MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO)
DEMONSTRATION
FACT SHEET

In contract year 2003, the Centers for Medicare & Medicaid Services (CMS) implemented a PPO Demonstration that offered thirty-five new Medicare Advantage plans (formerly Medicare+Choice (M+C) managed care plans). The demonstration sought to increase the number and variety of health plan choices available to Medicare beneficiaries and provide beneficiaries with greater opportunities to select a plan that best meets their individual needs. This project was designed to test the impact of enhanced payment and risk-sharing arrangements between CMS and the plans on the range of options and benefits available to beneficiaries. Plans made available under this initiative offered beneficiaries a wide variety of supplemental benefits including drug coverage and, most significant, the freedom to use out-of-network providers for a higher cost-share.

Background

The Medicare + Choice program was introduced as part of the Balanced Budget Act of 1997 (Pub. L. 105-33). It was intended to increase the range of alternatives to the traditional fee for service program for Medicare beneficiaries. The options anticipated were coordinated care plans, including PPOs and health maintenance organizations (HMOs) (including HMOs with a point-of-service (POS) option), unrestricted private FFS plans, provider-sponsored organizations (PSOs), and medical savings accounts. Unlike traditional HMO products, some of these options allow Medicare beneficiaries who choose to enroll, access to services provided outside the contracted network of providers. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which was enacted on December 8, 2003, establishes the Medicare Advantage (MA) program in Title II. The Medicare Advantage program replaces the M+C program established under Part C of Title XVIII of the Social Security Act, but retains most of the key features of the M+C program.

Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare program. This researched indicated that the success of the PPO concept was not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in, at that time, the M+C program, by increasing incentives for M+C organizations to enter the market and offer PPO products.

Legislative Authority

CMS is permitted to conduct the demonstration pursuant to Section 402 of the Social Security Amendment of 1967, which authorizes demonstrations and allows CMS to waive requirements in Title XVIII that relate to reimbursement or payment.

Selection Process
CMS issued the special solicitation for PPO demonstrations in the Federal Register on April 15, 2002. Because of the desire to make the new options available to beneficiaries in January 2003, proposals had to be submitted by May 30, 2002. A panel of technical experts reviewed the proposals in accordance with specified evaluation criteria, and made formal recommendations to the Administrator. On August 27, 2001, CMS announced the selection of seventeen organizations to offer PPO products to offer PPO products in 23 states.

Demonstration Plans
PPO Demonstration plans were initially offered in January 2003. Thirty-five PPO Demonstration plans were initially offered in 21 states under the demonstration. (One plan terminated effective contract year 2005.) The table below lists the plans that were made available under this demonstration.

This demonstration program was modeled after the PPO coverage available in the commercial market. Although all plans were required to offer out-of-network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost effective manner while not providing a disincentive towards seeking appropriate care. As a result, the plans offered a wide variety of options for beneficiaries. All offered out-of-network benefits.

Referrals were not required for accessing out-of-network care, although in some cases there were pre-certification requirements. Most plans offered a prescription drug benefit, although the level and type of benefits covered varied. Some plans also offered additional supplemental benefits, for example vision and hearing screenings, disease management, and other services not covered under the traditional Medicare program. Many of the PPO demonstration organizations improved the benefits they offered as a result of increases in Federal payment rates with the enactment of the MMA. Primary benefit changes include reductions in premiums and/or copayments and enhancements to drug benefit options.

Risk Sharing
The key feature that distinguished the PPO products offered under this demonstration from that offered as part of the regular M+C program was the financing/payment provision. One of the risks to managed care organizations in offering a PPO is the potential for increased medical expenses and significant financial losses as a result of high utilization of out-of-network providers. As an incentive to get such organizations to enter this market, CMS offered participating organizations, under this demonstration, higher payment rates as well as risk-sharing arrangements in contract year 2003. Organizations that offered PPO products under the demonstration were paid the higher of the traditional M+C capitation rate or 99% of the average fee for service payment amount in each of the counties in which a plan was offered.

In contract year 2004, as a result of enhanced payments made available to Medicare Advantage plans under the MMA, all participating PPO Demonstration organizations

were paid the Medicare Advantage rates. All but eight of the participating organizations had a risk-sharing arrangement with CMS in contract year 2005, the last year of the demonstration. Risk sharing arrangements under this demonstration, where applicable, were specific to each plan offering a PPO product, and were symmetrical, meaning that the risk assumed by CMS was the same for both losses and savings.

The risk sharing arrangement specified a targeted medical loss ratio, or medical expense target, reflected as a percentage of total plan revenue. The risk sharing arrangement is reconciled 12 months after the close of the contract year, at which point the actual medical loss ratio will be established. To the extent medical expenses exceed the targeted medical expense by more than a pre-established amount, CMS and the organization share equally in the losses. Similarly, if the participating organization experiences savings, CMS shares in the savings.

All of the participating organizations that have risk-sharing arrangements with CMS as part of their demonstration terms and conditions are at full risk in a 2-5 percent corridor around the medical loss ratio, meaning the first 2-5 percent of any loss or gain in relation to the targeted MLR is assumed by the plan. Beyond the full-risk corridor, both CMS and the plan share risk under various specified arrangements. However, CMS's risk is never more than 80 percent.

Evaluation

Research Triangle Institute (RTI), an independent contractor under the direction of CMS's Office of Research, Development & Information, was selected to conduct a comprehensive evaluation of this demonstration initiative. The evaluation includes a case study component to examine issues pertaining to the implementation and operational experiences of the PPOs as well as analyses of primary data collected from a beneficiary survey and secondary data. RTI has completed the following reports: "Medicare Geographic Service Report" and "Summary of PPO Case Study and Implementation Report". A report that provides an analysis of primary data collected from a beneficiary survey is also complete. RTI is finalizing a report that addresses the impact of the demonstration on Medicare program expenditures.

MEDICARE PREFERED PROVIDER ORGANIZATION DEMONSTRATION
PARTICIPATING PLANS AND SITES

The following plans were available as of January 1, 2005 (34 plans covering 21 states)*

PLAN NAME	STATE
Advantage Health Plan, Inc.	Indiana
Aetna Health Inc. of Maryland	Maryland
Aetna Health Inc. of New Jersey	New Jersey
Aetna Health Inc. of Pennsylvania	Pennsylvania
Aetna Health Inc. of New York	New York
Anthem Health Plans of Kentucky	Kentucky
Cariten Insurance Co.	Tennessee
Community Insurance Company (Anthem)	Ohio
Coventry Life and Health and Life Insurance Co.	Illinois/Missouri
Coventry Life and Health and Life Insurance Co.	Kansas/Missouri
Coventry Life and Health and Life Insurance Co.	Ohio/West Virginia
Group Health Incorporated	New York
Health Assurance of Pennsylvania (Coventry)	Pennsylvania
Health Net Life Insurance Co. *(Note: plan terminated effective January 1, 2005)*	Arizona
Health Net Life Insurance Co.	Oregon/Washington
HealthNow New York, Inc.	New York
Healthspring, Inc.	Tennessee
Horizon HealthCare of NJ, Inc.	New Jersey
Humana Insurance Co.	Florida
Managed Health Inc.	New York
OSF Health Plans, Inc.	Illinois
Pacificare of AZ	Arizona
Pacificare of NV	Nevada
Tenet Choices, Inc.	Louisiana
United Health Insurance Co., Inc. (2 different plans for 2 distinct service areas)	Florida
United Health Insurance Co., Inc. (2 different plans for 2 distinct service areas)	Alabama

MEDICARE PREFERED PROVIDER ORGANIZATION DEMONSTRATION
PARTICIPATING PLANS AND SITES (Continued)

PLAN NAME	STATE
United Health Insurance Co., Inc.	Illinois/Missouri
United Health Insurance Co., Inc.	North Carolina
United Health Insurance Co. of New York	New York
United Health Insurance Co., Inc. (2 different plans for 2 distinct service areas)	Ohio
United Health Insurance Co., Inc.	Rhode Island
UPMC Health Benefits Inc.	Pennsylvania

* The following products were not offered as planned: Cariten (Virginia) and Pacificare (California).

Status

The demonstration terminated on December 31, 2005, and the participating organizations successfully transitioned to the Medicare Advantage program, effective contract year 2006. The 2003 payment reconciliation process has been completed.