Uproar over Silent PPOs

By Mark Rieger

Leased provider networks have taken advantage of growing complexity to indulge in opportunistic practices - including cherry-picking, stacking and silent PPOs.

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THE AMA HAS BEEN USING THE TERM "Silent PPO" for over 10 years and the opportunistic behavior of payors, third party administrators and their agent PPOs has been documented and understood longer than that.

The CMA has been instrumental in enacting legislative reform to curb payor abuse including silent PPO activity.1 The purpose here is to re-familiarize physicians with the issues and create interest in continuing efforts to reform payor behaviors.

The defining characteristic of PPOs compared to HMOs is that choice trumps price. Premiums and patient co-pay amounts are higher than HMO plans, and utilization review practices (such as prior authorization) are minimal to non-existent. The PPOs' primary contribution to cost containment is based on the contracted discounts with its participating physicians.

Patients can choose any provider in the PPO or outside of the PPO, but have a financial incentive to choose the former. In exchange for participation in the PPO, the provider agrees to offer services at a discounted fee-for-service rate.

Today, PPOs of all types enjoy the lion's share (43 percent of covered lives) of all employer-sponsored health insurance plans; HMOs have 30 percent of covered lives.2 The evidence for the last 30 years is that health plan purchasers (i.e., employers) and their covered beneficiaries want broad provider networks. HMOs gained significant market share in the 1990s, but by the end of the millennium that trend not only slowed but began to reverse itself. At the current premium differentials of HMO versus PPO, the market has clearly said choice matters more than price.

Leased PPO networks

Of the roughly 800 group health PPOs (excluding specialty PPOs like dental, vision, podiatry, chiropractic, and mental health) operating in the US in 2002, about half qualify as a "leased PPO network" (LPN).3 LPNs are the focus of this discussion.

The easiest way to differentiate an LPN is that the entity with which the physician holds the contract does not pay for services. Rather, the LPNs' payor clients "lease" access to the provider network and associated discounts. LPNs operate in every state in the nation with over 100 LPNs doing business in California.

A review of agreements executed between physicians and LPNs reveals three contract terms that have led to opportunism by the payors and hence much of the physician dissatisfaction with this industry. The first two are nearly universal and the third is present

only with directed networks.

1. The PPO is not financially responsible to pay the physician and can only make "best efforts" to insure the entity that is responsible pays according to the terms of the LPN's fee agreement with the physician.
2. The PPO can lease the rate with the physician to various entities without prior approval from the physician. These entities include third party administrators, self-insured employers, financial institutions and associations, insurance companies, other PPOs, HMOs, and/or the clients of any of the preceding entities. Collectively these entities are called "payors."
3. In exchange for the discount, the PPO agrees to publish a directory with the physician's name in it and make best efforts to insure that its payor clients create financial incentives for patients to choose an "in-network" physician.

Complexity and opportunism

Over the last 20 years, an industry has developed in which some 2,500 payors are using one or more of some 400 LPNs to access most of the nation's physicians. The average physician will have about 12 LPN agreements, each with somewhere between a dozen and several hundred payor clients.

The explosion in both numbers of LPNs and the numbers of physicians participating in multiple LPNs in the late 1980s and early 1990s quickly led to the evolution of "non-directed" networks.

The hallmark of these networks is the absence of obligations by the payors to actively direct patients to participating providers. Instead, physicians are offered only an opportunity to market their participation in the PPO and the associated discount. In spite of this, these PPOs were no less successful in enrolling physicians.

In fact, a common practice for LPNs wishing to expand into a market is to sign first with the local IPAs, often at above market rates, to quickly establish a presence. Then, over time, they contract the physician or physician groups individually, often at lower rates.

Beginning in the early 90s, certain payor behavior emerged that took advantage of loose contract language in LPN agreements and the difficulty providers have in adequately policing certain payor behaviors.

For a physician to take advantage of current regulations, he or she must keep track of the current controlling entity for the LPN (e.g, the contract may be with Community Care Network, now owned by First Health), the current client list for that LPN (which may not be current when the claim is paid), and the third party administrator (TPA) for each client.

Add to this the fact that the patient's health card may or may not list the PPO used to access the physician's discount, and you create a nearly impossible set of relationships for the physician to manage.

Practice management systems are inadequate to track these relationships; even if they were, the cost of data entry cannot be justified by the potential revenue recovery.

It is the sheer numbers of these entities (payor, TPA and network) in the LPN marketplace, and the means by which they compete with each other, that contributes to the complexity. This complexity eventually results in the physician trying to sort out relationships between the parties and whether they are complying with the agreement that controls how the physician is paid.

Opportunism at its worst

Cherry picking.

One such behavior created when physicians enter into multiple LPN agreements at

different rates is called "cherry picking." The payor seeking to take advantage of the disparate rates contracts with multiple PPOs that have overlapping provider contracts.

If the payor or the agent TPA has control of re-pricing the claim, it can use its database of discount rates to find the PPO with the best rate and apply that rate to that claim.

The rate associated with the PPO listed on the patient's card is not necessarily the one used to reprice the claim. A review of the client lists between the various LPNs with whom the physician is contracted will almost always expose the overlap that leads to this behavior.

Stacking.
LPNs have attempted to create exclusivity with their clients to protect their market share and direct patients to their contracted physicians. However, in the tug-of-war between LPNs and their payor clients, another subterfuge emerged called "stacking."

Here the payer contracts with a primary PPO but fails to honor exclusivity and contracts with several other PPOs in the same market to reduce "out-of-network" claims. The payer loads all PPOs into its computer, effectively eliminating out-of-network providers. This waters down the physician's *quid pro quo* with the LPN to direct patients in exchange for a discount. The physician is especially disadvantaged both in detecting the practice and leveraging the LPN to police the behavior of its clients.

Silent PPO.
For these purposes, "Silent PPO" is a situation where, without the knowledge of its contracted physicians, an LPN leases to a client - giving the third party the advantage of the discount the health plan has negotiated with the physician.

A distinguishing characteristic is that the LPN's client is relieved of certain obligations to the physician contained in the LPNs agreement with the provider. The broad definition of "payor" in LPN contracts and the evolution of "non-directed" networks created ample opportunity for this behavior to become commonplace.

One of the most common forms of Silent PPO activity is an indemnity plan (such as a medical benefit rider on an auto insurance policy) that leases discounts through LPNs. These payors do not issue "preferred provider" directories and make no effort to "steer" patients to a particular physician. In essence, the discount is taken simply because access to it is easily obtained from the LPN eager to receive a shared savings fee.

Getting on the right side of the issue

To reverse this pervasive and insidious problem, physicians must leverage the single most important item they bring to the table: the discount. Physicians must make access to the discount contingent on certain terms and conditions. Failure to comply with these should unambiguously cause forfeiture of the discount.

Regulatory reform should focus on business practices in the LPN industry, especially extra contractual discount practices and payment behavior.

Specifically, the ability to connect the LPN, the payor, the discount rate, and the PPO listed on the patient's card for any paid claim should be fully transparent. The physician should be able to easily "connect the dots," so to speak, at the time of payment. The penalties for non-compliance must be a serious deterrent. The simple fact today is that for the average physician, the cost of audit and appeal exceeds the revenue recovery.

In general, market-based reform will always be more efficient and, in the end, more satisfactory to all the parties. Physicians know they must offer a competitive rate to the market to have access to patients.

Beyond that, they want evidence that the payor has a right to the discount along with

accurate and timely payment. The need to limit panel size is secondary to these payment practices.

The market is wide open to a solution in which access costs for payors can be reduced and physicians can regain some control over the terms and conditions of their discount. If physicians want to take the lead in this, they must get comfortable with how to offer the market a competitive price for services.

Things like the HIPAA claim and remittance file formats, newer low-cost re-pricing technology, and creating an electronic marketing portal for payors and consumers, can be combined to make this more realistic today than was ever possible.

The effect would be to drive payors seeking discounts into legitimate access agreements and, most importantly, restore honesty and integrity to the LPN industry.

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1. See Business & Professions Code §511.3; Health & Safety Code §1375.7, Insurance Code §10178.4, and Labor Code §4610.
2. American Association of PPO's (AAPPO), Rise to Prominence, The PPO Story, pg 47.
3. Aventis, Managed Care Digest Series, 2003.

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