The PPO Value Proposition: 
A Roundtable Discussion for Plan Sponsors

Introduction

Over the course of the past several years, the value proposition of Preferred Provider Organizations (PPOs) has come under increasing scrutiny. Many have thought that if price can be controlled, health care costs can be controlled or at least mitigated. The truth is that health care costs are an intricate and complex balancing act between price and utilization (here simply defined as the number of units consumed). Attempts to control one have always resulted in equal and opposite reactions in the other. PPOs perform a necessary service for the industry, but their clout seems to be fading and with it, their value proposition has been called into question.

The purpose of this discussion is to review the background and open a dialogue regarding the current PPO value proposition. It has been developed by members of the SIIA Benefits Committee from various points of view to help Plan Sponsors understand the issues and raise awareness of the complexities surrounding “discounts,” pricing, and access fees (whether direct or indirect, per employee per month or contingency). Further, the Benefits Committee makes various recommendations to promote resolution to the issues raised. The paper is not designed to provide final answers; rather its intent is to further the dialogue and spur creative solutions to the ever-increasing costs of healthcare.

The following topics are included for discussion:

- Measuring PPO Value
- Balance Billing
- Discount Comparison Methodologies
- Price Control through Benefit Plan Design
- Out-of-Network Claims
- Specialty Networks and Carve Outs
- Audit of Bills
- Understanding the Pitfalls of Network Access Agreements
- Direct Negotiations
- Conclusion

Measuring PPO Value

There is no generally accepted method to determine the relative effectiveness of PPO “discounts.” The term “discounts” as used in this paper is generically defined as the difference
between what is charged (billed charges) and the amount a provider has agreed to accept for
payors using the network (allowed charges). It is against this amount that the payors apply the
benefit provisions (e.g., coinsurances, etc.) to determine what the benefit plan will pay and what
the participant will pay.

For self-funded plan sponsors, there is often an assumption that the quoted discount is a
measure of the value of the net payment. Discounts, however, have little documented
correlation to allowed charges which equate to plan costs. Stop loss carriers have developed
several methods of taking discounts into account when underwriting a plan’s risk (discussed
below), but these methods vary widely and are often limited by underwriting guidelines that
proscribe variances in the rate-to-manual ratio beyond a certain level. Further, outlier provisions
(provisions whereby discounts are lessened in the event of high dollar or complex cases) have a
significant impact on the stop loss carriers’ liability.

There are several possible methods to mitigate the issues surrounding how to determine the
effectiveness of reported provider network discounts. This section proposes the adoption of an
industry-wide methodology to measure and report to risk takers and participants the net effect
on cost of the wide variety of discounts.

• Current Method. The current method has evolved from the practice of insurers and self-
  funded plans to limit payments to providers to some level of usual, customary, and
  reasonable (UCR) charges. Plan’s generally determined to pay at the 80th or 90th percentile
  of the array of professional charges (MSRP) within a defined geographical region. Large
databases were developed using the data from several large payors to calculate these UCR
charge levels. Unfortunately, no equivalent UCR was developed for hospital-based
services. Further, the current UCR methodology focuses on the providers’ billed charges
rather than the prevailing accepted amount thus inflating the payment. To gain competitive
advantage, insurers began to negotiate with providers that their plan participants could not
be balance billed for charges in excess of the UCR in exchange for being listed among the
insurer’s participating providers. Thus was born the preferred provider network discount.
From there, insurers and other networks began to promise volume to providers in exchange
for a determined discount off of billed charges.

The percentage discount off of billed charges has become the easiest measurement of
pricing that a PPO could provide. Unfortunately, this methodology only compares discounts.
It does nothing to measure whether one provider is more or less costly than another. The
table below provides an illustration:

<table>
<thead>
<tr>
<th>Hospital A</th>
<th>Hospital B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge $15,000</td>
<td>Charge $10,000</td>
</tr>
<tr>
<td>Discount 40%</td>
<td>Discount 20%</td>
</tr>
<tr>
<td>Allowable $9,000</td>
<td>Allowable $8,000</td>
</tr>
</tbody>
</table>

Using the common methodology of comparing discounts, Hospital A’s “value” is twice as
good as Hospital B’s value. But looking at the underlying cost to the plan, even with the
higher level discount, Hospital B is the better value, assuming equivalent quality.

At issue is the lack of any uniform method of determining or comparing a provider’s charges.
The manufacturer’s suggested retail price (MSRP) for providers is generally undisclosed
except at the time of billing. A provider could, if it desired, increase its MSRP just to
advertise a higher level of savings. Beyond the setting of the price for individual providers,
there is little if anything in a network’s contract to prevent the increase of services to offset any decrease in prices.

In evaluating the effectiveness of any given network, it is critical that the risk taker understands the dynamics of discounts vis-à-vis the charges and that some measurement of the utilization component be added. Risk takers are in agreement that it is worth paying more for an individual service if there is evidence that on average, that individual service is performed no more often than accepted practice patterns would indicate.

- **Methods to Mitigate the Problems**: TPAs, plan sponsors, stop loss carriers, and various networks have recognized this problem and have begun to measure the impact on the net cost to the plan. The best way to mitigate the problems with the current method of comparing a network’s effectiveness is to disregard the discount and compare only on the allowed amount. To ensure apples-to-apples comparisons, the term “allowed amount” must be defined. A recommended definition would be: the amount after all discounts or price adjustments but before the application of any plan provisions, whether deductibles, coinsurance, limits, etc.

Still, prices vary widely from one area to another and from one specialty to another. Medicare has taken these regional and specialty-based differences into account in establishing its resource-based relative value scale (RBRVS) pricing, in the use of geographical proactive cost indices (GPCI), and in the use of diagnosis-related groups (DRGs). As a result, Medicare is the only nationally recognized “benchmark” against which all pricing could be compared. For this reason, we recommend that all net costs be presented as a fraction or multiple of Medicare.

The Benefits Committee, therefore, proposes that the industry begin to measure the value of a PPO as it relates to Medicare. Among the issues to be resolved are how to compare per diem or discount off charges reimbursement methodologies with DRGs and RBRVS conversion factors. One method to deal with these issues would be to transform future contracting to align with Medicare processes.

**Balance Billing**

As pointed out, while also negotiating price reductions, the networks have provided a valuable service in preventing the provider’s ability to balance bill the patient. Balance billing refers to the provider’s practice of recouping the monetary difference between the negotiated rate and the allowable amount covered under the plan. Prior to the introduction of the PPO networks, the plans could quantify the benefit payment through the adoption of maximum allowable fee (MAF) schedules or through the use of UCR. The current use of UCR is, however, outmoded at best and highly inflationary. Furthermore, UCR no longer bears any relation to the amounts providers actually accept from other payors for the exact same services. Regardless, the baseline problem with both the MAF and UCR is that neither requires the provider to accept the plan’s payment. Consequently, the providers may pursue the patient for the full amount of the charges less any payments from the patient’s benefit plan.

The question the industry must ask itself is: why would a provider offer a greater discount to one payor over another? The answer is found back in the history of PPO development: the promise of volume (or the threat of steering that volume elsewhere). Because PPOs and the participation in such are extremely widespread, the question can be raised whether any
meaningful steerage is actually achieved? Most providers belong to multiple overlapping PPO networks and most health benefit plans have attempted to obtain the broadest possible geographical coverage in their chosen networks. The current practice of providers belonging to multiple PPO networks nullifies any steerage incentive that a particular PPO network could claim through negotiating favorable price reductions and its ensuing volume. Along with current inflation for the cost of living, retail prices for medical services have also increased, producing deeper negotiated PPO network discounts. Nevertheless, plan sponsors and subscribing payors are paying higher corresponding access fees to PPO networks that promise higher negotiated discounts. Therefore the total actual payment has not truly been reduced and the actual net cost of the claim is seemingly the same amount the provider would have accepted from any other non-subscribing payor.

So back to the question, “why would a provider offer a greater discount to one payor over another?” The answer in today’s world is that there is little reason to do so. Furthermore, with the recent legislative trend of patient advocacy laws, perpetuating disparaging pricing practices would not be very highly recommended for today’s providers. It would be prudent practice for providers to keep prices in range with the standards of the geographical locale that they practice in. In promoting such practices, even the out-of-network providers who, if they have the economic clout, can retain the business even when they can balance bill.

The Benefits Committee proposes that the industry consider ways to eliminate balance billing practices (except for deductibles, coinsurance, co-payments, etc.) for any payment within a reasonable multiple of the prevailing amount accepted as payment in the community as measured as a multiple of the Medicare allowable amount. Among the ways currently being discussed are full and complete communications to and education of plan participants, employers, and providers both in the summary plan description and at the point of payment explaining what the reimbursement level is and why it is considered reasonable.

Discount Comparison Methodologies

While there are many different approaches to evaluating the effectiveness of a PPO network, the discounts that are applied to services can vary greatly. Thus, having a set of governing measures is critical to evaluating a network’s effectiveness.

Rate discounts for plan sponsor stop loss are somewhat reflective of the effectiveness of a network, both on the specific rates and the aggregate factors. Pure savings reports are generally not enough information in setting these discounts.

In a perfect world, the Plan Sponsor, their representative, or the stop loss carrier would have the ability to review and understand:

- Network penetration and breadth
- Actual provider contracts
- Geographic coverage and influences
- Network utilization statistics
- Actual discount statistics to validate contracts

Why are these elements important to the overall comparison of networks? The following is a basic discussion on each of the above points for consideration:
Network penetration and breadth – Plan sponsors want convenient, geographic access as well as choice for their health plan participants. In order to maximize the coverage utilizing a managed care network, it is also important to the risk taker to make sure that the coverage is adequate. This does not mean that all facilities in a location will be in the network. If too many facilities are included, there would not be adequate steerage to drive down the negotiated fee schedule.

Review “Actual” Provider Contracts – Actual contracts between the network and the provider is the most revealing document available while evaluating the actual agreed upon discount. In the absence of provider contracts, a plan sponsor may be provided an average discount report or something similar on an aggregated basis. While not always available, the comparison of the contracted terms to the actual discounts is a critical step in the review process.

It is a common misconception that there is a logical and well-accepted methodology to assign pricing to the treatments, services and supplies that hospitals and other health care providers charge. Medicare’s use of diagnosis-related groups (DRGs), resource based relative value systems (RBRVs) and, more recently, its foray into pricing for outpatient hospital services have provided some means of comparison, but they have not changed the way hospitals develop their charge masters (their pricing schedules). One of the major difficulties in attempting to evaluate one network against another is how to evaluate a discount or how to compare different methods of giving price breaks.

Examples of the types of hospital contracts vary. In many hospital contracts, there is a limit (outlier) in which the discounting methodology may change. Most frequently, after the outlier is reached, the discount reverts to a much lighter discount (e.g. a discount off of the mysterious billed charges) and the lighter discount applies only to charges in excess of the threshold. Typically, thresholds range from 50k to 150k with few higher or lower than this range. Becoming more common and prevalent, is an outlier provision that reverts to a lighter discount and applies to all costs back to dollar 1. The latter type of discount creates the biggest gap in discount levels between small claims and larger catastrophic claims. Outlier provisions that are tiered and those that produce a deeper discount beyond the outlier threshold are far less common, but do occur.

Geographic coverage and influences – Various regions of the country have cost variances including basics such as cost of living, localized provider practice pattern differences, state regulation, etc. An example of provider practice patterns is the high utilization of expensive specialty facilities which causes costs for all care to push up. Specialty hospitals focus on the higher margin services limiting the ability of primary facilities to subsidize across an adequate spectrum of margin generating services. An example of state regulation exists in Maryland where hospital fee schedules are mandated by the state. While discounts may vary by hospital in Maryland, the uniform fee schedule limits variation in the “undisclosed” drivers of cost variation across the state.

Understanding the differences in a network that is very large will explain the acceptable variances in the contracting methodology and therefore apply to the pricing. It should be noted that it is critical to assess networks and geographical cost differences in tandem. Failure to do so would severely limit the usefulness of any analysis aimed at estimating the final cost of claims.
Network Utilization statistics – The stability of network utilization is important in that the contracts could potentially be at risk in the event of significant membership loss. On the contrary, a large membership gain could increase the networks negotiating power with the facility. Actuaries and underwriters use this measurement for these reasons.

Actual Discount Statistics – In a perfect world, the discounts can be validated through a comparison of what actually was paid versus the contracted rate and/or discount. When looking at a very large network or a tightly managed regional network, this comparison can tell us about the volume and size of claims running through the facility as well.

In order of importance, the actual hospital contracts are highly beneficial. This is what drives catastrophic claims savings. On the first dollar side, physician claims discounts can be evaluated by looking across inpatient, outpatient, and general physician claims. The actual discounts seen in the claims data do not often match the published discounts in the contracts. As mentioned above, this is why it can be effective to compare the contracts versus the claims paid.

Although not all of these items are typically available or provided, working with your network to obtain as much information as possible will assist in this regard.

In addition to the comparison of “discounts”, plan sponsors must also take into account the cost of access. The actual net claims cost is not the discounted charge but the discounted charge with any cost of access added back in. Access is generally purchased by plan sponsors either as a per-employee-per-month fee or a percentage of savings. A question that must be answered in evaluating access fees relates to what is reasonable. If a significant discount is obtained, one must question whether the original charge was not inflated. Thus the question must be asked whether it is reasonable to pay a percentage of that inflated discount.

In conclusion, the Benefits Committee recommends that the industry move towards a standardization of information requested from networks in order to compare their effectiveness. Fee transparency and a true comparison of the contracted rates against an industry standard benchmark would be an initial step. Geographic differences and actual discounts obtained in a given facility would also be preferred. Further, the industry must determine the impact of access fees on the net claims cost.

Price Control through Benefit Plan Design

As has been mentioned, employee benefit plans already have the means of limiting costs by limiting the amount they will reimburse – regardless of what it charged. The problem is two-fold: (1) the employee must deal with balance billing from the provider which in turn generates employee relations issues; and (2) competition for labor. The first has been explained above. The second relates to the fact that in a tight labor market, benefits can be the deciding factor in making an employment decision and few plan sponsors want to be the first to implement a change. Beyond pricing controls through maximum allowable fee schedules, employee benefit plans have several other tools that are widely used. The following is a brief list of some of those benefit limits currently in use:

- Limits on treatments and procedures
- Annual and lifetime limits
• Carve outs and specialty networks
• Waiting periods
• Coordination with Medicare

The Benefits Committee recommends that plan sponsors evaluate their plan design in conjunction with labor market requirements to implement appropriate benefit limitations to strengthen price controls.

**Out of Network Claims**

Out of network claims have typically been paid at a reduced benefit level and reimbursed based on a UCR Fee Schedule. Increasingly, however, benefit plans are turning to other mechanisms to limit the price paid for services provided by out of network providers. An entire cottage industry has grown up around the idea of using “secondary” networks to obtain these discounts. This section will discuss “silent PPOs”, “travel PPOs”, and the “stacking of PPOs”.

• **Silent PPO** – Under a program with a silent PPO, there is no steerage, but if a plan participant happens to go to a contracted provider, a discount is taken by the plan. Since there is no steerage, often the presence of the network is not communicated. Such arrangements may be logo-ed (i.e., the logo of the network is printed on the ID card) or non-logo-ed. These arrangements, however, do not comport with the economic premise of a PPO – a discount in exchange for steered volume. Providers are increasingly frustrated at having their promised discounts taken without steerage. Plan sponsors should be wary of these arrangements because they may not meet the terms of the contract between the network and the provider. Plan sponsors can find themselves having to pay the amount of the discount upon audit which usually occurs several months after any stop loss policy period covering that claim to have passed.

• **Travel or Out-of-Area PPO** – Treated as a primary PPO for benefit determination for participants living outside. Ensure contract terms are followed.

• **Secondary PPOs.** This term refers to the practice of payors utilizing PPO contracts to achieve discounts outside of the primary PPO network. A provider contracting with a network for a certain discount generally does so based on an assumption of increased volume the network represents. Delivering the increased volume requires “steerage” within those benefit plans. If a participant receives services outside the primary network, payors have begun the practice of looking to see if they can piggy back on the discounts of other networks. Many providers are surprised that they are giving discounts for out-of-network services. See the description of the silent PPOs for some of the issues that arise. These arrangements should be entered into only with a full understanding of the potential consequences and a review of the network arrangements to ensure the plan sponsor has valid access and is not accessing the discounts contrary to contract terms.

• **Stacking** networks refers to using multiple networks in order to achieve the desired access or improve discounts. Multiple networks may be used when re-pricing out of network claims, with step one being to identify the network that has the particular sought for provider. If the provider is in multiple networks, it is then a question of determining which network has the best discount with the provider in question. Many networks have contractual language that prohibits stacking.
Specialty Networks and Carve-outs

Some of the typical specialty networks we hear about today are Transplant, Neonatal, Cancer and Psychiatric. These specialty networks have been developed to provide a better value proposition to the employee/patient, the plan sponsor, the stop loss carrier, as well as other risk takers. This value proposition centers on the opportunity for enhancing both the quality of outcomes and the cost efficiencies provided by access to and case management by a network that specializes in complicated high risk and high cost, not to mention emotional and traumatic medical events. Contrast the Specialty Network experience against the typical random meandering through a general PPO in search of appropriate information, analysis, choices and treatment.

The specialty networks can stand-alone or be combined with a carve-out specialty program. The specialty carve-out programs are most often offered on a fully insured basis, where besides the benefits outlined below, they also may serve as a defense tool against the need for future lasers or rate increases related to known high cost cases.

When an employee or dependent is suddenly faced with catastrophic health issues, they are often thrown into a world in which they have no familiarity. There is a sudden onset of fear, stress and a need for information. Having a specialty network available gives the patient and their family a focused resource where they can tap into information and appropriate care. They find patient advocacy and the best practice guidance within the specialty network for their very serious health issue.

From a plan sponsor’s point of view, having a specialty network available helps to assure the most appropriate care and education will be delivered, which only helps to enhance the health and productivity of their workforce. In facilitating employees’ access to a network that specializes in transplants for example, they are exposed to the most experienced centers as opposed to a provider center that may not have a dedicated focus on transplants or the volume of experience.

From a risk takers perspective having the increased likelihood of better outcomes for a lower cost is good for all concerned. Specialized networks often have case rates without outliers or limited outliers, which means it coordinates well with stop loss coverage. Also, specialty networks can help reduce the amount of inappropriate care by reducing the occurrences of incorrect diagnosis, as well as incorrect prognoses.

One area that is a particularly difficult to manage regarding out-of-network billed charges is Behavioral Health (mental health and substance abuse) treatment. Psychiatric hospitals have taken the position that there is no UCR regarding their charges. Therefore, a health plan that provides out-of-network benefits without addressing this issue leaves itself open to billed charges well above appropriate amounts, especially when there is a reduced co-pay for out-of-network treatment. The hospital simply increases its billed charges to capture a higher payment (from the plan) than a network facility may receive even though the network facility has the higher co-pay applied to its charges.

To address this situation, the health plan needs to incorporate what is called a Non-Network Fee Schedule (NNFS). This is not UCR but a published schedule that is part of the plan and used to reprice out-of-network charges. The out-of-network co-pay is then applied to this repriced amount. The facility may balance-bill the patient for what is not paid, but the patient is making a choice to use a non-network facility.
The rates established for the NNFS should be based on average contracted rates with network facilities for each level of care. A good rule of thumb for each NNFS rate is the contracted rate (baseline) plus 20 percent. The defense for the NNFS is the contracted rates used as the baseline will establish an UCR themselves. The extra 20 percent added to the baseline rates is to cover any discount that may be “factored in” from network facilities for volume.

In conclusion, plan sponsors, TPAs, and brokers should review their plan costs and PPO networks to determine if existing networks provide access to quality treatment in these areas while providing the savings necessary to control unnecessary expense to the plan. Left unchecked, hospitals will continue to extract excessive payments from health plans for certain conditions not defined and managed under general PPO networks.

Audit of Bills

A Plan Sponsor should never give up his or her rights to validate a medical bill simply because a discount off billed charges is available. The Sponsor may be “buying” an incorrect and overcharged medical bill despite the discount. It may be appropriate to conduct an actual medical record audit of Provider bills which are under a PPO contract. However, before doing so the network access agreement should be reviewed to determine if any contractual prohibitions against doing so or if the contract defines how and when such an audit can be conducted.

Most contracts state that before a bill may be audited, a minimum payment or percentage of expected reimbursement under the contract must be made. In some cases, the contract states that 100% of expected reimbursement must be received prior to initiating an audit. Other provisions may state that the Hospital’s audit policy must then be followed. These are terms and provisions which should be reviewed and considered carefully before acceptance of the PPO agreement. Whenever possible, a Plan should not accept terms which restrict or prohibit an audit from being conducted. The Plan should avoid agreeing on payment up front at 100% of expected reimbursement. Instead, payment should be made on the portion of the bill which is valid and fully supported. The Plan should also avoid acceptance in advance of the Provider’s audit policy, unless he or she has seen it and it is fair. The Plan Sponsor should insist on obtaining a copy.

In additional to a bill audit, a medical record audit may be appropriate. A medical record audit is based on the itemized bill for all services and the complete medical record which supports the services and charges contained in the bill. It is an attempt to validate every charge on the bill with a corresponding “order” for such services by the physician or qualified health service provider. The record should also contain documentation that ordered services were actually rendered to and received by the patient. It is not unusual for the medical record to be incomplete. The audit company will determine how best to resolve missing records with the Provider. If the records are not available or cannot be produced to support the service, the plan sponsor should not be expected to pay for it.

An undercharge may also be discovered. This results from the record containing the order and documentation of the provision of such service, but the corresponding charge does not appear on the bill. A reputable auditor will report both overcharges and undercharges.

Upon completion of the audit, the Provider is given the opportunity to respond to the auditor’s report and resolve any discrepancies and or “appeal” the results. A reasonable period of time...
should be given to this process, usually up to 30 days. It may result in the audit report being
amended or corrected based on the additional documentation received or resolution of disputed
findings. In some cases, the auditor and the Provider’s auditor will not agree. An appeal process
should be followed according to contractual provisions, if any and the state mandated
procedures.

In summary, it is important that the plan sponsor understand the provisions of the Network
Access agreement before conducting an audit. Negotiation of these provisions before entering
into the contract can and should provide for a fair process to validate the medical bill through a
medical record audit. The Provider’s audit policy should be reviewed and negotiated as well, if it
is referred to in the network agreement.

**Summary Recommendations:**

1. Review the PPO agreement carefully for provisions which restrict or prohibit the right to
   review and validate billed charges.
2. Do not give up the right to audit.
3. Protect the right to validate charges on a medical bill with a bill review and, if necessary,
   a complete medical record audit, regardless of the PPO discount.
4. Do not pay on charges which are in question, unsupported or suspect. Evaluate the bill
   prior to payment and then pay timely on the validated portion of the bill under the PPO
   agreement and the discount rate.

**Understanding the Pitfalls of Network Access Agreements**

For a brief overview of language requirements, see the Appendix.

Network access agreements are very complex due to multiple parties being involved not only in
the agreements, but also the administration. It is important for the Plan Sponsor to understand
the underlying nature of the agreements and where and when they may be a party to the
agreement. For the benefit of maximizing the contractual discounts, the SIIA Benefits
Committee recommends that the following topics be explored:

**PPO Network Contracts with Providers.** The PPO Network is formed by a series of contracts
between health care Providers (hospitals, medical systems, physicians and other health care
providers) and the PPO Network entity. All of these contracts can contain different terms and
conditions, including the “contract rates of payment” to the Providers. The primary purpose of
these underlying contracts is for Providers to offer quality, discounted medical services and
products to the PPO Network’s clients and customers in return for the promise of a volume of
patients and a prompt reimbursement to the Providers. In addition, the Providers must agree to
waive reimbursement for any amounts over the contract rates, and collect any co-pays,
coinsurance or deductibles from the patient.

The PPO contracts between the PPO Network and the Providers form the foundation for the
PPO Network Access Agreement (the “Access Agreements”) with Payors. It is not uncommon
for many of the Providers to have different contract terms and requirements in their
PPO/Provider contracts. Generally, the larger the Provider, the more bargaining leverage they
have with the PPO during the contracting process. These Providers sometimes demand and
receive special or “non-standard” terms in their contracts. The Payor’s Access Agreement with
the PPO may or may not specifically address these non-standard terms, or provide a vague
reference to the PPO/Provider contract and incorporate them by reference. From the standpoint of the Payor some of the more objectionable “non-standard terms” might be:

1. Pre-certification determines eligibility and/or medical necessity of the treatment;
2. Notification of objections within 15 days of any challenges to a Provider billing or the objection is waived;
3. Payors required to pay between 85% and 100% of a challenged billed claim, or the PPO discount is lost;
4. Provider bills can not be audited unless paid in full and/or the Provider demands a fee for any Payor who wishes to perform a bill audit;
5. No challenge of duplicate, unbundled or mistaken billings, implicit in the no audit terms of the PPO/Provider Agreement; and
6. The PPO contract rate can not be challenged that it exceeds Usual and Customary (UCR) charges.

Complicating the entire process is the fact that many PPO/Provider contracts do not require a notice of changes in the Provider billing procedures or rates. Even if the Provider gives notice to the PPO, it may not trickle down to the Payor. There is little incentive for the PPO to disclose “medical costs in the PPO Network are rising”. This is particularly problematic where discounts off of billed charges are the basis of the PPO contract rates with the Provider. Providers normally have almost complete control in setting and implementing rate increases for non-governmental programs.

**PPO Network Access Agreements with Payors.** The Payor or Health Plan accesses the PPO network through a PPO Network Access Agreement. This is normally an agreement executed by the Payor (insurer, the individual Health Plan, Plan Fiduciary, or an authorized TPA). If the TPA executes the contract with the PPO, each individual Plan Fiduciary would normally execute a “Joinder Agreement” which obligates the Plan to the PPO Network Access Agreement, a copy of which should be attached to the Joinder Agreement. If the Plan Sponsor or his agent has directly contracted with the PPO, the TPA should be involved in the negotiation process and be provided a copy of the final Network Access Agreement.

Although the PPO strives to have a uniform and consistent PPO Access Agreement, the Agreement may vary in terms depending upon the market power of the Payor. It is not difficult to imagine the large national health carriers, who also have their own proprietary PPO Network, may be able to negotiate a different and more favorable PPO Access Agreement than a Health Plan with 40 employee lives. It would do no harm to ask the PPO for the same PPO Access Agreement that is utilized by the large national carriers.

**Standard Provisions in a Network Access Agreement.** Most PPO Network Access Agreements contain the following similarities and standard provisions:

- **Description of the Relationship and Process.** The PPO Network Agreement preamble and Process sections describe what each party does and what they expect from the Agreement. The Payor agrees to pay access and service fees on a per capita or percentage of savings basis, pay Provider claims timely (usually within 30 days) and incorporate Plan benefit incentives to drive patients to the PPO Network. In return, the Provider will accept discounted fees negotiated by the PPO, waive any balance billing, and accept patients on a non-discriminatory basis.
• **Mutual Rights and Obligations of the Parties.** This is a relatively short list of mutual obligations, with both parties agreeing: to maintain confidentiality of information; to comply with HIPAA; to maintain records and allow audits of each others records; and, to mutually indemnify each other for damages or losses caused by the other party's negligent or intentional acts or omissions.

• **Obligations of the PPO.** Since the PPO usually drafts the PPO Network Access Agreement, the standard PPO obligations to the Payor are few, namely agreeing to: recruit, create and maintain a provider panel and provide a directory; assist the Payor in reconciling Provider issues and problems; and in some cases, provide utilization review (for a separate fee) and re-pricing services; and, permit the use of the PPO logo.

• **Rights and Obligations of the Payor.** The Payor obligations can be a very extensive list; and, although the agreement may refer to the “rights of the Payor” in the title, there are few, if any, specifically set forth in the Agreement. Generally, the Payor is required to: pay the access fees on time, use only the contract rates in paying Provider bills or lose the discounted rate; provide financial incentives in the Plan to drive participants to the PPO Network; agree to not solicit Providers; pay all claims within the specified (30 day) period or lose the discount; adhere to various warranties and representations of solvency, benefit levels that meet or exceed the PPO contracted rates, and re-insurer indemnification; and, finally, adhere to any non-standard terms and conditions.

**Plan Fiduciary Contracting Issues.** Some PPO Network Access Agreements can, at times be problematic due to the fact that the Payor may be considered as a fiduciary of the Health Plan. As stipulated within ERISA, the Payor is required to act in the best interests of the Health Plan and adhere to the provisions of insurance policies and Plan documents of the Health Plan. Most Health Plan Documents and most health insurance policies contain provisions that limit or deny any benefits or claims for: a) medical services that are not medically necessary; b) medical services that are experimental or investigational; and/or c) charges for medical services that are excessive and above UCR. These Plan Documents and policies usually do not provide coverage for mistaken, duplicate, unexplained or unbundled medical charges. Consequently, if the Plan Sponsor or Fiduciary executes a PPO Access Agreement that is contrary to the specific provisions of the Health Plan, or the insurance policy reinsuring the Health Plan, it can create numerous questions, issues and problems. How does the Plan Sponsor exercise his or her fiduciary duty to only pay valid claims according to the Plan Document if there are conflicting, non-standard PPO Access Agreement provisions that do not allow a challenge? The basic recommendation is to not execute PPO Access Agreements that restrict or prohibit reasonable rights of the Health Plan to challenge issues like medical necessity, experimental treatment and unreasonable, mistaken, fraudulent, or excessive medical charges.

**Non-contractual issues.** There are also some PPO Access Agreement issues that may not be directly addressed in the Agreement, involve general contract law, or are uncertain as applied to the circumstances:

• **PPO Access Agreement Breach by the Payor.** There is a potential argument by the Provider (and presumably the PPO), that any breach of the Access Agreement by the Payor can negate the PPO discounts. The next issue is whether the Provider(s) can make a claim for all discounts that were taken by the Payor after the breach of the Agreement. Thus, it would be important to have a provision in the PPO Agreement that provides for written notice of the breach and the right to cure any breach within a
reasonable time. Additionally, the Payor should have the explicit right to choose to ignore or not access the PPO contract rates and choose UCR as to any claimant.

- **Balance Billing by the Provider.** Under the standard Provider documents executed by patients, the Provider can take an assignment of the patient’s insurance policy or health plan benefits, or hold the patient personally liable for any charges not paid by the Health Plan. Even if the PPO Access Agreement does not address claims adjusted downward for UCR, it is possible for the Provider to ignore the “assignment of the insurance or Plan benefits” and sue or make a claim against the patient for any amounts not paid by the Plan. A more aggressive Provider stance would be to simultaneously sue the Health Plan and the patient for unpaid charges.

The difficulty with many of the PPO contract issues is that there may be differences in the laws of the various states, and even in various U.S. District Courts. Many of the issues have not been litigated to provide a clear and certain path for either the Providers or Payors. It is vitally important that the Health Plan Document (including the reinsurance policy behind it) and the Provider Access Agreement are consistent. In addition, it makes sound business sense to review the Provider billing rates and practices, evaluate the true discounts before selecting and executing the PPO Provider Access Agreement, and prohibit “incorporating by reference” the terms of the PPO/Provider agreements and changes thereto. It is helpful to receive notice of Provider/PPO contract rate changes. Most importantly, in order for the Plan Sponsor and Payor to properly exercise their fiduciary duties to the Health Plan, it is critical that the Payor does not agree to non-standard Access Agreement provisions that unreasonably restrict the ability to audit or challenge unjustified, false, inappropriate or inflated Provider billings.

**Direct Negotiations**

If there is one area of health plan expenses plan sponsors feel they have little control over, it’s definitely provider discounting. Networks promise an overall average discount and may even guarantee that discount. Plan sponsors that have a significant presence in a market area may be able to take back some control by directly contracting with providers. Direct contracting is not a new concept. Larger companies have worked on provider negotiations for years.

Is direct contracting a viable solution? Yes, but this solution is definitely not a cookie-cutter fix all. It doesn’t work in all areas in the country and the plan sponsor has to be willing to expend the administrative effort required to negotiate and implement the direct contract.

**Conclusion**

The foregoing topics have been presented to encourage discussion among the various stakeholders in the industry. Price control, while important, cannot be viewed without considering utilization. Nevertheless, the contracts offered through preferred provider organizations have greatly influenced the market. Among their greatest advantages are the elimination of balance billing and the introduction of broad based price negotiations with providers. The Benefits Committee has raised various questions and provided some recommendations to further the debate about the value proposition, the transparency of provider pricing, and the evaluation of a PPO’s effectiveness. Further discussions are necessary to bring closure to the situation. Those discussions must include Plan Sponsors, PPO Networks, Third Party Administrators, Stop Loss Carriers, and Providers. Only by creating a common ground for discussion among these parties can the issues be fully explored and concluded. It has been the purpose of this paper to begin the process of creating that common ground.
Appendix

PPO Contract Language

- Parties to the Agreements:
  - Providers
  - Networks
  - Payors
  - Plans
  - Participants

- Issues to watch for
  - Non-Standard Terms
  - Pre-cert authorization within 24 hours
  - Verification of eligibility
  - Notification of objections within 15 days
  - Pay 85% of billed claim or lose discount
  - No challenge of duplicate, unbundled or mistaken billings
  - Notice of changes in Chargemaster; violations by Provider allows for increase in discounts equal to increase in Chargemaster
  - Right to get medical records; audit should be in SPD
  - Discounts applied to “clean bills” (eliminated unbundled charges, duplicate payments and mistaken billings, etc.)
  - Right to pay UCR if different than PPO discounted billed charges and making the PPO Access Agreement consistent with the Plan Document, the reinsurance policy, and ERISA fiduciary duties of the Plan
  - Balance Billing Issues
  - PPO Discounted Billed Charges exceed Hospital Average Costs by 120 -150% or more;
    PPO Discounted physician or other service provider by 150% or more of RVRBS (CMS/Medicare) charges
  - PPO: identified as the representative of the Payor, not the Provider