



Is There a Place for Preferred Provider Organization (“PPO”) Networks In Today’s Health Benefits Marketplace?

by Ron E. Peck, Esq., Shauna Mackey, Esq., The Phia Group

Modern employee benefit plans are exploring alternatives to Preferred Provider Organizations (“PPOs”). To understand why, we must understand the history of PPOs. Only by identifying the value once created by PPOs can we subsequently identify when and why this money-saving resource for benefit plans has apparently ceased to be so. We must then explore the alternatives with an open mind, understanding that alternatives – while resulting in cost savings for the benefit plan – are not cost free. Indeed, the cost may be more than some benefit plan sponsors are willing to bear.

A Brief History of PPOs

PPO’s were originally developed so that select providers of healthcare services (“providers”) could offer services at discounted rates to benefit plans in exchange for steerage. Early PPO networks were effective because the discounts were significant and were applied to charges generally deemed to be usual, customary, reasonable, and appropriate; (fair market pricing). Providers were willing to offer these real savings in exchange for in-network status, which at the time was truly exclusive. In other words, it was worth a lot to be “preferred” and providers took it on the chin (on a claim by claim basis)

in order to achieve in-network steerage. Volume more than compensated for a per-claim loss on profitability.

Over time, as the networks expanded, exclusivity of in-network status became significantly lessened. This loss of exclusivity resulted in less value attached to in-network status for providers, a subsequent loss in network negotiation power, and resultant diminished discounts applied to resultant higher prices.

What’s in a Name?

Some individuals have suggested that the solution to this issue resides in the use of EPOs (Exclusive Provider Organizations) in lieu of PPOs. Please

note, however, that EPOs and PPOs may suffer from the same weakness.

PPOs consist of a network of “preferred” providers. PPO plan participants who visit an in-network provider will enjoy lower deductibles, and will not worry about balance billing (payment of billed amounts in excess of plan payments). PPO participants are incentivized to visit in-network providers, but they may choose to visit an out-of-network provider. If they do so, their benefit plan will pay a usual and customary rate to the participant or to the provider (if benefits were assigned via an assignment of benefits). The participant will then be balance billed for the difference between the charged amount and the paid amount. Participants are thus incentivized to utilize in-network providers, since – by so doing – they avoid balance billing, and frequently enjoy lower deductibles.

With an EPO, however, participants must visit exclusive, in-network providers, or the benefit plan will not provide coverage at all. Some EPOs may offer some partial-payment to the patient when the patient visits an out of out-of-network provider, (particularly when treatment occurs due to an emergency situation) but in general, benefits are much more limited (or non-existent) when an EPO participant visits an out-of-network provider; (when compared to a PPO). Thus, EPOs incentivize participants to remain in-network better than PPOs. If the EPO gets too large, however, such that in-network status is not exclusive and no steerage results for participating providers, even an EPO will suffer from the same inflated rates and lack of negotiation power described above.

EPOs and PPOs... In either case, payors need to limit the size of their network, and offer the provider real value in exchange for real discounts off of fair rates. Otherwise, the same doomsday scenario described below will be set into motion.

The Status Quo

If PPOs no longer offer substantial discounts on fair market prices, why do benefit plans continue to utilize PPOs? The answer is simply that discounts are not the only reason to use a PPO. Currently, many benefit plans, including The Phia Group’s own benefit plan, utilize a PPO for reasons other than a reduced cost of care.

While PPOs may no longer be as valuable as they once were, and they are certainly not the solution for skyrocketing costs of care, they do represent peace and harmony for the plan and plan member. PPO agreements represent pre-negotiated terms (allowing users to avoid case by case disputes), and usually include a contractual prohibition on “balance billing” (providers contractually agree not to charge patients for the difference between their charge amount and amount paid by the benefit plan, so long as the plan pays the amount set forth in the network’s fee schedule, and do so within a certain period of time).

Forced Change

If benefit plans are willing to apply minimal discounts to inflated charges, in exchange for prohibitions on balance billing, why is there suddenly a noticeable market shift away from PPOs?

For some time, stop-loss carriers have reimbursed benefit plans for claims paid in excess of that plan’s specific deductible, when those claims are paid in accordance with applicable PPO network arrangements. In other words, a benefit plan would receive claims from an in-network facility, the PPO network would apply the network’s fee schedule to the claims, the benefit plan would pay that amount, and amounts in excess of the plan’s specific deductible would be submitted to stop-loss for reimbursement.

A trend has developed, however, which has forced benefit plans to reconsider this methodology. Stop-loss policies protect the benefit plan; they insure the plan document. It is important to understand that terms negotiated by the benefit plan (or by the PPO on the plan’s behalf) with providers, that do not appear in the applicable benefit plan document, are not binding upon the stop-loss carrier.

Benefit plan documents regularly include language limiting how much the benefit plan will pay for a given service or supply. Terms such as “usual,” “customary,” “reasonable,” and “maximum allowable,” should come to mind. If a benefit plan pays in accordance with a PPO network fee schedule, rather than independently audit claims to confirm that the charges fall within the parameters set by these types of plan document provisions, they run the risk of paying claims in excess of the amounts allowed by the applicable benefit plan document.

Presently, stop-loss carriers are being more judicious in their review of claims payments made by benefit plans, and are stringently enforcing such limiting plan language. Some stop-loss carriers include in their stop-loss policies independent definitions of maximum payable amounts (their own definition of usual and customary, for instance), while others reserve the right to interpret the terms of the plan document independent of the plan administrator’s interpretation of the same terms. Regardless of the methodology, however, more benefit plans are finding themselves between this rock (stop-loss carrier enforcement of plan document language and price limitations set forth therein) and hard-place (PPO network contractual obligations to pay network rates, or suffer the hardships of balance billing and accusations of contractual breach).

Forced to choose a side, many benefit plan administrators are choosing to shed their PPO and administer claims solely in accordance with the terms of their plan document.

The Conflict

The information presented thus far begs the question, "why can't benefit plans administer claims in accordance with the terms of their plan documents and apply network discounts?"

PPO network agreements make it difficult, if not impossible, to audit claims submitted by in-network providers. Some network agreements openly prohibit the application of plan-based limitations, such as usual and customary rates, even if the benefit plan document places a ceiling on payable rates. Other network agreements prohibit the review of provider bills by the plan administrator; limit or eliminate the plan's ability to obtain invoices, disallow audits by the plan or its representatives, and apply ambitious deadlines after which discounts are lost and balance billing commences.

Administration of claims in strict adherence to the benefit plan document often takes more time than the network agreement allows. This deadline, along with the aforementioned prohibitions on in-depth claims review, often forces benefit plans to pay claims blindly. In the meantime, the provider holds the discounts – and much more importantly – the plan participants, hostage. If the plan fails to meet the provider's demands, the provider will "pull the trigger," and begin submitting bills to the patient. These bills, often exceeding six-figures, as well as threats to ruin credit, result in upheaval at the employer's office, and eventually results in the plan caving in. Providers do not expect their patients to cut a check to the hospital for \$250,000.00. They expect the patient to retain legal counsel, pursue claims against their employer and their benefit plan, and force those entities to pay the provider.

In their scramble to avoid balance billing, employers and benefit plans have shielded their participants from any and all exposure to the actual cost of their healthcare. This separation between consumption and payment has led to an egregious lack of transparency in pricing. The market is perfect for providers to inflate rates, many times in excess of reasonable profitability, as the consumer has no skin in the game (the patient does not care how much the care costs, as long as they aren't balance billed), and benefit plans will not push back for fear of balance billing and black balling of their members; (providers refusal to treat members of the given benefit plan).

Whether it is a benefit plan seeking details to confirm that claims are covered by the plan, and inadvertently exceeding the deadline set by the PPO agreement, or a benefit plan attempting to apply a plan-based cap on payable



Shores, Tagman, Butler & Company, P.A.

CERTIFIED PUBLIC ACCOUNTANTS

PROVIDING SERVICE TO THE SELF INSURANCE INDUSTRY FOR OVER 34 YEARS IN OVER 30 STATES

Audits
Tax Preparation, Compliance and Minimization
NAIC Annual Statements, assistance and preparation
Management Consultation
Expert Witness
Regulatory Matters

Contact: William L. Shores, CPA
17 S. Magnolia Ave.
Orlando, Florida 32801
(407) 872-0744 Ext. 214
Lshores@shorescpa.com

amounts for a given procedure, any behavior that strays from the network terms is met with balance billing, as well as accusations of contractual breach, promissory estoppel, and bad faith.

Mercury Rising

Providers are not always to be blamed for these inherent conflicts. Benefit plan sponsors execute agreements with their PPO assigning what is in essence a power of attorney to the PPO to negotiate on the plan's behalf with providers. Providers, in turn, execute contracts with the PPO (negotiating on the plan's behalf) that they – the providers – presume will control the payor / payee relationship. These contracts cover everything, from delivery of services to payment terms. Providers proceed in reliance upon the (reasonable) belief that the network contract is in place and will control the entire procedure.

If the payor agrees to a contractual arrangement whereby the provider charges many hundreds of times what they receive from other payors, what of it? Why shouldn't the provider accept this contractual windfall, adopted – willingly – by the benefit plan?

Some providers, however, take this advantage to the next level. Most PPOs assert that their discounts are confidential. In fact, they argue that the agreement they negotiate with the providers (in the name of the payor) are confidential; so much so that the payor – in whose name the contract was signed – cannot see its terms. In other words, the benefit plan is expected to comply with a contract they cannot see, but which was signed in their name.

In addition to this unseen agreement, the terms of both the agreement with the provider, and agreement between the network and payor limit the plan's right to review the provider bills, analyze claims, audit charges, view invoices, etc. As a result, benefit plan payors must give providers

the benefit of the doubt, and "hope" that the provider makes no mistakes.

In the State of California, the State's insurance commissioner identified multiple instances where – it is alleged – facilities belonging to a particular hospital system charged benefit plans for services they didn't provide, in excess of industry standards, and committed other billing fraud related to anesthesia claims. The State, furthermore, asserted that the hospital system knowingly committed these acts of fraud, confident that they would not be caught thanks to the shield their network agreement provided. In other words, the terms of their network agreements concealed their fraudulent billing practices, by limiting the payors' rights to review the claims.

As a result, the State included the applicable PPO as a defendant as well, for – in essence – aiding and abetting the fraud.

In addition to this case, most people have heard other cautionary tales, from the \$75 aspirin to the \$300,000.00 appendectomy. Yet, because consumers (the patients) did not feel the sting of the charge (at least, not until their premiums increased a year later), there was no impetus to address this issue – the unconscionable cost of care.

That was the case, at least, until PPACA resulted in new expenses to benefit plans. Now, facing the real threat of plans no longer being financially viable, plan sponsors must address the cost of care, or cease offering benefits entirely.

Cost Plus is a Real Plus

The industry at large is now contemplating new pricing methodologies, whereby the benefit plan identifies a fixed rate (a benchmark) upon which it bases what it deems to be a fair market value. The benefit plan issues payment equivalent



Premiere Access to Telemedicine

- Substantial ROI by redirecting unneeded visit to the ER or PCP
- Increase level of care and control costs at the same time
- Easy access to doctor improves quality of care and health
- Private access to doctor increases chances of early detection
- Increase plan design flexibility
- Get your clients ready for Obamacare today, if you don't someone else will.
- Don't wait for your clients to get it from someone else, when you can offer it today

Contact us for a no-cost no obligation price analysis (855) 793-2582 ext 50 or siia@payyourselffirst.com

to that allowable amount to providers. The benchmark can be based upon some percentage of Medicare, or any other number of parameters. Providers that charge more than the allowable amount receive less than their billed amount from the Plan. What happens next is up to the Provider:

Fair and Balanced Billing

In response to this trend, some providers (primarily those associated and/or sharing ownership with PPO networks) have advised that implementation of such fixed-cost systems may (and likely will) result in balance billing of the patients. The process is similar to any benefit plans' out of network procedure. The benefit plan pays the amount set forth within the plan document, and the provider bills the patient for the difference.

Many benefit plan sponsors and claims administrators have shied away from fixed-cost methodologies for fear of balance billing. Yet, many of these entities are the same entities clamoring for "price transparency" and patient "skin in the game."

Providers that threaten to react to fair, profitable, fixed-cost pricing are – in many ways – shooting themselves in the foot. If balance billing occurs, then the veil will be lifted. Patients will see how much their healthcare really costs, and will feel the sting of excessive charges in their wallet. Over time, individuals faced with a need for care will take the cost of that care into consideration as well.

Unfortunately, many benefit plan sponsors falsely believe that there exists a "silver bullet;" that they can limit how much their benefit plan will pay for a given claim and can prohibit the provider from balance billing.

The only way to stop balance billing is to have the provider agree – in writing – not to balance bill. That, in turn, will only happen if and when the provider receives something valuable

in exchange for sacrificing the right to balance bill. Take note, however, that providers don't actually expect patients to whip out a checkbook and cut a check for a quarter-million dollars to the hospital. They balance bill hoping to receive pennies on the dollar via a convoluted payment plan, or better yet, upset the patient such that the patient protests the plan's limited payment and forces their employer to pay additional amounts to the provider. As such, the amount balance billed reflects a number much larger than the actual value of the right to balance bill. In other words, the right to balance bill is worth less to the provider than the amount balance billed. Identifying the value of that right, and compensating providers in exchange for prohibiting balance billing, is the key to success.

How Much is that Transplant in the Window?

Despite its name, health "insurance" is not "insurance" as that product is known in other industries. Insurance is a safety net, purchased by insureds, so that if and when they suffer a loss, they are provided with monetary compensation equal in value to that loss. In health care, payment is made (more often than not) to the service provider (not the insured), and the amount paid is not based upon the value of the loss, and rather, is based upon the amount the service provider charges.

An immediate conversion to standard-insurance practices like the one described above is not possible. This is because, in health care, nobody knows what the fair market value of a particular loss (i.e. a hospital bill) even is. "Hospital A" in a city can charge double for the same service as "Hospital B" in the same city.

Perhaps this is the reason why the cost of health insurance has sky-rocketed compared to other types of insurance: the actual cost of health care is not a part of the conversation.

Contract to Kill

Contracts are enforceable unless and until proven to be otherwise. Contracts executed by minors, people lacking capacity, and people under duress, for instance, are unenforceable. Likewise, contracts requiring one or all parties to commit a crime are void for illegality.

Health plan administrators have a fiduciary duty, under ERISA, to prudently manage plan assets and to uphold the terms of the applicable plan document. In an effort to contain costs, many self funded plans draft plan language stating that the plan will only pay what is usual, customary, and reasonable. Upon adoption of said document, it becomes the administrator's fiduciary duty to cap payments at those rates.

If a provider's bill calls for payment in excess of a usual, customary, and reasonable amount (as defined by the plan in its document), the plan administrator is required – by their fiduciary duty and applicable Federal law – to pay no more than the maximum allowable amount, in accordance with the terms of the plan. If the health plan pays the bill in excess of that allowable amount, that would be in violation of the terms of the plan document, and constitute a breach of the administrator's fiduciary duty. If the plan pays the claim pursuant to the terms of the plan document and pays only what is reasonable, it will be violating the terms of the PPO agreement.

If paying claims that are in excess of what the plan document allows forces a health plan to breach its fiduciary duty to its plan participants, it can be fairly said that the network agreement requires the plan to breach its fiduciary duty. This paradox between the terms of the PPO contract and the terms of the plan document puts the

Consolidate. Deliver. Reward.

ECHO's one-of-a-kind, breakthrough technology and financial system provides leading healthcare payment solutions for Third Party Administrators (TPAs) that:

- ▶ Consolidates statements and funds into one;
- ▶ Delivers electronic payments and EOBs faster;
- ▶ Rewards your bottom line immediately, saving you time and money!

WE MAKE A DIFFERENCE FROM DAY ONE

How? The Electronic Payment Clearinghouse (EPC) Trust:

- ▶ Industry's only consolidation and delivery system;
- ▶ Secure, ERISA and HIPAA compliant;
- ▶ Streamlined, innovative, cost-effective process.



GET REWARDED TODAY

ECHOHealthInc.com

info@ECHOHealthInc.com

440.835.3511

benefit plan in a very difficult position. Certainly, given this scenario, an argument can be made that the PPO contract is void for illegality because it conflicts with the benefit plan's terms, and requires a breach of the administrator's duty created by ERISA.

Agreeing on the Options

Providers and PPO networks are justified in their outrage. Benefit plans have for decades taken advantage of discounts, and much more importantly, have stifled providers' rights to balance bill. They executed agreements and triggered activities taken by providers in detrimental reliance upon the benefit plan's representations. It is not the providers' responsibility to review the applicable plan document and warn the benefit plan sponsor that the network may run afoul of the plan terms. Providers, justifiably so, presumed that plan sponsors executing network agreements had the legal authority to do so.

Providers and networks stewing in their angst, however, must come to terms with the facts that face us today. Benefit plans cannot be chastised back into the classic PPO arrangements that have, for many years, been the status quo. For decades, benefit plans could deal with excessive charges minus discounts, if it also meant harmony for patients. Now, the election is behind us and Obamacare is the law of the land. In the coming years, the combined rising cost of doing business within the traditional PPO structure and complying with the new law will drive employers away from private plans and to the exchanges.

The individuals presently included in PPO plans, which the providers and networks desperately want to preserve, will instead be uninsured, members of the exchange, Medicaid or Medicare recipients. Rather than receive Medicare

plus a percentage, they will receive only Medicare rates, or a percentage less than Medicare. If the hospitals and the PPOs resist the current trends towards innovative cost containment, the hospitals will face a fate much worse than Medicare-plus pricing.

The Once and Future Law

For the past six years in Massachusetts, the Commonwealth Care Plan has been in effect. This program, also known as Romney Care, is essentially the predecessor of Obamacare. Interestingly, the Commonwealth Care Plan offers its members rich benefits and yet many providers refuse to see patients. The uptick in covered individuals resulted in more unnecessary visits, frivolous use of medical resources, and a shortage of available appointments and caregivers. In addition to this influx of unnecessary (and time consuming) care (resulting in a shortage of resources), "Massachusetts Exchange" patients are refused appointments because these plans pay less than other private payors, and payment takes a lengthy time to achieve. There is no network agreement based deadlines, and navigating the bureaucratic red tape is time consuming indeed. In the face of this looming possibility, Medicare-plus pricing is something area providers are actually keen to accept, so long as payment occurs quickly and conflicts are kept to a minimum.

Making the Pie Larger

Too often, the parties (payor, patient, provider, and PPO) enter the negotiations prepared to fight over the pie. Whoever gets the biggest slice wins. Unfortunately, PPACA will soon feed upon the pie, and what will remain is not large enough to feed any of the players. Soon, if the industry sticks

to the status quo, they will all starve. Instead, these entities need to make the pie larger.

Benefit plans need to work, hand in hand, with the most important providers in their applicable areas, and/or their PPOs, to develop new programs that offer true value to providers in exchange for cost-effective care. Identifying one or two select caregivers to receive all steerage, agreeing to cover the cost of co-pays and deductibles for providers that agree to accept the plan maximum allowable payment as payment in full, agreeing to initiate electronic claims submission and electronic payment, sticking to prompt-payment deadlines, and agreeing upon an equitable fixed-payment rate prior to the provision of medical care are all carrots benefit plans can offer to providers. Likewise, prohibiting assignment of benefits to providers that refuse to coordinate with the benefit plan, such that payment is made to the participant and providers are forced to pursue the patient for payment, is the stick.

If all of the beneficiaries of private health insurance do not innovate together, and improve upon the expensive and unsustainable status quo, traditional health insurance will lose out to the exchanges, or benefit plans will become nothing more than auto insurance policies and homeowner's insurance... prohibiting assignment of benefits entirely. If plans eliminate assignment, patients will obtain care, receive the bill, submit the claim to their insurance, receive fair market value, and haggle over payment with the provider, like so many used car dealers. Either scenario – socialized medicine or the end of assignment – would be devastating to providers, and the entire industry. The time has come to stop resisting change, and embrace the innovative options that

are becoming available; the options that exist today, compared to those that belong to yesterday, may be the industry's only hope for tomorrow. ■

Shauna Mackey started her career at The Phia Group, LLC in 2006 as a Claim Recovery Specialist. In this role, Shauna investigated potential subrogation opportunities, and pursued reimbursement from Plan members, insurance carriers, and their attorneys. Shauna joined The Phia Group's Legal Team as Legal Administrator in 2010 while attending law school at night. In that position, she handled complex subrogation matters as well as health care consulting and compliance projects. Shauna graduated from Suffolk University with a bachelor's degree in Political Science and received her J.D. from Suffolk University Law School. She was recently admitted to the Bar of the Commonwealth of Massachusetts and currently serves as legal counsel. In this role, she handles various consulting matters including the review and revision of stop loss contracts, ASA agreements and PPO contracts. She also assists clients in complying with HIPAA, PPACA and the various other regulations affecting our industry.

Ron Peck, Sr. Vice President and General Counsel, has been a member of The Phia Group's team since 2006. As an attorney with The Phia Group, Ron has been an innovative force in the drafting of improved benefit plan provisions, handled complex subrogation and third party recovery disputes, and spearheaded efforts to combat the steadily increasing costs of healthcare. In addition to his duties as counsel for The Phia Group, Ron leads the company's consulting, marketing, and legal departments.

Ron is also frequently called upon to educate plan administrators and stop-loss carriers regarding changing laws and strategies. Ron's theories regarding benefit plan

administration and healthcare have been published in many industry periodicals, and have received much acclaim. Prior to joining The Phia Group, Ron was a member of a major pharmaceutical company's in-house legal team, a general practitioner's law office, and served as a judicial clerk. Ron is also currently of-counsel with The Law Offices of Russo & Minchoff.

Ron obtained his Juris Doctorate from Rutgers University School of Law and earned his Bachelor of Science degree in Policy Analysis and Management from Cornell University. Ron is also a Certified Subrogation Recovery Professional ("CSRFP").



A Revolutionary Passion for Savings

Reducing the Cost of Health Plans Through Innovative Technologies, Legal Expertise and Focused, Flexible Customer Service.

<i>Claims Recovery Services</i>	<i>Plan Document Services</i>	<i>Consulting Services</i>
Subrogation & Reimbursement	Document Assessment	ASA & 3rd Party Agreements
Phia Rewind™ - 2nd Pass Audit	Plan Review & Revision	Gap Free™ Review
Overpayment Recovery	Custom Plan Design	Balance Billing Disputes
Attorney Consultation	Compliance Updates	Stop-Loss & IRO Relations
Coordination of Benefits	ERISA & PPACA	Claims Consultation

Free Webinar
Medicare-Plus & Other Cost-Plus Methodologies – The Controversy...
Wednesday, February 12, 2013 @ 1pm EST
Register at www.phiagroup.com

The Phia Group, LLC | 163 Bay State Drive Braintree, MA 02184 | Phone: 866-THE-PHIA | Email: info@phiagroup.com