

Medicare+EvenMoreChoice: U.S. Encourages PPO Option

The government offers financial incentives that include \$100,000 in seed money, risk-sharing deals, and higher payment rates.

By Frank Diamond
Senior Editor

The federal government wants to make it easier for PPOs to participate in Medicare+Choice, but health insurers must hurry if they'd like to take part in demonstration projects slated to get under way next Jan. 1.

The Centers for Medicare and Medicaid Services published a notice calling for PPO participation in M+C in the *Federal Register* on April 15 that includes offers of \$100,000 in seed money as well as waivers from the program's payment guidelines. The agency wants to use a competitive application process to serve beneficiaries better.

"Our objective is to introduce more variety into the Medicare+Choice program so that Medicare

beneficiaries have broader choice and more options available," the notice says. Currently, of the 179 M+C contracts, only two are PPOs.

Applications must be filed by May 30.

"We haven't gotten any feedback from our members to suggest that the time frames will present a barrier," says Susan Pisano, a spokeswoman for the American Association of Health Plans. "However, it is a more realistic opportunity for a company that already has a PPO network in place."

"It is rushing things," admits Alissa Fox, director of policy at the Blue Cross/Blue Shield Association, "but they have a great objective. Their objective is to have it up and running Jan. 1. We're happy about that. It's quick, but we've done a lot of thinking about this."

CMS aims to have the options available to beneficiaries by autumn's open-enrollment period. The

PPOs must show what's at stake

The Centers for Medicare and Medicaid Services says that any insurer that wants to work out a risk-sharing arrangement with the government for a Medicare+Choice PPO needs to describe its proposal in detail. "The applicant should include examples that illustrate the risk-sharing arrangement," the CMS notice in the *Federal Register* says. "The shared risk of gain or loss between CMS and the PPO must be symmetrical, and the PPO will always remain at significant financial risk."

In a white paper it submitted to CMS, the Blue Cross/Blue Shield Association outlined one possible risk-sharing arrangement based on a prospective target that would be equal to total premium minus administrative charges.

Computing medical expense target

CMS monthly M+C payment	\$500
Beneficiary premium	\$50
Total premium	\$550
Negotiated administrative charges	(\$40)
Medical expense target	\$510

What's gained, what's lost under 50/50 shared-risk agreement

	Gain scenario	Loss scenario
Medical expense target	\$510	\$510
Actual medical expenses	\$480	\$530
Plan savings	\$15	
CMS savings	\$15	
Plan loss		\$10
CMS loss		\$10

SOURCE: "BCBSA PROPOSAL FOR PRIVATE PLAN OPTIONS IN MEDICARE: SHARED-RISK PAYMENT ALTERNATIVES," A BLUE CROSS/BLUE SHIELD ASSOCIATION WHITE PAPER

PPO push is slated to take place in 12 geographic areas (yet to be chosen) and is intended to last three years. CMS has not placed a limit on how many plans may participate.

“For each selected demonstration, we will assign a project officer who will serve as the point of contact with the demonstration project staff and who will provide technical consultation regarding waiver requirements, implementation, and monitoring activities, and also provide feedback to us on demonstration status,” the notice says.

Despite looking minuscule relative to the kind of money usually discussed in managed care, the \$100,000 being offered to help launch the PPOs came as a nice surprise, says Fox.

“A lot of these demonstration projects don’t pay for start-up costs,” she says. “We’re real pleased that they’ve put that in there. It’s probably not enough, but it’s great that they put some amount of money in there.”

Welcomed waivers

Participating PPOs will not all have the same level of flexibility, but some of the things that health insurers can get are:

- Payment based on the higher of either M+C or fee-for-service rates;
- Risk-sharing arrangements with CMS (see “PPOs Must Show What’s at Stake” on page 33);
- Not having to submit “adjusted community rate” proposals; and
- Scaled-back requirements regarding the size and composition of physician networks.

CMS makes it clear that it will try hard to reward participation. For example, the agency states that while “we cannot waive quality assurance requirements, our payment-related waiver authority could potentially have the effect of permitting an entity to operate a PPO product under this demonstration without being subject to quality assurance requirements that would otherwise apply.”

For more information: Health plan executives seeking more data about PPO demonstration projects may contact Ron Deacon, a CMS project officer, at (410) 786-6622 or ppodemo@cms.hhs.gov.

CMS has held numerous meetings with industry representatives to find out what needs to be done to encourage PPO participation.

“We’ve identified a number of things that could be changed in order to have PPOs work in Medicare,” says Fox. A Blue Cross/Blue Shield white paper on the subject was one of the documents on which CMS based its *Federal Register* notice.

Despite such industry input, however, health insurers still seem somewhat reluctant to make a commitment.

“We’re studying the proposal and everything that CMS is offering or proposing for introducing a PPO product,” says Mary Sellers, a Humana spokeswoman. “We’re pretty much supportive of providing benefits with the types of options to our Medicare+Choice members as would be available to those who are under 65, but beyond that, I think we’re really still evaluating — and it would be premature for us to say more than that.”

That seems to be the stance taken by many health plans.

“I don’t really have a way to gauge the level of interest right now,” says the AAHP’s Pisano. “What I can tell you is that this community has always been highly supportive of there being available to beneficiaries the kinds of choices that are available to people with employer-sponsored coverage.”

It will cost more

Of course, one of those choices CMS would like to see offered is prescription drug coverage, but that — like other benefits beyond what’s presented in fee-for-service Medicare — will cost more.

“Choice always comes at a price,” notes Thomas Morrow, MD, the medical director at One Health Plan of Georgia. “Most of the PPOs come with a 20-percent copayment. With the HMOs, the full freight’s paid. The entire bill is paid by the HMO except for, typically, a small copayment.”

Still, there seems to be support for the PPO option, because it mirrors what’s taking place in managed care overall, says Morrow.

“We’re seeing that the PPOs are growing faster than the HMOs,” he notes. “PPOs are where the commercial population is growing, because of the choices they offer.”

It remains to be seen how much Medicare beneficiaries will value such choices. **MC**