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Health, Education and Human Services Division

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The Honorable John H. Chafee
The Honorable Edward M. Kennedy
The Honorable Joseph I. Lieberman
United States Senate

The Honorable Benjamin L. Cardin
The Honorable John D. Dingell
The Honorable Nancy L. Johnson
The Honorable James H. Maloney
The Honorable Charlie Norwood
House of Representatives

Subject: Health Plan Quality Information: Efforts to Report on PPO Plan Performance

Some purchasers and consumers view information about health plan performance as critical in choosing the highest quality health plan for the dollar and in promoting efficiency and responsiveness in providing health care services. The Congress is considering legislation that would make information about the quality of health plans and providers available to the public. To varying degrees, the bills call on health plans to provide information on enrollee satisfaction, quality indicators, clinical outcome measures, and provider network characteristics.

Concerns have been raised, however, that certain plans offering broad access to providers–specifically preferred provider organization (PPO) plans –need not and cannot comply with the information disclosure requirements without being substantially redesigned. Typically, PPO enrollees choose from a wide network of providers (who are paid a set fee for each service rendered) or may go to a provider outside the network but at a higher cost. Some groups contend that meeting performance information requirements would make it difficult for PPOs to continue to offer their members a large choice of providers.[1] In light of

[1]These concerns were presented in an analysis of the Patients Bill of Rights Act of 1998 (H.R. 3605) and the Health Care Quality, Education, Security, and Trust

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these concerns, you asked us to examine (1) large health care purchasers' efforts to collect and disseminate quality performance information about PPO plans and (2) existing requirements for PPOs to demonstrate quality assurance efforts.

To respond to your request, we drew from our work with large public and private purchasers known for their role in health benefits innovation to determine the extent to which PPOs provide information on generally accepted quality measures.[2] We reviewed the information collection and disclosure requirements of bills being considered by the Congress as well as recently enacted federal and state legislation. We also discussed current activities in health plan information disclosure with Blue Cross/Blue Shield health plan and association representatives, large health benefits purchasers, managed care experts, National Committee for Quality Assurance (NCQA) and American Accreditation Healthcare Commission/Utilization Review Accreditation Commission (Commission/URAC) officials, and health services researchers. Through our discussions, we identified one state, Georgia, that has established quality assurance standards for certifying PPO plans. We performed this review in June and July 1998 in accordance with generally accepted government auditing standards.

RESULTS IN BRIEF

Some of the largest health care purchasers in the country–the California Public Employees Retirement System (CalPERS), the federal Medicare program, and the Federal Employees Health Benefits Program (FEHBP)–have collected or plan to collect and disseminate performance data from contracting health plans, including PPOs. Although the information requirements apply to all plans, the entities implementing the requirements recognize that not all performance indicators are appropriate for all types of plans. For example, an indicator measuring the rate at which a PPO provides a specific preventive care service may not be appropriate for a PPO that does not cover that service in its benefits package. Other purchasers have been slower to collect quality-related information from PPOs due to difficulties in collecting clinical and

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(QUEST) Act (S.1712) prepared for the Blue Cross Blue Shield Association by the law offices of Mark S. Joffe, Apr. 29, 1998.

[2]See Health Insurance: Management Strategies Used by Large Employers to Control Costs (GAO/HEHS-97-71, May 6, 1997) and Consumer Health Care Information: Many Quality Commission Disclosure Recommendations Are Not Current Practice (GAO/HEHS-98-137, Apr. 30, 1998).

administrative data needed to ensure complete and accurate assessments. Still other health care purchasers have chosen not to collect PPO data, believing that the broad access afforded consumers by these plans precludes the need for such an effort.

In addition, Georgia and accreditation agencies are now (or will be) requiring PPOs to demonstrate quality assurance activities, including a plan's ability to collect and analyze quality, performance, and satisfaction data. Information on whether a PPO has been certified or accredited is generally made available to the public. Unlike in the case of CalPERS, Medicare, and FEHBP, consumers will learn whether a health plan has met the state or accreditation agency standards, but they would not know how well the plan performs on specific quality-related measures, either on its own or in comparison with other plans. Comparisons of plans on a range of performance indicators are expected to improve over time as more sophisticated measures become available.

BACKGROUND

Managed care has grown rapidly and become a central feature of most employers' health benefits programs.[3] By 1997, managed care plans covered nearly 85 percent of insured employees. PPOs enrolled 34 percent of employees, while health maintenance organizations (HMO)[4] covered 30 percent and point-of-service plans (POS)[5] covered 20 percent of the market. A total of 1,035 PPOs were operating in 1997, covering an estimated 89 million employees. Insurance companies owned more than half–60 percent–of PPO plans. On average, PPO plans contracted with 2,259 primary care physicians, 4,187 specialists, and 113 hospitals. About 92 percent of PPOs paid physicians on the

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[3]Managed care plans control employees' choice of health care provider by directing enrollees to selected physicians and hospitals with which the plan has negotiated payment methods and utilization controls.

[4]In contrast to PPOs, HMOs are generally more tightly controlled. A patient's care, especially referrals to specialists and hospitals, is typically coordinated by a primary care physician. HMOs pay physicians on a fee-for-service basis, use capitation reimbursement, or have a salaried medical staff.

[5]Hybrid plans that incorporate elements of both PPOs and HMOs are often called "point-of-service" (POS) plans because the enrollee chooses whether to use the managed care network providers at each visit rather than when initially enrolling in the plan.

basis of a maximum allowable fee, or fee cap, and 82 percent of PPOs used discounted charges to pay hospitals.

Increasingly, the managed care arrangement is a hybrid of specific types of managed care mechanisms, blurring the distinction between managed care plans. To a provider or an enrollee, the differences between alternative health plans may appear slight. For example, more than two-thirds of HMOs allow members to use non-network providers at an additional cost. Similarly, a PPO may include primary care gatekeepers in their plans. Although many independent practice association (IPA-model) HMOs have some of the same mechanisms used in staff or group HMOs, the relatively large number of physicians that IPA-model HMOs contract with more closely resembles a PPO network.[6]

Some large employers hope to improve the quality and cost-effectiveness of their managed care networks and increase employee satisfaction by collecting and disseminating data on quality. (In addition, employer coalitions have emerged to enhance individual employers' purchasing power and data collection.) Data to assess health care quality can take many forms, including

- clinical outcomes and quality of care indicators, such as cancer survival rates, surgical outcomes and complication rates, and preventive care services;

- accessibility indicators, such as appointment waiting times, choice of provider, or after-hours availability;

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[6]HMOs are of several types. Staff- and group-model HMOs are generally the most tightly controlled managed care plans. With these models, physicians serve HMO enrollees exclusively and are either paid a salary or a fixed amount per enrollee for providing comprehensive health services. A patient's care, especially referrals to specialists and hospitals, is typically coordinated by a primary care physician. A third type of HMO, the IPA model, consists of networks of individual physicians that also serve non-network patients. Typically, IPAs contract with a large number of physicians, and their enrollees represent a small portion of each physician's practice. As a result, IPAs generally have less leverage over physicians' use of services than do staff or group model HMOs. Fee-for-service pay schedules are commonly used to reimburse IPA physicians for their services to members.

- service performance measures, including patient satisfaction with services offered by providers and staff (such as waiting times in the doctor's office) and services from plan administrative staff (such as claims payment and responding to member inquiries); and

- provider qualifications, training, privileges, and interpersonal communication skills.

Data used to demonstrate performance on each indicator vary; sources include administrative data, medical records, and surveys. For example, information on patient satisfaction with providers and staff may require a patient satisfaction survey that is completed and returned by a sample of patients. For data on a quality of care indicator, the plan might obtain data from an administrative database on the number of patients receiving an annual cholesterol screening or winter flu vaccination. A plan that pays providers a fixed amount per member per month and collects no claims or encounter data for each service provided may collect these data using a combination of administrative data and a sample of medical records.

LARGE PURCHASERS ARE COLLECTING PPO PLAN DATA

Several large health care purchasers are collecting or plan to collect and disseminate PPO performance data. CalPERS now collects and reports on quality indicator and member satisfaction information from one of its largest PPOs. In addition, the Balanced Budget Act of 1997 directs the Secretary of Health and Human Services to disseminate information for comparing Medicare+Choice plans.[7] FEHBP is currently working with its health benefits carriers as it prepares to collect and disseminate information on quality, satisfaction, and network characteristics for all of its health plans, including PPOs. Other purchasers have been slower to collect this information, or have chosen not to collect it, citing PPO data collection problems, or because they believe the access available with a PPO is a sufficient proxy for quality.

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[7]The Balanced Budget Act of 1997 outlined the parameters by which Medicare beneficiaries would have more choices of health plan benefit design–called Medicare+Choice plans. These plans can be of the following types of health insurance plans: coordinated care plans–such as an HMO, a provider-sponsored organization, or a PPO; a combination of a medical savings account plan and contributions to an associated medical savings account; or a private fee-for-service plan.

Some Purchasers Currently Require Performance Data on PPOs

CalPERS, one of the largest purchasers of health care coverage in the nation, offers one example of efforts to monitor PPOs' performance.[8] For the 1998 open enrollment season, in addition to the data it requires from its HMOs, CalPERS collected satisfaction data and quality indicators for PERSCare, a PPO that uses the Blue Shield of California's preferred provider network of approximately 47,000 physicians and 300 hospitals.

CalPERS reports standardized measures chosen from the Health Plan Employer Data and Information Set (HEDIS) for assessing health plan performance.[9] CalPERS compares the performance of its HMOs on six preventive services measures: childhood immunizations, cholesterol screening, prenatal care, cervical cancer screening, breast cancer screening, and diabetic eye exams. CalPERS separately rates PERSCare on these HEDIS measures, indicating how the PPO performed relative to the average results of other PPOs nationwide (scoring each measure below average, average, or above average).[10] In addition, CalPERS surveys its members about their satisfaction with their plan and physicians, the accessibility of care, and other measures.

Another example of a large purchaser collecting performance information from its PPOs is Abbott Laboratories, a maker of health care products with 35,000 U.S. employees. Abbott has a standard set of detailed performance measures that it uses with all of its managed care plans. It requires plans to submit information annually on HEDIS indicators, provider credentials, network access, patient satisfaction, provider satisfaction, and other measures of quality performance. According to the firm's benefit manager, PPOs cannot complete some data items requested of HMOs because of differences in the level of medical management or the structure of PPO plans. For example, PPOs

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[8]CalPERS provides health benefits to over one million people.

[9]HEDIS has been developed by a group of health plan representatives and corporate purchasers under the auspices of the NCQA. The current version of the HEDIS measures–HEDIS 3.0/1998–includes 86 reporting and testing measures in eight areas: effectiveness of care, satisfaction with the experience of care, health plan stability, use of services, cost of care, informed health care choices, and health plan descriptive information

[10]For the next open enrollment season, CalPERS is collecting data on eight HEDIS measures from its two largest PPOs.

typically do not offer a comprehensive range of preventive services, so indicators measuring these services would not be appropriate.

The number of PPOs that produce standard quality performance reports is growing. A 1997 survey showed that more than half of the 902 PPO plans that responded supplied reports to clients on quality information, up from about 40 percent the previous year.[11] Most of the PPOs that report on quality were owned by insurance companies, were relatively small (covering fewer than 100,000 individuals), and had some operating history (more than 3 years).

Other Large Purchasers Are Planning to Collect PPO Performance Data

Several other large health care purchasers have plans for collecting and disseminating performance information on PPOs. The Balanced Budget Act requires the Secretary of Health and Human Services to collect and disseminate a variety of health plan benefit and performance information to beneficiaries. Moreover, federal administrators will soon require additional information from all government-sponsored health plans and programs. Some private-sector purchasers are also working on adding PPO performance measures to the information they already provide to employees.

The Balanced Budget Act of 1997 also directs the Secretary of Health and Human Services to disseminate Medicare+Choice plan information to beneficiaries to "promote an active, informed selection among such options." Specifically, the act requires this information to include, among other things and to the extent available, plan quality and performance indicators, including disenrollment rates, enrollee satisfaction, and information on health outcomes. These requirements apply to a broad range of plan types, including HMOs, POS plans, and PPOs.

The Health Care Financing Administration (HCFA) expects to develop a core set of performance measures for reporting by all plans, with the expectation that additional reporting requirements will be developed to reflect a plan's characteristics, such as benefit design or type of delivery system. HCFA has begun requiring reporting of quality measurement data through HEDIS and

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[11]Managed Care Digest Series, 1998: HMO-PPO/Medicare-Medicaid Digest, (Kansas City, Mo.: Hoechst Marion Roussel, forthcoming), p. 66. Preliminary 1997 survey data were obtained from SMG Marketing Group Inc., Chicago, Illinois. Survey respondents did not identify the specific types of quality-related information included in standard reports.

customer satisfaction data using a standardized set of survey instruments called the Consumer Assessments of Health Plans Study.[12]

In February 1998, the President instructed federal health program administrators to bring their health plans and programs (which serve over 85 million people) into compliance with the Consumer Bill of Rights.[13] Specifically, the Consumer Bill of Rights requires that consumers receive information on comparable measures of quality and consumer satisfaction as well as characteristics of provider networks and plan rules for using providers. FEHBP, which currently reports consumer satisfaction survey results, intends to collect and disseminate information on other performance measures for all of its health plan options, including PPOs.[14]

The Pacific Business Group on Health (PBGH) hopes to add PPO quality data to the catalog of performance information on HMOs it provides to employees.[15] A PBGH official we interviewed said that data collection issues remain but that the coalition members want information on PPOs and plan to begin discussing specific measures in the fall. This official said that while the limitations of existing databases will affect which measures the group chooses, PBGH believes it is reasonable to expect health plan (HMO and PPO) data systems to improve over time and for more sophisticated measures to be available in the future.

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[12]Sponsored by the Agency for Health Care Policy and Research, this set of survey instruments was developed by a consortium of Harvard Medial School, RAND, and Research Triangle Institute researchers and involved the participation of health plans, purchasers, and accreditation agencies.

[13]Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Consumer Bill of Rights and Responsibilities, Report to the President of the United States (Washington, D.C.: Nov. 1997).

[14]FEHBP is the largest employer-sponsored health benefit program in the United States, including 350 carriers and covering 9 million individuals.

[15]PBGH is a health care purchasing coalition with 33 member firms, covering approximately 2.5 million people. PBGH member employers collectively spend $3 billion annually on health services for their employees and dependents. PBGH provides extensive information on HMOs, including plan clinical quality, hospital clinical quality, and customer satisfaction.

Other Purchasers Choose Not to Collect PPO Information

Other purchasers have been slower to collect performance information or have chosen not to collect it because of difficulties with the availability and quality of data or because they believe the plan design precludes the need for such an effort. Much of the current performance measurement reporting for PPOs comes from plan administrative (claims) databases, which were designed mainly for reimbursement purposes. PPO plan administrative data can be used to measure some aspects of health plan quality, but they have weaknesses that limit their reliability for reporting on specific indicators. For example, one expert we interviewed said that administrative data are often improperly coded or incomplete. According to one former PPO administrator, patient diagnosis information is rarely accurate because these codes, unlike procedure codes, have no bearing on reimbursement.

Managed care experts told us that some purchasers do not try to collect these data because of concerns about quality and completeness. The number of members with specific conditions or fitting certain categories that are frequently measured, such as people with diabetes, only appear in administrative claims databases when those patients receive service.[16] In addition, health plans may not have access to information on where members get some medical services. For example, patients may have received immunizations at a community health department or school; therefore, the immunizations would not appear on the health plan's records.[17]

Experts we interviewed told us that these sorts of data difficulties are not unique to PPOs. They also affect HMO plans' efforts to demonstrate quality because HMOs often rely on claims-type data to measure utilization and monitor performance. Like PPOs, HMOs may be unable to accurately measure the number of members who should be receiving certain types of services if diagnoses not actively treated are not recorded in the administrative data. In

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[16]When health services researchers discuss this characteristic of PPO administrative data in the context of service performance rate (or measures), they refer to it as a "denominator" problem. That is, the PPO may not have an accurate count of the number of members in the denominator of the rate.

[17]This example describes a situation known as "numerator" problem. That is, even when a PPO knows how many members it has enrolled with a specific characteristic–such as the number of enrollees under age 12–they may not capture all of the services these members receive, even though the members did, in fact, receive the recommended services.

addition, care received outside of the network would not be recorded. Coding errors and differences in coding practices also affect the accuracy and completeness of plan performance data.

Some purchasers are not concerned about holding PPO plans accountable for their performance on quality indicators. Because a PPO's plan design is often more similar to indemnity insurance than an HMO, purchasers do not expect PPOs to be accountable for the health of their enrolled population. Instead, these purchasers view the open access to a wide range of providers as sufficiently ensuring their employees' access to high-quality care. To these purchasers, broad access means that the consumer has the opportunity to obtain necessary services without plan interference, but it is also the consumers' responsibility to seek these services without direction from the plan. Purchasers recognize that employees are likely to judge a plan by their ability to maintain a relationship with a particular physician or by how easily they can obtain referrals to their preferred specialists.

PPOS INCREASINGLY REQUIRED TO DEMONSTRATE QUALITY ASSURANCE EFFORTS

To varying degrees, governments and accreditation agencies are increasingly requiring health plans to be accountable for their performance. The state of Georgia requires all managed care organizations–including PPOs and POS plans–to collect a broad range of information to receive state certification to operate; and accreditation agencies require PPOs to demonstrate their ability to collect various performance information to attain accreditation. Although the general requirements apply to a broad range of plans, Georgia will take into account differences in plan type when implementing the requirements.

Georgia Requires Quality Assurance Information for State Certification

In 1996, Georgia enacted legislation requiring that managed care plans–including PPOs–be certified to conduct business in the state. The law directed the Commissioner of Insurance to establish standards for certification. Beginning in 1998, the Insurance Commissioner required PPOs to demonstrate that they have quality assurance programs in place and that these programs include procedures to

- monitor and resolve complaints,
- monitor provider performance,

- monitor patient satisfaction,
- establish appropriate quality indicators based on current standards of the relevant health care profession,
- meet reasonable thresholds regarding quality indicators,
- credential network providers according to established standards,
- ensure access to network providers by maintaining sufficient numbers of primary care physicians and other types of providers within the managed care entity's service area, and
- detect both underutilization and overutilization of services.

According to a Georgia Insurance Department official, the quality assurance requirements are flexible regarding acceptable quality indicators. Some plans submit HEDIS data to satisfy this requirement; others provide less detailed information. In some cases, private accreditation provides enough evidence to satisfy certain parts of the requirements.

Accreditation Agencies Establish Standards for PPO Quality Assurance

Some health care purchasers recognize private accreditation as evidence of both organizational and clinical quality. The American Accreditation Healthcare Commission/Utilization Review Accreditation Commission (Commission/URAC) began accrediting health networks and health plans (including PPOs) in 1996. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has published draft health network accreditation standards. Both the Commission/URAC and JCAHO standards include measures of clinical quality and customer satisfaction.

The Commission/URAC offers accreditation programs in three areas related to health plans and insurers: health utilization management, health networks, and health care practitioner credentialing.[18] Health plans and insurers may seek accreditation for all or part of their operations. Within the full health network accreditation program, the review covers network management, utilization

[18]The Commission/URAC also offers accreditation programs for workers' compensation utilization management, workers' compensation networks, and credentials verification organizations.

management, quality management, credentialing, and member participation and protection. As of June 1, 1998, 13 health networks had received health network accreditation.[19]

The quality management area of Commission/URAC standards involves a review of a PPO's ability to collect and analyze a variety of quality, performance, and satisfaction data. To receive health network accreditation, a health plan is expected to develop and implement a quality management program that monitors, evaluates, and works to improve the quality of care and of services provided by participating network hospitals and physicians, and other health care providers by using a variety of quality management studies, reviews, and evaluations. These include member surveys, provider surveys, the monitoring and investigation of member complaints about quality of care and of service, access studies, medical record reviews, utilization studies, and other data analysis studies.

Also included in the review of health plan quality management are a series of target analyses that the Commission identifies as activities a network should conduct. The Commission/URAC expects an accredited health network to have 60 percent of these recommended activities in place at the time of accreditation, with the added expectation that a network will be moving toward 100-percent compliance. These activities include provider performance evaluations, statistical studies and evaluations, inpatient and outpatient screens (clinical indicators), treatment outcomes studies, or use of treatment protocols or practice guidelines. The health plan should also develop standards that monitor such aspects of patient care as availability and accessibility of care, patient satisfaction with care, coordination and continuity of care, preventive care, disease management, acute and chronic care, medical record keeping, or high-volume services.

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[19]American Accreditation Health Care Commission/URAC accredited health networks include Anthem Insurance Co. (Mason, Ohio); Blue Cross Blue Shield of Georgia (Atlanta, Georgia); Blue Cross Blue Shield of Louisiana (Baton Rouge); Blue Cross Blue Shield of Maryland (Owings Mills); Blue Cross Blue Shield of Michigan-Custom Care-USA (Southfield); Blue Cross Blue Shield of Oklahoma-Blue Preferred PPO (Tulsa); Consumer Health Network, Inc. (Piscataway, New Jersey); The Emerald Health Network, Inc. (Cleveland, Ohio); Integra Group, Inc. (Cincinnati, Ohio); Medical Mutual of Ohio (Cleveland); Preferred Care-Blue Cross Blue Shield of Alabama (Birmingham); PrefferredOne Management Company (Minneapolis, Minnesota); and Sloans Lake Managed Care (Denver, Colorado).

JCAHO is also developing standards for health network accreditation. Some of these standards are general, such as the proposed requirement that new processes are designed effectively, while others, such as the requirement for continuing measurement of outcome data on prevention, physiological function, functional status, and physical and psychological comfort of members, are much more directive. Like the Commission/URAC, JCAHO believes that health networks will have to "grow into" many of these standards. Accreditation may therefore depend more on progress toward meeting the standards than on actually meeting them.

The Georgia and accreditation agency standards require health plans to demonstrate that they measure and monitor a variety of performance and satisfaction measures. The result of each review, however, is essentially a "pass" or "fail" grade. Unlike in the case of CalPERS, Medicare, and FEHBP, consumers will know that a health plan has passed the state or accreditation agency test but not how well the plans perform either on their own or compared with other plans.

CONCLUSIONS

PPOs have become popular with employers because they allow substantial freedom of choice and access to providers. The available evidence indicates that several large purchasers already collect quality-related information from PPOs, in addition to their other managed care plans, and other purchasers are planning to request PPO performance data. Comparisons of PPO plans on a range of performance indicators will probably become more meaningful as more sophisticated methods of data collection are developed to improve accuracy and reliability of such information.

Please call me at (202) 512-7119 if you or members of your staff have any questions about the information in this letter. Other contributors to this study were Rosamond Katz and Mark Ulanowicz.

Sincerely yours,

Bernice Steinhardt
Director, Health Services Quality
and Public Health Issues

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