Cite this article as:
J Gabel and D Ermann
Preferred provider organizations: performance, problems, and promise
Health Affairs 4, no.1 (1985):24-40
doi: 10.1377/hlthaff.4.1.24

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Prologue: With over 140 in existence and many under development, preferred provider organizations (PPOs) are attracting considerable interest among health policymakers as a growing option in the rapidly diversifying field of health care delivery. However, the surprising finding of Jon Gabel and Dan Ermann’s research is that PPOs currently play a more important part in health policy debates than in actual delivery of health care. They see some provider-sponsored PPOs, in particular, as “little more than a marketing tool.” The authors applaud the PPO concept, but express concern over its execution. They feel that PPOs will not share a significant slice of the health care marketplace until greater emphasis is placed on cost control. PPOs currently serve less than one-half of one percent of the U.S. population. In this thorough overview and analysis of PPOs, the authors, who are senior economists at the National Center for Health Services Research and Health Care Technology Assessment, have relied on interviews with key persons within the PPO movement and on what sparse empirical data could be culled from the literature. Even more difficult than presenting definitive data on PPOs is formulating an exact definition of a PPO. Max Fine, executive director of the American Association of Preferred Provider Organizations, has said, “If you’ve seen one PPO, you’ve seen one PPO.” The authors write, “Generally, PPOs are a group of health care providers who agree to provide services to a specific group of patients on a discounted fee-for-service basis.” But within this general framework, there are many permutations. In this essay, the authors provide a snapshot of the rather fuzzy world of PPOs and help bring it in sharper focus. This paper is one in a series of articles the authors have written over the past two years on the changing organization of health care. The series has covered such topics as multihospital systems, investor-owned systems, urgent care centers, and ambulatory surgery centers. Their evaluation of multihospital systems was published in the Spring 1984 Health Affairs.
few changes in the organization of health care have been received
with greater enthusiasm than preferred provider organizations
(PPOs). PPOs have been embraced as a market-oriented solution
for controlling health care costs by a wide spectrum of groups with often
conflicting interests. Health policy analysts view PPOs as a mechanism
for instilling price competition in the provider and insurer marketplaces.
To employers, PPOs can reduce health care costs without restricting em-
ployees’ freedom to choose their provider or increasing patients’ cost-
sharing liabilities. Providers interpret PPOs as a marketing tool to increase
patient volume without accepting financial risk and other restrictions of
practice associated with health maintenance organizations (HMOs). To
insurers and third-party brokers PPOs present a quick inexpensive vehi-
cle for organizing a vertically integrated delivery system. For patients the
PPOs can reduce cost-sharing without loss of freedom of choice.

These high and sometimes conflicting expectations suggest the need to
examine the likely impact of PPOs on the delivery of health care. Through
a synthesis of more than 200 articles and interviews with twenty PPO
administrators, this article examines the structure, growth, and perform-
ance of PPOs.

At present, PPO development is in an embryonic stage. With the ex-
ception of a few case studies, there is no empirical research that evaluates
the ability of PPOs to control costs or assure access and quality of care.
Little data are available about PPOs beyond their numbers, location, and
sponsors. Consequently, this article relies on case studies, locational pat-
terns, and sponsorship information to address the following questions:
(1) What is a PPO, and how does it differ from other delivery systems? (2)
How many PPOs are there, and what is their rate of growth? (3) What
types of markets do PPOs enter, and who are their sponsors? (4) What
are the forces fostering PPO growth? (5) What do available case studies
suggest about the ability of PPOs to control costs and assure access and
quality of care?

In addressing these questions, we note several caveats. First, there
great diversity among PPOs. Brevity requires us to focus on central tend-
cencies of PPOs rather than their variations. Second, PPOs are in a state
of rapid transition. A survey of PPOs in 1983 may not accurately portray

The views expressed in this paper are those of the authors. No official endorsement by the National
Center for Health Services Research and Health Care Technology Assessment or the Department of
Health and Human Services is intended or should be inferred. The authors wish to thank Ernest
Feigenbaum, Max Fine, Sharon Graugnard, Paul Ginsburg, Fred Hellinger, Harold Luft, Suan
Maerki, Peggy O’Kane, Tom Rice, Larry Rose, and Joan Trauner for their helpful comments. We
also thank Eloise Van Riper and Chris Mitchell for their excellent secretarial support.
the PPO industry of 1984 which in turn may differ from the industry of tomorrow.

What Is A PPO?

A preferred provider organization may be an organization, a delivery system, or an “arrangement” between providers and third-party payers. Generally, PPOs are a group of health care providers who agree to provide services to a specific group of patients on a discounted fee-for-service basis. Subscribers are usually members of an employer group and retain the right to choose other providers, but are given economic incentives, such as lower cost-sharing, to use the preferred providers. Providers, in turn, are rewarded with an increased pool of patients and more rapid payment of claims. Financial risk is generally assumed by a third-party payer rather than the providers of care.

There are nearly as many PPO organizational configurations as there are PPOs. PPOs vary by sponsorship, legal status, governance, administrative structure, method of paying providers, limitations on freedom to choose non-preferred providers and utilization review programs.

Sponsors of PPOs include physician groups, hospitals, independent entrepreneurs, and purchasers of medical care including insurers, third-party administrators, employers, employer trusts, union trusts, and joint ventures. At this time, physicians and hospitals are the major sponsors of PPOs. Most PPOs are organized at the local level, although there are an increasing number of operational networks at the statewide, regional, and national levels.

The legal organization of PPOs varies by sponsorship. The range of provider-sponsored PPOs includes contractual arrangements, partnerships, nonprofit associations, nonprofit corporations, and for-profit corporations, with the last being the most common type of entity. Insurer-sponsored PPOs may be a separate health insurance option offered to employees or an additional benefit to an existing experience-rated indemnity plan.

A typical provider-sponsored PPO is governed by a board of directors with about half the board composed of physicians. An administrator usually directs a small staff whose responsibilities include recruiting new providers and negotiating agreements with employers. An outside organization generally markets the plan to employers and an insurance company or third-party administrator often assumes the responsibility for claims processing. A 1982 survey by the American Hospital Association (AHA) of the nation’s PPOs reported that existing hospital committees commonly performed utilization review. This finding is supported by an American Medical Association survey which found that approximately 40 percent of reviews are conducted by the PPO itself, 50 percent by contracting physicians, and the remaining 10 percent by outside contractors.
PPOs generally reimburse hospitals on the basis of discounted usual charges. While physicians are most commonly paid through a negotiated fee schedule, some plans pay on the basis of discounted usual and customary charges.\(^9\) The discounts range from 5 to 30 percent for physicians and 7 to 15 percent for hospitals.\(^10\) A growing number of PPOs are negotiating per diem rates with hospitals, and in a few instances, per case rates.\(^11\)

PPOs attempt to direct their subscribers toward preferred providers through increased benefits, such as yearly physicals, well baby care, home health care, or through reduced patient cost-sharing. A 1983 survey by the California Hospital Association found that for 49 percent of the PPOs, subscribers received 100 percent hospital coverage when using preferred providers, and 80 percent coverage when using nonpreferred providers.\(^12\)

**Strengths And Weaknesses**

In controlling costs, PPOs hold a number of advantages over traditional health insurance. First, they reward patients for using efficient providers. Second, PPOs contract with providers about price and utilization review activities before the patient enters the health care system. PPOs have superior knowledge, bargaining power, and time-to-shop over individual patients in negotiating more favorable terms.\(^13\)

A major weakness of PPOs is their failure to provide financial incentives for providers to control health care costs. In most PPOs, providers do not bear the financial risk for excessive utilization. PPOs usually reimburse hospitals and physicians on a traditional fee-for-service basis, although a few PPOs have negotiated per case payment with hospitals. Under fee-for-service payment, a provider’s income grows as the volume and complexity of services increases. Therefore, PPO discounts may fail to produce savings if providers are able to induce increases in the quantity and complexity of services. Thus, the key to PPO cost-control efforts may not be discounts, but utilization review and selection of efficient providers.\(^14\) Selective contracting may yield short-run savings, as providers reduce charges or contain their rate of increases, and long-run savings as providers are rewarded for increased efficiency in the organization and delivery of care. Since providers have no short-run financial incentive to limit services, utilization review is an essential component of an effective PPO.

**Comparing PPOs With Related Organizations**

PPOs are not the first organizational entities to contract with selected physicians and hospitals at below market rates on a fee-for-service basis with a utilization review program. (See Exhibit 1.) Others include: Blue
Cross and Blue Shield participating agreements, Foundations for Medical Care, Multiple Employer Trusts (METs), Taft-Hartley Union Trusts, and Independent Practice Associations (IPAs). None of these organizations has proven to be an effective force on a national basis in controlling costs. Some, such as IPAs and METs, have never achieved a significant share of the health insurance market. Others, such as traditional Blue Cross and Blue Shield plans, have been unable to control their own costs, let alone stimulate a competitive provider marketplace.

### Exhibit 1
Operational Characteristics Of PPOs And Similar Organizations

<table>
<thead>
<tr>
<th>Organizational Mode</th>
<th>Provider Discounts</th>
<th>Sponsors Provider Participation</th>
<th>Provider Utilization Review</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Preferred provider organizations</td>
<td>Negotiated physician and hospital discounts</td>
<td>Provider groups, insurers, third-party administrators</td>
<td>Selective contacting</td>
<td>Yes, poor start</td>
</tr>
<tr>
<td>2) Exclusive provider organizations</td>
<td>Negotiated physician and hospital discounts</td>
<td>Provider groups, insurers, third-party administrators</td>
<td>Selective contracting</td>
<td>Yes, little evidence</td>
</tr>
<tr>
<td>3) Foundations for medical care</td>
<td>Physician, sometimes hospital, foundation establishes fee schedule</td>
<td>Usually county medical societies</td>
<td>Usually in all members of county medical</td>
<td>Yes, poor history</td>
</tr>
<tr>
<td>4) Independent practice associations</td>
<td>Negotiated physician discounts, sometimes hospital</td>
<td>Insureres, provider groups</td>
<td>Selective contracting</td>
<td>Yes, poor history</td>
</tr>
<tr>
<td>5) Mutual employer trusts, Taft-Hartley union trusts, and employer self-insured plans</td>
<td>Negotiated physician and hospital discounts</td>
<td>Union trusts, employers, and employer trusts</td>
<td>Selective contracting</td>
<td>Yes, little evidence</td>
</tr>
<tr>
<td>6) Blue Cross-Blue Shield plans</td>
<td>Physician and hospital discounts are determined by plan</td>
<td>Blue Cross and Blue Shield plans</td>
<td>Seek universal participation</td>
<td>Yes, poor history</td>
</tr>
<tr>
<td>7) Medicare and Medicaid</td>
<td>Physician and hospital discounts are determined by plan</td>
<td>Federal and state governments</td>
<td>Seek universal participation</td>
<td>Yes, poor history</td>
</tr>
</tbody>
</table>

Refer to traditional Blue Shield Plans.

Why might PPOs succeed where other discount delivery systems have failed? First, a growing number of states now permit private insurers to contract selectively with different providers at different reimbursement rates, and thereby encourage patients to use more efficient providers. Nine states—California, Wisconsin, Florida, Virginia, Indiana, Nebraska, Minnesota, Louisiana, and Michigan—have enacted such legislation, and similar legislation is pending in fifteen other states. Members of both political parties have introduced legislation in the U.S. Congress that
would override state insurance laws in twenty-eight states that inhibit the establishment of PPOs.\(^{18}\) Formerly, selective contracting with providers was limited to METS, Taft-Hartley Trust Funds, and self-insured employer groups. The Employee Retirement Income Security Act (ERISA) of 1974 placed these groups under the jurisdiction of the U.S. Department of Labor, thereby exempting them from state regulation of health insurance.\(^{19}\) Until recently, these groups held only a small percentage (3 percent in 1977) of the employer-based health insurance market.

A second reason that PPOs might succeed where others have failed is the increased familiarity of employers and providers with “exclusive provider arrangements” now used by a few Medicaid programs. Exclusive provider arrangements require patients to use “preferred providers” only. These providers are usually chosen through a contract bidding process. The largest and best-known exclusive provider arrangement is the California Medicaid Program (Medi-Cal). In June 1982, California enacted legislation authorizing Medi-Cal to negotiate discounted rates with selected hospitals and physicians. Through a competitive bidding process and negotiations with individual hospitals, Medi-Cal had awarded contracts by August 1983 to 245 of 417 hospitals invited to participate in negotiations.\(^{21}\) Hospitals which contract with Medi-Cal are paid at an all-inclusive per diem rate determined through negotiations. Medi-Cal contracting created a preferred-provider ethos for the state hospitals and doctors.

Third, PPOs, in theory, contract with select providers rather than attempting to secure agreements with all area providers as is the case with traditional Blue Cross-Blue Shield plans, Medicare, and Medicaid. In addition, PPOs may be sponsored by numerous organizations, whereas Foundations for Medical Care are sponsored by county medical societies most cases.

### PPO Growth, Sponsorship, And Location

In 1982, the American Hospital Association (AHA) identified thirty-three PPOs in its first census of PPOs.\(^ {22}\) A 1983 survey by the Institute for International Health Initiatives (IIHI), a research arm for the trade association representing Foundations for Medical Care, determined that there were seventy-eight operational PPOs (defined as PPOs with provider contracts) or preoperational.\(^ {23}\) The AHA identified 11.5 operational PPOs in their June 1984 survey.\(^ {24}\) The American Association of Preferred Provider Organizations (AAPPO) determined that there were 143 operational PPOs in their December 1984 survey.\(^ {25}\) AHA data from their June 1984 survey (see Exhibit 2) indicated that forty-four of the 115 operational PPOs are located in California.\(^ {26}\) Ohio with ten and Florida and Colorado with seven PPOs each are the next most active states. A survey by the California Hospital Association found that PPOs which contracted...
with hospitals were located largely in the urban and overbedded counties of San Francisco, San Mateo, Los Angeles, and Orange. There was little activity in rural California.\textsuperscript{27} Ohio, Florida, and Arizona exhibit similar locational patterns.\textsuperscript{28} PPO activity has tended to be lowest in states where Blue Cross and Blue Shield receive substantial discounts from providers. Data from the American Hospital Association indicate that mid-sized nonprofit voluntary hospitals in large urban areas are more likely to have established a PPO than other hospitals.\textsuperscript{29} Physicians most likely to sign contracts with PPOs are younger physicians, pediatricians, and other medical specialists. Surgical specialists and hospital-based physicians are less likely to contract with PPOs.\textsuperscript{30}

Provider groups are the major sponsors of PPOs. The American Association of Preferred Provider Organizations indicates that hospitals and physician groups sponsor nearly half of the nation’s PPOs. (See Exhibit

\begin{table}[h]
\centering
\begin{tabular}{|l|c|}
\hline
State & Number of PPOs \\
\hline
California & 44 \\
Ohio & 10 \\
Colorado & 7 \\
Florida & 7 \\
Illinois & 5 \\
Minnesota & 4 \\
Wisconsin & 4 \\
Missouri & 3 \\
Nevada & 3 \\
Alabama & 2 \\
Arizona & 2 \\
Georgia & 2 \\
Kentucky & 2 \\
Indiana & 2 \\
Massachusetts & 2 \\
Michigan & 2 \\
New York & 2 \\
Texas & 2 \\
Washington & 2 \\
Iowa & 1 \\
Louisiana & 1 \\
Mississippi & 1 \\
North Carolina & 1 \\
Oklahoma & 1 \\
Oregon & 1 \\
Utah & 1 \\
Virginia & 1 \\
\hline
\end{tabular}
\caption{Distribution Of Preferred Provider Organizations By State (June 1984)}
\end{table}

\textit{Source:} American Hospital Association, unpublished
“Both provider-sponsored and third-party-sponsored PPOs have been more successful in contracting with providers than enrolling beneficiaries.”

3.) Traditional commercial and Blue Cross/Blue Shield plans sponsor 22 percent of the identified PPOs. Both provider-sponsored and third-party-sponsored PPOs have been more successful in contracting with providers than enrolling beneficiaries. A survey by the American Medical Association in 1983 found that 5 percent of the nation’s physicians had a contractual agreement with a PPO. The Insurance Dentists of America report enrolling 21 percent of the nation’s dentists in their PPO. Over half of California’s physicians have contracted with a PPO. Yet, a survey by the California Medical Association found that of those physicians contracting with PPOs, only 35 percent of San Francisco physicians, 11 percent of Los Angeles physicians, and a negligible proportion of Sacramento and Fresno physicians have treated any PPO patients. This phenomenon may reflect the early stage of PPO development.

Results from a survey conducted by the California Hospital Association (CHA) in the fall and winter of 1983 indicate why so few physicians reported treating PPO patients. With twenty-five of fifty operational PPOs responding, the CHA found that total PPO enrollment in the state was

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Physician/hospital</td>
<td>31</td>
</tr>
<tr>
<td>Physician</td>
<td>30</td>
</tr>
<tr>
<td>Insurance carrier</td>
<td>20</td>
</tr>
<tr>
<td>Entrepreneur</td>
<td>14</td>
</tr>
<tr>
<td>Hospital</td>
<td>11</td>
</tr>
<tr>
<td>Investor</td>
<td>9</td>
</tr>
<tr>
<td>Blue Cross/Blue Shield</td>
<td>5</td>
</tr>
<tr>
<td>Third-party administrator</td>
<td>4</td>
</tr>
<tr>
<td>Blue Shield</td>
<td>3</td>
</tr>
<tr>
<td>Blue Cross</td>
<td>3</td>
</tr>
<tr>
<td>IPA</td>
<td>2</td>
</tr>
<tr>
<td>Employer</td>
<td>2</td>
</tr>
<tr>
<td>HMO</td>
<td>1</td>
</tr>
<tr>
<td>Community-based</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: American Association of Preferred Provider Organizations. Directory of Provider Organizations. (January 1986).
Eleven of the responding twenty-five PPOs reported no enrollees. More current figures from the AAPPO indicate that nearly 1,300,000 Americans have a health insurance plan with the option of using a PPO. The largest provider-sponsored PPOs are Mountain Medical Affiliates in Denver with 200,000 members and Lutheran Society of Southern California with 90,000 members. The nation’s largest PPO is Blue Cross of California with a projected January 1985 enrollment of 345,000 members, a majority of whom are recent converts from private nongroup coverage.

There are no surveys of the sociodemographic characteristics of PPO enrollees. Some believe that PPOs attract a young, healthy population, contending that individuals with poor health status are more likely to have a regular source of care and are less willing to switch to a preferred provider. Others argue that by including additional benefits such as hospice care, PPOs attract a population with more chronic health problems.

**Forces Fostering PPO Growth**

A discussion of factors fostering the growth of PPOs begins with the so-called purchasers’ revolution. Following decades of acquiescence to double-digit increases in health insurance premiums, employers are changing their buying habits in an effort to control their expenses for health insurance coverage. Why the purchasers’ revolution was so long in coming is difficult to determine. One explanation is that, measured in absolute terms, the inflationary increases in employer contributions during the eighties overshadowed earlier increases. Another explanation is that the 1981-1982 recession, the longest and deepest since the Great Depression, eroded the bargaining position of the American employee and made employers more cost conscious. Increased foreign competition may have further increased this sensitivity. There is evidence that the revolution is more than rhetoric. For example, a 1983 survey of 143 large employers by Machinery and Allied Products Institute reported that 80 percent had increased deductibles, 57 percent increased copayments, and 50 percent had made second opinion surgery mandatory in their insurance plans. Other identifiable trends include a movement toward self-insurance, introduction of multiple choice health insurance options with fixed employer contributions, and the promotion of alternative delivery systems. One ramification of the purchasers’ revolution has been the rapid rise of employer-dominated health care coalitions that have been formed to address the issue of rising costs. In 1983 there were 123 such coalitions in the nation, and two-thirds were less than three years old. In San Diego, a health care coalition sponsors a PPO.

A second factor fostering the development of PPOs has been changed policies on the part of state government. We noted earlier that California
passed legislation in 1982 mandating exclusive provider arrangements for Medi-Cal and authorizing conventional insurers to selectively contract with providers. Eight other states have passed legislation repealing restrictions which prevent insurers paying differential rates to different providers.

A third factor is the growing excess capacity of hospitals and physicians that weakens their bargaining position. This may take the form of persistently low hospital occupancy rates and an increasing physician-population ratio. It is no accident that PPO activity is greatest in the hospital- and physician-rich urban areas of Los Angeles, San Francisco, Orange County, Denver, and Dallas, and that physician group practices and hospitals are the leading sponsors. These provider groups view PPOs as an opportunity to expand patient volume and market share and fend off new practitioners and alternative delivery systems.

Technological advances in electronic data processing have further encouraged PPO development. Increased productivity in data processing makes the selection of efficient providers, as well as utilization review, more efficient and less costly.

The continued growth of HMOs and group practices is likely to further stimulate PPO development. Provider-sponsored PPOs, like IPAs and Foundations for Medical Care, represent a competitive response to HMOs as providers attempt to preserve fee-for-service practice. Group practices represent ready-made preferred provider groups that are ripe for contracting with insurers and third-party administrators. The majority of PPOs in California currently are group practices and many are IPAs, Foundations for Medical Care, and HMOs.

Federal antitrust laws may inhibit the growth of PPOs, particularly provider-sponsored ones. The crucial element in determining whether the antitrust laws are violated is the reimbursement arrangement between the PPO and the participating providers. The FTC found no unlawful price fixing in a New Jersey case because the providers set their prices independently, and no more than 10 to 15 percent of the area providers were enrolled in the plan. In contrast, PPOs with a predominant market share (roughly 70 percent) may be open to charges of monopolization. For example, a threatened antitrust challenge by the U.S. Department of Justice lead to the disbanding of the Stanislaus PPO in California. The Stanislaus PPO signed up half the practicing physicians in Modesto and 90 percent in nearby Turlock. Participating physicians were forbidden in their contract from contracting with other PPOs. This inhibited the development of competing PPOs according to Paul McGrath, Chief of the Justice Department’s Antitrust Division.
To gain a substantial share of the employer-based health insurance market, PPOs must demonstrate that they can deliver comparable care at lower cost than their fee-for-service competitors. A number of PPO proponents, such as administrators, insurers, employers, and sponsors of PPOs, have claimed that their PPOs have realized significant savings. However, the calculation of these savings is not based on scientific studies that use experimental or statistical controls and comparison groups, but on anecdotal evidence.

There is only one scientific study to date that examines the impact of PPOs on costs. That study by A.D. Little, Inc. of Teamsters Local 988 documents some of the potential problems that PPOs may encounter such as increased utilization. In 1980, Teamsters Local 988 in Houston, Texas contracted with the Kelsey-Seybold Clinic, a large multispecialty physician practice. The Teamsters received a 4 percent discount from Kelsey, which had a reputation for practicing conservative medicine. There was no contractual arrangement with any hospital, nor was there any new utilization review program implemented. Members who used the clinic had their deductibles and copayments waived. A.D. Little, Inc. found that costs measured in constant dollars increased 4 percent more than the national average during the first year of the preferred provider arrangement. Cost increases for the year preceding the implementation of the plan had been substantially below the national average. When cost increases were decomposed, it was found that savings from hospitalization had been more than offset by two- to threefold increases in office visits, and laboratory and x-ray use. The A.D. Little, Inc. study points to the pitfalls of decreased cost-sharing and the need for a strong utilization review program in PPOs.

The results from the A.D. Little, Inc. study contrast sharply with the preliminary findings about MediCal’s first year of experience with exclusive provider contracting. Johns and her colleagues estimate that selective contracting reduced payments to hospitals by $180 million, or 13 percent of total Medi-Cal payments to hospitals. This was achieved without any evidence of deterioration in the quality of care received by Medi-Cal patients or in their access to hospital care. There were surprisingly few horror stories reported in the first year of exclusive provider contracting, no administrative scandals, and only two lawsuits.

Future research on PPO performance should focus on the systemwide effects of PPOs on patients, providers, insurers, and employers. The issues of adverse selection and cost-shifting are crucial to understanding whether PPOs save society resources. First, if young healthy patients or patients who use low-cost providers self-select into PPOs, competing health plans will experience increases in costs, and there may be no systemwide
"PPOs now serve less than one-half percent of the nation’s population, and play a more prominent role in health care policy debates than in the delivery of health care."

savings. A second issue is the competitive response of providers. Do preferred providers “cost-shift” to their non-PPO patients, or do they carry over a conservative practice style? Do nonpreferred providers respond by reducing charges and services per patient, or do they expand their services per patient to fill up their time? Third, to what extent and how quickly do competing insurers and third-party administrators react to PPOs by increasing their cost-control efforts directed at providers such as improving their utilization review programs and changing their methods of reimbursing providers.

There are fears that PPOs will jeopardize access to care for their beneficiaries and the medically indigent and accentuate a two-tier system of care. To control costs, preferred provider plans may limit coverage for nonemergency care from 9:00 a.m. to 5:00 p.m. thereby increasing waiting times. Fears that the growth of PPOs will reduce access to care for uninsured patients are based on traditional arguments against policies that increase competition among providers. As hospitals and physicians feel increased financial pressure, one of their first responses will be to reduce care to uninsured patients. Medi-Cal adopted exclusive provider contracting in July 1983 and uncompensated care (charity care plus bad debt) in private hospitals increased only 19 percent during the last six months in 1983 compared to the same period in 1982. Uncompensated care had increased 32 percent in these hospitals during the first six months of 1983 (before exclusive provider contracting) compared to the same period of 1982.

Critics of PPOs have charged that cost-cutting and selection of low cost providers will translate into reduced quality of care. There is no research refuting or supporting these contentions.

Discussion

This article has provided a snapshot of PPOs in their early stage of development. PPOs now serve less than one-half percent of the nation’s population, and play a more prominent role in health care policy debates than in the delivery of health care. A distinguishing characteristic of PPOs is their diversity. It is this diversity that makes it difficult to generalize
about PPOs. Present evidence about PPOs’ ability to control costs is too scant to warrant any conclusion. Similarly, there is no research to support or refute fears that PPOs will accentuate a two-tier health care system, one for the healthy and affluent, and another for the sick and poor.

Forces encouraging the growth of PPOs are likely to remain strong. These include: a purchasers’ revolution by employers, growing excess capacity in the hospital and physician sectors, increasing uses of exclusive provider arrangements by Medicaid programs, the removal of state restrictions on selective contracting, and the continued growth of group practices and alternative delivery systems such as HMOs and continued technological advances in electronic data processing. However, a number of factors suggest that PPOs are unlikely to realize their potential to control costs and secure a significant role in the delivery of health care.

First, if the key to PPO success in controlling costs and creating a competitive insurer and provider market is utilization review and the selection of efficient providers, PPOs are off to a slow start. These are the factors that distinguish PPOs from discount systems that failed to control costs such as Blue Cross-Blue Shield, Foundations for Medical Care, and Medicare. Many PPOs have begun operations with weak utilization review. A survey by the AHA in 1983 found that few PPOs had developed utilization review criteria separate from what had previously been implemented in participating hospitals. A more recent survey by the AAPPO indicates some improvement. Nonetheless, 67 of 143 PPOs had not developed any criteria in the areas of concurrent review, preadmission certification, and retrospective review. The experience of IPAs suggests that it is difficult to impose strict utilization review controls after two or three years of operation. PPOs are also lagging in their selection of low-cost providers. One reason that many PPOs have been lax in implementing utilization review and screening high-cost providers is that provider groups sponsor the majority of PPOs. Even some insurer-sponsored PPOs have been organized by the provider community enlisting all willing volunteers rather than identifying low-cost providers.

A second limiting factor is the reluctance of commercial insurers to sponsor PPOs. While there are some notable exceptions, such as Metropolitan, Prudential, and Aetna, the Blues appear to be developing PPOs on a much broader scale than the commercials. The commercials’ slow response is puzzling since PPOs could remove one competitive advantage which the Blues have held over them—the ability to secure discounts from providers. One possible explanation for the slower response of commercial insurers is that local Blue plans are more familiar with local providers than the nationally based commercials and have a history of negotiating contracts with providers. The commercials may view the fixed investment in developing a PPO as excessive, given the small market share of most commercials. There may be a reluctance by the com-
“...there is no research to support or refute fears that PPOs will accentuate a two-tier health care system, one for the healthy and affluent, and another for the sick and poor.”

Commercial insurers to commit resources to a line of business traditionally regarded as a loss-leader for their more profitable businesses—life insurance and casualty-property insurance. 

A third factor is the tendency of some Blue Cross-Blue Shield plans to contract with nearly all hospitals and physicians, reminiscent of traditional Blue Cross-Blue Shield practices. For example, California Blue Shield has contracted with nearly all plan area physicians, and the Minnesota Blue Cross-sponsored PPO has contracted with nearly all area hospitals.

Fourth, in their rush to become operational, many PPOs have adopted an ethic that there can be “gain without pain.” Costs cannot be controlled without some rigorous policies. Reduced cost-sharing with no provider risk sharing, ineffective utilization review programs, and no loss freedom to choose one’s provider will lead to higher health care costs.

In the immediate future, there will be substantial increases in PPO enrollments as Blue Cross-Blue Shield plans convert many of their non-group subscribers to their PPO option. However, our analysis suggests that a shakeout of PPOs is likely to occur during the next few years. Provider-sponsored PPOs with ineffective utilization review programs and little patient cost-sharing are the prime candidates for failure. Surviving PPOs are likely to impose significant cost-sharing on patients who choose to use nonpreferred providers while subjecting providers to stringent utilization review. The popularity of the surviving PPOs will depend on the price that subscribers are willing to pay for the freedom to choose one’s provider and the distaste for nonprice rationing by patients and providers.
NOTES


3. Ellwein and Gregg, “An Introduction to Preferred Provider Organizations.”

4. Institute for International Health Initiatives, Directory of Preferred Provider Organizations (Winter 1984).


6. American College of Obstetricians and Gynecologists. “Preferred Provider Organizations.”


16. Multiple employer trusts are health insurance plans that are funded jointly by small employers. Taft-Hartley trust funds are also jointly funded health insurance plans administered through a union that has contracts with a number of small employers.


27. Trauner, “Preferred Provider Organizations,” 47.
31. American Association of Preferred Provider Organizations, *Directory of Preferred Provider Organizations*.
32. K. Adams, American Medical Association, personal communication.
33. “Dental PPO to Date Signs Up 21% of All Dentists,” *EPBR Weekly Digest* (12 August 1984), 4.
36. American Association of Preferred Provider Organizations, *Directory of Preferred Provider Organizations*.
37. T. Miller, executive director, Mountain Medical Affiliates, Inc., personal communication.
38. S. Maerki. California Blue Cross, personal communication.
40. J. Trauner, personal communication.
47. American College of Obstetricians and Gynecologists. “Preferred Provider Organizations.”


55. Emmott. “Public Hospitals.”


58. American Association of Preferred Provider Organizations, *Directory of Preferred Provider Organizations*.

59. DHHS. *Preferred Provider Organizations*; and Lewin and Associates. “Selective Contracting for Health Services in California” (National Governor’s Association, 1983), 93-124.


62. “California Blue Cross Launches Ad Campaign for Its PPO.” *Health Care Competition Week* (22 October 1984), 5; and M. Miller, Minnesota Department of Health, personal communication.