Silent PPOs

What is a “silent PPO”? A “silent PPO” refers to a situation where, unbeknownst to its contracting physicians, a managed care organization (MCO) “sells” or “rents” its Preferred Provider Organization (PPO) network of providers to a third party (typically a third party administrator, insurance broker, or smaller PPO) and that third party gets the advantage of whatever discount the MCO has negotiated with the physician. The physician becomes aware of this only after he or she provides services to a patient who is not covered by the PPO. After filing a claim for his or her services with the patient’s health plan or insurer, the physician receives less than full payment and an explanation of benefits (EOB) referencing the discount with the original MCO PPO. Both the “seller” and the “purchaser” of the discount rely heavily on the fact that a busy physician practice will have difficulty spotting this anomaly on an EOB.

Depending on the terms of the physician’s contract, silent PPO activity may constitute a breach of contract. The AMA also believes that silent PPO activity may be fraudulent. Because of the potentially significant sums of money involved, physicians should take special precautions to assure that their managed care agreements do not contain “all payer” clauses that allow the MCO to rent or lease its physicians’ services to non-contracted entities. Section 1.0 of the Addendum to the AMA Model Managed Care Contract includes an example of a contract definition of “payer” that could potentially allow the MCO to rent or sell the discount.

Why are silent PPOs harmful to physicians? Silent PPOs are financially harmful to physicians (and hospitals), and they violate fundamental concepts of fair business dealing. The silent PPO takes discounts to which it is not entitled, without negotiation, and without the physician’s consent or knowledge. Silent PPOs cut out the main incentive that induces physicians to enter into managed care contracts – patients.

When contracting for a PPO product, physicians and the managed care company engage in a deal. The physician offers a negotiated fee discount in exchange for access to a base of patients, as well as other benefits that result from participation on a PPO panel, such as inclusion in the PPO’s physician directory. In return, the PPO agrees to direct and encourage its patients to visit participating network physicians in exchange for discounted rates.

In a silent PPO, the physician or physician group/network unknowingly gives up a valuable asset—the discount—but does not receive a patient base in return. Patients may also be harmed because they may be paying inflated or incorrect copayments.

How does a silent PPO operate? The following example demonstrates how a physician may become a victim of a silent PPO.

- Dr. Y is an internist who is a member of ABC PPO’s network and has negotiated a 25% discount for services rendered to PPO patients.
Silent PPOs, continued

- Patient X, who is covered by an indemnity plan (not ABC PPO), presents to Dr. Y for an office visit. Dr. Y treats the patient and presents a bill to the indemnity insurer for the reasonable and customary charge of $100.

- The indemnity insurer, after receiving the bill, contacts a third party administrator, broker, or any PPO to determine whether Dr. Y is on a physician network with a negotiated discount.

- ABC PPO offers to allow the indemnity insurer to use its negotiated 25% discount, for a fee.

- Instead of reimbursing Dr. Y the indemnity fee he is entitled to, the indemnity insurer then remits its portion of the discounted fee negotiated by ABC PPO, with an EOB. Dr. Y is instructed to collect the copayment from the patient.

Dr. Y is unlikely to realize what has happened. Most physicians do not have the computer technology or personnel required to compare each EOB statement to the patient’s insurance coverage.

This example illustrates one type of silent PPO scenario. It is important for physicians to be alert to other situations where payment received is less than payment negotiated in the contract.

What is the financial impact of silent PPOs?

Given the difficulty in detecting the use of silent PPOs, it is impossible to determine the amount of money physicians have lost due to this practice. However, it has been estimated that physicians and non-physician health care providers nationwide have lost between $750 million and $3 billion annually since the practice began in the early 1990s.

How can physicians recognize a silent PPO in a managed care contract?

Provisions for silent PPOs may appear in contracts in a variety of forms, or they may not be a part of the physician’s contract at all. Physicians should first scrutinize their managed care contracts for “all payor” clauses. These clauses typically require the physician to accept the discounted rate as payment in full from any payor. This may permit “selling” or “renting” the negotiated discount. However, simply because a contract does not contain an obvious “all payor” clause does not provide full protection from silent PPO activity. Therefore, physicians should try to gather as much information from the PPO representative before signing a contract, including asking direct and pointed questions about the PPO’s relationship with its payors.

The AMA offers several suggestions physicians can use to protect themselves from the unauthorized use of negotiated discounts by silent PPOs.

1. Ensure that all PPO patients eligible for discounts are steered toward using in-network physicians. For example, PPO patients commonly receive a financial incentive to use network physicians.

2. Extend discounts only to patients with PPO identification cards.

3. Require the PPO (within the physician contract) to provide timely notice of changes to the list of payors authorized to receive the network discount.
4. Require the PPO to disclose any discounts applicable to a PPO patient at the time the physician verifies coverage.

**How do “silent PPOs” relate to companies that “reprice” claims for insurance companies?**

A number of large “repricing” companies have developed healthcare networks that allow them to offer “custom” networks to MCOs, at a significant discount. In a typical example, an MCO (or self-insured employer) seeks access to providers in an area where the MCO has a limited number of covered lives. Therefore, the MCO may not have the leverage to extract discounts from providers. Instead, it “rents” the network of the “repricing” company.

The primary difference between silent PPOs and repricing arrangements is that physicians have actually entered into a contractual agreement with the “repricing” company and agreed to allow their services to be “rented” to the company’s clients. Physicians need to be aware of what it means to sign a contract with one of these entities and the impact the agreed-upon discounts will have on their practices.

**What is being done to combat silent PPOs?**

The American Medical Association (AMA) is attacking this practice on a number of levels. The AMA succeeded in getting silent PPOs banned from all Federal Employee Health Benefits Plan (FEHBP) contracts, which was an important victory in light of the federal government’s liberal use of silent PPOs as a cost savings mechanism in the FEHBP.

In addition, the AMA Litigation Center and the Medical Association of Georgia filed “friend of the court” briefs in *HCA Health Services of Georgia v. Employers Health Insurance, Co*, which involved a challenge by a medical center to a silent PPO arrangement whereby an insurance company reduced the plaintiff’s payment by 25%. In February 2001, the U.S. Court of Appeals for the Eleventh Circuit rejected the defendant’s arguments that the plaintiff did not have “standing” to sue the insurance plan and held that the defendant’s interpretation of the provider contract was arbitrary and capricious. The AMA Litigation Center continues to look for other possible legal challenges to silent PPO arrangements.

One state, North Carolina, has implemented a law specifically addressing silent PPOs. The North Carolina law (N.C. Gen. Stat. 58-63-700) makes it an “unfair trade practice” for insurers to make a “material misrepresentation to a health care physician to the effect that the insurer or service corporation is entitled to a certain preferred physician or other discount off the fees charged for medical services, procedures, or supplies provided by the health care physician, when the insurer or service corporation is not entitled to any discount or is entitled to a lesser discount from the physician on those fees.”

**How does the AMA Model Managed Care Contract deal with silent PPOs?**

Section 1.11 of the AMA Model Managed Care Agreement specifically restricts MCOs from selling or renting their networks to others not entitled to the negotiated discounts and does not include an “all payors” clause.