

SILENT PREFERRED PROVIDER ORGANIZATIONS WHAT IS ALL THE NOISE ABOUT?

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In recent years, the term, "silent preferred provider organization ("PPO")" has become commonplace in the healthcare and employee benefits marketplace. Its connotations are negative, due in large part to the position taken by the American Medical Association and its related public relations, regulatory and legislative activities.

Initially, the term "silent PPO" was merely a reference to a non-directed PPO where the contract was "silent" with regard to steering of patients to a particular medical provider. More recently, the term has acquired a more restrictive meaning synonymous with unethical, improper and/or illegal practices. "Silent PPOs are arrangements under which a traditional fee-for-service insurance plan contracts with a PPO . . . to gain access to discounts the PPO has negotiated with a provider. When a consumer insured by the traditional plan goes to the provider, the plan pays the provider the discounted rate the provider had agreed to accept from the PPO in return for preferred access to the PPOs consumers. The consumer, however, being unaware of the silent arrangement, is not offered an incentive to go to that particular provider. Thus, the provider is paid a discounted rate for its services without receiving the preferred access it had expected in return. Silent PPO arrangements are permitted under some PPO contracts, but in other cases are fraudulently perpetrated in violation of contract terms."¹

Perceived Harm

The American Medical Association ("AMA") and American Hospital Association ("AHA") have both argued that silent PPO's are tantamount to fraudulent billing schemes providing illegal discounts to payors and resulting in medical providers losing revenue to which they are entitled. In addition, the AMA and AHA argue that there are possible adverse financial ramifications for the patient/members.

Case Law

HCA Health Services of Georgia, Inc. v. Employers Health Insurance Co.

To date, there are very few cases that have expressly addressed the issue of silent PPOs and whether such arrangements are permissible under applicable state and/or federal law. Currently, the leading case on the subject is *HCA Health Services of Georgia, Inc. v. Employers Health Insurance Co.*, 240 F.3d 982 (11th Cir. 2001). In that case, the U.S. Court of Appeals for the Eleventh Circuit held that a silent PPO agreement violated the Employee Retirement Income Security Act ("ERISA") because the silent PPO deprived beneficiaries of their rightful expectations of higher payments to out-of-network providers.

The *Employers Health* case was an ERISA case involving the denial of benefits under a group policy.² The surgical center (HCA) as the assignee, billed the insurance company its usual and customary fee for the surgery, but the insurance company claimed, that by virtue of a series of contracts, it was entitled to discount the bill.³ The series of contracts upon which Employers Health Insurance Company ("Employers Health") relied included the surgical center's promise to a third party that it would charge a discounted fee upon rendering specified medical services; the third party, in turn, "leased" the right to the discounted fee to a fourth party; then, without the knowledge of the patient and the surgical center, the fourth party "leased" the right to the discount arrangement to Employers Health.⁴ When the surgical center demanded payment of its full, billed charges, Employers Health refused.⁵ The surgical center eventually brought a lawsuit for recovery of benefits due to it as the assignee of the plan benefits. The trial court entered a ruling in favor of HCA.

Employer's Health appealed the trial court's decision. In reviewing the relevant employee benefit plan documents and related contracts, the court found that Employers Health had misinterpreted the meaning of "expense" in its contract with the patient (the employee benefit plan).⁶ The court rejected Employers Health's assertion that the surgical center's promise to discount its fees traveled through several contracts to modify the term "expense" in the contract between Employers Health and the patient's employer.⁷

Using a series of hypothetical scenarios, the court reasoned that Employer Health's interpretation of the plan deprived participants of their contractual expectation, which was to receive a higher level of medical service from providers outside the network.⁸ The court's hypothetical scenarios all suggest that "the level of service participants receive is directly related to this reduction in fees."⁹ Stated another way, patients who paid a higher premium for the freedom of seeking medical care outside the network were not receiving the benefit of that higher premium. Ultimately, the court held that Employer's Health interpretation of the plan was arbitrary and capricious. As a result, the court affirmed the district court's original judgment and ordered Employers Health to pay the surgical center's claim without regard to the discount arrangement.¹⁰

Regulatory Action

Lobbying Efforts at the National Level

The AMA and AHA have vocally called for and supported legislation that would furnish providers adequate disclosure of network discounts and the concomitant ability to opt out of the sale or lease of such network discounts. Dr. James Rohack, then Chair of the AMA's Board of Trustees testified before the National Association of Insurance Commissioners ("NAIC") in June 2005 about "The Need for Fairness and Transparency in Health Care Contracting and Payment." Dr. Rohack provided the same testimony to the National Conference of Insurance Legislators ("NCOIL") in July 2005. In his presentation to the NAIC, Dr. Rohack charged that health plan payors "systematic effort to obfuscate payment makes it extremely difficult for physicians to dispute the amounts they are paid." To that end, the AMA requested the assistance from the NAIC and NCOIL in regulating the healthcare claims marketplace in connection with these issues.

The Proposed Model Act Concerning Regulation of the Secondary Market in Physician Discounts

In response to a variety of complaints and related dialogue, the NCOIL Health, Long-Term Care, and Health Retirement Issues Committee is set to consider the *Proposed Model Act Concerning Regulation of the Secondary Market in Physician Discounts* in late 2006/early 2007.¹¹ The proposed legislation would require separate amendments to network contracts and a related requirement that payors give providers 90 days to consider those amendments any time the payer seeks eligibility to claim a discounted rate, either directly or indirectly.¹² It would also give the provider the right "to affirmatively opt in and/or opt out of any agreements to lease, sell, transfer . . . discounts without penalty, sanction, or retaliation of any kind."¹³ Contracts between plans and providers would include provisions obligating the payers not to further "disclose, lease, sell, transfer, aggregate, assign or convey the physician panel and associated discounts to any other payor or entity."¹⁴ Network members would receive subscriber identification cards which would clearly and accurately identify any third-party entity, responsible for paying claims and any third-party entity, or which affects reimbursement for claims filed pursuant to the subscriber contract.¹⁵ Under the Proposed Model Act, there are several requirements that also apply to contracting agents.

The penalties set forth in the Proposed Model Act include a fine of \$1,000 per violation and a restitution remedy.¹⁶

State Action In Connection with Silent PPOs

State legislative and/or regulatory activity in connection with silent PPOs has only recently begun to foment. There are a handful of states that have already adopted aggressive silent PPO legislation and another handful with legislation in process. It is likely that the lists contained in this article will almost immediately be outdated given the legislative and regulatory momentum surrounding silent PPOs. Nevertheless, they provide a relevant backdrop about the legislative momentum and serve as a guidepost about how other states may handle the issues if presented.

California

In 2000, the California legislature took action to "prevent the improper selling, leasing, or transferring of a health care provider's contract."¹⁷ In California, every arrangement that results in a payor compensating a health care provider at a reduced rate for health care services based on the health care provider's participation in a network must be disclosed to the provider in advance. Also, the payor shall actively encourage beneficiaries to use the network, unless the health care provider expressly agrees to provide discounts without active encouragement.¹⁸

Under California law, payors¹⁹ must provide an explanation of benefits that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.²⁰ A payor must also demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor, or risk paying the undiscounted amount in 10 days.²¹

There are also provisions pertaining to contracting agents. Every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, must disclose whether the list of contracted providers can be sold, leased, transferred, or conveyed to other payors or other contracting agents.²² The contracting agent must also disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate.²³ Contracting agents must disclose a payor summary of all payors currently eligible to claim a provider's contracted rate and allow providers to decline to be included in a list of contract providers that is sold, leased or otherwise transferred to those payors that do not actively encourage beneficiaries to use contracted providers (also referred to as "steerage").²⁴

Kentucky, Louisiana, Minnesota, North Carolina, Oklahoma and Texas

Kentucky requires the disclosure of discounted fees in KRS §304.17A-728. In Kentucky it is an unfair claims settlement practice to fail to identify the products and markets applicable to any discount in the contract provisions.²⁵ It is also an unfair claims settlement practice to pay the provider a discounted fee without the provider's written consent.²⁶

The Louisiana Public Health and Safety Code requires that "a preferred provider organization's alternative rates of payment shall not be enforceable or binding upon any provider unless such organization is clearly identified on the benefit identification card issued by the group purchaser."²⁷ The Louisiana statute continues with a list of how to determine which is the applicable contractual agreement when more than one preferred provider organization is shown on the benefit card.²⁸

Minnesota refers to silent PPO's as "network shadow contracting."²⁹ Under Minnesota law, absent the provider's affirmative consent, a health plan may not require providers to participate in a network that differs from their existing contract or results in a different "underlying financial reimbursement methodology."³⁰ This provision is not waivable.³¹ The statute also sets forth the procedure for obtaining consent. Plans may modify the category of coverage, health plan or product resulting in changes to financial reimbursement only with prior written notice to the provider.³² The notice must include information that identifies the company's name and the specific network; include a description of the proposal, names of all payors the plan expects will use the new category, plan or product; provide the approximate number of enrollees in the changed category; disclose all contract terms including the discount, care guidelines, utilization review criteria, and the processes for prior authorization and dispute resolution; and include a form for the provider's convenience in responding.³³

In North Carolina, the use of a silent PPO is considered an unfair trade practice. "It is an unfair trade practice for any insurer or service corporation . . . to make an intentional misrepresentation to a health care provider to the effect that the insurer or service corporation is entitled to a certain preferred provider or other discount off the fees charged . . . by the health care provider, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the provider on those fees."³⁴ Oklahoma law now also includes a section on improperly discounted fees in its Health Care Fraud Prevention Act.

Oklahoma law, Title 36 § 1219.3, requires that, before an insurer or third party administrator discounts fees for covered services, it must contract with either the provider or a PPO that has contracted with the provider.³⁵ The provider must agree to provide services under the terms of the contract.³⁶ Parties to a preferred provider contract are prohibited from selling, leasing or otherwise transferring information about the payment without the "express authority and *prior* adequate notification" of the other parties.³⁷

In Texas, parties to the PPO contract, "may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other

contracting parties.”³⁸ Third party administrators (“TPAs”) who violate §1301.056 are guilty of an unfair claims settlement practice.

Proposed State Action In Connection with Silent PPOs

The states of Pennsylvania, Indiana and Tennessee also currently have legislation or regulatory activity in process to address the perceived issues surrounding silent PPOs.

PPO Audit Firms

As with most trends in the healthcare and employee benefits marketplace, a commercial response has already begun to surface. In addition to the regulatory and legislative activity concerning silent PPOs, there has also been considerable activity in the marketplace by silent PPO audit firms. Essentially, these are entities or individuals that contact medical providers and offer to audit prior claim adjudications to determine whether payors may have improperly taken silent PPO discounts. While the business model of each firm differs, it is our understanding that silent PPO audit firms frequently contact hospitals and indicate that they will audit prior claim payments without charge to the hospital.³⁹ The silent PPO audit firm then audits the claim payments, identifies those claims that may have been subject to an improper discount and pursues recovery of those amounts from the payor(s). The silent PPO firm then retains a percentage of the recovered amount as its fee. The concept is similar to personal injury settlements where lawyers are not paid unless a recovery is obtained for the consumer.

Conclusion

The employee benefits and healthcare marketplace is responding to silent PPOs in a legislative and regulatory format. A number of states have already adopted legislation prohibiting or limiting the use of silent PPOs. Many more states are likely to consider such legislation, particularly once a model law is adopted by NCOIL. Employee benefit plans, insurance companies and health maintenance organization must be necessarily vigilant in the establishment and operation of preferred provider networks and related discounts in light of this recent regulatory/legislative activity. It is likely that state departments of insurance would monitor compliance with such laws via consumer complaint processes and market conduct examinations for insurance companies and health maintenance organizations. For employee benefit plans, it is expected that the U.S. Department of Labor and the federal court system (through beneficiary litigation), would monitor compliance with silent PPO laws.

Regardless of the method in which compliance is monitored, it is clear that insurers and employee benefit plans must be significantly more vigilant in the establishment and operation of PPO networks. All PPO network contracts must be carefully reviewed and modified as necessary to comply with legislative and regulatory changes that are sure to continue.

Endnotes

¹ Sharon L. Davies and Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?* Winter 1997 GA. L. REV. 391-92.

² 269 F.3d at 985.

³ 269 F.3d at 985.

⁴ 269 F.3d at 985.

⁵ 269 F.3d at 985.

⁶ 269 F.3d at 995-96.

⁷ 269 F.3d at 999.

⁸ 269 F.3d at 1006-07.

⁹ 269 F.3d at 1008.

¹⁰ 269 F.3d at 986 and 1009.

¹¹ The treatment of the Proposed Model Act in this article is not exhaustive. A copy of the full Proposed Model Act can be retrieved from NCOIL.

¹² Proposed Model Legislation § 4(b)(2).

¹³ Proposed Model Act § 4(b)(4).

¹⁴ Proposed Model Act § 4(b)(7).

- ¹⁵ Proposed Model Act § 4(l).
- ¹⁶ Proposed Model Act § 4(p).
- ¹⁷ California Insurance Code § 10178.3(a).
- ¹⁸ California Insurance Code § 10178.3(a).
- ¹⁹ "Payor" in this instance means only an insurer licensed in California to provide disability insurance that covers hospital, medical, or surgical benefits, or automobile insurance, if that insurer is responsible to pay for health care services provided to beneficiaries.
- ²⁰ California Insurance Code § 10178.3(c)(1).
- ²¹ California Insurance Code § 10178.3(c)(2).
- ²² California Insurance Code § 10178.3(b) (1).
- ²³ California Insurance Code § 10178.3(b) (2).
- ²⁴ California Insurance Code § 10178.3(b) (4) and (5).
- ²⁵ KRS § 304.17A-728 (1) and (3).
- ²⁶ KRS § 304.17A-728 (2) and (3).
- ²⁷ La RS § 40:2203.1(B).
- ²⁸ La. RS § 40:2203.1(B).
- ²⁹ Minnesota Statutes § 620.74.
- ³⁰ Minn. Stat. § 62Q.74(2)(a) and (b).
- ³¹ Minn. Stat. § 62Q.74(2)(c).
- ³² Minn. Stat. § 62Q.74(3)(a).
- ³³ Minn. Stat. § 62Q.74(3)(a).
- ³⁴ NC Insurance Code § 58-63-70(a).
- ³⁵ 36 O.S.C. § 1219.3(A)(1).
- ³⁶ 36 O.S.C. §1219.3(A)(2) and (3).
- ³⁷ 36 O.S.C. § 1219.3 (B).
- ³⁸ Texas Insurance Code § 1301.056(b).
- ³⁹ It is our understanding that silent PPO audit firms have focused their attention on hospitals and hospital claims to date. However, it makes sense that large physician claims would also be subject to audit and recovery.