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“Silent PPOs”
A Recent Case Emphasizes Need to Review Provider Contracts
by James M. Jorling

The expansion of managed care contracting over the last decade has resulted in the proliferation of networks of health care providers that contract with insurance companies, employers or other provider networks. Many of these contracts are drafted very broadly. A network may claim that it has the right to provide virtually unlimited access to providers and provider discounted fees.

Providers often lack a full understanding of how their provider contracts may be utilized by these provider “intermediaries” and insurance companies. Often a provider unwittingly allows a patient to obtain services at the provider’s discounted rate. The discount is provided to the patient’s insurance company or employer even though the provider is not really a preferred provider in the payor’s provider network. In fact, the payor may contract with most providers in the area either directly or indirectly. In some cases the provider may in fact be an out-of-network provider but the payor pays the provider discounted fee anyway.

The issue of improper access to discounted rates was raised in a recent decision of the United States Court of Appeals for the Eleventh Circuit. The case, HCA Health Services of Georgia, Inc. v. Employers Health Insurance Company was decided February 2, 2001. The case is important because of its discussion of the validity of some PPO provider contracts and the obligations of health insurers and employers making benefit decisions with respect to these contracts.

FACTS OF THE CASE

Software Builders, Inc. (Employer) established a health benefit program for its employees with Employer's Health, Inc. (Insurance Company). Steven J. Denton (Employee) underwent outpatient surgery performed by HCA Health Services of Atlanta, d/b/a Parkway Medical Center (Hospital). The Hospital contracted as a preferred provider with MedView Services, Inc. (PPO A). In its contract with PPO A, the Hospital agreed to accept 75% of its usual and customary fee when providing services to PPO A subscribers. PPO A leased its provider network to Health Strategies, Inc. (PPO B). PPO B then leased its network, including PPO A’s network, to the Insurance Company in exchange for a percentage of the savings that the Insurance Company gained from accessing the discounted fees.

At the time he had the surgery, the Employee assigned to the Hospital his right to reimbursement under the Employer’s health benefits plan (Plan). The Hospital then billed the Insurance Company. Because the Hospital was not a member of the Insurance Company's preferred provider network, the Hospital was considered an out-of-network provider under the Employer’s plan. As such, the Insurance Company covered 80% of the cost of the health care services and Employee was responsible for 20%. Under the plan, an in-network provider would receive 90% of its contracted rate. Utilizing the Hospital's contract with PPO A, the Insurance Company took advantage of the discounted fee and then paid the Hospital 80% of the discounted fee.

The Hospital sued the Insurance Company to obtain benefits under the Employee’s health benefits insurance plan. As an out-of-network provider, the Hospital sought payment of 80% of its usual and customary fee (not its discounted fee) for providing the outpatient surgery services to the Employee.

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2001 U.S. App. LEXIS 1427 (February 2, 2001)
**THE DECISION**

The Federal Appeals Court affirmed the lower court’s holding in favor of the Hospital on the grounds that the Insurance Company had not properly interpreted the health benefits provided under the Employer’s plan. In doing so, the court interpreted the plan documents to disallow payments that were based on an alleged contract with a provider that was not a preferred provider (i.e., an out-of-network provider). In addition, while not ultimately the reason for the Court’s decision, the Court found that the string of contracts between the Insurance Company and the Hospital were probably not enforceable.

Because the Insurance Company had discretion to interpret the term of the Employer’s benefit plan, the Court reviewed the Insurance Company’s decision to determine if it was not reasonable, giving deference to the Insurance Company’s interpretation.

- First, with reference to out-of-network providers, the Court found that the Employee’s Certificate of Insurance (“COI”) contained a reference only to reimbursement based on a Maximum Allowable Fee. This Fee "could not validly be interpreted to mean a charge reduced or discounted through [Employer’s] contract with [PPO B]." The only references to discounted fees were contained in the preferred provider provisions of the COI and the Hospital was not a preferred provider. The Court found that the Employee would be entitled to reimbursement based on the provider’s "reasonable, usual and customary fee" under the Maximum Allowable Fee definition. A discounted fee would not fit this definition "because it only arises out of a specified contractual relationship." Therefore, the Court found that the Insurance Company’s interpretation was not consistent with the terms of the COI.

- Second, the Court found that the Insurance Company erroneously construed the series of contracts in order to "access" the Hospital’s discounted rates. PPO A's contract with the Hospital allowed only persons accessing the Hospital's services as a "Preferred Hospital" to obtain the benefit of the discounted rates. Therefore, the Court found that the Employee was not eligible to obtain medical care from the Hospital at the discounted rates set forth in the Hospital's contract with PPO A. Interestingly, in a footnote, the Court noted that it "could find that, due to the lack of clear adequate consideration, the [Hospital/PPO A] contract is not valid." While the Court did not feel the need to review this issue, it stated that "it is clear that the [Hospital/PPO A] contract contemplates that [PPO A] would act as a middleman between Hospital and a third party payor (such as an insurance company) and that the third party payor would steer its participants to [Hospital] in return for [Hospital's] promise to discount its fees. Without the benefit of steerage there is no reason for [Hospital] to agree to discount its fees." Hospital was clearly not listed in the Insurance Company’s provider directory and, therefore, patients would have no reason to prefer to utilize the Hospital.

- Finally, the Court held that the Insurance Company’s interpretation was tainted because its decision suffered from a conflict of interest. In this case the Insurance Company had such a conflict because it paid claims out of its own assets; it benefited directly from payment of the Hospital at the discounted rate. Therefore, because of the conflict, the Court decided not to provide the Insurance Company’s decision with the deference usually provided in such cases.

**WHAT TO DO?**

Health care providers will benefit from reviewing their PPO and third party payor contracts in order to determine whether they need to be modified to protect providers from improper access to the provider's discounted fees. In addition, the provider should audit payments under these contracts to determine whether the provider has been paid correctly.

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2/ It is interesting to note the Court did not find that these arrangements would never be valid. The Court stated that "[o]ur holding should not be read to mean that payors, such as insurance companies, can never contract with out-of-network providers for reduced fees." However, the provider contracts and plan documents must clearly set forth the terms of this arrangement.
The following are some guidelines to utilize as part of a managed care contracting program. These guidelines should help providers avoid “Silent PPO” problems:

- **Financial Incentives**
  Require coverage differentials between in-network and out-of-network providers.

- **Network Identification**
  Require inclusion of the PPO’s name on all member identification cards and require that these cards be presented at time of receipt of services.

- **Provider Directory**
  Require listing of the name and address of the health care provider in payor’s provider directory.

- **EOB Identification**
  Require identification of payor's use of PPO on the Explanation of Benefits.

- **Cross Access**
  Prohibit use of access agreements, allowing one PPO to "sell" its discounts to another network or to a payor without the health care provider's consent.

- **Payor/Employer List**
  Require the PPO to provide a list of payor's and employers accessing the PPO network.

- **Audit PPO Staff**
  Determine whether PPO has sufficient staff for customer service, claims/repricing administration, and provider relations.

- **Other Matters**
  - Obtain PPO fee schedule.
  - Does PPO credential providers? If not, this may indicate that it is not a "real" PPO.
  - Include penalties for lack of steerage (e.g., right to bill usual and customary fees).

**Other Matters, cont’d**

- Audit Billing Practices:
  - Copy beneficiary's identification card.
  - Ensure that contracted PPO is listed on identification card.
  - Review activity reports.
  - Match EOBs to admission system information.
  - Know which employers are contracted with which payor/PPO.
  - Identify duplicate payor/employers on PPO's lists.
  - Perform due diligence on managed care companies.
  - Terminate bad contracts.

**Key Points to Remember**

The recent Employers Health Insurance Company decision is illustrative of the “Silent PPO” problem for health care providers. Understanding provider contract issues is only part of this “Silent PPO” equation — the other part should include assessment, structuring, and ultimate implementation of an effective provider contracting strategy. In this regard, we leave you with three Key Points to Remember:

- Review current contracts to determine whether necessary language is in the document, and renegotiate if possible.
- Adopt appropriate contracting and compliance programs and policies.
- Establish a regular audit program to determine whether the provider is paid correctly.

If your organization has any questions regarding the impact of the Case, please do not hesitate to contact the author James Jorling or one of the members of the Gardner, Carton & Douglas Health Law Department shown on the next page.
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