challenge. The trick is to do proper physicians profiling; to get in the good ones and keep out the poor ones; to do good profiling, there must be good data. There are certain profiling rules of thumb:

- Bring in 25% of physicians and then screen out some by objective criteria (credentials, reported violations, extent of malpractice, past litigation history). Goal is preferred, not run-of-mill physicians. Get spread of physicians by geographic location, hospital staff privileges and specialty.
- Bring in hospitals based on location, reputation, availability of both acute and specialty services, and price.

Management of Utilization. A common observation of PPOs is that they stress discounts over utilization disciplines. The better PPOs have graduated to where they have effective utilization review programs as well as carveouts for the ancillary services. The utilization review includes large case management. The utilization review has dramatically expanded in recent years and many PPOs have not kept up; examples:

- Review of ambulatory surgery
- Review of other forms of outpatient care (home, skilled nursing, e.g.)
- High tech and experimental procedure assessment
- Ancillary care carveouts
- Mental and substance abuse
- Rehabilitation review
- DRG management
- Protocol development
- Medical software/technology.

Important point: UR firms are getting into PPOs faster than PPOs are getting into UR; facing this possibility, PPOs will lose market share in the future. Further, UR firms tend to be more broad-based geographically than PPOs.

Data Reporting. Generally speaking, data output with PPOs is poor. Clients want specific information on the following:

- Utilization
- Costs
- Cost savings

- Quality.

Sometimes, PPOs provide *smoke and mirrors, phantom savings, shadow pricing, etc.* A cost savings is *touted* but quality has been sacrificed. The typical data output system measures cost but not quality.