I believe it was Mark Twain who once said “The reports of my death are greatly exaggerated”.

I begin the article with this because of the rhetoric in the market place regarding the impending demise of PPOs. It has been suggested that in five to ten years the PPO will go the way of the Dodo. There are even organizations that counsel payers to eliminate PPOs from their service offerings because it puts them at risk of “breaching fiduciary responsibilities”. The contention is that language within many PPO contracts can limit the ability of a payer to impact the medical costs of their clients by utilizing more aggressive reimbursement methodologies, including UCR, Medicare and other “referenced based” options. From a conceptual standpoint, I certainly understand the desire to effectively manage the Plan’s medical costs. However, we need to consider another key objective of most employers; attracting and retaining high performing employees. Essential to this goal has traditionally been to offer a benefits program that provides access to quality providers at an affordable cost. Consequently, employers developed Plans that utilize preferred, contracted providers in order to limit provider billing of employees to anticipated deductibles, copays and/or coinsurance, while also impacting health plan medical costs. There was no desire to put employees in situations where balance billing or collections was the result of aggressively reduced payments to providers. The fact that PPOs have been the accepted form of provider access for over 30 years suggests that there is value to this model. As a side note, I also find it interesting that a number of the organizations promoting the elimination of PPOs happen to offer products as replacements.

But, let’s not kid ourselves. Today, many PPO’s are providing less than stellar savings. Although originally designed to direct significant patient volume to “preferred” providers in return for material savings, PPOs have evolved into provider inclusive organizations. Who is included in the network has become just as
important as the savings the provider is willing to offer. And frankly, we as consumers are part of the problem. We’ve come to expect that we can have a high level of benefits, reasonable premiums AND have all our providers in-network.

The good old days. In the late 1970s, early 1980s, the Americans were experiencing significant increases in health insurance premiums. This upward cost pressure resulted in “managed care”, typified by the HMO. The HMO was designed to provide enhanced benefits at a reasonable cost, by limiting the providers who participate in the network, while also adding a level of cost management not used previously (you may recall the “referral mechanism”). Employees appreciated the increased benefits and low copays, but there remained a strong push back against limited provider access. The result of this market pressure was the development of the PPO. It was intended to provide similar benefits and costs, but allow more flexibility in provider access. However, it was not intended to offer participation to every provider in the market; at least not in its original form.

Back to the future. Millions of Americans are uninsured or under insured and the cost of care is rising rapidly as are health insurance premiums. This has prompted many companies to move to a consumer driven health plan model that requires employees to share in more of the cost burden for services; e.g. higher deductibles. Additionally, some companies are considering dropping their benefit programs to stay solvent. As a result we have seen several changes in the market, including the implementation of the Affordable Care Act, as well as a focus on “referenced based” reimbursements like Medicare as an alternative for managing healthcare costs for self-insured employer groups. And now we are back to the purported demise of the PPO.

What I hear in the market when talking with payers, employers and PPOs is something very different. There is a recognition that changes to the PPO market need to be made, but we don’t have to throw the baby out with the bath water. Instead, we may find that by revisiting the original intent of the PPO, we can develop solutions that will help address many of the cost pressures we are now experiencing. PPOs need to focus on controlling the cost of services rather than on the percentage discount off billed charges; since billed charges have steadily increased over the past decade, often without a corresponding change in the contracted discount, many providers have been able to see to a disproportionate increase in their compensation compared to medical inflation.

Coming full circle. We all know the adage; the more things change the more they stay the same. I think that can be applied appropriately to the PPO market. The original intent of the PPO was to drive down medical costs by limiting provider access and creating a synergy between the Plan, the providers and the patients. With the recent changes in the health insurance landscape, it appears we may be seeing a fundamental shift back to this original concept. Listed below are several options that could have a material impact on healthcare costs, while also providing a level of protection to employees and members necessary for maintaining a quality work force.

EPO (Exclusive Provider Organization): For those of us that have been in the industry for a few years (or a lot of years), this is not a new concept. In the 90’s a number of carriers developed this type of smaller, more focused network for those clients that were looking for options to further impact their healthcare costs. The intent was to take the existing PPO network and pare it down so that they could gain deeper discounts from providers by driving more patients to them instead of competing providers. In some cases, the organization took the next logical step by attempting to select providers based on quality and cost effectiveness. These programs essentially fell to the wayside as cost pressures relaxed, and consequently so had the appetite for a limited provider network. However, I am starting to hear rumblings of an “EPO” like product. There is at least one national PPO that is considering the development of a more focused network option. Additionally, this concept appears to be gaining traction again with a number of carriers in terms of the networks they will make available to the participants that purchase coverage through the Exchange, or more recently called, “The Marketplace”. The networks are much smaller; thus, access is significantly limited. However, the savings are expected to be higher than what is available in the networks offered to the private market and employer provided plans. If the carriers feel this approach will work within the Exchanges, it should also be considered for the broader market.
Medicare Plus Contracted Network: If you take the concept of a tighter, more focused network, and build the contracts based on a percentage of Medicare, you potentially have the best of all worlds; a focused network with fees based on a standardized reference based model and protections for the patient. Add to this transparency in pricing and a selection process based on quality indicators and you have the next generation of the PPO. As we all know, the concern with many PPOs today is that the discounts haven’t kept pace with the increases in fees, resulting in the common recognition that a percentage discount means very little. A Medicare based contract helps eliminate the guess work in estimating medical costs, and can positively impact stop-loss premiums. It also has the added bonus of protecting the patient from balance billing and collections.

Hybrid PPO and Medicare Plus: Another option that has recently gained traction is a hybrid solution that combines a traditional PPO for accessing physician and ancillary services with the application of Medicare Plus repricing for facilities. The PPO access enables an employer to offer a contracted physician network for the roughly 80% of the medical bills that will be incurred. These represent the majority of claim activity for most employees. For the other 20% of claims that typically can equate to 70-80% of the total claim dollars, the providers are paid at a more aggressive percentage of Medicare.

There are a couple variations within this model; the repricing entity can contract with a limited number of facilities based on a Medicare plus reimbursement, or they can allow the patient to seek care from any facility, and reimburse the provider based on a Medicare Plus rate. The benefit to the first option is that patients are protected from balance billing.

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billing, but are also limited in the number of providers they can access for care. The second option allows patients to seek care from any facility, but may be subject to balance billing or even collections if the provider is unwilling to accept the Medicare payment or to negotiate a reimbursement. Employers who continue to believe in the value of a high performing workforce are more likely to consider the first rather than the second option.

Utilizing the hybrid method can be an attractive option for employers that have employees throughout a large geographic area, and also want to offer reasonable access to the providers most commonly used. It also enables them to focus on high cost services by limiting payments based on contracted rates or utilizing a referenced based payment mechanism.

**Never play leapfrog with a Unicorn.** Payers and employers need to understand the needs of their employee population, along with the prevailing attitude of the provider market. Attempting to put into place a benefit plan that does not take into consideration both of these elements is extremely risky and could lead to unintended consequences. Clearly, effectively managing medical costs are critical to the ongoing financial health of any Plan, but carefully measure the potential impact on other aspects of the business, including key employee retention. I believe there are several good options being developed around the PPO model that can meet the financial goals of the Plan, while also maintaining the viability of the organization.

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