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Prologue: In the Spring 1985 issue, Health Affairs published an essay authored by Jon Gabel and Dan Ermann which reported that only 1.3 million Americans were eligible to use preferred provider organizations (PPOs) and that these plans placed only limited emphasis on utilization review. Gabel and Ermann concluded their rather pessimistic assessment of PPOs, which was based on a synthesis of more than 200 articles and interviews with twenty plan administrators, by saying that PPOs “play a more prominent role in health care policy debates than in the delivery of health care.” In this essay, based on information gathered less than one year later in detailed interviews with PPO executives, the authors report a striking change in the status of such plans nationally. The number of operating PPOs has increased, their enrollment has risen dramatically, they are placing far more emphasis on utilization review as a management instrument, and the media is devoting more space to the development of alternative delivery systems. In short, the authors conclude, PPOs are evolving in a fashion that suggests they will play a significant role in the financing and delivery of medical care in the future. Thomas Rice is an assistant professor of health economics at the School of Public Health, University of North Carolina (UNC), and previously worked at the Stanford Research Institute. Greg de Lissovoy, a research associate at UNC’s School of Public Health, was formerly affiliated with a state rural health care program. Gabel and Ermann are both prolific writers on the changing American health delivery system. Ermann is a senior health economist at the National Center for Health Services Research and Health care Technology Assessment. Gabel is associate director for research and policy development at the Health Insurance Association of America.
preferred provider organizations, or PPOs, have drawn more attention than any other recent development in health care organization. It is easy to see why. Not only do they affect all of the major actors in the health delivery and financing arena—doctors, hospitals, insurance companies, and purchasers—but individual PPOs have been started by each. PPOs illustrate a new competitiveness in the health care market: doctors and hospitals, fearing the competition, reportedly are cutting their prices; third-party payers are finally exercising their considerable bargaining power; and purchasers are carefully shopping for the best arrangements.

PPOs merit attention because they differ from more conventional health care organizations. Until recently, many observers believed that health maintenance organizations (HMOs) were the most effective health care arrangement for controlling costs, but that their lack of widespread popularity has curtailed their ability to control aggregate health care costs. PPOs, on the other hand, may prove more acceptable to providers and consumers alike because they normally do not abridge fee-for-service medicine or consumer freedom of choice. If they are also able to control costs, PPOs could become the system of choice for a very large number of people.

But what exactly is a PPO? Although many definitions appear in the literature, most have some commonalities. PPOs are not the first fee-for-service discount delivery system. One characteristic distinguishing PPOs from other systems such as Foundations for Medical Care and traditional Blue Cross/Blue Shield plans is the goal of contracting selectively with cost-effective providers. PPOs have a contractual agreement with a defined group of providers—typically both hospitals and physicians—to offer discounted services to a particular group of individuals, usually a firm’s employees or a pension fund’s clients. Providers are willing to offer discounts to the payer or broker because the PPO agreement should result in a larger pool of patients that will use their services. Although patients can choose whether or not to see a preferred provider each time they seek services, they are typically given an incentive to do so, often through lower deductibles and/or copayments. In theory, the employer group can afford to do this not only because it is given a discount, either directly (by the providers) or indirectly (through lower insurance premiums), but also because PPOs are supposed to conduct stringent utilization review to control against inappropriate or excessive usage. Some definitions also go on to say that providers are given rapid claims turnaround by the third party or broker, and that the risk of excessive utilization is not borne by the PPO.

The authors thank Maren Anderson of Lewin and Associates, and Ernest Feigenbaum, Jra Raskin, and Larry Rose of the National Center for Health Services Research and Health Care Technology Assessment for their helpful comments on a draft of this article.
There is currently little known about many of the most crucial issues: How prevalent are PPOs, and how rapidly are they growing? Do PPOs put much effort into selecting the most cost-effective hospitals and physicians? Does PPO provider reimbursement offer effective incentives to control utilization? Is utilization review performed in an effective manner? How much incentive are consumers given to use the PPO? Are they actually using the PPO? How are PPOs affecting the market for health services? Will they be able to remain competitive in the health care market?

To try to answer these questions, we conducted a lengthy telephone survey of executives in the majority of PPOs in the United States. In this article, we present the findings from the survey, and in so doing, formulate answers to several of these important questions.

Previous Documentation Of The PPO Phenomenon

One indication of the tremendous interest in PPOs is the amount of press they have generated in such a short amount of time. In a previous article in this journal, two of the authors presented findings from a synthesis of over 200 articles on PPOs. The abundance of literature, however, belies the fact that very little empirical information has been compiled. With a few exceptions, most work on the subject has been of the “how to” variety. There also have been several in-depth case studies, but typically they have been based on a relatively small number of PPOs.

There are three previous studies that are based on fairly large data bases. Citing figures from the American Association of Preferred Provider Organizations (AAPPO) directory, Gabel and Ermann report that 1.3 million Americans were enrolled in a health insurance plan with the option of using a PPO, as of December 1984. The authors also expressed their concern about the ability of PPOs to control costs. Providers did not generally bear the financial risk for excessive utilization, and PPOs did not appear to be selective in choosing cost-effective providers. The AAPPO survey indicated that only half of the PPOs had developed criteria for utilization review activities of concurrent review, preadmission certification of hospital stays, and retrospective hospital review.

In a recent study by Johns, Derzon, and Anderson, which is part of a larger study on selective contracting in California conducted during 1984 and 1985, the authors conducted extensive site visits with insurance companies, hospitals, physicians, and employers in California to document their experiences with PPOs. Much of their effort centered on insurance companies. Of the twelve commercial insurance companies and Blue Cross or Blue Shield plans in the study, eleven were marketing PPOs; at the time of the survey, these eleven companies already had 2.5 million eligibles. The primary reason for forming PPOs was to prevent loss of market shares to other companies or to Kaiser Permanente Health Plan, which
had 23 percent of the health insurance market. Most of the PPOs first contracted with hospitals, and next signed up physicians. The insurers did not sign up most area hospitals and physicians; they deemed it sufficient to initially contract with only 15-25 percent of hospitals in their market areas, and with a similarly low proportion of physicians. Some hospitals were in several PPOs, and these hospitals often were not the least expensive ones. Signing up hospitals with very good reputations in the community was considered essential, perhaps even more important than the hospital's costs.

The survey of physicians found that almost all (twenty-five of twenty-seven) surveyed physicians had received offers to contract with PPOs, and some had received as many as half a dozen. Of these twenty-five, eighteen had already signed up with one or more. Most noteworthy, however, is that at the time of the interview (summer 1984), only one of the eighteen had actually seen any PPO patients. Of the fifteen hospitals in the study, all had been involved with private sector contracting, offering discounts usually ranging from 10 percent to 40 percent. Finally, of the twelve employers interviewed (representing 650,000 employees), all had been approached by PPOs. Those that had not signed up cited barriers such as employee relations and long-standing ties between the firm and a particular insurer.

Another survey was recently completed by the American Medical Care and Review Association (AMCRA), which regularly publishes a directory of PPOs. To obtain its information, AMCRA mails a survey form to all PPOs in the United States that it can identify. The June 1985 directory identifies 229 operational PPOs in the United States, although much of the information was only collected from about 75 of these. Noteworthy findings include that 56 percent of PPOs are for-profit, over 175,000 physician contracts and 2,700 hospital contracts have been signed (although a significant number of physicians and hospitals are responsible for more than one), and that PPO membership exceeds 3,000,000 nationally, two-thirds of which is in California. With respect to utilization review, the directory reports that more than half of the reporting PPOs employ preadmission certification, concurrent review, and/or retrospective review of hospital services, but less than half have mandatory second surgical opinion or retrospective ambulatory service review.

The National Survey

The purpose of the survey reported on here was to collect up-to-date, comprehensive national information on the organization, operation, and growth of PPOs. The two authors from the University of North Carolina personally conducted telephone interviews with executives in over 140 PPOs. Although a questionnaire was used to guide the interview, the
telephone interview allowed us to discuss details of the PPO's operation at length and to ask a variety of follow-up questions. Thirty-two questions were asked of each organization, concerning the PPO's history, number and type of provider contracts, provider selection and reimbursement, utilization review, number of employer contracts and consumer incentives, market penetration, and demographic characteristics of eligible consumers. Interviews lasted an average of thirty minutes, but varied in length from ten minutes to over an hour. We began the survey in late March and concluded in July 1985.

To obtain a comprehensive list of operational PPOs, we attempted to contact every organization on two lists: the directory of the American Association of Preferred Provider Organizations (AAPPO), and a list of all Blue Cross/Blue Shield (BC/BS) plans that are engaging in PPO activities. There were 143 organizations listed in the January 1985 AAPPO directory, and another 21. on the BC/BS list that were not listed on the former because many BC/BS plans were established very recently. Thus, we tried to contact 164 organizations. The AMCRA directory, discussed earlier, contains approximately 100 operational PPOs not included in our 164. We conducted a random survey of these 100 PPOs and found that most were relatively small operations that were just beginning. We therefore have concluded that while our survey does not encompass all PPOs that were operating during the first half of 1985, it does include a large majority of PPO activity.

We attempted 164 interviews. Twenty-three of the organizations were not interviewed, or were interviewed but not included in the tabulation, for any of several reasons: nine turned out to be entities other than PPOs; three were no longer operational; and eleven were duplicates of other PPOs interviewed. For example, if we surveyed a hospital-sponsored PPO network and also interviewed individual hospitals in that network, this was considered duplicative.

Of the remaining 141 organizations, we successfully interviewed 134, giving us a high response rate of 95 percent. In the seven cases where we did not conduct an interview, typically, an interview time could not be arranged. Only two PPO executives refused to participate.

The aggregate results are classified according to sponsorship. Although we observed ten types of sponsorship, in the analysis we have collapsed these into six final categories because some of the ten were very similar. These categories are: "hospital," which includes PPOs sponsored by hospitals, those sponsored jointly by hospitals and physicians, and also corporate hospital chains; "physician," which includes PPOs sponsored by both physicians and medical groups-most notably, Foundations for Medical Care (FMCs) in California; "insurer;" "Blue Cross/Blue Shield;" "investor," which is composed of entrepreneurial organizations other than hospitals, physicians, and commercial insurers, including third-party ad-
ministrators; and “other,” which includes eight PPOs that do not fit into the previous categories. These PPOs include two that are sponsored by community groups, two sponsored by HMOs, two dental PPOs, one employer-sponsored plan, and one plan that is a mixture of several of the above.

### How Large Is The PPO Movement?

Our survey allows us to establish a minimum estimate of the number of persons eligible to use PPOs. Over 90 percent of the PPOs surveyed offered an estimate of the number of eligibles, and of these, all but six PPOs reported to have some enrollees. The total number of people eligible to use these PPOs was approximately 5,750,000. We view this as a conservative estimate not only due to nonresponse, but because there were other operational PPOs not listed in our two directories. What is exceptional is how quickly the number of eligibles has grown—it increased over fourfold, from the 1,300,000 figure collected by AAPPO in its December 1984 survey to almost six million in our survey, which took place less than a year later.\(^9\)

About 44 percent of the 5.75 million people eligible to use PPOs live in California. Colorado is the only other state in double digits, with 10 percent, and Florida is third with 7 percent of the total. Most of the remaining 39 percent are distributed fairly evenly throughout the other regions of the country with the exception that very few are in New England and the middle-atlantic states.

Exhibit 1 compares the number of PPOs in each of the six sponsorship categories with their aggregate enrollment. It is evident that hospitals are still the major sponsors of PPOs, with one-third of all eligibles, but BC/BS plans are catching up, with almost 30 percent of the total. What is particularly interesting about this trend is that whereas most hospital plans had been in existence for two or so years at the time of the survey, many BC/BS plans had just been formed. These trends portend that BC/BS plans will soon have the most PPO members, particularly as more BC/BS plans form PPOs.

Responding PPOs had a total of about 2,900 contracts with hospitals. If each hospital were affiliated with only one PPO, this would mean that about half the nation’s hospitals would have been members of PPOs during the study period. However, as noted earlier, Johns, Derzon, and Anderson found that many California hospitals were members of more than one PPO, so it is difficult to estimate the proportion of U.S. hospitals that currently have PPO contracts.\(^10\) Our survey also found that PPOs had signed about 260,000 contracts with physicians nationwide. The American Medical Association’s Periodic Survey of Physicians reports that in the spring of 1985, 28 percent of the nation’s patient care physicians had
Exhibit 1
Proportions Of PPOs And Aggregate Enrollment By Sponsor

<table>
<thead>
<tr>
<th>Type of sponsor</th>
<th>Hospital</th>
<th>Physician</th>
<th>Insurer</th>
<th>BC/BS</th>
<th>Investor</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of eligibles</td>
<td>18,000</td>
<td>13,000</td>
<td>25,000</td>
<td>18,000</td>
<td>20,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Number of hospital contracts</td>
<td>6</td>
<td>2</td>
<td>27</td>
<td>16</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Number of physician contracts</td>
<td>430</td>
<td>240</td>
<td>2,600</td>
<td>1,700</td>
<td>780</td>
<td>600</td>
</tr>
</tbody>
</table>

signed contracts with PPOs. Thus, the typical physician had signed three to four PPO contracts.”

Exhibit 2 shows the characteristics of the median, or typical, PPO within each of the sponsorship categories. The number of people eligible to use the typical PPO is surprisingly similar among all types of PPOs except those sponsored by physicians, averaging from 25,000 members for insurer-sponsored plans, 18,000-20,000 for hospital, investor, and BC/BS plans, and 13,000 for physician-sponsored groups. On the other hand, Exhibit 3 shows tremendous diversity concerning the number of hospital and physician contracts. The typical insurance plan had many more providers than any other plan type: 27 hospitals, and 2,600 physicians. Physician-
sponsored plans were conspicuous in that they averaged only two hospitals and 240 physicians under contract, both of which were much lower than the other types.

What Prompts The Formation Of PPOs?

In looking at the factors leading to the formation of the PPO, different types of PPOs often cited different reasons, but similarities were intriguing. Competition was the most common reason mentioned, with most hospital PPOs citing hospital competition, physician-sponsored PPOs mentioning physician competition, and insurers and BC/BS plans noting insurer competition. In fact, there was almost a universal belief among those surveyed that their organizations were located in areas that had a surplus of hospital beds and physicians, and that this excess capacity was stimulating competition among providers.

Competition from HMOs was another reason cited by about 40 percent of the hospital and physician-sponsored plans, 30 percent of the BC/BS plans, but none of the commercial insurer plans. The BC/BS figure is particularly interesting because only three of the BC/BS plans were located in California or Minnesota, areas with high HMO penetration rates. Clearly, the recent growth in HMOs has prompted much activity among both provider PPOs and many BC/BS plans. Another reason
that prompted the formation of many PPOs was pressure from employers and other large purchasers, such as Taft-Hartley pension funds. Two-thirds of the insurers, half of the BC/BS plans, and over 20 percent of all other PPO types indicated that group purchasers (for example, employers and pension funds) were instrumental in convincing the organization to form a PPO. A final reason cited by many PPOs, particularly insurer and investor-sponsored ones, was that selective contracting was “the wave of the future,” and that they did not want to miss the boat.

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**How Are PPOs Organized And Operated?**

**Provider selection.** Selectivity is an important mechanism for controlling costs because hospitals and physicians, which are typically paid on a per service basis, do not have a direct financial incentive to act in a cost-effective manner. If a PPO contracts with hospitals that overhospitalize and physicians that do not try to keep costs down, it is easy to imagine that such a PPO will not be able to stay price competitive.

In our telephone discussions, we asked respondents how they selected hospitals and physicians. In addition to recording their methods, we made a subjective assessment of whether or not the PPO was, in our estimation, selective in its choice of both hospitals and physicians. We define a PPO as “selective” if it chose providers on the basis of cost or quality.

Different types of PPOs selected member hospitals in different ways; the only criterion mentioned by most of the PPOs in each sponsorship category was geographic location. In general, PPOs were very concerned about having at least one hospital in each section of their market areas. One striking difference among the different kinds of PPOs concerned whether hospital costs were analyzed before choices were made. Both hospitals and physician-sponsored plans mentioned this less than 15 percent of the time, whereas insurers identified this 60 percent of the time, and investor and BC/BS plans 40 percent of the time. One reason for this disparity is that companies involved in claims processing (for example, insurance companies) would be more likely than providers to have the data and expertise to assess hospital costs and utilization rates.

Selecting physicians was clearly a more difficult task for PPOs. A variety of considerations were noted by respondents—a clean malpractice record, board eligibility, geographic location, and so on—but no one reason was mentioned by a majority of PPOs. Almost all hospital PPOs selected physicians mainly on the basis of having hospital privileges in a PPO hospital, and this reason was mentioned by about one-third of the PPOs in the other sponsorship categories. Only insurers and investors showed much concern about the cost-effectiveness of physicians, and even then, most did not analyze claims in making their selection decisions. About one-third of the insurers said that they analyzed physician
costs; 10-15 percent of the BC/BS and investor PPOs did so, and less than 5 percent of the hospitals and physician groups did. A common remark was that the PPO hoped to become much more selective in choosing physicians, but first had to show purchasers that they had a substantial number of providers in the PPO. Additionally, they had to obtain enough data with which to make these decisions.

Exhibit 3 shows our subjective assessments of hospital and physician selectivity among the different types of PPOs. We rated all of the insurer PPOs as selective in choosing hospitals, and over 50 percent as selective regarding physicians. Investor and BC/BS plans were also relatively selective concerning hospitals; however, whereas almost half of investor plans showed selectivity in choosing physicians, only 15 percent of BC/BS plans did so. Most of the latter simply included all physicians who were members of BC/BS plans. About one-third of both provider PPO groups showed selectivity in choosing hospitals, but almost none showed any concerning physicians. This may not be too surprising since many provider-sponsored plans began PPOs to increase or maintain their market shares.

**Provider payment.** Exhibit 4 shows the primary method of hospital reimbursement among the surveyed PPOs. The vast majority relied on either per diems (40 percent) or discounted usual charges (36 percent); the only other method commonly employed was case-mix, or DRG reimbursement. Discounted usual charges were used more often by insurer and investor-sponsored groups. Few PPOs paid hospitals according to their usual charges (that is, without a discount). Among all types of PPOs, hospital payments averaged 10-15 percent less than usual charges.

We were surprised that so many PPOs paid hospitals according to a DRG-type system, that is, paying a fixed payment to hospitals per patient stay that is not tied to length-of-stay. Fifteen percent of PPOs primarily relied on such a system, and another 8 percent used it occasionally. The types of sponsors using DRG reimbursement most commonly were the insurers; fully one-half of the insurer PPOs, 29 percent of BC/BS plans and 12 percent of hospital PPOs relied on DRGs as their primary method. The use of DRGs is noteworthy because it gives hospitals a major financial incentive to keep their stays short and their use of ancillary services low.

Exhibit 4 also shows the frequency of physician reimbursement methods. Overall, almost 70 percent of PPOs paid physicians according to a fee schedule. Discounted usual charges were used 20 percent of the time, and usual charges 9 percent. Other methods, such as capitation, were used only rarely. In general, it appears that physician reimbursement is less innovative than hospital reimbursement. For example, only a handful used primary care gatekeepers to manage patient care. Among all plan types, physician payments averaged 9-15 percent less than usual charges.
Utilization review. Utilization review appears to be the major mechanism for controlling costs: almost all the literature on PPOs, and practically every PPO executive with whom we spoke believes that utilization review is the key to PPO success. Most respondents who had sufficient data found the savings from utilization control to be much more important than discounts.

The survey asked respondents about four types of utilization review: preadmission review of hospital admissions, concurrent review of hospital stays, mandatory second opinion programs, and the use of retrospective or claims review of hospital stays. Exhibit 5 shows the frequency with which different types of PPOs used these mechanisms. Concurrent review was used by almost all hospital and insurer-sponsored PPOs, and by over 70 percent of the other major types. Preadmission review was even more common, occurring in at least 85 percent of the sponsorship groups (except for the “other” category). With the exception of insurer-sponsored PPOs, mandatory second opinion programs were used between one-fourth and one-half of the time, and were often only employed
Exhibit 5
Proportions Of PPOs That Conduct Utilization Review

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Physician</th>
<th>Insurer</th>
<th>BC/BS</th>
<th>Investor</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent review of hospital stays</td>
<td>98%</td>
<td>73%</td>
<td>100%</td>
<td>75%</td>
<td>81%</td>
<td>63%</td>
</tr>
<tr>
<td>Preadmission review</td>
<td>90%</td>
<td>87%</td>
<td>100%</td>
<td>93%</td>
<td>88%</td>
<td>75%</td>
</tr>
<tr>
<td>Mandatory second surgical opinion</td>
<td>38%</td>
<td>32%</td>
<td>89%</td>
<td>46%</td>
<td>46%</td>
<td>25%</td>
</tr>
<tr>
<td>Retrospective review of hospital stays</td>
<td>76%</td>
<td>73%</td>
<td>67%</td>
<td>79%</td>
<td>65%</td>
<td>75%</td>
</tr>
</tbody>
</table>

when a particular subscriber group requested it. Insurers relied on it much more often—almost 90 percent of the time. Those PPOs not using mandatory second opinion often said that it was not cost effective when a good preadmission review program was available. Retrospective review was used by over 65 percent of the PPOs in each of the six categories. One out of every four PPOs also volunteered that they were conducting reviews of outpatient services and compiling profiles of physician utilization patterns, and more planned to do so when the data were available. Finally, in almost all cases, utilization review was conducted either by the PPO itself or was contracted out. Rarely was it simply delegated to member physicians and hospitals.

These findings are intriguing because they show substantial growth in utilization review activities in just the last year. In the previous survey of many of these same PPOs conducted by the authors, it was found that about half of the PPOs had not developed any criteria in the areas of concurrent, preadmission, and retrospective hospital review. PPOs appear to be making substantial improvements in this area.

Risk. A final issue of importance in the area of PPO organization is who bears the risk of high utilization. One would expect PPOs that bear such a risk to have a strong incentive to make sure that contracting hospitals and physicians are providing services in a cost-effective manner. The only PPOs that ever fully bear this risk are those in the business of underwriting: Blue Cross/Blue Shield plans and commercial insurance companies. Even in these cases, however, the PPO typically does not bear risk because their employer group subscribers are often self-insured. Other PPOs occasionally bear some risk if they guarantee their rates for some period of time.

Who Uses PPO Services?

Encouraging employees and their families to use PPOs is one of the major challenges facing employers and providers alike. Unlike HMOs, which actually enroll members, most PPOs interviewed do not have
subscribers in the technical sense. Rather, employees simply are eligible for discounts when they use “preferred” providers. Previous research has indicated that although PPOs often sign up many physicians, hospitals, and employers, few providers actually see PPO patients—at least as of 1984—because PPOs were still in their early stages.

Since our survey was directed at PPOs rather than providers, it was difficult to learn how many people were taking advantage of PPO benefits. Our most interesting finding in this regard was the lack of knowledge among PPOs concerning their market shares. With the exception of the insurance-sponsored PPOs, the vast majority of plans did not know, even vaguely, what proportion of people who were eligible to use PPO benefits were actually using them. Only insurance companies seemed well-informed on this topic: about half were able to provide the information to us. These companies responded that their enrollees were using preferred providers about 55-60 percent of the time. Although the lack of knowledge about this rather basic market penetration statistic is noteworthy, it may not be surprising given that most PPOs do not have claims information on the people who do not use their services. Nevertheless, information would seem extremely useful for PPOs in their quest to attract contracting employer groups and providers.

We asked PPOs what incentives consumers were given to use the PPO. In almost all cases, these incentives were not given directly by the PPO, but by the group (usually the employer) that contracts with the PPO. About 90 percent said employer groups were giving some incentives in the form of lower coinsurance, and about 65 percent said that lower deductibles were also employed. About 10 percent of the PPOs reported that no such incentives were given. Most incentives were in the form of lowered payments when PPO providers were used, as opposed to increases in these costs when people went outside of the PPO. The majority of PPOs said the coinsurance was lowered in the 10-15 percent range. For example, a typical firm might charge 20 percent coinsurance when an employee goes outside of the PPO, but only 5 percent or 10 percent when the employee uses the PPO. Those using the PPO often pay $50-150 less in annual deductibles than those who go outside for services. About one-fourth of the PPOs said that some of their group subscribers sometimes gave incentives to employees to use the PPO in the form of extra benefits not available outside of the PPO, most commonly, well-baby care.

A final question asked on the survey was what experience the PPO had with selectivity bias—specifically, whether the people using the PPO differed from others eligible to use it according to age, health status, education, or family composition. We were surprised to find that over 80 percent of the PPOs had no idea whether they were experiencing positive or negative selection. Although some doubted that there were any
selectivity biases because PPO utilization decisions are made on a service-by-service basis, they had little information to support this view. Given the concern among health insurers that healthy individuals are self-selecting into HMOs, one would have expected PPO administrators to be more knowledgeable about the issue. One reason that PPOs were uninformed about this, besides the difficulty in obtaining data, is because they typically do not bear the risk of excess utilization. However, if they have high utilization rates due to selection problems they may find it difficult to remain cost competitive.

PPOs And The Future

For the most part, our survey left us impressed with the way PPOs are developing. Many of our findings suggest dramatic changes have taken place among PPOs since our previous article. This organizational form is growing quickly. We calculate that in the period of less than one year, between late 1984 and mid-1985, the number of people eligible to use PPOs increased fourfold, with already more than 5.7 million people eligible to use PPO benefits. Utilization review, previously used by only about half of the PPOs, is now used almost universally, and appears to be taken very seriously. Concurrent and preadmission review of hospital stays are the norm, retrospective claims review is commonly employed, and many PPOs are developing ways of profiling the service provision patterns of member physicians.

Perhaps most important of all, PPOs seem to have provided the health industry with a mechanism to facilitate competition among both providers and insurers. Hospitals and physicians are finding it necessary to be more cost competitive by accepting predetermined, discounted fees, and often subjecting themselves to external review of the appropriateness of services they provide. Insurers, as brokers for large buyers of health care services, are realizing that if they do not keep costs down, their clients will go elsewhere. Although many factors are responsible, it appears that the old way of doing business—providers calling the shots on price, quality, and utilization, and insurers calling them on health insurance premiums—is becoming a thing of the past.

On the other hand, some aspects of PPOs are troubling. Because physicians are typically paid on a fee-for-service basis and hospitals on charges or per diems, each individual provider still has an economic incentive to increase quantities. Thus, if a particular PPO is to succeed, it must either instill in its hospitals and physicians the critical importance of cost containment, or else closely police the number of services they provide. It would appear that the most effective way for PPOs to ensure such cost-containing behavior would be to select physicians and hospitals that have a history of keeping utilization rates low. We did speak with some PPOs
that would contract only with groups of physicians who had experience in providing services for independent practice association networks. However, most PPOs we interviewed showed very little selectivity in picking their member physicians and hospitals. In this regard, Boland has stated, “Physicians are . . . especially unlikely to change their professional behavior if there is little financial threat or risk involved . . . [The] current generation of PPOs generally shields participating physicians from financial risk.”

What types of PPOs are likely to succeed? The prime candidates are those that both have a strong financial incentive to keep aggregate health care costs down, and those that can exercise some muscle over providers. Commercial insurance companies and entrepreneurial ventures are good bets because they typically are not locked into a group of providers, but instead can choose those they believe to be most efficient. These types of plans showed the most provider selectivity and have an advantage over some other types of PPOs because they typically have thorough data on hospital and physician costs. Insurance companies also often used DRG reimbursement for hospitals, which in turn may reduce hospital lengths-of-stay and costs. Blue Cross/Blue Shield plans have similar advantages, but their task appears harder because most plans have felt it necessary to include all member physicians. Multihospital systems that underwrite their PPOs through insurance subsidiaries have an advantage over other provider networks because they will share in the savings of lower utilization.

It is the other provider-sponsored PPOs that may face the biggest challenge, since member hospitals have the natural, but dangerous, desire to want to admit enough patients and keep them long enough to keep their beds filled. Similarly, physicians in physician-sponsored plans want to remain busy and thus do not have a direct financial interest in remaining cost-effective. We believe that these organizations are only likely to succeed in the long-run if the PPO management is independent enough to control both hospitals and physicians who are subverting the cost-containing goals of the organization. This must include the ability and desire to remove abusers from the system.
1. See the following sources for a definition of PPOs: Jon Gabel and Dan Ermann, “Preferred Provider Organizations: Performance, Problems, and Promise,” Health Affairs (Spring 1985); Linda Krane Ellwein and David D. Gregg, “An Introduction to Preferred Provider Organizations” (Excelsior, Minn: InterStudy, June 1982); “Preferred Providers Proliferate,” Washington Report on Medicine and Health (20 June 1983); Stephen Lewis, “Preferred Provider Organizations—A Developing Concept in Health Delivery,” Socioeconomic Report (California Medical Association, November/December 1982).

2. Gabel and Ermann. “Preferred Provider Organizations” This paper also presented some aggregate findings based on the mailed questionnaire sent out by the American Association of PPOs, and interviews with several PPO executives. The present research effort differs considerably in that comprehensive telephone interviews were conducted with executives in all PPOs, and the interview itself was more structured. Thus, while the earlier Gabel and Ermann paper was based on somewhat anecdotal data, this updated paper is much more definitive in its findings.

3. For example, see some of the articles in Peter Boland, ed., Preferred Provider Organizations (New York: Dow-Jones Irwin, 1985).


8. This estimate is based on only 75 reporting PPOs. The directory states that because this is only one-third of the operational PPOs in the country, the total membership may be about 10,000,000. However, it is our view that responding PPOs are most likely to be the largest and therefore such an extrapolation is not warranted.


12. Gabel and Ermann, “Preferred Provider Organizations.”