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PPOS: DO THEY DELIVER?

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- What do we mean by PPO?
- How do they fit into the current managed care environment?
- How do they fit into different markets?
- Competing against other products
- Controlling costs
- Selecting a PPO to meet employee and employer needs
- What to expect in the future

MR. ROBERT H. DOBSON: I want to reflect for just a moment on where we've been in the managed care area. I moderated a panel, back in 1985 at the San Francisco health meeting, during which projections were made of how much of the business would still be traditional indemnity insurance as we knew it by 1995. Well, I don't remember any of the percentages and our lingo has changed since then, including our definition of traditional indemnity, but I don't think anyone in this audience would argue that the predicted movement of the market away from traditional indemnity has occurred and continues to occur. So our purpose is really to discuss how PPOs fit into this evolving marketplace.

In line with that, Pennell Hamilton will start by talking about what a PPO is, the role of PPOs in the marketplace, and how PPOs fit into the spectrum of managed care. He will talk about HMO-PPO penetration issues and pricing. Pennell is an actuary at the Aetna, where his current responsibilities include work in the small group health market with primary responsibility for managed health care issues. He's been involved in the development of an integrated multiple option product on the West Coast, and he's also currently involved in working with the HMO side of Aetna in the small group market. Prior to being with Aetna, he worked in the small group health area for Central Life, and prior to that he was in group LTD with UNUM.

MR. PENNELL W. HAMILTON: Before I start, I'd like to give you a couple small caveats about some of the baggage that I bring with me. I've primarily been in the small group market for most of my career, and so I bring a focus on the uninsured issues and the fully funded kind of marketplace. I've always been in the indemnity side of the house, and so I bring the sort of perspective that that implies. However, I have been working with the HMOs recently, and I think my perspective is changing.

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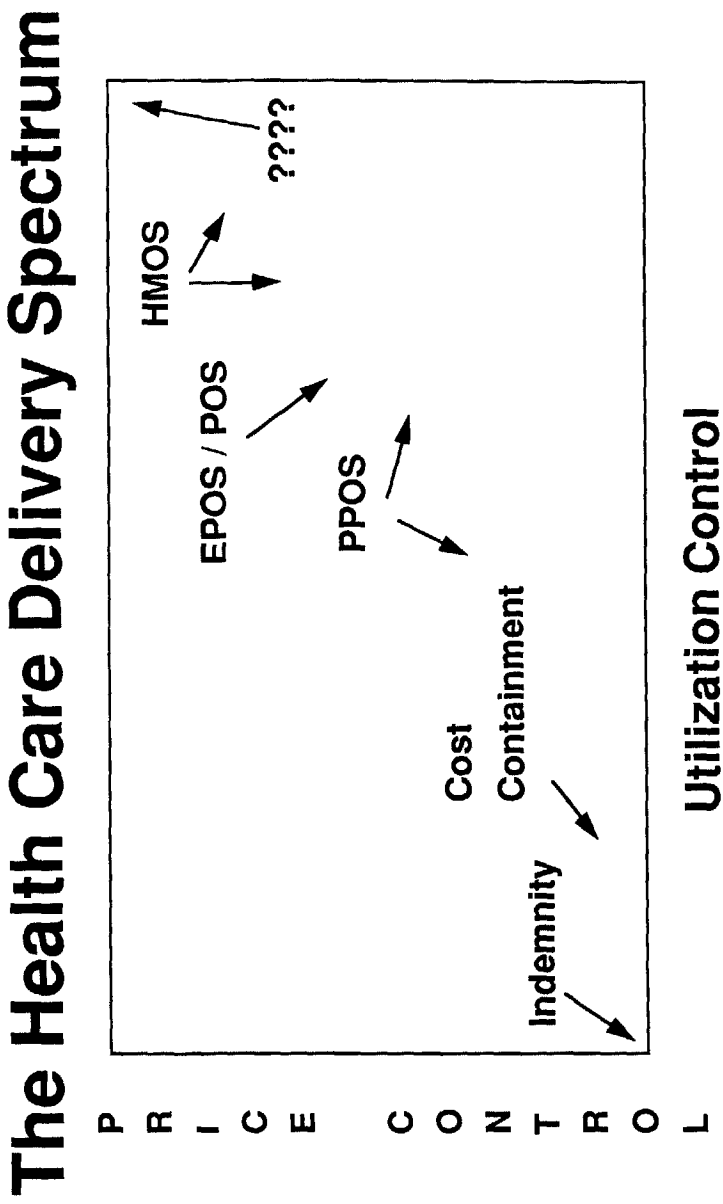
In preparing my presentation, I was asked to first speak about the question, what is a PPO? After reviewing about five definitions, all of them different, I came to the answer: Who cares? Now I don't mean by that answer that I don't care about PPOs. However, what I do mean to say is that I don't really care about the answer to this question for a number of reasons. First, I don't think that the answer provides us with any useful information. It's sort of like studying the nature of the automobile industry by asking, "What is a headlight?" PPOs are only one part of the health insurance marketplace. There are a number of different options out there ranging from PPOs to HMOs to exclusive provider organizations (EPOs) to point-of-service products. And looking at only one point in that spectrum really doesn't tell us anything interesting about the industry, how PPOs fit into that industry, or what their future might be.

Second, I think this question is actually misleading. By focusing on only one facet of the marketplace we miss the real question that we should be asking. Asking, "What is a PPO?", which is a product-focused question, leads us down the path of considering product over customer, and inventing customer needs to meet the product. Asking however, "What is the true, underlying nature of the business we're in today?" starts us down the road of considering what our customer needs are, and of designing our delivery systems to meet those needs.

So what is the true nature of the business we're in today? Fifteen years ago, if you asked a group health actuary that question, she would undoubtedly have told you that we are in the business of financing health care. You get sick; the doctor treats you; and we pay. But with the introduction of cost containment, the popularity of PPOs, and the increasing popularity of HMOs, our business has been transformed from one in which we are solely the financers of health care into one in which we are actually involved in the delivery of health care. A few weeks ago in Connecticut, one of the news stations ran a series of news shows entitled, "Who's Playing Doctor Now?" in which it accused the insurance industry of playing doctor. Initially I was sort of outraged at some of the assertions the station made in the show, but I began to realize that in fact it is correct. That is the business that we're in today, sometimes in an adversarial relationship with the doctors and hospitals, and sometimes and we hope most often in a strategic alliance with them. We cannot ignore the fact that that's what we do.

For one to think about PPOs within the context of the health care delivery business, one must consider the two facets of the health care delivery system that we try to control with our products: the price of care and the utilization of care. A somewhat traditional view of the spectrum of products would extend from indemnity insurance with the least control over price and utilization, to health maintenance organizations with the greatest control over price and utilization, with PPOs falling somewhere in the middle, and we hope with the price decreasing as you go up along the spectrum. (See Chart 1.) I would like to talk about some of the implications of this somewhat traditional view.

First is the implication for legislation. I often hear comments about the naivety of people who are for turning to the government for solutions to their health insurance problems, where our reaction has been to come up with small group health insurance reform, for example. But the real fact of the matter is that what customers are


The Health Care Delivery Spectrum
PRICE CONTROL
Utilization Control
Cost Containment
Indemnity
PPOS
EPOS / POS
HMOS
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complaining about is not the health insurance industry but the cost of health care, and when health insurance reform is all said and done, health care will still be expensive. So to me it seems that our two choices are, (1) to tell the customers they're ignorant, or (2) to try to design delivery systems that meet the customers' true needs. I'll leave it up to you to decide which one of those choices makes the most business sense.

A second implication of this health care delivery system view of our business, and a somewhat more practical one, concerns how we approach risk management. The traditional risk management practices of insurance companies have centered around the underwriting of risks and the pricing of risks. In fact, when an insurance company gets into trouble, I have most often observed that what it turns to first is pricing and underwriting. But the problems with this approach are: (1) that the government is eroding our ability to follow those traditional risk management practices through restriction of our abilities to underwrite and rate, and (2), that these relate only to the financing side of the business, and have absolutely nothing to do with the delivery of health care; and in fact, when you think of delivery of health care, the key risk management practice that has to come to mind is medical management -- a discipline that we hide away in our claims department, practiced by doctor and nurse specialists, which never reaches the mainstream of actuarial practice. In fact, medical management must have implications for the way we design products, the way we price products, and the way we underwrite products if we are to succeed in this marketplace.

Finally, I would argue that this question, "What is a PPO?" makes us miss important opportunities. By focusing on this question, we automatically focus on the indemnity side of the market since, after all, PPOs are an offshoot of the indemnity side, and this has led to years of warfare in my opinion between the HMO and indemnity sides of the house. But this, in my opinion, is foolish for in fact we are in the same business as HMOs, which is the delivery of health care, and if medical management is the key element of risk management, then who knows more about how to do it than the HMOs? As an example, consider the way a triple-option product is typically defined, as a choice between an HMO product versus an indemnity/PPO product. To my mind, we ought to be thinking about it as the choice between a managed health care product and a nonmanaged health care product, although sometimes I think we call PPOs managed health care when they really aren't managing the care.

I may have philosophized for enough time now, so I'd like to speak for a little while on the current penetration of HMOs and PPOs in the marketplace. There are a wealth of studies out there on how much HMOs and PPOs have penetrated the marketplace, the most common being the studies done by Inter Study which I have not used here. I have taken two more nontraditional sources which validate the figures that Inter Study produces and also, I think, provide some interesting insights into the marketplace. The first one is a study done by the Employee Benefits Research Institute (EBRI) in 1989, commissioned through the Gallup Organization, consisting of a poll of a 1,010 people, 878 of whom said they had health insurance. The demographics of this study by the way are fairly representative of the demographics of the United States. Chart 2 summarizes the raw numbers from that study for those people who claimed that they had health insurance, indicating that about 28% of the people are in some sort of managed health care plan -- 18% in an HMO, and 11% in a PPO.

CHART 2
HMO/PPO Market Penetration

Type of Coverage	Unadjusted Data	Adjusted to Cover Members with Rural Residents Excluded
Managed Care		
HMO	17.81%	24.87%
PPO	10.50	16.42
Other	62.10	58.71
Not Sure	9.59	--
	100.00%	100.00%

Source: *Public Attitudes on HMOs and PPOs*, EBRI, April 1990

In addition, 9-1/2% don't know what kind of plan they're in. These numbers probably don't fairly represent the actual penetration because, (1) they included both urban and rural populations, and undoubtedly, PPOs and HMOs are not very popular in rural areas due to the large capital cost in setting them up, and (2) because they only represent covered employees, and not covered members, but there was enough data to adjust for this. So adjusting for those two facts, for rural population and for covered members, we find that 41% of the people are in some sort of managed health care plan: 25% say they're in an HMO, and 16% say they're in a PPO.

Now let me turn to the second source of data that I used, which was the American Managed Care and Review Association (AMCRA). This study showed actual counts of people in HMO or PPO plans, as of January 1, 1991, which I divided by the 1990 census figures released in April 1991. This indicated that about 29% of the people are in some sort of managed health care plans – 17% in a PPO, and 13% in an HMO. (See Chart 3.)

CHART 3
HMO/PPO Market Penetration

Type of Coverage	Unadjusted Data	Adjusted to Exclude Uninsured and People Living in Rural Areas
Managed Care		
HMO	12.77%	19.09%
PPO	16.53	24.71
Other	70.70	56.20
	100.00%	100.00%

Source: American Managed Care and Review Association – 1990

I adjusted these numbers for two things. First, this included uninsured individuals, which the other study did not, so using some data from EBRI, I adjusted for the uninsured. Second, it also represented rural and urban populations again, so I

adjusted for that. The adjusted figures showed 44% of the people being in some sort of managed health care plan: 25% in a PPO, 19% in an HMO. This is consistent with the 41% of the people that the EBRI study indicated were in managed care plans, but there is an interesting thing to be noted here. The AMCRA study indicated that 56% of the people in managed care plans are in PPOs, whereas the EBRI study indicated that only 40% of such people are in PPOs. But you have to remember that the EBRI study dealt with what people thought they were in, whereas the AMCRA study statistics dealt with the type of plan people are actually in. This leads me to the conclusion that people understand when they're in a managed health care plan, but what they don't really care about or know is what type of plan they're in. So who really cares about the labels?

What other conclusions can we draw from this data? I think there are a couple. First, managed health care has been enormously successful. In preparing for this presentation, I found an article written in 1986 that said by 1995, 25% of the people in urban areas will be either in a PPO or an HMO plan. We've already hit 40% and it's only 1990. A second conclusion I would draw from this data is that managed health care has not been successful enough. With the legislative environment as it is today and with managed health care being put out in the marketplace as our solution to the health care cost problems, we should have 80% of the people in managed health care plans -- if they were delivering what the customer wanted.

I do want to back off for a second, and try to scare anybody who currently is working for a company that sells only indemnity insurance. As most people are aware, managed health care trends have generally traveled from the west to the east with a time interval of about five years. According to the same AMCRA study, looking at the penetration of HMO and PPO members by region, we find that for the northeast, the midwest and the south, it currently runs about 35-40%. But in the west, penetration is well over 70%, so one of my goals is to not be working for the last company selling indemnity-only insurance.

Now let's move on and talk a little bit about pricing, and see how the implications of dealing in the health care delivery system impact how we price. Chart 4 illustrates a traditional method of pricing PPOs, at least in the companies that I've been involved with. Here, we start from an indemnity base, and then adjust for any differences such as extra benefits in the PPO. Then we adjust the rates down for discounts and make an adjustment for if a network was bought. Then in order to keep the marketing department happy, we adjust for some utilization savings which we really don't know about but we put in anyway. Finally, we say it's a little more expensive so we adjust up for that. Well, what are the problems with this method? First, it starts from an indemnity base, whereas PPOs are, or should be, more closely aligned with the HMO side of the house. Second, if medical management is the key to risk management in the future for PPOs, where is medical management in this model for pricing? Nowhere! Third, as PPOs become more of the market in places like Los Angeles, this method becomes meaningless because there is no indemnity base to compare it to. And finally, this traditional type of pricing model almost invariably leads to the kind of experience analysis illustrated in Chart 5, at least when we attempt to measure experience by site.

CHART 4
Old Paradigm Pricing

	PPO 90/70 Plan	Indemnity 80% Plan
Claims and expenses under 80% indemnity plan (with cost containment)	$10,000	$10,000
Added value of preferred benefits	× 1.05	none
Value of discounts	× 0.91	none
Reduction for nonpreferred	× 0.97	none
Utilization savings	× 0.94	none
Network expenses	× 1.02	none
Plan premium	$ 8,975	$10,000

Note: Numbers chosen totally at random.

Chart 5 shows a loss-ratio-based analysis where we divide our business up by some underwriting category. In this case, I've used issue year. We collect premium and claims data; develop an incurred loss ratio; adjust for any price changes, such as for changes in area factors during the year; and, then, adjust everything to an average trend level. Then we compare the normalized loss ratio for each site to a national loss ratio, and if a particular site is credible, and it looks like it's running pretty good, we lower its price. But there are some problems with this method. One, it doesn't tell us why this site is running better, and two, it doesn't tell us how we can manage the claims better to get even more savings out of this site.

I would suggest that a more rational way to price PPOs is to use the kind of model HMOs use for a Per Member Per Month calculation. As shown in Chart 6, here we price by projecting claims in various categories. I would recommend using a lot more categories than shown in Chart 6. I would, for example, divide hospital inpatient into psychiatric, maternity, substance abuse, surgical, intensive care, and so forth. I would also look at these data from a current procedural terminology (CPT) code view or from a diagnosis code view. Later, when the actual data came in, we would measure the actual results in exactly the same categories. And what would this tell us about the site that we just lowered the price on? Well, first it would tell us that, in fact the site is running pretty good, and that, in fact, its price decrease may be justified. More specifically, it might show that the site is running better because the doctors' claims are running better, in which case we would address the question of whether that is going to continue, or instead whether some anomaly this year caused it to happen. The second thing we would note from this model is that the hospital utilization is higher than we anticipated. Then I would ask: Is this a trend? Is it getting worse? Do we have the right hospitals in our network? Are we working with these hospitals properly? Does medical management understand this is going on? And, does it understand the potential implications for pricing? In my opinion, this kind of pricing gets us towards the focus of medical management and away from purely financing health care.

Old Paradigm Experience Reporting

Site: Podunk USA

	Premium [$000]	Inc. Claims [$000]	Inc. Loss Ratio	Price Adj.	Average Trend	Normalized Loss Ratio
1984	1000	800	80.0%	80.0%	193.4%	64.8%
1985	500	600	120.0%	85.0%	193.4%	103.2%
1986	2000	1700	85.0%	90.0%	193.4%	77.4%
1987	3000	2000	66.7%	95.0%	192.5%	63.8%
1988	6000	4500	75.0%	93.0%	189.4%	69.1%
1989	5000	4000	80.0%	92.8%	186.2%	72.3%
<1988	12500	9600	76.8%	91.6%	191.3%	70.4%
<1989	17500	13600	77.7%	92.0%	189.8%	71.0%
					National LR	78.0%

Health Care Delivery Model

Site: Podunk USA

Benefit	Pricing Util.	Pricing Cost	Pricing Claim Cost	Actual Util	Actual Cost	Actual Claim Cost
Hospital Inpatient	521	$1,250	$54	600	$1,250	$63
Hospital Outpatient	445	$250	$9	445	$250	$9
Surgery	329	$802	$22	250	$672	$14
Other Physician	6285	$53	$28	5000	$40	$17
Maternity	75	$1,500	$9	75	$1,500	$9
Total			$123			$112

In conclusion, I would leave everyone with this thought: Welcome to the 1990s. The marketplace is changing faster than it ever has before, and if we are to stay in business, we must meet our customers' needs.

MR. DOBSON: Our second speaker will be Becky Hladky from the Tillinghast Kansas City office. Becky graduated from Washburn University of Topeka, and has an interesting degree combination -- a degree in math and a degree in counseling psychology. She works with insurers, health care providers, and employers on health benefits issues. Prior to joining Tillinghast, she was with J&H down in Miami. Becky has an underwriting background. Becky is going to be speaking on the impact of plan design on PPO pricing.

MS. REBECCA I. HLADKY: Over the years I've worked with a lot of employers as well as providers of care so I've been familiar with PPOs for a long time, and I've watched employers struggling to balance their need to provide attractive and meaningful benefits for their employees with managing the cost of those programs. And in their attempt if you will, to have their cake and eat it too, our job has been to help them wade through those difficult choices and come up with prices that they can still afford.

In order to give us all a common reference point for this discussion, I'd like to start by giving you a definition of a PPO: It's a managed care health plan that features a daily choice between network providers and benefits and nonnetwork provider benefits. The provider network is generally broad-based, consisting of large numbers of physicians and hospitals. The use of a primary care physician, or a gatekeeper as it's commonly called, is usually not required. Generally a PPO does not offer as large a savings potential as a point-of-service plan or an HMO plan because, (1) in the past, PPOs have traditionally been designed more as "incentive" plans, which I will talk about more, and (2) they haven't been able to deliver the volume to network providers that other managed care systems have, so therefore have not gotten as strong a discount from providers as the other plans.

What about PPOs in today's marketplace? They are still very popular among employers of all sizes, large employers, small ones, all across the board. Some employers have used PPOs as a first introduction into managed care. The switch from traditional indemnity coverage to only a PPO has been more palatable for employers to implement, and for their employees to get used to. Many employers are now viewing these plans as a transition product to tighter managed systems, whether it's to a tighter PPO management company or to a point-of-service plan or an HMO plan. Some employers, however, are viewing PPOs as a permanent part of their flexible benefit programs meeting choice needs of their employees. I think there are a lot of flexible benefit programs that are offered by employers now that don't even include a traditional annual indemnity option, where a PPO is offered as the least restrictive health care plan choice for the employees.

Over the years, we have found that PPOs have generally fallen into two major categories of design: incentive plans and disincentive plans. The distinction between incentive and disincentive plans can be seen by focusing on the nonnetwork benefits. I'll describe the incentive plans first. Typically, the nonnetwork benefits look pretty much like the traditional indemnity plan, such as an 80-20 plan with a reasonable

deductible. Often an incentive plan is the first type of PPO that an employer will implement. The employees are given incentives to use network providers, such as a reduced deductible, a higher level of plan coinsurance (sometimes 100% for hospital inpatient expenses), and often $5 office visit copayments and prescription drug card programs. (See Chart 7.) The other kind of plan is the disincentive plan. Typically this type of PPO is offered by an employer after the incentive type proves to be more expensive than the employer wanted to provide. Here, the nonnetwork benefit is less generous than under the old traditional indemnity plan. Rarely would you see an 80% benefit for nonnetwork. Thus, in the disincentive plan, in-network benefits may not be quite as generous as under an incentive plan. (See Chart 8.)

An important consideration with PPOs is what percentage of covered people actually access network providers for their care. Under incentive plans, historical network utilization has ranged from 20-50%, and sometimes more if there were extremely broad-based networks of physicians and hospitals. Once the disincentive plans are implemented, however, typical network utilization will range from 40% to as high as 90%, depending upon the level of nonnetwork coverage provided.

What I'd like to show you next are eight case examples, including four incentive plans and four disincentive plans, to illustrate some PPO pricing for you. Let me first outline the starting assumptions I used for my sample cases:

- The network has broad access of both physicians and hospitals. The discounts are 20% for physicians and hospitals, and there are no other types of providers contracted with.

- Network physicians will achieve a 10% overall utilization savings as compared to nonnetwork physicians. (This is certainly a debatable assumption.)

- The utilization review program, (precertification, large case management and concurrent review) also applies to nonnetwork services. In other words, it's not an unmanaged indemnity plan on the nonnetwork piece.

- In keeping with today's definition of a PPO, there is no primary care gatekeeper.

- Sick people choose between network and nonnetwork, no differently than healthy people choose. In other words, I did not account for the eventual impact of any adverse selection on the rates, just the effect that differences in benefit design have on the price.

Let me briefly describe the eight PPO plans that I priced. Charts 9-12 summarize the network and nonnetwork benefits and a network utilization assumption for each plan. Plans 1-4 are incentive plans and plans 5-8 are disincentive plans. For each plan, the first number (before the slash) is for network, and the second number (after the slash) is nonnetwork. For example, for Plan 1 when network providers are used, there is no deductible, 90% coinsurance, a $5 office visit copay, and a prescription drug card program. The nonnetwork benefits have a $200 deductible with 80% coinsurance. The "NA" on Chart 9 means that those nonnetwork services were simply treated as any other expense and paid as part of the comprehensive major medical plan. For

PPO PLAN DESIGNS

Incentive Plans

	Network	Non-Network
Deductible	$ 0	$ 200
Coinsurance	90% or 100%	80%
Hospital Inpatient	100%	80%
Hospital Outpatient	90%	80%
Office Visits	$5.00 Copay then 100%	80%
All Other Physician	90%	80%
Prescription Drugs	often card program	80%

PPO PLAN DESIGNS

Disincentive Plans

	Network	Non-Network
Deductible	$ 200	$ 400
Coinsurance	90%	70%
Hospital Inpatient	90%	70%
Hospital Outpatient	90%	70%
Office Visits	$10.00 Copay then 100%	70%
All Other Physician	90%	70%
Prescription Drugs	Card Program	70%

PPO PRICING EXAMPLES

Incentive Plans	Plan #1	Plan #2
Deductibles	$0/$200	$100/$200
Coinsurance	90%/80%	95%/80%
Out-of-Pocket Max.	$1,000/1,500	$500/1,000
OV Copay	$5/NA	$5/NA
Rx Copay	$3/NA	$5/80%
Network Utilization	45%	60%

Network/Non-Network

PPO PRICING EXAMPLES

Incentive Plans	Plan #3	Plan #4
Deductibles	$200/$400	$250/$250
Coinsurance	90%/80%	90%*/80%
Out-of-Pocket Max.	$1,000/1,500	$1,500/2,000
OV Copay	$10/NA	$5/80%
Rx Copay	80%/80%**	$5/80%
Network Utilization	30%	55%

* Inpatient at 100% if network hospital

** (i.e. no card)

Network/Non-Network

PPO PRICING EXAMPLES

Disincentive Plans	Plan #5	Plan #6
Deductibles	$200/$400	$200/$200
Coinsurance	80%/60%	90%/70%
Out-of-Pocket Max.	$1,000/2,000	$1,000/1,500
OV Copay	80%/60%	$10/70%
Rx Copay	80%/60%	$10/70%
Network Utilization	80%	70%

Network/Non-Network

PPO PRICING EXAMPLES

Disincentive Plans	Plan #7	Plan #8
Deductibles	$200/$200	$250/$500
Coinsurance	90%/70%	90%/60%
Out-of-Pocket Max.	$1,000/1,500	$500/3,000
OV Copay	90%/70%	$5/60%
Rx Copay	90%/70%	$5/60%
Network Utilization	65%	90%

Network/Non-Network

Plan 1, I initially assumed that 45% of the people will use network providers. For the other incentive plans, the network utilization assumption was chosen based on the levels of network versus nonnetwork benefits in those plans.

For the disincentive plans (Plans 5-8), again, I have simply introduced some variety so that we can look at the price impact of some of these. Plan 5 has relatively low benefits on the nonnetwork side and is starting to become more prevalent in some geographic areas. It has a $200/$400 deductible, and 80%/60% coinsurance for network/nonnetwork, respectively. Also, the nonnetwork out-of-pocket maximum is double that for in-network. For this plan, given the low level of benefit payments on the nonnetwork side, we picked a utilization assumption for the network of 80%. The benefits shown for Plan 6 are much more common. This has 90%/70% coinsurance, the same deductible for network/nonnetwork and a nonnetwork out-of-pocket maximum of only one and a half times that for in-network. Plan 7 is the same as Plan 6 except that I removed the office visit and prescription drug (Rx) copays, as some employers are beginning to do due to the high price tag attached to them in recent years. Plan 8, the last one, has the most dramatic difference between network and nonnetwork benefits, and therefore the highest network utilization assumption. This plan would be chosen by an employer that is very committed to keeping people in a network, since it provides a strong disincentive against going out of network.

After designing these plans and selecting a utilization assumption for each plan, I ran them through some pricing models to come up with a single employee monthly net claim cost for each plan. These claim costs are shown in Chart 13 for each plan. Also shown is the rate for a comparison plan, which is the indemnity plan that this employer had last year (80/20 plan with a $200 deductible and $1,000 out of pocket), just to give us a reference rate of $120. So going back to our Plan 1 with the incentives, which shows a rate of $124, it actually costs an extra $4 a month to move to this PPO for this particular employer due to the generosity of the network benefits. The rate for Plan 3 was lower than the comparison plan because, (1) we assumed only 30% of the people would use the network and, (2) it had a bigger nonnetwork deductible and out-of-pocket maximum than in the comparison plan.

You can see that for the disincentive plans, the rates come down pretty dramatically. Plan 5, with the network coinsurance at 80% is a very cost-effective plan compared to the indemnity plan, even with our 80% utilization assumption. The rates for the other disincentive plans come out higher than for Plan 5 due to richer network and nonnetwork benefits but are lower than the comparison plan.

So you can see that employers really struggle with selecting and managing the costs of the benefits that, in general, they would like to be providing, and often they turn to us for assistance in pricing benefit variations to help them in this struggle. This pricing becomes quite an exercise, and can be particularly difficult in the first year as these employers are switching over to new programs because it can be very difficult to gauge what the network utilization will be. This leads to the exercise that I have illustrated in Chart 14, which summarizes a sensitivity testing of the utilization assumptions.

PPO PRICING EXAMPLES

Sample Single Employee Net Claim Costs

Incentive Plans	Single EE Net Claim Cost
Plan #1	$124.07
Plan #2	$127.27
Plan #3	$111.87
Plan #4	$124.73
Disincentive Plans	
Plan #5	$102.24
Plan #6	$112.11
Plan #7	$114.04
Plan #8	$113.43
Comparison Plan	
80/20 $200 Deductible	$120.08

PPO PRICING EXAMPLES

Plan #	Network Frequency	Single Claim Cost		
1	45%/25%/65%	$124.87	$123.59	$126.16
2	60%/30%/90%	127.27	125.62	128.85
3	30%/10%/80%	111.87	111.61	112.52
4	55%/25%/75%	124.73	120.76	127.37
5	80%/30%/90%	102.24	94.94	103.70
6	70%/10%/85%	112.11	110.40	112.54
7	65%/35%/95%	114.04	112.22	115.85
8	90%/40%/100%	113.43	96.69	116.76
80/20 Indemnity			$120.08	

For each PPO plan, Chart 14 summarizes the rates that would be calculated using a utilization assumption that is lower or higher than the initial assumption. The first rate is the same as in Chart 13 based on the initial utilization assumption, and the next two rates are based on the alternative assumptions. For example, for Plan 4, if utilization is 25% or 75% instead of 55%, then the rate would change from $125 to $121 or $127, respectively. This demonstrates that there isn't a great deal of pricing impact for the incentive plans because, for the plans that we looked at, there wasn't a big difference between network and nonnetwork benefit payments.

The sensitivity testing for the four disincentive PPO plans produces far more interesting results, which are often not intuitive to employers. Employers have often been led to believe that, since we have efficient providers in our networks, and since we contract for discounted rates from hospitals and physicians, the overall plan costs will be lower as more people use the network. But that's not what we have been finding because, on these disincentive plans, the low level of benefit payments on the nonnetwork side distort the results. In effect, if you get a lot of people accessing the 60% coinsurance benefit, the rates will come down quicker than if you're continually putting the people in-network. So again, this has not been a real easy thing to demonstrate to employers, and it's not necessarily intuitive.

Employers need to understand this phenomenon and understand that they will lower their overall plan costs if people use more nonnetwork providers, but it will be because they have just shifted the cost to those people and not because the network was really saving that much money. These are the kinds of pricing considerations that employers are dealing with, and the kinds of challenges that we face as actuaries and underwriters in pricing.

What does the future hold for PPOs? I see a continuing strong appeal for all sized groups for the near term. There are still many employers out there that have not yet entered the managed care arena in any form, and again, a lot of employers see a PPO as a transition product for introducing managed care. A lot of employers are still very paternalistic in their attitude towards their employees. A lot of unions still want the most generous and very best benefits possible for their members. I think that when medical inflation escalates again, employers may have to approach PPO organizations to ask them to do a little bit of changing to become more cost effective; perhaps not to change their form dramatically, but to simply begin the process of working harder to control things. I see more plan design changes coming. I think the incentive plans will begin to disappear, and the disincentive plans will be what employers will be switching to during the next round of high cost increases. I think that in addition to plan design changes coming again, employers will be looking for PPOs that can provide deeper discounts, so I think it will be time to go back to the table to renegotiate some contracts. I think employers will expect their PPOs to select efficient providers, and to tell them who is an efficient provider. I think there is a perception out there that a large network means an inefficient network. Whether it's true or not, I don't know, but as long as this perception persists, I think that employers will be asking their PPOs to reduce their network size. Finally, another thing I would see happening is the introduction of a primary care gatekeeper. I think there is sufficient experience available to show that requiring patients to see a primary care gatekeeper who serves as case manager for all services does keep utilization down and it does save money.

MR. DOBSON: I have seen a number of situations where most of the plan design issues were decided before the pricing was even begun. Then, when the pricing shows results like what Becky was showing, it becomes necessary to redo the plan design and then price all over again. It certainly would be nice to have some of those ideas understood by the employers and some of the product design people.

Our final speaker today is Barbara Johnson. We've now heard from the insurance company side and from the employer side, and Barbara is actually with a PPO. She is with Select Care, located in the Twin Cities. She has an undergraduate degree from St. Olaf College, and a Master of Public Health degree from the University of Minnesota. She's been in the managed care business for 17 years now, though she says that at the beginning of those 17 years, there wasn't the buzz word "managed care." She spent eight years with the Blues, five years with a staff model HMO, and four years now with a PPO/individual practice association (IPA). She's worked in all of the major models in managed care organizations from the staff, network, and IPA model HMOs to traditional PPOs, and gatekeeper PPOs. Barbara is going to talk first about her definition of a PPO, from the perspective of someone who works for one. Then she's going to give us an insider's perspective of what an employer should look for in choosing a PPO, then some operational views and a prediction of the future.

MS. BARBARA O. JOHNSON: As Bob mentioned, I work for Select Care, which is a PPO located in the Twin Cities. My position there is Director of Managed Care, and I'm responsible for the utilization management, quality assurance, and provider evaluation systems of the PPO. Select Care has about 2,600 physicians, 44 hospitals, and numerous ancillary and allied providers that we work with. We've recently expanded into Western Wisconsin and much of rural Minnesota, but the vast majority of our 150,000 eligibles are located within the Twin Cities metropolitan area. Fourteen of our 44 hospitals are also located in the Twin Cities.

When I started to try to develop the definition of PPO, like Bob, I thought that would be pretty easy. After all, we are one. As I sat down to write it, however, I was reminded of the time my son asked me, "Mom, what do you do at work?." Well, I first tried explaining the intricacies of the relationships between doctors and hospitals and employers and patients, and he looked at me and said, "But mom, what do you do?." After about three times of going through this, I finally said something along the lines of, "I talk on the phone a lot, I read a lot of reports, and I sit in a lot of meetings." I hope that the following definition of a PPO is more helpful to you.

I define a PPO a little differently I think than most of the rest of you because I'm focusing on the organization itself. A PPO at its best is an organization which selectively contracts with cost-effective, high quality providers, and markets the services of these providers to employers and payers. The providers agree to participate in the PPO's quality assurance and utilization management activities, and to accept negotiated payment levels. There are a couple of other characteristics that were alluded to earlier. First, there is some kind of a driving mechanism in the plan design, usually a fee-for-service plan design, to encourage individuals to use preferred providers. We never ever recommend first-dollar coverage for any of our clients. We'd rather see copays at the point of service because they tend to reduce the number of times that Mom or Dad brings in the three kids instead of just the one with the sore throat. A second general characteristic of a PPO is that the PPO itself

is not a risk-bearing entity. The insurance risk remains with either the self-funded employer or, for insured products, with the insurer. Many PPOs are willing to give some performance guarantees however.

The question was raised, where do PPOs fit into the managed care spectrum? Chart 15, which is very similar to the one that Pennell provided earlier, shows a range of medical management. It ranges from the indemnity plan, where individuals and their doctors make decisions independently of any third party, to employer-owned health clinics, where the physician is actually providing care as an employee of the employer, with various levels of care management between the two. PPOs with and without gatekeepers both fall somewhere in the middle of those two perspectives. One of the things an employer needs to consider is how far along this continuum it is comfortable in moving its employees. As employers move down this spectrum, there are some employee relations issues that they need to consider, although a 1990 Rand Study showed very high levels of patient satisfaction with at least an open-access PPO.

CHART 15
How Do PPOs Fit into the Current Managed Care Environment?

Indemnity:	Medical decisions made by patient and physician
Managed indemnity:	Medical decisions reviewed by third-party utilization review mechanism
PPO – no gatekeeper:	Expanded utilization review Quality assurance Provider selection Provider evaluation Incentives to use participating providers Contracted fee schedules
PPO – with gatekeeper:	PPO characteristics as above Patient care managed by primary care physician
Group/staff HMO:	All care received through plan providers Risk transferred to HMO Medical policies established and enforced by HMO
Employer owned practices:	Employer established medical policies

So assuming the employer has decided that a PPO is a reasonable addition to the employee benefits program, the question then becomes, how does one select a PPO that's going to do what one wants it to do? The American Association of Preferred Provider Organizations, our trade association, has developed an accreditation program that includes eight broad categories of items that a PPO has to satisfy in order to become accredited. This accreditation has only been going on for about two years, so there are relatively few PPOs that have gone through the process. When Select Care went through this about a year and a half ago, and we did in fact pass the accreditation, we found it to be quite helpful. I think that many employers would also find these items helpful in their evaluation of a PPO. These items are outlined in Chart 16. I'd like to give a few comments about each of these and focus primarily on the last two, provider payment arrangements, and provider selection and evaluation.

CHART 16
Factors to Consider in Evaluating PPOs

1.	Management/administrative capabilities
2.	Legal structure
3.	Financial stability
4.	Managed care network
5.	Utilization management
6.	Quality assessment
7.	Provider payment arrangements
8.	Provider selection

Source: American Association of Preferred Provider Organizations

The first item is management and administrative capabilities. An employer should check the credentials and the experience of the PPO staff, what services the PPO is proposing to offer, whether or not it is willing to unbundle those services, and how the PPO is proposing to interface with the claim payer. At Select Care, we require that all claims be preprocessed by our internal member services department. This provides us with an incredible wealth of information that we use in our provider evaluation systems. We allowed one of our claim payers, at its request, to actually receive the claims, originally on the promise that we would get information from the payer, only to discover later that it didn't capture CPT level detail on its major medical payments, which really reduced our ability to evaluate provider performance. I would also always recommend that an employer get references from existing clients.

The second item is legal structure. The employer should check the legal structure to make sure that the provider contracts protect patients from balance billing, and also protect against billings for services that the PPO determines are medically inappropriate or unnecessary. The employer also needs to make certain that the PPO is in compliance with any regulatory requirements. There are relatively few at this point in time.

Third is financial stability. The employer should be looking for things like the level of malpractice insurance for the PPO itself, in terms of its medical management activities. The employer should probably get a copy of the certified financial statement, and should look at the diversity of revenues in the PPO. I always get nervous when a PPO only has one or two major clients that provide the major source of revenue. Loss of one of those clients could have very severe ramifications on the PPO's ability to provide services to an employer.

The fourth area is the managed care network. This is an area that an employer frequently focuses on, such as looking at the geographic distribution of specialties of providers as well as a specialty mix, and comparing the distribution of providers to the home addresses or home zip codes of its employees and their dependents. In terms of specialty distribution at Select Care, we try to keep a 50% primary care, 50% specialty mix. We feel that a primary care focus is very important in terms of managing health care services. The employer also needs to develop an understanding with the PPO about how it will handle services that are not available within the scope of the PPO.

The fifth area is utilization management. Here, again, it's important to look at the credentials of both the utilization management staff and the consulting physicians that the staff uses. The employer needs to understand what services are included in the utilization management activities. The common ones are precertification, concurrent review, discharge planning, second opinion programs, and catastrophic case management. We dropped our second opinion program a number of years ago because we found it to be ineffective. When we were accredited, our association recommended that we reconsider that position, so we did some additional research and confirmed that we really don't want to have a second opinion program. I would also give you a word of warning about the savings that are reported by utilization management firms, either independent firms or PPOs. They tend to develop their "savings" by asking a doctor at the point of admission how many days the patient is expected to need to stay in the hospital. As an example, for an appendectomy, the physician may say six days, simply because he doesn't want to talk to the utilization review (UR) nurse again. The UR firm approves three days for that, and reports a three-day savings when actually the average length of stay may only be three days. We've taken the position of developing our savings reports by comparing actual days to the medium length of stay for that diagnosis. Therefore, the savings that we report aren't as dramatic, but we feel that they're more reasonable.

Sixth is quality assurance. Employers need to look at how comprehensive the program is. One of the things that's usually included in a quality assurance program is some kind of patient satisfaction measurement. There are a lot of areas where quality assurance and utilization management have to work together. One is in the development of medical policies. Select Care took its first stab at developing practice guidelines about a year ago, when we developed some guidelines for preventive health services, which we published in a brochure to distribute to all of our primary care doctors. We also distribute those recommendations to patients as part of the employee packets that we send out, including recommendations for frequency and types of health screening for a symptomatic adult. We intend to continue this process of developing practice guidelines because we really believe that one of the keys to the future of a PPO is the management of care. Another area where quality assurance and utilization management need to fit together is in technology assessment. We're frequently asked to assess the appropriateness of new procedures, such as laparoscopic cholecystectomy, which is an alternative to the open surgical procedure. With this, they cut three little holes in the abdomen, insert a camera to view the gallbladder, and then remove it using a laser. Surgeons felt that this should automatically be approved. They also felt that it would produce cost savings because it's done with only a one-day length of stay or even as an outpatient procedure, that it significantly decreases morbidity and that they should be paid more for doing this because it is a somewhat more complicated procedure. Actually the problem is that this procedure takes longer, thus also increasing the operating room time, and increasing the anesthesia time. Also, frequently there's an obstetrician involved as a second surgeon to operate the laparoscope since a lot of general surgeons aren't very good at doing that. The other issue that you run into with making a procedure easier to receive is that more and more patients become candidates for the procedure. So the position that our utilization review and quality assurance department took was that, yes, it made sense to approve the procedure itself, however, we certainly are not going to pay physicians any more to do it.

The seventh area is provider payment arrangements. Provider payment mechanisms should ideally provide incentives for efficient and effective provider practices. Hospitals are generally paid by a PPO on either a diagnostic-related group (DRG) or per diem basis, or sometimes on a discounted fee-for-service basis. Physicians are typically paid on some kind of a negotiated fee schedule. It's really quite a challenge to develop a reasonable fee schedule. There are significant antitrust implications for PPOs. Our attorney sits on the committee that establishes our fee schedule. And we try very hard to differentially reward cognitive services versus procedural services in order to counteract the incentives to provide more procedure-oriented or laboratory or X-ray services, and to reward physicians for doing a careful and comprehensive history and physical. One of the things that we do to assess the reasonableness of our fee schedule is to try to count the number of fee complaints, formal fee appeals, and terminations that we have. We feel that if we don't have very many complaints or terminations then our fee schedule may be too rich. However, on the other hand, if you've got too many people complaining or walking, you have some other problems. So that's one of the areas that we continually monitor. PPOs must also have established policies and procedures for dealing with coding accuracy questions. We can always tell when one of our clinic managers has been to one of the creative coding classes.

The eighth item is provider selection, and I'm going to include provider evaluation and reevaluation, which I think is one of the most important areas for a PPO. It's also one of the most challenging areas for PPO management to assess. There are some things that are relatively easy to assess, such as whether providers have a license, are board certified, have active unrestricted privileges at a plan hospital, and what kind of malpractice history they have. Practice patterns however are much more difficult to assess, especially prior to the individual joining the plan. Once you've got the individual, you can do some assessment of the types of care he or she provides on an ongoing basis. But prior to the provider joining the PPO, you're relatively limited to anecdotal types of information from other physicians who know that particular doctor. The institutional practice patterns are pretty easy to manage. They're relatively limited in number, and I guess I've gotten to the point where I don't see a lot of variation in the way people practice on an inpatient basis. On an ambulatory basis, however, the practice patterns are much more diverse. For example, there are pediatricians who do both a rapid strep test and a throat culture for every child who shows up with a sore throat. There's a lot of pressure on the part of working parents to initiate treatment if in fact the child may have a strep throat. Other pediatricians will take the position that they will do a throat culture, and presumptively treat only patients who have clinical indications of a strep infection. We do a number of statistical comparisons among physicians of the same specialty in order to measure some of the differences in laboratory, X-ray, and office visit utilization. For example, we may compare data on pediatricians. We review the number of visits, the number of tests, the cost of the tests, and other information, which all feeds back into the reevaluation or the re-credentialing of the physician.

The PPO also must have a mechanism to terminate providers whose practice patterns are inconsistent with managed care goals. I would always encourage an employer to ask how many doctors have been involuntarily terminated from the PPO, but it's not easy to do. It doesn't mean necessarily that if somebody is terminated, then he or she is a bad doctor. It simply means that the doctor's practice style is such that he

or she doesn't fit within a PPO. For example, we had a dermatologist once who decided that the best way to remove warts was to use a laser, and he didn't even own the laser center. The problem with this was that it cost about ten times as much as using the liquid nitrogen. When we discussed the problem with him, he agreed to stop doing it. We then put a watch on all of his claims only to discover that the next set of claims that came in showed large charges for surgical trays, for pathology reports, and for wide excisions of lesions with layered repairs. Upon reviewing this information and comparing him to other dermatologists, our utilization review (UR) committee recommended termination. We're now in the appeals process, but I'm confident that our board members will support the termination. They've done it in the past, but it is difficult to get rid of a physician sometimes. I'm convinced that a PPO's ability to provide cost effective health care services to members, and to provide true cost savings to employers, is directly tied to its ability to recruit and retain physicians with cost effective patterns of practice, and its ability to terminate the contracts of those whose practice patterns are incompatible with managed care goals. These eight general areas can provide an employer with a good overview of the abilities of a PPO to meet the employer's expectations.

Bob also asked me to provide some kind of predictions for the future. My first prediction is that PPOs will be expected to provide improved documentation of cost savings and efficiency. PPOs that are able to provide and validate their savings and efficiencies will be successful, while those unable to provide such documentation will fail. I'd like to point out that it's relatively easy to report cost savings based on discounts, but it's much more difficult to measure the value of care that was avoided. But as one of my accounting friends said, if you can't count it, it doesn't count. I also predict that there will be more specialized PPOs, including PPOs in mental health and substance abuse, chiropractic networks, and worker's compensation networks. Finally, I would predict that PPOs will come under some form of state regulation. Areas to be regulated will probably include utilization management, provision of services that are not available within the PPO, and some kind of financial stability requirements.

MR. DOBSON: I would strongly second your comments about utilization review savings and the data.

MR. JOSHUA JACOBS: I'd like to ask Ms. Hladky about the PPO cost trends that can be expected in the future, assuming that benefit design doesn't change. Also, wouldn't the pricing trend depend on any changes over time in how many people use the network, and also on whether it was a strong disincentive or an incentive plan? Also, how do trend rates for contracted prices differ from indemnity inflation?

MS. HLADKY: In general, what I've seen historically is that utilization of network providers has increased more rapidly with disincentive plans than for incentive plans, as you can well imagine. From what I see reported by various insurance carriers, current trends for in-network services appear to be lower than they are for non-network services. Therefore, the more people you can get in the network the better off you are for the long term.

MR. DOBSON: But your pricing trend might then have to recognize the shift from the lower benefit levels out-of-network to the higher in-network benefits.

MS. HLADKY: That's right. So by the various pieces, you're still going to get a balancing effect, and it's difficult for the employers to see this. You have benefits pushing up the cost in-network, with the discounts and the utilization controls going the other direction.

MS. NANCY F. NELSON: Barbara, you mentioned measuring patient satisfaction as being important. I'd like to know how you collect that information, and how you disseminate it back to the providers and to employers. Also, is there a demand for variations in provider reimbursement rates based on employer size, and if so, how do you manage that?

MS. JOHNSON: For patient satisfaction surveys, we identify a sample of patients who have used network providers, and send out a questionnaire to these individuals to ask them about the specific encounter. We ask them things like whether they were satisfied with the doctor, whether they would go back to that doctor again, and would they recommend that doctor to their friends or neighbors. Also, we ask them about their satisfaction with the PPO itself, such as whether they understand the benefits, if the directory was helpful, those sorts of things. So it's based only on a sample of patients who have used the network.

MS. NELSON: At the same time, do you try to collect information such as how long it took to get an appointment, or how long you waited once you were there?

MS. JOHNSON: Yes, information like whether the appointment time was convenient or inconvenient, that sort of thing, is all fed back. We do it by practice instead of by individual physician, just to make the numbers more credible, and we do feed it back to the practice. And that information also feeds into the recredentialing information that we use.

MR. HAMILTON: I'll make one comment on the second question, but this is primarily from a small group perspective. Small groups couldn't care less about provider reimbursement relationships. They care about the rate. And as a result, we are very concerned as actuaries about the provider reimbursement relationships as they affect the rates.

MS. NELSON: Okay, I guess my question is more for a large employer who may be working with a self-funded arrangement. He thinks that since his employees are concentrated in a particular part of town he can really deliver volume at one of your hospitals. Can you work with that hospital to get him a better deal?

MS. JOHNSON: Sometimes.

MR. LARRY BERNSTEIN: I'm interested in the extra utilization from having a $5 or $10 office visit copay. Do you know how the utilization with this design compares to the utilization under the regular indemnity plan? Also, would you comment on the effect of any underreporting of utilization in an indemnity plan for patients who don't hit the deductible and therefore never submit any claims, whereas in the PPO, you go to a network doctor who submits the claim right away so that you appear to get extra claims that way? Does anyone have any idea about what the magnitude of these figures are?

MR. DOBSON: And before anybody answers, let me add that you can also have additional lab testing and prescription drugs as you get more people going into the office.

MS. HLADKY: In general, I think you've already answered part of the question by saying that, for all those persons who don't ever meet a deductible under an indemnity plan, we don't really know how many services they're actually using, so there isn't any way to accurately measure the extra utilization that comes under a PPO plan. We can compare it to a more managed care system to see how excessive it might be. In other words, if the average number of visits per person per year under your PPO is the same as under your local community HMO then the utilization might not be excessive.

MR. BERNSTEIN: Well, that addresses the underreporting issue, but how about just the fact that because I know I only have to pay $5 to a doctor, I go whenever I want to go. Do you have any studies that show how the utilization suddenly shoots up, and by how much? 10%, 20%, 50%?

MS. HLADKY: I don't think it would be as much as 50%, but again, because we don't know exactly where the utilization started under the indemnity plan, I can't tell you what percent increase there is.

MR. HAMILTON: I can provide some insight on that. I don't want to give actual numbers of pricing information, but we looked at loss ratio information for $5 versus $10 copays versus indemnity plans, and we found that the $5 copay is generally several points higher than the $10, whereas it's roughly equivalent to the indemnity. That's been my experience.

MS. CAROL J. MCCALL: Mr. Hamilton, given the current regulatory environment and the restrictions that we have, and expect to have, on our traditional risk management techniques, do you think that PPOs have a long life expectancy? I guess my question stems from your comments that we as insurance carriers are involved in the delivery of health care, that the actual level of control we have over the day-to-day physician behavior is rather weak, that any medical management we have, as Ms. Johnson alluded to, is usually retrospective and punitive, and that we can only manage after we've seen some experience. To rephrase the question another way, do you think that doctors need to be more at risk in order to help stabilize costs?

MR. HAMILTON: I think there are three questions there, and I'll try to answer them. For the one about PPOs, here is my personal view. I'm involved in a project for reengineering the business processes, where somebody asked me whether we will all still have jobs when it is over. My answer was that there will still be 350 jobs, but they just may not be the same people. I think the same way about managed health care products. We probably will continue to have managed health care products, but just not the same ones. You asked the question about controlling physicians. I think there are two views that exist in the world today. The indemnity side thinks of doctors as enemies, whereas the HMO side generally views doctors as their customers. Now I would contend that neither of these views is anywhere near correct. If doctors are our customers, they're the only customer I know you pay money to, and

they're certainly not our enemies because they should have the same concerns we do (we have the same customers). My view of controlling doctors is to try to develop more alliances with them under the viewpoint that they are in fact our customers. And concerning risk sharing, I think that the problem with PPO reimbursement relationships now is that they all tend to use per diems, discounts off charges, or DRGs. Of these, only DRGs actually transfer some of the risk, and we need more risk-sharing arrangements in our PPO plans to be effective.

MS. JOHNSON: I'd also like to comment on a couple of things regarding that. I think it is possible to have some risk sharing with providers in a PPO setting, especially in a gatekeeper-type PPO setting. What we've done is we've developed a gatekeeper PPO that pays physicians a variable percentage of the fee schedule based on the total cost of providing care for their patient population. We've seen in our HMO business some very dramatic changes in their willingness or interest in cost management as a result of doing that. Yet at the same time, their risk is limited to the services that they themselves provide so I think it can be done. I think the other thing that we need to do is to provide better feedback and better information to physicians on how their practice differs from other people's practices. Physicians are isolated into small practices, and don't really necessarily even know how they differ from other people.

MR. JED L. LINFIELD: What special design and pricing considerations would you use in designing a PPO for the retiree market, both under 65 and over 65 retirees?

MR. HAMILTON: I'll try to give an answer, although I must admit this is a question I really haven't given much thought to. When you think of the retiree population, I think you get into an area in which medical management becomes even more important than in the younger population. I probably would focus on those kinds of issues. Also, when you are designing the benefits, you should build in incentives and disincentives to help prevent people from going into the types of care that they shouldn't be in.

MR. LINFIELD: If they were over 65, wouldn't you want an inventive to get them in the hospital instead of keeping them out of the hospital, because of Medicare?

MR. HAMILTON: Yes, assuming they're not working.

MR. LINFIELD: Yes, assuming they're covered by Medicare, you'd want them in the hospital because then the government pays.

MR. DOBSON: Well, possibly.

MR. LINFIELD: A follow-up on that question. In the say, over-age-50 market, what level of acceptance is there of PPOs? Is it less than with the younger population?

MR. HAMILTON: Both of the studies I referred to earlier also showed information by age. These showed that there was as much acceptance among older people as with younger people. This surprised me because I had always accepted the myth that younger people pick PPOs or mid-type managed care plans, and older people don't. Another piece of anecdotal experience comes from the integrated multiple option

products I've been working with, where we look at age selection very carefully between the PPO and HMO plans. We have yet to really find any bad age selection from our products.

MR. JONATHAN ROSENBLITH: First of all, it's great to talk about aggressively doing as much as you can, but how about cases like one I heard about where on a mental health case, the company either denied coverage or was only willing to pay at a certain level. The person was discharged because he couldn't afford to pay the difference and then he committed suicide. Or another case, I think it's the Wickline case in California. How do you address the types of concerns raised in these cases while still trying to make health care coverage as effective as possible?

MS. HLADKY: I think this is an area of growing concern for employers and for providers. Case law always runs behind practices and ideas in the insurance or health care industries, and the cases are just starting, within the last year or two, to yield some judgments in this area. I think the quality of care issue is going to become far more important, and it may require that employers, case managers, insurance carriers and providers of care all do everything that is possible to ensure quality of care, in order to avoid being part of this litigation. Also required may be even stronger methods of credentialing physicians, such as looking much more closely at providers to ensure that the excess is not so broad and that physicians have been selected carefully enough to avoid the horror stories. The horror stories aren't any different than they've been in the past. They're in indemnity insurance, too. It's just that there was never any implied promise about the quality of care because indemnity insurance products never attempted to direct care. That's the only thing that's any different. The horror stories haven't changed at all. There is still a lot of good quality care being delivered in our country, but, unfortunately, sometimes the quality of care delivered is not quite as good.

MR. ROSENBLITH: But I think it's just in managed care where, for the first time, the insurer, the PPO, or the HMO has been included in the "malpractice case."

MS. HLADKY: That's right, which is why all of the things that Barbara was talking about are so important. It is absolutely critical to make sure that the providers are selected very carefully to serve on these panels.

MR. HAMILTON: I have to make a quick comment, too. To me, medical management implies an ability to identify those cases which are serious, and those cases which aren't. And one would hope that managed care plans aggressively pursuing medical management ought to reduce the number of these kinds of stories, and actually ought to promote quality.

MR. DOBSON: Barbara, do you have a comment on this one?

MS. JOHNSON: A good managed care program is probably going to reduce the number of incidents where patients receive inappropriate care, such as the case of an inappropriate discharge, or the Wickline case. There are also a number of situations where managed care organizations have helped patients to avoid procedures that had very high morbidity or mortality rates, and have provided excellent service and quality care. We just have to be careful, and we have to be insured.

MR. ROSENBLITH: Okay, I have one other question. I've heard very little throughout the last couple days about working with patients to aggressively educate them to be able to talk with their doctors about alternative procedures and treatment options. I know of two cases personally, involving a younger woman and an older woman, both facing mastectomies, who after getting more information on their own by aggressively questioning their doctors, ended up choosing different alternatives than were originally given to them, and at a lower cost and at a higher quality of life.

MS. JOHNSON: I would agree that patient education is critically important. That's why we distribute patient care guidelines to patients themselves. There's also some research going on in using interactive videos to identify, for patients who have had a procedure recommended, what the possible outcomes of that procedure are. I expect that this will probably expand as patient education becomes more and more critically important and as there are more choices.

MR. ROSENBLITH: Okay, but I understand that people are working on this for the future. But are any of you aware of anything that's happening right now, as a formal program doing the type of thing I described?

MS. JOHNSON: This program I referred to is doing some pilot studies, but it is still in the pilot stages. I'm not aware of any extensive programs in any PPOs. There are a number of HMOs that provide some extensive patient education types of programming. They're not necessarily identifying all of the treatment alternatives that might be available to the patient.

FROM THE FLOOR: Is the programming done using videos?

MS. JOHNSON: Yes, the way it actually is being presented is as an interactive video that's available in a private area of a physician's office.

FROM THE FLOOR: It's available to the patients?

MS. JOHNSON: Right.