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# The Puzzling Popularity Of The PPO

PPOs have overtaken HMOs as the most popular health benefit option among U.S. workers—to the surprise of many analysts.

**by Robert E. Hurley, Bradley C. Strunk, and Justin S. White**

**ABSTRACT:** Surging growth in preferred provider organization (PPO) participation has been fueled by migration away from the undesirable features of health maintenance organizations (HMOs). While employers, consumers, and providers seem to know what it is they do not want from HMOs, the advantages offered by PPO design are not so clear. This is attributable in part to difficulties in determining what a PPO arrangement actually is. But it may also reflect a lack of strong evidence that PPOs control costs, provide active care management, or promote quality improvement.

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Rapid growth in preferred provider organization (PPO) participation in recent years is both impressive and puzzling. More than half of people with private health care benefits, or more than 100 million people, now receive their care through these arrangements, far surpassing enrollment in health maintenance organizations (HMOs).[1] Not only has the PPO become the health benefit design of choice for private employers and consumers, it also has emerged as the "private plan" option most frequently touted by proponents of market-based Medicare reform.[2] What is curious about the strong popularity of the PPO is that its definition is fairly amorphous, and the industry itself appears to characterize itself less by what the PPO is than by what it is not—namely, an HMO. Even less clear is what value, if any, the PPO arrangement yields to its customers.

The widening appeal of the PPO is generally portrayed as a result of the managed care backlash directed against a discredited HMO product.[3] The PPO benefit option is assumed to offer more choice of providers, less restrictive features for consumers, fewer impositions on caregivers, and lower administrative costs to purchasers. Less apparent is that many employers, increasingly concerned about controlling rising costs, are adopting benefit offerings that are more flexible in terms of customized design and less subject to regulatory strictures. For them, the

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virtue of the PPO design is its malleability, as its component parts can be shaped into an infinite set of alternative arrangements including broader or narrower networks, richer or more meager benefits, maximum or minimal medical management, and more or less consumer cost sharing.

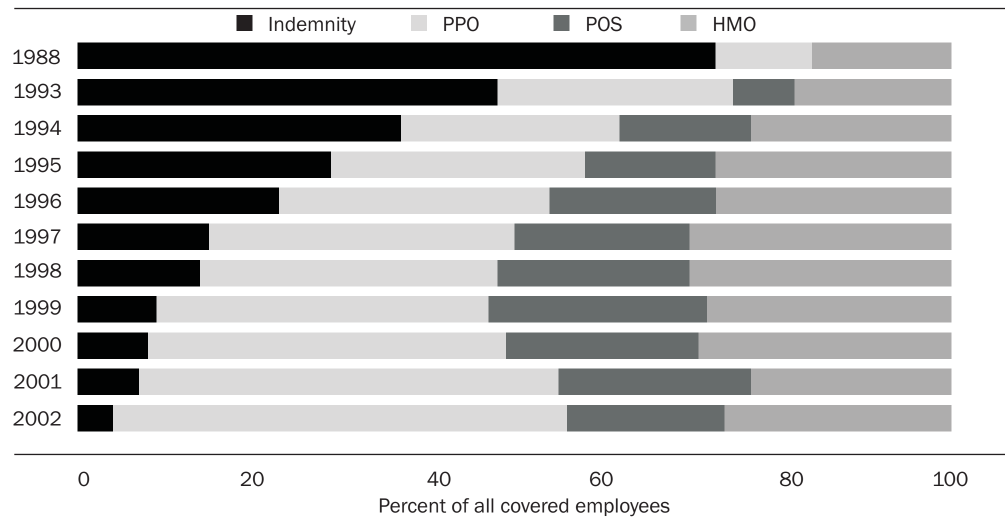
Why PPO participation has grown so rapidly in recent years has not been well documented, and whether PPOs actually control costs, provide active care management, promote quality improvement, and afford a measure of health plan accountability has received little attention. Using findings from the Community Tracking Study (CTS), we report on how the PPO option has evolved in twelve diverse markets and draw conclusions about its growth, appeal, and limitations.

## Background

■ **Surging popularity.** Jon Gabel and colleagues, adopting conventional product definitions, have documented the surging popularity of the PPO in recent years (Exhibit 1), as it has overtaken enrollment in both the traditional HMO and its derivative, the point-of-service (POS) product. From 1998 to 2002, PPO participation increased from 34 percent to 52 percent of all benefit arrangements offered by large employers. Growth accelerated between 2000 and 2002, reaching 112 million participants, according to the American Association of Preferred Provider Organizations (AAPPO).[4]

■ **Unclear distinctions.** Understanding PPO offerings and their role in the

**EXHIBIT 1**
**Enrollment Of U.S. Employees In Various Kinds Of Health Benefit Arrangements, Selected Years 1988–2002**




**SOURCE:** Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employee Health Benefits: 2002 Annual Survey* (Menlo Park, Calif.: Kaiser Family Foundation, September 2002).
**NOTES:** PPO is preferred provider organization. POS is point-of-service plan. HMO is health maintenance organization.

health benefit market has always been challenging and confusing. Even the industry's own trade association, the AAPPO, acknowledges that the PPO's boundaries are far from clear because of the disparate organizations that are classified as PPOs, offer PPO products, or provide component parts of PPO options.[5] Part of the confusion dates back to the start of the industry, when the term preferred provider *organization* first came into use, instead of what today seems a more apt characterization of preferred provider *arrangement*.[6] The confusion increased when observers drew a sharper distinction from indemnity coverage than may have been justified, equating the PPO with a health plan, analogous to the HMO, and presuming that PPOs have "membership" rather than participants with access to a contracted network of providers and incentives to use that network. Even when important distinctions were drawn between health plans and products, this difference was only meaningful when a multiproduct insurance carrier assembled the PPO components into a turnkey product that could be offered alongside or in competition with HMO options.[7]

■ **A definition.** The PPO health benefit option is best understood as a configuration of benefit design features offered through a contracted network (its major distinction from indemnity options) that can be assembled in many different ways. It may be assembled in a fully customized fashion by a self-funded employer or offered by an insurance carrier that develops network-based products that are sold to customers on an insured basis. Many self-insured employers rely on a third-party administrator (TPA) to assemble the package of services needed to launch a PPO offering, including renting access to a preferred provider network, selecting the kind of medical/utilization management to be used with the benefits, and claims processing. (In some instances, the administrator may be an insurance company providing administrative services only, or ASO, instead of bearing any risk.) Insurance carriers engage in similar decision-making steps in product development, although some or all of the components are already in place in their organizations.

The preferred provider network—the essence of the PPO arrangement—comes in many different shapes and sizes and is often misconstrued as the PPO "plan." Networks may be locally based provider-sponsored enterprises formed to contract directly with self-funded employers, TPAs, or insurance carriers. Preferred networks are also developed by entrepreneurs or investors to supply a key benefit-design element for employers and insurers, who pay a rental fee to gain access to the network. Some networks have become nationwide in scope, such as MultiPlan and First Health, either by contracting directly with providers or by stitching together a national network through contracts with existing local and regional provider networks, a feature highly valued by multisite employers. Other networks have been derived from contracted networks already established by multiproduct health benefit firms, such as Blue Cross or Blue Shield plans. In each case, network developers credential providers, negotiate terms and conditions of payments with them, and develop mechanisms to "re-price" (apply negotiated discounts to) claims.

## PPO Trends In The CTS Markets

The CTS has been examining change in twelve representative metropolitan markets since 1996 through intensive biennial site visits. The fourth round of visits was carried out between September 2002 and May 2003. More than 3,000 protocol-driven interviews were conducted with representatives of providers, purchasers, policymakers, and health plans during the four rounds. Health plan respondents in each round included the major health benefit offerers, which in Round Four was broadened to include TPAs in local markets, plus interviews with local and national preferred provider networks. Interview protocols with employers and providers also included questions related to PPO offerings.[8]

■ **Patterns of change.** The four rounds of site visits yielded three broad trends (Exhibit 2). In five markets the PPO is the dominant benefit design and has changed little since 1996. In Greenville, Indianapolis, and Little Rock, challenges from HMO products were easily fended off. In Lansing and Syracuse, market and regulatory factors delayed the transformation of indemnity products to PPO designs, which now are the prevailing offerings.[9] In a second set of markets, new HMO product offerings of the mid- and late 1990s represented a major threat to traditional dominant health benefit offerings that were PPO-based during this time, as illustrated by Cleveland, northern New Jersey, Phoenix, and Seattle. But the threats have now largely vanished, and the PPO is firmly established as the leading benefit option. In a third set of markets—represented by Boston, Miami, and Orange County—HMO products prevail, and PPO offerings are gaining only modest ground.

■ **Rounds One and Two.** Change in trends was most evident between the first two rounds of visits and the later two visits, roughly corresponding to pre- and post-2000. In the mid-1990s even some of the most stable markets where PPO options prevailed saw substantial growth in the number of HMO product offerings. In some markets, such as Syracuse and Indianapolis, community-based HMOs that dated back to the earlier prepaid health plan movement of the 1970s had large membership increases. In other markets, such as Phoenix and Cleveland, HMO promoters were national managed care companies, including CIGNA, Aetna, and United, responding to employers' surging interest in HMO designs. These strategies both stimulated and complemented local provider-promoted initiatives to develop risk-based contracting arrangements to offer HMO products as physician-hospital organizations (PHOs), independent practice associations (IPAs), and integrated delivery systems (IDSs). In still other markets, dominant regional carriers such as Blues plans reacted to competitive pressures from HMOs by adding an HMO or expanding current HMOs, which were typically small and sometimes indifferently marketed.

■ **Rounds Three and Four.** HMO enrollment growth and new market entry had largely ceased by the Round Three visits conducted between summer 2000 and spring 2001. Consumer backlash, intensified regulatory pressures, provider disenchantment with risk, and the unsustainable pricing practices of plans seeking to buy entry into new markets all conspired to produce a rapid reversal of fortune for

**EXHIBIT 2**
**Community Tracking Study (CTS) Markets By Strength Of PPO Benefit Offerings**

| Market classification | Major preferred provider network developers | Type of network developer |
|---|---|---|
| PPO consistently dominant | | |
| Greenville | BC/BS of SC | Health benefit company |
| | CIGNA | Health benefit company |
| | Premier | Provider-owned |
| Indianapolis | Anthem BC/BS of IN | Health benefit company |
| | Sagamore Health Network | Provider-owned |
| | Encore Health Network | Provider-owned |
| Lansing | BC/BS of MI | Health benefit company |
| | PPO of Michigan (subsidiary of BCBS of MI) | Investor-owned (health benefit company) |
| Little Rock | AR BC/BS | Health benefit company |
| | NovaSys Health Network | Provider-owned |
| | AR Managed Care Corporation | Provider-owned |
| Syracuse | Excellus BC/BS | Health benefit company |
| | MVP Health Plan | Health benefit company |
| PPO challenged by HMO | | |
| Cleveland | Medical Mutual of Ohio | Health benefit company |
| | Anthem BC/BS | Health benefit company |
| | Emerald Health Network | Investor-owned |
| Northern New Jersey | Consumer Health Network | Investor-owned |
| | Horizon BC/BS | Health benefit company |
| | Beech Street | Investor-owned |
| Phoenix | BC/BS of AZ | Health benefit company |
| | AZ Foundation for Med. Care | Provider-owned |
| | UnitedHealthcare | Health benefit company |
| Seattle | First Choice Health Network | Provider-owned |
| | Premera Blue Cross | Health benefit company |
| | Regence Blue Shield | Health benefit company |
| HMO dominant | | |
| Boston | BC/BS of MA | Health benefit company |
| | Health Care Value Mgmt. (First Health) | Investor-owned |
| | Private Health Care Systems | Investor-owned |
| Miami | BC/BS of FL | Health benefit company |
| | UnitedHealthcare | Health benefit company |
| Orange County | Blue Cross of CA (WellPoint) | Health benefit company |
| | Blue Shield of CA | Health benefit company |

**SOURCE:** Authors' compilation based on HealthLeaders Research Market Overviews and site interviews.
**NOTES:** Precise preferred provider organization (PPO) participation data are not available on a local-market basis; regional and statewide participation data are more reliable and are used in construction of this exhibit. BC/BS is Blue Cross/Blue Shield. HMO is health maintenance organization.

the HMO product and stimulate a massive migration into PPO arrangements.[10] In markets where the PPO option remained ascendant throughout this period, the main casualties were companies that had invested heavily or exclusively in HMOs, providers who may have participated in ill-fated risk-bearing schemes, and purchasers and consumers who now faced fewer product offerings and higher prices. The main beneficiaries of this trend were those health benefit companies or insurance carriers whose lead benefit offering had been the PPO and the entrepreneurs and provider groups that had developed or sponsored PPO networks.

The surviving HMOs in most markets also made substantial changes in product designs to respond to the multiple pressures brought to bear on them, and, in the process, they have became more "PPO-like." By the time of the Round Three site visits, HMO purveyors typically had broadened their networks, substituted open-access (self-referral) arrangements for primary care gatekeeping, and retooled and relaxed utilization and medical management practices.[11] Further changes were evident in Round Four, as HMO products added expanded cost-sharing features, as permitted by law and regulation, that would allow them to compete with comparable PPO product offerings. Other HMOs began to allow self-insured employers to rent access to their networks and infrastructure for the first time. For some national firms such as United and CIGNA, their core products have become hybrids of HMO and PPO designs to such an extent that the distinction between them has lost most of its meaning, except as it relates to their state-level regulatory status.

■ **The players.** Exhibit 2 identifies the major organizers of PPO networks that employers rely upon for PPO-based health benefit offerings. Blue Cross and Blue Shield plans dominate most markets, with other multiproduct health benefit companies as key players in several markets as well. A few markets have large, independent networks that represent keen competition to the commercial insurers and Blues networks. These networks appear to offer important alternatives for larger, self-insured employers and to regional insurance carriers in markets such as Indianapolis, Phoenix, and Cleveland that are dominated by national carriers or Blues plans.

Network development requires an ability to get contracts with an adequate number of providers and to negotiate discounts that have some credibility with purchasers or their agents. For their PPO offerings, Blue Cross plans use their own highly inclusive networks. Only in rare instances (Phoenix and Greenville, for example) do they rent access to these networks, since to do so would give away a key competitive advantage. Other multiproduct health benefit companies employ two parallel strategies: contracting with individual providers or collections of providers to gain entry into markets, or contracting with existing provider networks previously assembled by local, regional, or national preferred network developers. Locally based networks often have provider sponsorship, typically as an instrument of strategic positioning for a health system seeking to maintain or increase market share by offering modest discounts.

The position of Blues plans is notable in many of the CTS markets in terms of

*"The PPO, as its proponents argue, can be whatever a purchaser wants it to be—if the purchaser is self-insured."*

both market dominance and their distinctive preference for the PPO option. In some markets, such as Indianapolis and Phoenix, plans are so singularly focused on the PPO option that their HMO product is largely a token offering or is retained primarily for national employer accounts that demand availability of an HMO in all markets where they have employees. The Blues are uniquely positioned to offer attractive PPO options because in most local markets they have the broadest provider networks and often enjoy superior discounts, given the negotiating leverage they have accumulated with providers through their broad product portfolios. They also have well-developed infrastructures for the basic functions in PPO offerings and can package these into ASO arrangements for self-funded employers or launch a fully insured product for employers that prefer that alternative. As one senior Blue Cross executive, touting his organization's versatility and adaptability, noted: "We make no value judgments about product preferences."

Some of the large Blues plans, including WellPoint and Anthem, have made major investments in product configurations that can be customized by both employers and individual employees to accommodate prices and benefit preferences. In its Anthem-by-Design set of offerings, the company has adopted an automotive motif in which employers select a basic set of product designs (models) and then choose additional features (accessories) to arrive at the selected product or products to be made available to employees. Flexible PPO arrangements represent the ideal platform for executing these trade-offs, unencumbered by the regulatory restraints that have focused on HMOs.

## Factors Associated With PPOs' Rise To Prominence

Three features contributed to employers' stronger preferences for PPO offerings: capacity for flexibility and customization, advantages relative to the HMO, and suitability for positioning for future benefit trends.

■ **Flexibility and customization.** Employers' current frustration with sharply rising benefit costs evokes memories of a similar frustration in the mid- to late 1980s that breathed life into nascent managed care.[12] Employers rejected limited off-the-shelf product options offered by traditional indemnity insurers and demanded innovation in product design, delivery options, and financing alternatives. Renewed disgruntlement has launched a similar search for new, more flexible arrangements. Likewise, dissatisfaction with the HMO has made it such a pariah that many managed care companies have ceased to offer HMOs in their traditional form.

The PPO, as its proponents argue, can be whatever a purchaser wants it to be—if the purchaser is self-insured.[13] The standard HMO products being sold may have more comprehensive benefits than an employer wishes to offer. In a PPO op-

tion, the component parts can be acquired separately from different vendors and assembled in a highly customized fashion. The benefit design can be built up or bought down from an à la carte menu, and varied combinations of cost-sharing provisions can be selected. The design can afford considerable transparency to consumers, who are advised of what is covered and not covered, which providers are in or out of a network, and what the differential level of coverage will be based on the site of service. For small employers that offer a single benefit design, a PPO option can enable workers to choose a narrow or a broad network, differentiated by coinsurance levels.

Interviews with providers indicate that they have a less adversarial relationship with PPO networks than with HMOs. Providers attribute this to more inclusiveness in network composition, less intrusiveness in medical management, fewer disputes over payment practices, and greater accommodation of providers' preferences for payment methods and amounts. One prestigious health system was particularly dismissive of PPO networks, characterizing them as "nothing more than just a guy with a rate sheet." However, these responses also reveal that most PPO networks, with the exception of Blues-sponsored ones, generally have less leverage (and smaller discounts) with providers than HMOs do because they have weaker steering mechanisms.

■ **Comparative advantage over HMOs.** One of the most striking trends evident in Rounds Three and Four is the diminished price spread on premiums in the CTS markets between fully insured HMO and PPO offerings with comparable benefits. In seven of the twelve markets, HMOs have little or no remaining price advantage. This reflects in part the now-failed strategies of new HMO entrants to underprice products to gain market share, which erroneously implied that the HMO product could be delivered at a substantial price advantage over other offerings. Likewise, the eagerness of some provider organizations to accept substantial financial risk fostered an illusion in other markets that the HMO could be less costly despite its having more comprehensive benefits.[14] Only in Miami, Boston, and Orange County does there seem to be a sizable price advantage for the HMO, owing to either competitive dynamics, culture differences, or some combination. The evaporating price advantage for a more restrictive product, albeit one with richer benefits, has hastened the decline of the HMO. While many companies that offer HMOs have made major modifications to make them more appealing or less unattractive, benefit mandates, consumer-protection impositions, and solvency requirements have limited their adaptability compared with PPOs.

Disenchantment over HMOs' inability to sustain apparent cost savings of a half-decade ago has led many employers to doubt whether HMOs add value commensurate with their higher administrative expenses, narrower networks, and more aggressive medical management techniques. The more modest—some would say even minimalist—practices found in PPOs are more transparent to purchasers and typically cost less than half of what might be paid to an HMO in ad-

ministrative costs. Purchasers can also directly influence how much they pay by adding or deleting features such as utilization review, disease management, or case management that are priced and sold separately. Finally, employers in a number of markets complain that HMOs failed to provide them with sufficiently detailed utilization and cost information to allow them to adequately assess the value of what they are buying—or even to investigate if they should consider switching to other products and vendors.

■ **Positioning for future trends.** As the drumbeat for increased consumer responsibility builds with more cost sharing, increased benefit buy-down opportunities, multi-tier provider networks, and various consumer-driven health plan designs, PPO arrangements seem well positioned to respond to these preferences.[15] The positioning to offer one or more of these options is apparent in every market, as employers grow more restive about what existing product designs can deliver by way of cost containment and interest shifts from supply-side to demand-side interventions. The coinsurance feature of PPO options is especially valued as a means to cultivate price-sensitivity as consumers begin to spend more of their own money for their medical care. PPO networks in several markets also reported recently contracting with purveyors of consumer-driven health products such as Definity Health and Destiny Health.

The public sector also beckons as a possible market for PPO promoters. Medicare instituted a PPO demonstration at the beginning of the Round Four site visits, and demonstration programs were being implemented in Cleveland, Indianapolis, northern New Jersey, Orange County, and Phoenix.[16] Medicare appeared to be trying to capitalize on the surging popularity of the PPO product in the commercial sector by adding a PPO option under Medicare+Choice (M+C), which has suffered numerous defections by participating HMOs in recent years. However, the demonstration was designed to require PPO sponsors to bear some financial risk. This made it unattractive to many PPO network developers, which have panned the initiative. One executive of an independent preferred provider network developer characterized the demonstration as "that PPO program being done by HMOs," citing the experience as an indication that public policymakers have yet to understand how they might be served by PPOs.

## What The PPO Does Not Deliver

A thornier question, beyond why the PPO health benefit option has become so appealing, is whether it really delivers value. The fact that PPOs have grown in popularity at the same time that overall health benefit costs have risen sharply is not a ringing endorsement; nor are the trends reported for PPO premiums different from HMO premium trends.[17] Thus, it does not appear that PPO arrangements have played much of a role in cost containment despite the fact that more than half of all commercially covered lives are in PPOs. What they do seem to deliver is cost displacement by moving costs from employer-sponsors to individuals, which,

*"The PPO's value lies in what it delivers relative to its cost: a contracted network, discounts, and some provider credentialing."*

nonetheless, has the real effect of moderating the rate of increase in employers' contributions for benefits. In addition, the flexible PPO design enables employers to buy down benefits by requiring more cost participation for existing benefits or to lower their premium contributions by shifting more cost to consumers in the form of user fees. Organizations that offer HMO products are doing some of this as well, such as adding or expanding deductibles, but HMOs' malleability is more limited by regulatory constraints.

Even more challenging is trying to determine how authentic and meaningful the discounts are that preferred provider network developers negotiate with providers. We found that most employers using these networks see discounts as partly real and partly illusory. The realness lies in the fact that contracting with a preferred provider network that has negotiated discounts is superior to paying providers full billed charges, which purchasers would have to do unless they negotiated their own discounts. The illusion may be that the meaningfulness of discounts off charges for physician and hospital services disappears quickly, if the network developer can do nothing to limit the charge increases that hospitals can impose by simply raising their overall charges. Recent controversies about the pricing practices of investor-owned hospital chains underscore this point.[18] We also saw no indication in Round Four that preferred provider networks are being spared the consequences of aggressive provider pushback, especially from hospitals. A number of network developers noted that they have had to retreat from case rates to per diem rates and, in some cases, back to percentage-of-charge payments.

Preferred provider networks in general make fewer demands on providers and aspire less to altering clinical practice patterns than HMOs do. In return, networks charge employers lower administrative fees, commensurate with their modest efforts to manage care. In fact, many preferred provider networks have little overall leverage to promote behavior change, such as in the case of drug prescribing practices, and most have eschewed risk-based payment methods or use of incentives or sanctions. A laissez-faire approach has defused providers' resistance to contracting but offers little promise of influencing care delivery or promoting quality improvement.

Some PPO designers stress that their ability to affect care delivery is greatly curtailed because they do not have enrolled populations in the sense that HMOs do.[19] While they collect data on services rendered by network providers, the ability to assemble utilization profiles is impeded because PPO participants are free to use out-of-network providers and no specific physician is responsible for all of their care. This makes systematic reporting of members' experiences and providers' performance problematic. This view is not shared by some of the Blues plans

that have invested heavily in developing PPO options that closely resemble HMO products and that include the ability to produce comparable performance indicators. Thus, it is not surprising that there are within the PPO industry widely divergent views about how much accountability a PPO benefit option should and can realistically accept for improving the quality of care rendered by network providers and received by participating consumers.[20] We found similar ambivalence when we probed the level of interest in accreditation; although some support this movement, others view it as either unnecessary or counterproductive to their business.

## PPOs As A Solution For What Or Whose Problems?

Based on Round Four findings, continued PPO growth is expected in every market. This is even true in HMO-dominated markets, such as Orange County, Boston, and Miami, where sharply rising HMO premiums are closing the gap between HMO and PPO product offerings and where even the most stellar HMO promoters are adding PPO and PPO-like options to their product portfolios. The Blues plans are enjoying dramatic product growth in ten of the twelve markets, as they appear to have the most and best of what the PPO can offer. The product also seems to comport favorably with the role that many Blues plans see for themselves—which is not managing care, but providing employers with the best available array of benefit design options and provider discounts. One benefit consultant suggested that instead of being called "managed care companies," most organizations offering PPO options should be characterized as "discount management firms."

■ **Value to purchasers.** The PPO's value to purchasers lies in what it delivers relative to its cost: a contracted network with some level of discounts off of full charges and some provider credentialing, possibly with some medical management features, typically for an additional fee. This can be as little as $3–$5 per member per month, although broader networks with better discounts like those offered by Blues plans may have much higher fees. But this is still considerably less than the 10–12 percent of premium—$15–$25 based on a typical premium—that HMOs spend for administration. Many purchasers of PPO products contend that they are getting just what they are paying for.

Many employers have no illusions that they are buying managed care in the PPO. They see the PPO arrangement as malleable enough to introduce more cost sharing and benefit reductions into their benefit designs, at the time when buying down benefits—not more care management—is the only effective antidote to sharply rising health insurance costs. It is not quite so clear whether purchasers really think that they are controlling cost growth through preferred provider networks, although they know that they would face higher payment rates if they did not buy a contracted network. One TPA executive noted that "the PPO is retail now. Anyone who isn't in a PPO is paying above retail."

■ **Less accountability.** Preferred provider network developers are not doing much to hold providers more accountable or position themselves to systematically improve care. Many such networks perceive this as being beyond the scope of their responsibility, and some even take comfort in the fact that their limited field of vision in care delivery absolves them of a need for a stronger sense of responsibility. One observer suggested that "asking PPOs to be more responsible for quality of care is like trying to eat soup with a fork." The fact that most purchasers seem untroubled by the limited sense of responsibility suggests how completely faith in the value of managed care has been repudiated since the late 1990s.

■ **Suitability for public programs.** These findings are pertinent to the current debate regarding the suitability of the PPO as a policy option for major public-sector programs such as Medicare. The current demonstration program, as noted earlier, seems to widely miss the mark in terms of attracting the major offerers of PPO options into Medicare participation and more likely is an exit strategy for M+C HMOs looking to salvage something from a dying business. More generally, however, interest in advancing the PPO alternative as a private-plan option (Medicare Advantage plan) to traditional Medicare seems to reflect a lack of understanding of what the PPO is and does. Almost certainly, PPOs cannot get sustainable discounts from physicians or hospitals that approximate rates paid by Medicare, as even the tightest network HMOs rarely approach Medicare's administered prices. In that respect, Medicare is the "mother of all PPOs" because it enjoys superior discounts over virtually all private payers. That the PPO will not be able to achieve the low administrative costs of traditional Medicare is a point conceded even by proponents of PPOs.[21] Finally, care management typically found in PPO options is considerably less extensive than in HMOs and available only for an additional fee.

Much of the appeal of the PPO option lies in its asserted superiority relative to HMOs in terms of choice, limited medical management, accommodation of providers' preferences, and lower administrative expenses. However, the PPO arrangement enjoys none of these advantages relative to traditional Medicare. Moreover, as current trends indicate, much of the recent growth of the PPO is driven by its flexibility to enable employers to shift more costs to consumers and shrink benefit packages, not augment them. Finally, the fact that most PPO networks harbor limited aspirations to manage care, reward provider behavior, and promote aggressive quality improvement for participants makes it far from clear what it is that Medicare hopes to obtain from the PPO product.

The popularity of the PPO is subject to much misunderstanding. The confusion is attributable in part to the diversity of forms in which PPO offerings appear in the market. It is also related to the fact that PPO participation growth resulted from flight from the undesirable features of the HMO and widespread skepticism about the value of managed care, rather than from a migration to the attractive features of the PPO. Seen from a slightly different angle, how-

ever, PPO growth also represents a retreat from the era of benefit expansion of the 1990s because financing these benefits, particularly via provider discounts, has proved unsustainable. In this vein, the PPO option is an instrument for private purchasers to realign what they wish to pay for health benefits with what they believe they can afford to pay. For consumers, the continued "success" in PPO growth almost certainly translates into paying more to try to hold onto what they have.

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## NOTES


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