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Medicare Preferred Provider Organization (PPO) Case Study and Implementation Report

Summary Report

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SECTION 1
INTRODUCTION

1.1 Background

The purpose of this project is to evaluate the Centers for Medicare & Medicaid Services' (CMS') Medicare Preferred Provider Organization (PPO) Demonstration, which began providing services to Medicare beneficiaries on January 1, 2003. By initiating this demonstration project, CMS has the following policy goals:

- Increase access for Medicare beneficiaries to managed care alternatives to traditional fee-for-service (FFS).
- Fulfill the ideals of the Medicare+Choice (M+C) program by expanding the number and types of managed care products available to Medicare beneficiaries.

Provide a mix of product options under M+C that more closely mirrors the private sector.

1.2 Purpose of this Case Study/Implementation Report

For this report, CMS asked RTI International (RTI) to prepare case study reports for each of the MCO participants under the demonstration. To accomplish this, we prepared a basic description on each of the MCO service areas, compiling such information as Medicare managed care penetration rates, competing M+C plans, service area population, and premiums/benefit packages offered. This preliminary information was compiled in our "Geographic Service Area Report" submitted to CMS in April 2003. To build on this information, we then conducted site visits with each of the parent company organizations to discuss in more detail the characteristics of their PPO demonstration MCOs and the experiences they had in implementing the demonstration sites. Site visits were conducted between April and July 2003. The MCO personnel we interviewed varied across sites but typically included the Medicare product manager, government relations specialist, actuarial/financial personnel, marketing directors, and MCO management. We also spoke with representatives from the CMS Central Office and CMS Regional Offices regarding their perspectives on the implementation process for this demonstration.

This report begins with an overview of the demonstration implementation thus far, summarizing the key themes we heard regarding the demonstration's implementation and operations to date. We compare the PPO demonstration's goals with progress to date. The remainder of the report includes a chapter on each parent company summarizing six key areas:

- Information on the demonstration MCOs and their market areas
- Reasons for organizational participation in the demonstration and implementation issues faced
- Design and characteristics of the MCO demonstration products
- Marketing the demonstration product to Medicare beneficiaries

- Provider issues
- MCO perceptions and comments on Medicare PPOs

Readers may note that we do not always use the term "PPO" to refer to all the demonstration products. During this study, we learned that not all the demonstration MCOs are PPOs; some are more accurately called Point-of-Service (POS) products. In addition, we found that different understandings exist among the MCOs regarding the differences between PPOs and POSs. According to some MCOs, the key dividing line between a PPO and POS plan is the level of out-of-network (OON) services offered. PPO plans typically offer an OON option for all services, whereas POS plans restrict the OON benefit to particular services. Some insurers in the demonstration developed a POS product because the insurance license under which they operate is an HMO license; this is an important distinction for licensure because in many states a different license is required for a PPO. Among other demonstration MCOs, the distinction between a PPO and a POS does not relate to the OON benefits offered. Rather, the difference is that with a POS you have to choose a primary care physician (PCP) and get referrals for specialists, whereas with a PPO, you do not—you can go to any doctor you want. A POS is a health maintenance organization (HMO) with an OON benefit. Therefore, within network, a POS operates like an HMO. This difference in definition of a PPO versus POS highlights the somewhat fluid nature of these concepts, even within the managed care industry.

1.3 Demonstration Parent Companies

Table 1 summarizes the 17 parent companies participating in the demonstration. We visited and prepared a case study on each with the exception of Anthem, whose demonstration product, at the time of the site visits, was still in the relatively early stages of planning. Individual case studies were reviewed by the respective demonstration parent company. All but one parent company offers other M+C products, although the majority do so on a local basis only. The big national or regional M+C players—Aetna, Humana, PacifiCare, and United HealthCare—are offering at least one demonstration PPO, but only United (with 10 offerings) decided to offer products on a large scale basis. Humana, in contrast, is taking a cautious approach to the demonstration, offering a PPO product in only one Florida county. Kaiser, the largest M+C player nationally, is conspicuous by its absence. Although we did not interview Kaiser, the PPO concept does not appear to fit well with its staff model HMO. All of the parent companies are for-profit, with the exception of the three New York MCOs. Most of the parent companies are insurers, although four of them are owned by provider networks (for example, the University of Pittsburgh hospital system owns the insurer UPMC). The provider networks typically established the affiliated insurer as a safeguard against other insurers directing business away from them and now see the insurer as a way to cement or expand their Medicare business. Serving publicly-insured populations (Medicare, Medicaid) is a core part of their mission and business strategy. The provider-owned MCOs are relatively small, local players, and in some cases (e.g., Advantage) are near start-ups.

The map at the end of this chapter shows the service areas of all the PPO demonstration sites. Demonstration PPOs are offered in all but one of the 10 CMS regions but are concentrated in the Northeast.

1.4 Goals of the PPO Demonstration

In launching this demonstration, CMS outlined three broad goals:

- **Increase access of managed care products to Medicare beneficiaries.** If successful, CMS expected to see beneficiaries choose the new managed care options, primarily from FFS but also from other M+C plans.
- **Expand the number and type of MCOs participating in the Medicare managed care program.** CMS hoped that organizations not currently participating with Medicare would offer a PPO product. In addition, CMS would have liked to see current M+C organizations expand into new service areas with a PPO product, particularly underserved rural areas.
- **Provide access to the most popular private sector managed care option to Medicare beneficiaries.** Although PPOs are the most populated managed care option in the private sector—offered primarily through employer groups—HMOs remain the dominant product in M+C. Therefore, a goal of this demonstration was to increase the availability of PPOs to Medicare beneficiaries.

In the remainder of this introductory section, we examine the performance of the demonstration MCOs relative to these goals.

1.4.1 Increase Access of Managed Care Products to Medicare Beneficiaries

More Managed Care Options for Medicare: The PPO demonstration, at a basic level, has increased beneficiary access to managed care products. When fully operational, it is anticipated that 38 new PPO/POS MCOs will be available to Medicare beneficiaries, so interest in the demonstration among MCOs was clearly high. One demonstration organization—Group Health, Inc.—joined the demonstration as a new M+C contractor. Some of the demonstration MCOs expanded their managed care service areas into previously unserved counties. Considering the 206 "open enrollment" PPO counties, the demonstration has expanded managed care into 27 counties that, to date, have no managed care enrollment in M+C plans. These 27 counties combined have just under one-half million Medicare eligibles. Some of the current demonstration MCOs are currently expanding their demonstration PPO service areas. Additionally, some of the demonstration MCOs include large expanded service areas (available to employer groups only) beyond the 206 open enrollment counties. Coventry, whose employer-only group service area includes all of West Virginia, is a prime example. Initially, CMS projected that up to 11 million Medicare beneficiaries would have access to these new demonstration PPO plans, although only 150,000 individuals are expected to enroll.

- *Increased Medicare Enrollment in MCOs:* Current enrollment figures for the PPO demonstration MCOs fall well below those expectations. As of September 1, 2003, enrollment in the PPO demonstration was almost 74,000 beneficiaries. For most MCOs, with the exception of Horizon and Aetna whose enrollments are high, enrollment has been slower than projected; MCOs did not report to us, however, that they plan to abandon the project or that they feel the PPO is not a viable Medicare product. Instead, most MCOs with disappointing enrollment conclude that Medicare

Table 1
Demonstration parent companies

Demonstration Parent Company	Plan type	# MCOs (Contracts)	Service area	Profit/ nonprofit	Ownership	Other M+C products	Scope of M+C products
Advantage	PPO	1	Indiana	For Profit	Provider	Yes	Local
Aetna	POS	3	Maryland, New Jersey, Pennsylvania	For Profit	Insurer	Yes	National
Anthem (pending)		2	Kentucky, Ohio	For Profit	Insurer	Yes	Regional
Cariten	PPO	1	Tennessee	For Profit	Insurer	Yes	Local
Coventry	PPO	3	Illinois, Missouri, Ohio, West Virginia	For Profit	Insurer	Yes	Regional
Group Health, Inc.	PPO	1	New York	Nonprofit	Insurer	No	__
HealthFirst	PPO	1	New York	Nonprofit	Insurer	Yes	Local
Health Net	PPO	2	Arizona, Oregon Washington	For Profit	Insurer	Yes	Regional
HealthNow	PPO	1	New York	Nonprofit	Insurer	Yes	Local
HealthSpring	PPO	1	Tennessee	For Profit	Insurer	Yes	Local
Horizon	POS/ HMO	1	New Jersey	For Profit	Insurer	Yes	Local
Humana	PPO	1	Florida	For Profit	Insurer	Yes	Regional
OSF Health Plans	PPO	1	Illinois	For Profit	Provider	Yes	Local
PacifiCare	POS	[1]2	Arizona, Nevada	For Profit	Insurer	Yes	Regional
Tenet Choices, Inc.	PPO	1	Louisiana	For Profit	Provider	Yes	Local
United HealthCare	PPO	10	Alabama, Florida, Illinois, Missouri, North Carolina, New York, Ohio, Rhode Island	For Profit	Insurer	Yes	National
UPMC	PPO	1	Pennsylvania	For Profit	Provider	Yes	Local

[1]Subsequent to our site visit, PacifiCare decided to withdraw its PPO planned for Southern California.

beneficiaries simply need time to "get used to a new product." MCOs argue that CMS' aggressive timeline for enrollments may have been unrealistic. Most MCOs told us that any new product for Medicare beneficiaries needs time in the marketplace to establish positive word of mouth. In addition, most MCOs marketing the PPOs to Medicare beneficiaries are finding that getting beneficiaries to even consider changing insurance options is a major hurdle. This is particularly the case since media coverage of the PPO demonstration, expected by some MCOs to be higher, has been almost nonexistent. As a result, beneficiaries are hearing about the new PPO options almost exclusively from the MCOs offering the option. MCOs reported to us that many beneficiaries (not unreasonably) are wary of information they get from "someone trying to sell them something." Currently, however, no other prominent source of information on the PPO option exists. Our discussions with the CMS Regional Offices did not uncover any known educational efforts about PPOs. We have been told, however, that the 2004 *Medicare & You* handbook will include some information about PPO options.

Attractiveness of PPO/POS to Medicare Beneficiaries: Price appears to be the factor that most influences Medicare beneficiaries' willingness to consider new options such as the PPO. The MCOs we spoke with observed that many beneficiaries are willing to pay sometimes high Medigap premiums to maintain freedom of provider choice and access to all services without referral. That said, many MCOs also noted that beneficiaries are sometimes willing to consider other options if they can save money, particularly among beneficiaries who may be feeling increased financial pressures. Beneficiaries do not seem willing, at least so far, to pay higher premiums for a PPO/POS than for available HMOs or to switch from Medigap without substantial savings. The demonstration MCOs that have been most successful have tended to offer a well-priced PPO option. Horizon, the site with the largest enrollment so far, offers a product that while officially a POS option maintains many provider restrictions found in their HMO product. Drug benefits offered by Horizon are limited and offered only under a more expensive option that has higher co-pays than the base POS. What Horizon does offer, however, is a well-priced product in a marketplace with few other affordable options. Aetna, the PPO demonstration MCO with the second largest enrollment to date, also appears to offer a well-priced POS product with a limited generic drug benefit. Most demonstration MCOs told us that the premium price and, to a lesser extent, out-of-pocket payments were a major factor in getting beneficiaries to join any new product. Originally, some MCOs were conservative and priced their PPO products high because of a concern about, or lack of experience with, OON utilization and possible adverse selection into the product. They may have also misjudged the extent of beneficiary demand for PPO/POS products. A number of demonstration MCOs enacted mid-year benefit enhancements that lower premiums and cost sharing to attract more beneficiaries. Over time, as MCOs experiment with different combinations of premiums and in- and out-of-network cost sharing, they may offer PPO products that are more attractive to beneficiaries. If beneficiaries could save money by joining the PPO relative to their Medigap policy, or if the PPO offered clearly better benefits for only a marginal increase in cost relative to other managed care options, then the PPO product could be successful. Some demonstration MCOs specifically priced the PPO product at 30 to 40 percent below the most popular Medigap policies to make this point.

The demonstration MCOs do not seem to observe, at this point, that the OON features specifically attract large numbers of beneficiaries; the OON benefit per se is not valued enough by most beneficiaries to draw in large enrollments or command a large price premium over

HMOs in the marketplace. It is also true that MCOs require substantial OON cost sharing, 20 percent or 30 percent coinsurance, often with a deductible and no or a high out-of-pocket maximum. Although this serves to give enrollees strong incentives to use in-network providers, it means that utilizing the PPO OON benefit is very expensive for them, limiting its attractiveness. As with premiums, some MCOs are enhancing their PPO products with OON maximums or lower OON cost sharing for 2004. Although many MCOs are using the availability of OON coverage as a primary selling point, beneficiaries seem to focus on total monthly premiums. Some MCOs told us that unless beneficiaries can save at least $100 per month in premiums, they were unlikely to make a change. In addition, many MCOs told us that getting beneficiaries to switch from Medigap plans is very difficult unless the premium for Medigap has become unaffordable—something happening more often as age attained rates for older beneficiaries continue to rise. Similarly, the drug benefits offered under the PPO products seem to be attractive to beneficiaries in some markets but less so in others depending on availability of drug benefits from existing HMOs and/or other state drug assistance programs. Moreover, many demonstration MCOs have not differentiated their PPO product from their HMO product other than through the PPO OON benefit. If the OON benefit is not highly valued, the PPO is viewed simply as a more expensive version of the HMO, and beneficiaries interested in managed care tend to choose the lower-priced HMO. Several MCOs told us that they plan to create greater differences between their PPO and HMO products over time (e.g., a larger PPO provider network).

1.4.2 Expand the Number and Type of MCOs Participating in the Medicare Managed Care Program

New Medicare MCOs: Under the most ideal circumstances, many MCOs new to M+C would have offered products under this demonstration. The more favorable payment arrangements and reduced administrative burden for the application process were designed to encourage increased participation. However, the very aggressive time frames for the demonstration implementation—less than 1 year between demonstration application due date and first enrollments—may have all but eliminated the chances that organizations new to Medicare would participate in the demonstration. During the site visits, we learned that most demonstration MCOs were able to achieve the January 1, 2003, start date only because of their past experience with M+C. They chose service areas for the demonstration that relied on existing provider networks and the ability to enact contract amendments (rather than establish new provider contracts). These MCOs told us that it would have been very difficult to offer the PPO product in this demonstration without past experience working with CMS and an existing provider network. Also, many private sector PPOs do not bear risk, and even with CMS sharing risk, they would have to be licensed as risk-bearing entities by their states.

Retaining Medicare MCOs through PPO/POS: Although the PPO demonstration did not attract many new MCOs to Medicare, the features of the demonstration—primarily the favorable payment rates—did keep some MCOs participating when they might otherwise have left M+C. The best example of this was Horizon in New Jersey, which substituted its M+C HMO product with the new PPO product; they did this because of the higher reimbursement rates available under the demonstration, and because they were finding it increasingly difficult to offer their former product under M+C. Horizon currently has, by far, the largest enrollment of the PPO

demonstration with more than 45,000 enrollees. In the absence of the PPO demonstration, many of these beneficiaries may have been left with no M+C option, because Horizon is the only remaining statewide Medicare managed care option.

In addition, some MCOs either re-entered Medicare markets from which they had previously withdrawn (for example, Aetna which had withdrawn its product in Maryland) or expanded into areas where they did not offer an M+C product (for example, Health Net had M+C contracts in Arizona but expanded Medicare business into its Oregon organization). In these cases, expanded choices were offered to Medicare beneficiaries, although not necessarily by new MCOs.

We also found that, aside from the more favorable financial arrangements offered under the demonstration, a number of MCOs were genuinely interested in testing out the PPO product for Medicare. We asked why they had not done so under the regular M+C program—PPOs have been allowed since the Balanced Budget Act of 1997 (BBA) was implemented. The MCOs told us that, although allowed under M+C rules, it was hard to commit to a new M+C product at a time when the decision to continue to participate with Medicare was made year to year based on the new payment rates. So although many MCOs liked the PPO model and perceived it as either the "up and coming product" for Medicare or as a logical companion to HMO products, financial considerations simply made new Medicare products difficult to launch. The demonstration, with potentially more favorable payment rates and the availability of risk sharing, gave plans the opportunity to try out a PPO product.

Finally, we asked the demonstration MCOs about their willingness to offer the PPO, or any managed care product, in traditionally underserved rural areas. The demonstration MCOs cited two related factors that make managed care expansion into rural areas difficult in most cases: (1) CMS network requirements and (2) payment rates. CMS currently maintains the same provider network requirements for rural areas as for urban areas. However, meeting these requirements in many rural areas can be nearly impossible, the MCOs told us. The supply of physicians and hospitals, as well as other providers, in rural areas can be very limited. Some MCOs told us that they could not meet CMS network requirements even if they signed up every provider in an area. Because of this relative scarcity, rural providers sometimes require more than 100 percent of FFS Medicare payments in order to participate in managed care networks (we heard figures up to 110 percent). As a result, many MCOs view rural areas as less attractive potential markets.

1.4.3 Provide Access to the Most Popular Private Sector Managed Care Option to Medicare Beneficiaries

Greater Medicare Access to PPOs: By offering PPO options in more than 200 counties, the PPO demonstration is making some headway in mirroring the private sector—where PPOs are the dominant product. As of the time of the site visits, it was unclear whether MCOs are considering expansions beyond the original demonstration service areas. A few MCOs, such as United and Advantage, are already implementing limited service expansions. However, most demonstration MCOs are taking a more wait and see attitude, especially since enrollment has been somewhat slower than originally anticipated.

Related to understanding why PPOs have not been more widely offered in the Medicare program prior to the demonstration, we asked MCOs why PPOs have not dominated the market in Medicare the way they have in the commercial market. A number of MCOs told us that employers, faced both with rapidly rising health care costs and with some backlash from employees about traditional HMO coverage, find PPO options something of a middle ground. PPO options tend to cost less than traditional indemnity insurance plans, which are increasingly rare. Under most employer contracts, choices are often limited to one or two options, so minimum enrollments are more likely to be achieved for MCOs bidding for employer contracts. Under M+C, however, most MCOs told us that they are struggling year to year with difficult financial decisions in participating with Medicare at all. Most MCOs we talked to were concerned about the adequacy of M+C rates. They argued that under difficult financial constraints, they would be unlikely to offer a new, more risky Medicare product. The PPO demonstration, however, provided many of them the opportunity to experiment with PPOs and Medicare under more favorable payment rates and with the security of risk sharing with CMS.

Impediments for Medicare PPOs: A major challenge for Medicare PPOs is that their low enrollments limit their bargaining power with providers. The PPO model is based on insurers obtaining price discounts from providers in return for in-network designation. These discounts allow the sponsoring insurer to lower the premium charged to employers (in the private sector) or to Medicare beneficiaries (in Medicare). PPOs can thus be priced lower than traditional indemnity products with no networks (e.g., Medigap). But Medicare PPOs have such low enrollments that they have limited bargaining power to obtain discounts from providers—we heard that discounts were typically 5 to 10 percent or less. This limits the price discount Medicare PPOs can offer relative to Medigap, which is necessary since PPOs increase cost sharing for non-network providers relative to Medigap. In the private sector, in contrast, a large employer or insurer has considerable enrollment to use to bargain for lower rates from providers. Medicare PPOs suffer from a chicken and egg problem—they need larger enrollments to get provider discounts and offer a lower price to beneficiaries, but they need a lower price to get larger enrollments.

Another way in which PPOs could offer a lower price than Medigap is through managing beneficiary utilization to eliminate unnecessary or low-value care. But the MCOs we interviewed did not expect significant savings relative to Medicare FFS through care management. Virtually all of the PPOs engage in some combination of disease management, utilization review, physician profiling, or prior authorization. But the lack of PCP gatekeeping, the OON benefit, little risk sharing with providers, and the sometimes broader PPO provider networks limit the ability to manage care in a PPO compared with an HMO. The PPO is more of a "open access" model that focuses on beneficiary choice of provider, not the tight utilization controls, provider risk sharing, and narrow networks of the most efficient providers that may exist in HMOs. Even in HMOs, there is a general trend away from tight utilization management and putting providers at risk as this has not proven successful in the marketplace.

The competition faced by PPOs relative to other insurance options may also limit their widespread appeal to Medicare beneficiaries. It is difficult for PPOs to compete with subsidized employer-supplements (although some employers may decide to offer PPOs to their retirees as a cost control measure, and employer-sponsored retiree coverage is projected to erode over time). Lower income beneficiaries care mostly about price and do not value the PPO OON benefit

highly—they tend to prefer Medicare HMOs or may have Original Medicare only. This leaves PPOs competing with Medigap insurers, who account for about one-third of the total Medicare market. But Medigap has certain advantages over PPOs. It offers complete freedom of choice like the PPO and has limited cost sharing for all providers, not just network providers. Limited provider discounts and savings from utilization management limit how much PPOs can underprice Medigap. Also, Medigap is typically allowed to age-rate premiums whereas PPOs cannot, further eroding PPOs' price competitiveness for the younger elderly, a natural target market.

SECTION 2
MCO REASONS FOR JOINING THE DEMONSTRATION

Most of the demonstration MCOs cited financial reasons for offering PPO products through the demonstration instead of the regular M+C program. These financial reasons included the availability of risk sharing with CMS, which lowered the financial risk of offering a new Medicare product. Another financial incentive offered by the demonstration included the higher county base payment rates offered only through the demonstration. In the demonstration, MCOs are paid based on the higher of either 99 percent of the Medicare FFS rate or the regular M+C county rate book. Even though in most areas this special demonstration county rate was not higher than the regular M+C county rate in FY2003—in most cases the rates were within 5 percent of each other—some MCOs told us that an important factor in the demonstration county rates was the prospect for higher growth rates in the future rather than the current demonstration rate.

Most of the demonstration MCOs received a $100,000 implementation grant from CMS. None of the participating organizations cited this as the most important reason for joining the demonstration. That said, a number of sites found that this funding from CMS was an important gesture from the agency and was helpful in convincing their organization's senior management to support the demonstration product. For some organizations, this was particularly important as senior management was sometimes making decisions related to Medicare participation; launching a new Medicare product was something of a "hard sell" in some MCOs.

All the MCOs we talked to supported any effort by CMS to lessen the administrative burdens associated with M+C participation, including during the application phase. However, most demonstration MCOs considered the demonstration application process somewhat streamlined—for example, demonstration MCOs did not have to complete an Adjusted Community Rate (ACR) filing. Despite the fact that some administrative processes were streamlined in the demonstration application, in general, most demonstration MCOs still found the application process for the PPO project time consuming and made somewhat more difficult because of the very aggressive time frame CMS laid out for the process (about 9 months between demonstration application and first enrollments).

Some demonstration MCOs were considering a Medicare PPO as a possible addition to other M+C products they offered in their areas prior to the announcement of the demonstration. Once the project was offered, these organizations decided to join the demonstration rather than launch the PPOs on their own as part of the M+C program. In some of these cases, their M+C

products were doing well, and the PPO was envisioned as a way to expand market share (e.g., HealthNow, HealthSpring, PacifiCare, Tenet, United HealthCare, and UPMC). In other cases, demonstration MCOs were considering leaving the M+C market (e.g., Horizon), had exited M+C in many areas (e.g., Aetna), or were struggling to maintain a financially viable M+C product (e.g., OSF); for these MCOs, participating in the demonstration and offering a PPO product was seen in part as a way to redirect or reinvigorate Medicare business.

Table 2 summarizes the reasons reported by the demonstration MCOs for offering a PPO/POS product through the demonstration. The most common reasons MCOs cited for offering a PPO under this demonstration were as follows:

- Availability of Risk Sharing: Many MCOs found the ability to share risk with CMS an appealing feature of the demonstration. This option allowed MCOs to try out a new Medicare option without bearing the full financial risk. CMS requires symmetrical sharing of any savings or losses, however.
- Higher County Payment Rates: Many MCOs were attracted to the demonstration by the prospect of higher county payment rates (based on 99 percent of FFS rather than the existing rate book). We found, however, that for most MCOs, the minimum levels set in the M+C rate book were higher than the demonstration rates. MCOs also told us that the prospect for FFS-based growth rates (rather than 2 percent minimums) was important in these higher rates.
- Streamlined Administrative Process: The demonstration application process was streamlined relative to the regular M+C contract application, an attractive feature to some MCOs. In particular, under the demonstration, MCOs did not have to file an ACR.
- $100,000 Implementation Support: Demonstration MCOs were offered $100,000 in implementation support, not available under the regular M+C program.
- PPO Product Appeal: A number of MCOs reported that they found the PPO an appealing product in the current Medicare marketplace. Many noted that the PPO/POS option is a complement, not competitor, for HMO products.
- CMS Exposure: A number of demonstration MCOs joined the demonstration, in part, because they expected to take advantage of CMS-sponsored visibility for the project. Some of this expected CMS exposure, however, did not materialize.

2.1 Implementation Issues

CMS' time frame for the solicitation and implementation of the PPO demonstration was extremely aggressive. Perhaps because of this very quick schedule, a number of demonstration MCOs faced implementation issues. The most common implementation issues reported by the MCOs related to the approval process for PPO marketing materials and mid-year benefit changes, a lack of awareness and/or acceptance by non-network physicians of the PPO, and less than expected publicity from CMS and local media regarding the new PPO option for Medicare. We discuss these issues in more detail below.

Table 2[1]
MCOs' reasons for joining the demonstration

Demonstration MCO	Availability of risk sharing	Higher county payment rates	Streamlined adminis-trative process	$100,000 implemen-tation support	PPO product appeal	CMS exposure on the PPO demonstration	Other reasons
Advantage	Very Important			●	●		Large employer approached the MCO
Aetna	●	●	●	●			
Cariten				●	●		
Coventry	Very Important	Very Important	●	●			
Group Health, Inc.	●	●		●	●		
HealthFirst	●			●	●		
Health Net	Very Important	Very Important	●	●	●	●	
HealthNow					●		PPO an opportunity to increase Medicare business
HealthSpring				●			PPO an opportunity to increase Medicare business
Horizon		Very Important	●	●			Waiver of FFS cost sharing Limits
Humana	●	●	●				Ability to test PPOs on a limited basis
OSF Health Plans		Very Important	●	●			
PacifiCare	●	●		●	●		PPO an opportunity to increase Medicare products
Tenet Choices, Inc.		Very Important			●	●	
United HealthCare	Very Important	●	●	●	●		
UPMC		●			●		PPO an opportunity to increase Medicare products

[1] In this table, we note factors that were important to MCOs in two ways, Factors noted by MCOs as especially important are identified as "very important." Other factors noted are indicated by "●"

2.1.1 CMS Administrative Approvals

Most demonstration MCOs cited delays in getting marketing materials, letters to providers, and other PPO-related communications approved by CMS. In some cases, MCOs told us this hampered their ability to get out in the market and attract beneficiaries. MCOs argued that—particularly when launching a new product—timing is very important, and the approval process required by CMS limited their ability to react to changing market conditions. Some plans considered these approval delays as a key reason why PPO enrollments have lagged behind expectations. At the onset of the implementation process, CMS attempted to streamline the approval process by creating a special approval team comprised of staff from many Regions. Because of this, approvals were initially conducted by staff different from MCOs' usual lead Region. Eventually, CMS found that this process did not work well and, in an attempt to improve the process, has generally returned to the usual lead Region model. That said, CMS staff feel in most cases that they have been as responsive as possible to MCO requests for quick approval of marketing and other administrative materials. Because of the additional regulatory responsibility of CMS and its programs for the Medicare population, it may ultimately not be practical for CMS staff to act as quickly as would be desired by the MCOs.

2.1.2 Out-of-Network Provider Resistance

Lack of knowledge/willingness to provide OON benefits by non-network providers is seen as a huge issue for a number of the demonstration MCOs. In some cases, we were told that local physicians are turning away enrollees in the PPO because "they don't accept" that particular MCO's insurance. Beneficiaries are then disenrolling in the product because they were counting on the use of the OON benefit. This is the case even though the OON providers will receive payments at the Medicare reimbursement level in total using the same claims processing and timing found in FFS. The demonstration MCOs experiencing this problem (including United, Health Net, and Health Spring) perceive that the legitimacy of the OON option and their willingness to pay for OON benefits is not being communicated, or accepted, by some in the local provider community. MCOs are dealing with this by sending letters to enrollees explaining how to communicate to OON providers about this benefit when making an appointment. Another MCO is attempting to educate OON providers about the PPO model and their role in it. However, the MCOs feel strongly about getting CMS assistance in this area because materials from CMS are perceived to have greater credibility.

We found in speaking with CMS Central and Regional Office staff that a few cases of these problems are surfacing, although with enrollment increasing gradually, the problem may increase in the future as more and more beneficiaries attempt to use OON benefits. Aside from lack of knowledge, other reasons suggested to us why some physicians may be resistant to providing OON services include a more general unwillingness to conduct business with local managed care firms and/or Medicare. CMS also hears anecdotes that some providers are becoming "fed up" with either managed care plans and/or Medicare. Therefore, at this point, it is difficult to sort out both the magnitude and the cause of provider resistance. This is a particularly difficult issue because no single association or group speaks for physicians in a reliable way. Future work on this evaluation may include discussions with non-participating physician groups to understand this issue better, particularly if PPO MCOs continue to see this

issue as a problem that extends beyond the initial start up phase of the project. If prevalent, physicians' unwillingness to provide OON benefits could become a serious problem for expansions of the PPO model for Medicare.

2.1.3 Lack of Publicity Surrounding the New PPO Options for Medicare

A number of demonstration MCOs were expecting CMS to conduct a more significant rollout of the PPO demonstration, which they believed would have created more "buzz" about the demonstration. These sites are not necessarily looking for free marketing—they have done significant marketing on their own. Rather, they were counting on the CMS stamp of approval or endorsement for the PPO concept, which they argue is very important to Medicare beneficiaries in their area. Instead, they have seen almost no exposure for the PPOs from CMS beyond the initial press release, which was not even picked up by local papers in most areas. This has been a big disappointment for some MCOs (e.g., Tenet and Health Net) and a reason they believe they have had less success in attracting beneficiaries than might have been possible.

This issue relates to the more general concern that many plans had that beneficiary awareness of the PPO option in most areas is extremely low. When we asked CMS Central and Regional Office staff if they knew of any significant local educational programs to teach beneficiaries about the Medicare PPO option, none were identified. Information on the PPO was all but nonexistent in the 2003 version of the CMS *Medicare & You* handbook (likely due to timing issues), although more information on PPOs is included in the 2004 version.

If CMS' expectation for beneficiary enrollment in PPOs continues to be high, it seems reasonable that the agency may have to invest more in beneficiary education on this topic. Although many demonstration MCOs are doing a great deal of education through their sales and marketing efforts, many beneficiaries are sensitive (with good reason) to the fact that MCO-sponsored messages are intended to "sell them something." Therefore, even if PPO enrollments increase in 2004, the project may never generate the levels of enrollment expected by CMS without some non-MCO-sponsored education and exposure for the project. Plans have an incentive only to promote their own product, not the general PPO concept, which could benefit their competitors as much as themselves if there is more than one PPO product in the market (either now or in the future).

SECTION 3
DESIGN AND CHARACTERISTICS OF THE PPO PRODUCTS

3.1 Product Type

A large majority of the demonstration MCOs offer a true PPO product, but three MCOs offer a POS product (Aetna, Horizon, and PacifiCare). These three MCOs offering a POS vary in how they differ from the traditional PPO model. For instance, Aetna does not require a gatekeeper PCP, but the product also does not offer OON options for all services. PacifiCare of Nevada, on the other hand, for in-network services requires the selection of a PCP and referrals.

Horizon offers a POS with OON coverage but with high cost sharing. Additionally, the Horizon plan retains many of the HMO referral requirements.

Most of the MCOs designed service areas that are contiguous and have existing M+C or commercial HMO/PPO provider networks. A handful of MCOs have service areas that are not geographically adjacent to one another. HealthNow, for instance, has two noncontiguous service areas in upstate New York: the Buffalo metropolitan statistical area (MSA) and surrounding counties in western New York and the Albany MSA and surrounding counties in Eastern New York. United HealthCare also has noncontiguous service areas in North Carolina, Florida, and Alabama. Few MCOs expanded their demonstration plan into "new" service areas not already serviced by an M+C product or commercial business product. Health Net was one of the few MCOs that expanded their service areas beyond the existing M+C product by adding rural areas of Northern Arizona and Oregon. Two primary reasons the MCOs did not expand into additional service areas beyond their M+C market was the aggressive start date of the demonstration (January 1, 2003) and the fact that most provider contracts required only an addendum to their existing HMO contracts.

Most provider networks established for the demonstration mirror the MCOs' commercial and/or M+C HMO networks. In fact, availability of an existing network was one of the primary drivers in choice of geographic service areas. Some MCOs that expanded provider networks beyond their existing HMO network (e.g., Cariten) used the leverage of their commercial business to get providers into Medicare. Group Health, Inc., was the lone MCO to join the demonstration without an existing M+C plan or Medicare business, so they put pressure on their existing commercial provider network to participate in the Medicare PPO product.

3.2 Benefit Packages

As can be seen in Table 3, premiums range from a low of $0 for New York City residents (Group Health, Inc.) to a high of $184 for a plan with a generous prescription drug benefit in Western Pennsylvania (UPMC). Although monthly premiums vary widely among the demonstration plans, the majority of premiums fall within the $50 to $100 range.

A waiver was granted to all of the MCOs allowing them to exceed the actuarial value of coinsurances/deductibles. MCOs differ in their use of out-of-pocket maximums. These out of pocket maximums apply to all services, although there may be different limits for services obtained in and out of network. Out-of-pocket (OOP) maximum amounts for out-of-network services typically range from $2,000 - $3,000. Some MCOs offer an OOP maximum for in-network services, but not OON services.. For beneficiaries who join the PPO with the intention to access OON services, high OON cost sharing (20 percent coinsurance is common) can expose enrollees to significant financial risk. This potential lack of financial protection may limit PPOs' appeal to lower-income beneficiaries who cannot afford such high out-of-pocket costs and to the many elderly who prefer predictable medical expenses that they can budget for. In our site visits, a number of the PPO MCOs told us that beneficiary concerns over possibly high out of pocket costs, or uncertainty about what out of pocket costs might be particularly if they decided to use OON services, was a major reason beneficiaries cited for choosing not to enroll in the PPO (after initially considering the product). Because of this, a number of MCOs told us that they planned

to lower out of pocket costs for in and out-of-network services to improve the appeal of the PPO. This may be why a number of the PPO MCOs indicated an intent to add an OOP maximum, standard in commercial PPOs.

Office visit co-payments to see a PCP or specialist do not vary substantially among the plans, but inpatient hospital co-payments and coinsurance rates for the OON benefit do. A typical co-payment to see a PCP is $10, whereas a typical specialist office visit co-payment is $20. Some MCOs charge a flat co-payment for a hospital stay, regardless of the length of stay (Advantage, Aetna, Cariten, and OSF). Other MCOs charge a daily co-payment only for up to 5 days. Four MCOs have at least one plan option with no inpatient hospital co-payment (Group Health, PacifiCare, Tenet, UPMC), but they offset this benefit by charging a higher premium or not offering a drug benefit.

Most MCOs offer a limited prescription drug benefit, but the type of coverage, benefit maximum, and service area of the benefit vary considerably among the MCOs. As seen in Table 3, some MCOs offer drug coverage for generic drugs only. Among those MCOs that offer a generic drug benefit, some offer unlimited generic drugs and others offer a generic formulary with capped annual limits. A few MCOs offer plans that provide coverage for both brand name and generic drugs that are on a formulary. Depending on county reimbursement rates, market conditions, and other factors, some MCOs offer a drug benefit in select service areas but not all of them (e.g., Coventry, Health Net, United HealthCare, UPMC). On the other hand, MCOs such as Group Health or Horizon offer two different PPO options that allow the beneficiary to choose between a plan with or without drug benefits. The benefit maximum is unlimited for the majority of plans offering a generic drug benefit, but other MCOs cap the annual drug limit at $500 or $100 to $125 per quarter. Some MCOs also pointed out that their enrollees enjoy the benefit of drug price discounts negotiated by the MCO at participating pharmacies, which can be substantial.

The OON benefit also varies to some degree among participating MCOs. For our study, we asked the PPO MCOs to describe their OON benefit. Slightly over half of the MCOs offer at least one PPO option with 20 percent coinsurance for OON services. Some require a deductible to be met first, whereas others only require coinsurance rates. Less common is 30 percent coinsurance rates or a specific co-payment amount for an OON service. PacifiCare and OSF, for example, require an $812 inpatient hospital co-payment (for days 1–150) for the OON benefit. Group Health's OON benefit is also somewhat unusual in that it requires both 20 percent coinsurance and a $150 annual deductible for inpatient OON hospital visits. Regardless of the exact structure, all the demonstration PPO or POS plans require OON cost sharing. This gives enrollees strong incentives to use in-network providers, which should help MCOs control costs and perhaps win bigger price discounts from network providers. But, from the beneficiary's point of view, using the OON benefit is quite expensive, and often subject to no out-of-pocket maximum, limiting its attractiveness. In our site visits, a number of the PPO MCOs expressed concern that initial benefit package OON cost sharing was perceived by some beneficiaries as too high or too hard to predict (leading to financial uncertainty). Some of the PPO MCOs indicated an intent to lower OON cost sharing.

Table 3
2003 Demonstration plan benefits

Demonstration MCO	Plan type	Premium per month	Out-of-pocket maximum (All services)	Inpatient hospital in-network/ (out-of-network)	Prescription drug benefit	
					Benefit type	Benefit maximum
Advantage	PPO	$95	None	$100 (20 percent coinsurance after $100 deductible)	Generic only	$125 quarterly limit
Aetna	POS	$95 – $130	2,500	$350 co-pay (20 percent coinsurance)	Generic only	Unlimited generic
Aetna (employer group plans)	POS	$0	2,500	$200 per day for days 1–5 (20 percent coinsurance)	None	N/A
Cariten	PPO	$63	None	$250 co-pay per stay (limited to 70 days annually, with 50 percent coinsurance)	None	
Coventry	PPO	$46–$105	None	*Illinois/Missouri area:* $250 daily co-pay for days 1-5 (30 percent coinsurance) *Pittsburgh area:* $50 per stay (20 percent coinsurance) *Ohio/West Virginia area:* $250 per stay	*Illinois/Missouri area:* Generic and brand name formulary *Pittsburgh area:* Generic formulary *Ohio/West Virginia area:* Generic	*Illinois/Missouri area:* $500 annual limit *Pittsburgh area:* $500 annual limit *Ohio/West Virginia area:* $500 annual limit
Coventry (employer group plans)	PPO	$34–$87		*Illinois/Missouri area:* $250 daily co-pay for days 1-5 (30 percent coinsurance) *Pittsburgh area:* $50 per stay (20 percent coinsurance) *Ohio/West Virginia area:* $500 per stay	*Illinois/Missouri area:* None *Pittsburgh area:* None *Ohio/West Virginia area:* None	

(continued)

Table 3
(cont)

Demonstration MCO	Plan type	Premium per month	Out-of-pocket maximum (All services)	Inpatient hospital in-network/ (out-of-network)	Prescription drug benefit	
					Benefit type	Benefit maximum
Group Health, Inc.	PPO	$0 (NYC area) $100 (surrounding counties)	$7,500	*Option 1:* $0 co-pay (20 percent coinsurance plus $150 annual co-pay) *Option 2:* $250 co-pay (20 percent coinsurance plus $150 annual co-pay)	*Option 1:* None *Option 2:* Generic only	*Option 2:* Unlimited
HealthFirst	POS	*Option 1:* $32 *Option 2:* $103	None	$25 daily co-pay (cost sharing same as Medicare FFS)	*Option 1:* None *Option 2:* Generic and brand name	Unlimited generic; $600 annual limit for brand name
Health Net	PPO	*Arizona:* $89–$159 *Oregon:* $80	$1,000 in-network $3,000 out-of-network	*Arizona:* $50 daily co-pay for days 1 to 5 ($750 co-pay per admission) *Oregon:* $100 annual deductible ($250 annual deductible)	*Arizona:* Generic only *Oregon:* None	Unlimited
HealthNow	PPO	$86–$182	None	*Option 1:* $100 co-pay (20 percent coinsurance) *Option 2:* $0 co-pay (20 percent coinsurance)	*Option 1:* None Option 2: Generic and brand name at designated pharmacies	Unlimited
HealthSpring	PPO	$70	None	$50 daily co-pay for days 1–10 ($200 daily for days 1–10)	Generic formulary	Unlimited
Horizon	POS/HMO	Option 1: $84.60 Option 2: $115.70	$2,000 $3,000	$750 annual deductible (Option 1: $1,000 annual deductible plus 20 percent coinsurance) (Option 2: $2,000 annual deductible plus 20 percent coinsurance)	Option 1: None Option 2: Generic and brand name formulary	$100 annual deductible. Unlimited generic; $600 annual limit for brand name

(continued)

Table 3
(cont)

Demonstration MCO	Plan type	Premium per month	Out-of-pocket maximum (All services)	Inpatient hospital in-network/ (out-of-network)	Prescription drug benefit	
					Benefit type	Benefit maximum
Humana	PPO	$59	$2,500 in-network $5,000 out-of-network	$150 daily co-pay for days 1-5 ($500 annual deductible, then 30 percent coinsurance)	Generic and brand name drugs	Unlimited generic; brand name formulary
OSF Health Plans	PPO	$75	$800 in-network $2,400 out-of-network	$150 co-pay per stay ($812 co-pay per admission)	Generic only	$100 per month limit
PacifiCare	POS	*Arizona plan:* $75 *Nevada plan:* $55	None	$0 co-pay ($812 co-pay per admission for days 1-150)	Generic only	Unlimited
Tenet Choices, Inc.	PPO	$85	None	$0 co-pay (20 percent coinsurance)	Generic only	Unlimited
United HealthCare	PPO	$39–130	$1,800 in-network None for out-of-network	$25–$75 daily co-pay (20 percent coinsurance)	Varies	Varies
UPMC	PPO	$96–$184	None	$0 co-pay (out-of-network limited to 70 days annually)	Option 1: None Option 2: Generic and brand name formulary	$150 limit per quarter ($350 limit in Pittsburgh service area)

Some MCOs exclude ambulatory or ancillary services for the OON benefit, particularly MCOs that offer a POS product rather than a true PPO. PacifiCare, for example, has no OON benefit for home health, skilled nursing facility care, and mental health/substance abuse services. These MCOs generally feel that these services are predictable and can be better managed in-network where negotiated provider discounts apply. Another MCO commented that beneficiaries are not bothered by the lack of OON benefits for these services; they are concerned about doctor and hospital choice.

3.3 Utilization Review, Case Management, and Other Cost Management Techniques

Table 4 summarizes various cost management techniques employed by the demonstration MCOs. Many of the demonstration MCOs ask for notification of use of OON services. The MCOs tend to use this notification to attempt to "know what's going on" with enrollees rather than to try to steer them back into the provider network. On the other hand, MCOs use this as an opportunity to remind enrollees of the OON cost sharing. Some MCOs told us that enrollees sometimes equate OON benefits with coverage for any service (e.g., cosmetic surgery). Therefore, MCOs can use the prenotification process to advise enrollees whether the services are covered at all. A number of MCOs require prior authorization for some services, most commonly inpatient hospitalizations. If the beneficiary does not pre-authorize, a penalty may be charged. For example, PacifiCare charges $500 for unauthorized admissions, in addition to any other applicable cost sharing. One MCO, Horizon, has retained its HMO referral requirements in the demonstration POS product.

All participating MCOs institute some degree of utilization review and/or case management for their demonstration products. In general, the PPO plans tend to use the same basic utilization management/case management protocols found in their other managed care products. Many of the demonstration MCOs use an initial assessment visit to assess enrollee health needs and identify individuals who should be targeted for disease management. Disease management protocols tend to focus on the high cost, high prevalence diseases among the Medicare population: diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). Some of the MCOs conduct these programs internally, whereas others hire independent disease management vendors.

Physician profiling, also done to some extent by many of the demonstration MCOs, tends to be for internal review purposes. None of the MCOs we spoke to provides public reporting of profiling results.

In general, however, MCOs did not seem to expect large cost savings versus Medicare FFS from utilization management. The market has moved away from stricter and more punitive cost control methods for both providers and beneficiaries. "Positive" incentives are currently in vogue, such as bonuses for meeting cost or quality targets. Also, cost control possibilities are lesser in PPOs than HMOs; the latter tend to have smaller provider networks including only the most efficient physicians, require gatekeeper referrals, sometimes share risk with providers, and do not have the PPO OON benefit.

Table 4
Cost management techniques

Demonstration MCO	Preauthorization required	Prenotification requested	Disease management/ case management	Physician profiling
Advantage		●	●	●
Aetna	●		●	●
Cariten			●	●
Coventry				
St. Louis			●	●
Pennsylvania			●	●
West Virginia	●		●	●
Group Health, Inc.			●	
HealthFirst	●			
Health Net		●	●	●
HealthNow	●		●	
HealthSpring			●	
Horizon	●		●	●
Humana	●		●	
OSF Health Plans	●		●	●
PacifiCare	●		●	
Tenet Choices, Inc.			●	●
United HealthCare		●	●	●
UPMC	●		●	●

SECTION 4
MARKETING OF THE PPO PRODUCT TO MEDICARE BENEFICIARIES

4.1 General Approach and Target Population

Many of the participating MCOs sought to market the PPO as a new product in their overall product mix—not as something "new" but as an expansion of their overall product line. Aetna and United HealthCare, for instance, are careful to not market the PPO as something "new and different," for fear that this message portrays a temporary product that will eventually leave the market. Most MCOs already offer an M+C HMO product, and the PPO gives the organizations an opportunity to offer a slightly more expensive plan with greater freedoms and OON opportunities. Other MCOs saw the Medicare supplemental market as a potential niche for business and have marketed their plan to draw beneficiaries away from Medigap products and into the PPO for cheaper premiums and services.

For those MCOs already offering an HMO M+C product, the target population is typically younger beneficiaries who have middle or higher incomes than their HMO counterparts. Many MCOs target beneficiaries who travel a lot or live as "snowbirds" for half

the year and therefore value an OON benefit. Group Health, for instance, recognizes that many of their potential enrollees travel to Florida and therefore has plans underway to offer a network of providers in southern Florida for their permanent New York enrollees who travel or live in Florida on a seasonal basis. Similarly, Health Net offers provider networks in Arizona and Oregon to snowbirds who live in both service areas throughout the year.

Other MCOs directly target Medigap purchasers to the PPO, particularly in markets where Medigap premiums are high and are potentially pricing beneficiaries out of the product line. For instance, Advantage shared with us that beneficiaries coming to marketing meetings are experiencing rapidly rising Medigap premiums, and they saw this as their niche for offering cheaper premiums than the Medigap F and G products for comparable coverage. Likewise, Coventry priced their PPO in the St. Louis market at about one-third of the Medigap Plan F premium to attract Medigap "types." Although a number of the demonstration MCOs conceded that it is difficult to get Medicare beneficiaries to give up their Medigap plans, MCOs also see an opportunity when beneficiaries are looking for cheaper alternatives. Due to rapidly rising health care costs, increasing numbers of Medicare beneficiaries may be facing lost or reduced retiree benefits (one example is the elimination of retiree benefits for Bethlehem Steel workers). Medigap premiums for individually purchased policies rise as beneficiaries age. Because of these factors, a number of demonstration MCOs have positioned their PPO/POS products to attract these price sensitive beneficiaries.

A final target group many of the MCOs market to are age-ins, or those who are aging into the Medicare population at age 65. This group is seen as having the largest long-term potential, largely because these younger groups are more familiar with the PPO concept and with managed care in general. Many of the MCOs told us they have a large commercial PPO business with a working age population that will begin aging into Medicare, and the PPO product will allow these age-ins to continue having similar coverage upon Medicare eligibility.

There is considerable variation in whether the MCOs use the term PPO or something else to market the product. As Table 5 shows, all MCOs give the product a trade name for their advertising and information dissemination.

4.2 Marketing Themes and Methods

All the MCOs have conducted ad campaigns to some degree, recognizing that eligible beneficiaries are largely unaware of the new PPO option within the M+C program. Although the MCOs differ in their focus of marketing techniques, the large majority of them at a minimum do direct mailings to eligible groups they have targeted as potential enrollees. United HealthCare, for instance, looked at specific demographics of the area—age and income—in placing direct mail. Relatively few MCOs use television or radio advertising, although most ran newspaper ads at the onset of the demonstration enrollment period to create a publicity "blitz" for the product.

Table 5
Demonstration MCOs' product trade names

Demonstration MCOs	Trade name
Advantage	Advantage Preferred Plus
Aetna	Aetna Golden Choice
Cariten	Cariten Senior Health PPO
Coventry	
Pittsburg market	Health Assurance Advantra M+C PPO
West Virginia & Ohio area markets	Advantra PPO
St. Louis area market	GHP Advantra PPO
Group Health, Inc.	GHI Medicare Choice PPO
HealthFirst	
Option 1	HealthFirst PPO Select Plan
Option 2	HealthFirst PPO Complete
Health Net	SeniorCare Options Plus
HealthNow	Traditional Blue Medicare PPO
HealthSpring	HealthSpring Medicare + Choice PPO Plan
Horizon	
Option 1	Medicare Horizon Blue
Option 2	Medicare Horizon Blue Plus
Humana	Humana Gold PPO
OSF Health Plans	OSF Care Preferred
PacifiCare	Secure Horizons Medicare POS
Tenet Choices, Inc.	Health Care Select
United HealthCare	Medicare Complete
UPMC	UPMC for Life PPO

The following are some of the key marketing themes among the MCOs:

- More freedom of choice to see providers and go out of network
- No referrals or authorizations required
- Lower premiums than most Medigap plans
- Savings when seeing a doctor in-network
- Easier and less paperwork than FFS or supplemental insurance
- Prescription drug coverage (if applicable)

In sum, key marketing themes are "choice," "value," "freedom," and "convenience." Disease management, extensive provider networks, and out-of-pocket limits (for applicable plans) are marketing themes used to a lesser extent but are still considered by some MCOs as important selling points when presenting the product.

The majority of demonstration MCOs reported to us that they rely primarily on direct mail with in-person follow-up to attract most of their enrollees. MCOs conceded that this approach can be very costly, but they also report that this is necessary given all of the education they need to do about Medicare managed care and PPOs specifically. Some plans also continue to conduct seminars and other group sessions. These are less successful in some areas, however, since new restrictions on gathering attendee names and phone numbers have been put into place. In general, the MCOs have found that PPO marketing cost per member enrolled—"member acquisition cost"—is quite high.

4.3 Enrollment

For most MCOs, enrollment to date has been slower than they expected and/or predicted. However, MCOs across the board were not very discouraged by this and recognize that enrollment should grow steadily over time (which has indeed occurred). Those MCOs who were most disappointed with their enrollments also accept the notion that Medicare beneficiaries are going to be slow reacting to a new product and that it will take time to raise awareness in a population generally not accustomed to the product type. As of July 2003, most MCOs were experiencing slow but steady increases in enrollment. Table 6 shows enrollments to date for the MCOs.

4.4 Employer Only Groups

A few demonstration MCOs have focused particular attention on recruiting employer groups to their PPO/POS products. To accomplish this, MCOs generally offer a basic benefit package at a zero premium to employer group enrollees. Employers then tailor a specific add-on package to this basic benefit, often paid for by the employer. These plans are not available for open enrollment. The benefit to the employer under this approach is that Medicare, on behalf of enrollees, pays for the basic Medicare covered services. Employers pay only for additional benefits. For MCOs, this is a way to enroll large groups of members without the cost of extensive marketing. Also, employer group enrollees tend to be tied to the MCO through the provision of the additional benefit package. In these cases, MCOs often apply for "801" series benefit packages under their regular H-number Medicare contract.

Table 6
Enrollment as of July 1, 2003

Demonstration MCO	Enrollments as of 7/1/2003
Advantage	64
Aetna	11,046
Cariten	12
Coventry	277
Group Health, Inc.	761
HealthFirst	17
Health Net	936
HealthNow	100
HealthSpring	349
Horizon	46,103
Humana	45
OSF HealthPlans	1,338
PacifiCare	356
Tenet Choices, Inc.	225
United HealthCare	5,662
UPMC	266
Total	67,557

Three demonstration MCOs—Coventry, Aetna, and UPMC—currently offer employer group only "801" plans. One organization within Coventry, Advantra in West Virginia/Ohio, is concentrating almost exclusively on employer group enrollment for its PPO product. However, absence of an "801" plan does not mean that an MCO does not intend to pursue employer group business in the future. United HealthCare is beginning negotiations with some employer groups and has worked out a way with CMS to handle these enrollees for the purpose of risk sharing; they may apply for "801" plans next year.

SECTION 5
PROVIDER ISSUES

Because of the quick timing involved in implementing the PPO demonstration, the MCOs relied on its existing networks in establishing their demonstration service areas. The goal of most MCOs was to either use already established provider networks (which may have included language to cover all insurers) or, if necessary, to employ provider contract amendments to add the Medicare PPO product. In most cases, the demonstration MCOs told us that they have few difficulties with this approach. However, in a few cases, demonstration MCOs were not able to sign up either a specific physician group practice or a hospital system. In most cases, the reasons

for resistance among these provider organizations was related to unwillingness to participate with a Medicare product or accept the payment rates offered by the MCO. In the few cases where demonstration MCOs attempted to add rural providers in expansion counties around the established network service areas, unwillingness to accept MCO payment rates and/or participate in managed care were barriers. For example, Health Net of Arizona told us that they might have included the semi-rural area between their current PPO service areas around Tuscon/Phoeniz in southern Arizona and Flagstaff in northern Arizona, but providers in this area required reimbursement of more than Medicare FFS rates—not a feasible payment level for this demonstration. One MCO, PacifiCare, was unable to offer a PPO product in Southern California because of difficulties in recruiting a provider network for the product. PacifiCare's HMO provider network was accustomed to accepting capitated risk and engaging in extensive care management and was not very amenable to shifting to the more open PPO model. Over time, several MCOs plan to expand their PPO provider networks beyond their HMO networks, consistent with more of a higher-priced, "premium" product.

Almost universally among the demonstration MCOs, in-network providers are reimbursed at discounted Medicare FFS rates. For physicians, this translates into a discounted Medicare Fee Schedule amount. For hospitals, payments are generally based on either Medicare diagnosis-related group (DRGs) or a per diem amount. Very few MCOs reported to us any risk-bearing payment arrangements among providers; in these few cases, only primary care physician groups were still paid on an at-risk basis. Although no MCOs would tell us exactly the FFS discount level they achieve, a figure of not more than 10 percent was mentioned as a reasonable guideline. For OON services, providers are paid based on 100 percent of Medicare FFS. As noted earlier, some demonstration MCOs are finding cases of physicians "not accepting" OON service coverage and turning PPO/POS enrollees away. It is not clear at this point whether the issue is lack of understanding among the provider community regarding the legitimacy of OON benefits under PPOs and/or unwillingness to participate with Medicare or the particular MCO. This is an issue of particular concern to CMS as any widespread problem in provision of OON benefits by providers may prove troubling to Medicare reform efforts that feature PPOs.

SECTION 6
MCO OVERALL PERCEPTIONS AND COMMENTS ABOUT PPOs

In general, the demonstration MCOs have a favorable view of the PPO product for Medicare, despite slower than expected enrollments. These MCOs remain committed to the PPO demonstration product and are willing to give it some time. Many told us that launching a new product for Medicare is often a slow process, as beneficiaries are often slow to respond to anything unfamiliar. A number of demonstration MCOs also told us that, in general, most Medicare beneficiaries have little interest in shopping around for new Medicare coverage. If they have a Medigap policy and can continue to afford the premiums, getting beneficiaries to consider something else is a challenge. That said, with Medigap premiums rising as Medicare beneficiaries get older (a process sometimes referred to as higher age attained rate bands), many of the demonstration MCOs are positioning their PPO/POS product to be attractive to beneficiaries who may need to make a switch for financial reasons.

To make the PPO product viable for MCOs, we heard most often that payment rates are a critical factor in the success of the PPO (as with any of the Medicare managed care products). If the reimbursement rates for Medicare PPOs are not adequate, then MCOs will not be able to offer products—particularly a more expensive product like the PPO. We also heard a number of times that encouraging increased participation from nonparticipating providers (e.g., noncontracting providers being willing to provide services to PPO members) is critical to the long-term success of the PPO product.

Finally, many demonstration MCOs told us that education is the key to success for the Medicare PPO product, and there has been limited education and exposure of PPOs by CMS. MCOs believe that beneficiary and provider understanding of PPOs, and how they differ from HMOs and other managed care products, can be very limited in some areas. Therefore, MCOs have stressed the importance of a more proactive education campaign by CMS for both beneficiaries and providers about PPOs in improving acceptance of PPOs on a wider scale.

Figure 1
Location of Centers for Medicare & Medicaid Services' Medicare Preferred Provider Organization Demonstrations