MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO)
DEMONSTRATION
FACT SHEET

The Centers for Medicare & Medicaid Services (CMS) has implemented a PPO Demonstration that currently offers thirty-five new Medicare Advantage plans (formerly Medicare+Choice (M+C) managed care plans). The demonstration seeks to increase the number and variety of health plan choices available to Medicare beneficiaries and provide beneficiaries with greater opportunities to select a plan that best meets their individual needs. This project tests the impact of enhanced payment and risk sharing arrangements between CMS and the plans on the range of options and benefits available to beneficiaries. The new plans offer beneficiaries a wide variety of supplemental benefits including drug coverage and, most significant, the freedom to use out of network providers for a higher cost-share.

Background

The Medicare + Choice program was introduced as part of the **Balanced Budget Act of 1997 (Pub. L. 105-33). It was intended to increase the range of alternatives to the traditional fee for service program for Medicare beneficiaries. The options anticipated were coordinated care plans, including PPOs and health maintenance organizations (HMOs) (including HMOs with a point-of-service (POS) option), unrestricted private FFS plans, provider-sponsored organizations (PSOs), and medical savings accounts. Unlike traditional HMO products, some of these options allow Medicare beneficiaries who choose to enroll, access to services provided outside the contracted network of providers. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which was enacted on December 8, 2003, establishes the Medicare Advantage (MA) program in Title II. The Medicare Advantage program replaces the M+C program established under Part C of Title XVIII of the Social Security Act, but retains most of the key features of the M+C program.**

Through independent contractors, CMS researched specific health care models in the non-Medicare market, in an attempt to ascertain whether these models might be effective in the Medicare program. This researched indicated that the success of the PPO concept is not being replicated in the Medicare program. Based on the results of this research, CMS decided to design a demonstration initiative to expand options and choices in, at that time, the M+C program, by increasing incentives for M+C organizations to enter the market and offer PPO products.

Legislative Authority

CMS is permitted to conduct the demonstration pursuant to Section 402 of the Social Security Amendment of 1967, which authorizes demonstrations and allows CMS to waive requirements in Title XVIII that relate to reimbursement or payment.

Selection Process

CMS issued the special solicitation for PPO demonstrations in the *Federal Register* on April 15, 2002. Because of the desire to make the new options available to beneficiaries in January 2003, proposals had to be submitted by May 30, 2002. A panel of technical experts reviewed the proposals in accordance with specified evaluation criteria, and made formal recommendations to the Administrator. On August 27, 2001, CMS announced the selection of seventeen organizations to offer PPO products in 23 states.

Demonstration Plans

PPO Demonstration plans were initially offered in January 2003. There are currently 35 PPO Demonstration plans in 22 states for the 2004 contract year. The table below lists the plans offered under this demonstration. Information regarding plan-specific benefits, as well as plan contact information, is available on the CMS Medicare Personal Plan Finder website, located at *www.medicare.gov*.

This demonstration program is modeled after the PPO coverage available in the commercial market. Although all plans were required to offer out of network benefits, few other specific requirements were applied to the benefit design. Differential cost sharing requirements in and out of network were intended to encourage enrollees to use services in a cost effective manner while not providing a disincentive towards seeking appropriate care. As a result, the plans offer a wide variety of options for beneficiaries. All offer a range of out of network benefits although, in some cases, not all Medicare-covered services may be available on an out of network basis.

Referrals are not required for accessing out-of-network care, although in some cases there may be pre-certification requirements. Most plans offer a prescription drug benefit, although the level and type of benefits covered vary. Some plans also offer additional supplemental benefits, for example vision and hearing screenings, disease management, and other services not covered under the traditional Medicare program. Many of the PPO demonstration organizations improved the benefits they offer as a result of increases in Federal payment rates with the enactment of the MMA. Primary benefit changes include reductions in premiums and/or copayments, and enhancements to the drug benefit options.

Risk Sharing

The key feature that distinguishes the PPO products offered under his demonstration from that offered as part of the regular M+C program is the financing/payment provision. One of the risks to managed care organizations in offering a PPO is the potential for increased medical expenses and significant financial losses as a result of high utilization of out of network providers. As an incentive to get such organizations to enter this market, CMS offered participating organizations, under this demonstration, higher payment rates as well as risk-sharing arrangements in contract year 2003. Organizations that offered PPO

products under the demonstration were paid the higher of the traditional M+C capitation rate or 99% of the average fee for service payment amount in each of the counties in which a plan was offered.

In contract year 2004, as a result of enhanced payments to be made available to Medicare Advantage plans under the MMA, all participating PPO Demonstration organizations will be paid the Medicare Advantage rates. All but four of the participating organizations currently have a risk sharing arrangement with CMS. Risk sharing arrangements under this demonstration, where applicable, are specific to each plan offering a PPO product, and are symmetrical, meaning that the risk assumed by CMS is the same for both losses and savings.

The risk sharing arrangement specifies a targeted medical loss ratio, or medical expense target, reflected as a percentage of total plan revenue. The risk sharing arrangement will be reconciled 12 months after the close of the contract year, at which point the actual medical loss ratio will be established. To the extent medical expenses exceed the targeted medical expense by more than a pre-established amount, CMS and the organization will share equally in the losses. Similarly, if the participating organization experiences savings, CMS will share in the savings.

All of the participating organizations that have risk sharing arrangements with CMS as part of their demonstration terms and conditions are at full risk in a 2-5 percent corridor around the medical loss ratio, meaning the first 2-5 percent of any losses or gains in relation to the targeted MLR is assumed by the plan. Beyond the full-risk corridor, both CMS and the plan share risk under various specified arrangements. However, CMS's risk is never more than 80 percent.

Evaluation

Research Triangle Institute, an independent contractor under the direction of CMS's Office of Research, Development & Information, has been selected to conduct a comprehensive evaluation of this demonstration initiative. **The evaluation includes a case study component to examine issues pertaining to the implementation and operational experiences of the PPOs as well as analyses of primary data collected from a beneficiary survey and secondary data. The survey will focus on beneficiary awareness and understanding of the PPO option; reasons for enrollment; experience and overall satisfaction with the plan; and reasons for disenrollment. The secondary data analyses will focus principally on the impact of the demonstration on Medicare program expenditures. The case study report has been completed. RTI plans to field the survey beginning May 2004.**

MEDICARE PREFERED PROVIDER ORGANIZATION DEMONSTRATION
PARTICIPATING PLANS AND SITES

The following plans are available as of January 1, 2004 (35 plans covering 22 states)

PLAN NAME	STATE
Advantage Health Plan, Inc.	**Indiana**
Aetna Health Inc. of Maryland	**Maryland**
Aetna Health Inc. of New Jersey	**New Jersey**
Aetna Health Inc. of Pennsylvania	**Pennsylvania**
Aetna Health Inc. of New York	**New York**
Anthem Health Plans of Kentucky	**Kentucky**
Cariten Insurance Co.	**Tennessee**
Community Insurance Company (Anthem)	**Ohio**
Coventry Life and Health and Life Insurance Co.	**Illinois/Missouri**
Coventry Life and Health and Life Insurance Co.	**Kansas/Missouri**
Coventry Life and Health and Life Insurance Co.	**Ohio/West Virginia**
Group Health Incorporated	**New York**
Health Assurance of Pennsylvania (Coventry)	**Pennsylvania**
Health Net Life Insurance Co.	**Arizona**
Health Net Life Insurance Co.	**Oregon/Washington**
HealthNow New York, Inc.	**New York**
Healthspring, Inc.	**Tennessee**
Horizon HealthCare of NJ, Inc.	**New Jersey**
Humana Insurance Co.	**Florida**
Managed Health Inc.	**New York**
OSF Health Plans, Inc.	**Illinois**
Pacificare of AZ	**Arizona**
Pacificare of NV	**Nevada**
Tenet Choices, Inc.	**Louisiana**
United Health Insurance Co., Inc. (2 different plans for 2 distinct service areas)	**Florida**
United Health Insurance Co., Inc. (2 different plans for 2 distinct service areas)	**Alabama**

MEDICARE PREFERED PROVIDER ORGANIZATION DEMONSTRATION
PARTICIPATING PLANS AND SITES (Continued)

PLAN NAME	STATE
United Health Insurance Co., Inc.	Illinois/Missouri
United Health Insurance Co., Inc.	North Carolina
United Health Insurance Co. of New York	New York
United Health Insurance Co., Inc. (2 different plans for 2 distinct service areas)	Ohio
United Health Insurance Co., Inc.	Rhode Island
UPMC Health Benefits Inc.	Pennsylvania

NOTE: The following products will not be offered as planned: Cariten (Virginia) and Pacificare (California).