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Commentary

Trends In Second-Generation PPOs
by Peter Boland

As the health care industry shifts from being provider dominated to purchaser driven, first-generation preferred provider organizations (PPOs) are giving way to more sophisticated second-generation delivery systems. As a barometer of market trends, PPOs are evolving along with the market in response to emerging purchaser priorities and new information system technologies.¹

At least five major trends have evolved as the market shifts from first- to second-generation PPOs: (1) Hybrid organizational and financing structures are emerging that will make it increasingly difficult to tell the difference between individual practice association (IPA)-model health maintenance organizations (HMOs), PPOs, and managed fee-for-service health plans. (2) Internal administrative controls, such as provider-selection standards, utilization-review procedures, and information systems, are replacing discounts as the most effective strategy for achieving long-term cost savings. (3) Program flexibility is accommodating health benefits redesign and “carve-outs” for particular specialty services such as mental health care and dental coverage. (4) Quality assurance is becoming the single most important delivery system feature, because it is the key to ensuring appropriate treatment, cost-effective services, and targeted cost control. (5) Second-generation PPOs are taking on more characteristics of a mature health care industry by offering a comprehensive mix of services, integrated product lines, clearly defined distribution channels, and financial stability.

A number of insurance companies that entered the market quickly with first-generation PPOs are now experiencing financial losses. Many of these arrangements were designed hastily and incorporated few incentives other than discounts to influence the traditional behavior of providers or consumers, thus achieving modest, if any, cost savings.

Hybrid Organization

Many second-generation PPOs and HMOs, particularly IPA health plans, are evolving into managed-care programs. However, neither PPOs nor HMOs are synonymous with either the concept or the practice of managed care at this stage. Only by melding the positive features of PPOs (freedom of choice, administrative flexibility, and funding alternatives) and those of HMOs (cost control, utilization management, and predictable pricing) with new information technology would a truly managed health care delivery system be created.

The second generation of PPOs is emerging in two kinds of markets around the country: metropolitan centers undergoing the third or fourth cycle of preferred provider contracting, and major cities in which HMO penetration has begun to peak. These PPOs are closing the gap between the inflated expectations of early PPOs and the performance of managed-care systems. PPOs continued to gain widespread acceptance and significant membership throughout the country in 1986 and 1987 for two principal reasons: PPOs offered greater cost savings than conventional indemnity insurance plans, and they offered more flexibility than either staff- or IPA-model HMOs.

Internal Administrative Controls

Replacing discount-oriented health plans. First-generation PPOs rode an initial crest of publicity resulting from the appeal of price discounts and freedom of choice. Discounts from billed charges were a dramatic departure from standard indemnity insurance options; freedom of choice in selecting physicians from a large provider network offered a sharp contrast to the restrictions of most prepaid health plans.

When contracting for health care services first became widespread in California in 1982–1983, the mainstay of the provider arrangement was an up-front discount off billed hospital charges. First-generation PPOs typically were provider based and discount oriented. Now, as the notion of fee discounting lessens in importance, utilization management, quality assurance, and accountability are growing in importance.2

The reason for this change in emphasis is that discounts alone did not achieve the level of cost savings that PPO sponsors advertised and purchasers anticipated. Unless sufficient management controls are built into the delivery system to protect the value of price discounts, they can serve as a perverse economic incentive: to order additional tests, increase lengths-of-stay, and schedule more frequent follow-up office visits to offset price reduction, which is the opposite intent of a discount. Discounts will fade over time as a principal cost-containment device because they are not a prerequisite for managed care. The capacity of a hospital
to offer a discount bears no relationship to its capacity to provide cost-effective patient care and appropriate medical treatment. Nor is the level of discount related to medical outcome.

**Provider selection standards.** Employers have had little to lose by offering PPOs and encouraging employees to use them. Because of the structure of most PPOs, enrollees could decide whether to use a preferred provider at the time of illness. However, as employers today realize the economic advantage of channeling more patients to preferred providers, the disincentives to go outside the plan for medical care will become greater. In particularly competitive markets, the amount of financial disincentive for using nonpreferred providers may, for all practical purposes, restrict or “lock in” enrollees to the preferred provider.

Second-generation PPOs are likely to include even larger disincentives to direct more enrollees to less expensive providers and to assure these providers more predictable volume. Preferred providers originally entered into agreements expecting that front-end discounts would be offset by increased patient volume. Many first-generation PPOs—particularly insurance company-sponsored plans—promised substantial new volume to physicians and hospitals in return for large discounts from billed charges, multiyear fee caps, and utilization-review restrictions.

Relatively few providers increased their patient base enough to justify the level of discounts negotiated during the first round of preferred provider contracting. Unfortunately, representations about the number of “eligible” policyholders were not a meaningful predictor of preferred provider utilization. PPO use was far more dependent on adequate health plan design, large provider networks, comprehensive marketing efforts, and effective employee communications.

Many hospitals involved in the early stages of PPO contracting, such as California in 1983–1985, realized only marginal patient revenue (for example, 2 percent of total hospital revenue) in return for discounts of 17–25 percent for inpatient services. During the last year of contracting, more hospitals began to require greater proof from insurance carriers about how they were going to divert patients into their delivery systems. Two of the most frequently used mechanisms to accomplish this are greater copayment differentials between preferred and nonpreferred provider use and more effective marketing efforts.

**Need for utilization review.** The purpose of introducing a PPO as an employee benefit option is to change employees’ utilization patterns by channeling workers and dependents to providers who are preferred specifically because they manage health care resources more appropriately than others do. Employers and payers need to understand how their health care resources are being managed by a PPO. They want to know the effects of PPOs on utilization patterns. Employers need to analyze the utilization experience of all covered employees (and depen-
dents) to establish a common “population denominator” for comparing
PPO experience. Since few PPOs generate claims data, available informa-
tion is confined largely to the type and amount of medical services used
by enrollees, including statistics on plan penetration, utilization levels,
cost savings, and demographic characteristics of subscribers.

Information sharing between a carrier (claims data) and a PPO (service
information) is a prerequisite for comparing preferred versus nonpre-
ferred utilization experience among a total group of policyholders. By
combining selective data elements from a carrier’s claims database and
from a PPO’s information system, regular client reports can be produced
that address such issues as: (1) What increase was experienced in per
capita medical costs in relation to the previous year? (2) How much of the
increase was due to higher inpatient rather than outpatient per capita
expenses? (3) To what extent was the increase in per capita costs due to
greater utilization rates rather than to higher medical prices?

Need for improved information systems. Many first-
generation PPOs
proclaim significant cost savings in part based on the difference between
“billed charges” and “PPO covered charges.” This may be misleading
because the billed charge includes amounts not eligible for payment
under the PPO plan (for example, noncovered services). Employers need
information about PPO savings based on the difference between the
“covered charges” and the “PPO covered charges.” Dividing that differ-
ence by the covered charge indicates the true percentage of savings.

Unfortunately, many PPOs still provide summary statistics about
utilization activity rather than actual changes in utilization behavior.
This is partially explained by the fact that most PPOs are new and do not
have access to more than a year of utilization data for particular custom-
ers. Without multiyear baseline data on each account, a PPO cannot
compare first-year results with second-year experience. To evaluate the
financial impact of utilization-review activities, for instance, employers
need information on changes in four key areas: (1) inpatient and outpa-
tient use of services (for example, visits per member); (2) inpatient and
outpatient surgery rates; (3) patient days and hospital admissions per
1,000 covered lives; and (4) average length of hospital stay.

In determining the financial impact of utilization review, purchasers
and payers are seeking more sophisticated cost analyses than early PPOs
offered. Many first-generation plans cut too many corners in calculating
savings based on utilization-review procedures. It was commonplace to
claim credit for exaggerated plan savings by using such simplistic and
misleading formulas for determining savings as the following: utilization
cost savings equal the number of hospital days requested less those not
approved, multiplied by the average charge per patient day.
This formula is inaccurate. Plan sponsors cannot assume that all non-
approved hospital days would have been used in the absence of utiliza-
tion controls. A phenomenon inherent in utilization-review activities is the tendency of physicians to request authorization for more hospital days than needed in case a patient’s condition worsens, to avoid requesting additional inpatient days later on.

Using the average charge per patient day further inflates the savings estimate. Unapproved hospital days tend to be for surgery that can be more appropriately performed in an outpatient setting or for convalescent care—both less expensive options. In other words, tremendous cost savings are credited to utilization review when, in fact, they are more appropriately related to comparatively healthier patients.

As the alternative delivery system market continues to mature, purchasers and payers will hold PPOs and HMOs to similar standards as a condition of doing business. Data will become increasingly important in evaluating health plan cost-effectiveness. To demonstrate both health plan efficiency and treatment effectiveness, second-generation PPOs must document the impact of quality-assurance programs. Providers also are being asked to define quality in operational terms and outcome measures. Purchasers want focused information on results, not just the input resource or the process measure. PPOs can answer these questions with comprehensive data systems and sophisticated medical software currently on the market. However, this level of reporting requires sizable capital investment and corporate commitment.

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### Increasing Flexibility

The next generation of PPOs is emphasizing utilization-management controls as the chief means of decreasing inappropriate medical care and unnecessary costs. However, some delivery systems are going a step further by experimenting with modest risk- and gain-sharing formulas that set aside a small portion of patient revenue to be returned according to preestablished performance objectives. As second-generation PPOs develop variable pricing arrangements (based on service per days and diagnosis-related groups, or DRGs) and document performance, they will be better able to provide a “lock-in” product such as an exclusive provider organization (EPO) to replace HMOs. Product flexibility is becoming as important as providing various delivery options.

Product flexibility refers to an organization’s capacity to tailor a preferred provider agreement to the needs of a particular client. For example, if an insurer already has its own utilization-review system in place, it will want the PPO to uncouple its utilization-review mechanism from other provider network services. If a sophisticated purchaser has very specific information requirements, it may want the PPO to generate in-depth provider profiles or reports on health-plan effectiveness. Thus, product flexibility represents both willingness and ability to provide an
optimal range of unbundled services.

One of the effects of this type of preferred provider contracting is to link efficiency and productivity to financial reward. This feature will certainly distinguish first-generation PPOs from second- and third-generation models. Utilization review and control will play a larger role in the second generation of PPOs than in the first because comprehensive data systems now are available to monitor physician practice patterns and hospital use of medical resources. In fact, the success of second- and third-generation PPOs will be strongly influenced by the capacity of information systems to interrelate quality-assurance programs, utilization statistics, and cost-management techniques. The emphasis will be on cost-effectiveness rather than cost cutting.

Quality Assurance Indicators

There is growing awareness among knowledgeable purchasers and insurers that quality of care, not price, is emerging as the overriding issue in determining which health plan to buy. First-generation PPOs marketed quality without sufficient regard for definition or product application. Quality was difficult to explain and frequently dismissed as advertising jargon by skeptical employers.

Second-generation plans are taking quality issues more seriously. This includes systematic peer review, risk-adjusted outcome indices, ambulatory care treatment standards, and clinically based measures of appropriate care. Computer software companies and medical researchers have begun to construct analytical models and apply medical protocols that express quality in terms of the type of care given. The best measure of quality is treatment outcome. Sophisticated preferred provider plans are addressing such questions as: Were medical resources appropriately used? Was the desired treatment outcome achieved? Did the patient regain optimal functioning? In short, medical outcome is the chief index of whether a health care organization is truly a managed-care system.

Increasing Maturity Of PPOs

The challenge for successful second-generation PPOs is to integrate genuine cost control with systematic quality assurance. That approach will enable such PPOs to develop into effective managed-care systems. Second-generation PPOs and many IPA-HMOs already incorporate a number of essential managed-care building blocks (for example, service mix, quality assurance, accountability, flexible funding, and administration options). Well-positioned PPOs currently are investing resources to strengthen major program functions that demonstrate managed care capability, such as: (1) utilization review and management (for example,
provider profiling, quality assurance protocols); (2) management information systems (for example, client report generation, internal performance data); (3) claims administration (for example, preprocessing and adjudication); (4) contracting procedures (for example, provider negotiation format, pricing mechanisms); (5) provider relations (for example, physician and hospital selection process, grievance appeal process); and (6) client services (for example, membership eligibility verification, provider referral). Significant market share and long-term customer loyalty will be gained by delivery systems—PPOs, IPAs, or both—that package managed-care resources most effectively in the next three years.

NOTES

6. Jon Gabel, Health Insurance Association of America, Washington, D.C., personal communication, 9 September 1987. Gabel observes that PPOs often overstate cost savings by failing to control for secular trends in health care. The analytic question is, what would the costs be for a particular employer if their traditional “unmanaged” indemnity product had been continued? Hence, to evaluate savings requires both before and after observations of cost, utilization, and other “dependent variables” with a comparison group of similar employers that continued their traditional health plans.
8. Boland Healthcare Consultants, internal client memorandum prepared by Leslie Alexandre.