

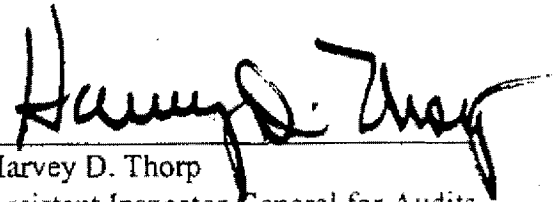
ENCLOSURE

REPORT OF REVIEW

OFFICE OF THE INSPECTOR GENERAL
OFFICE OF PERSONNEL MANAGEMENT

REPORT ON THE USE OF SILENT PPOs
IN THE
FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

REPORT NUMBER 99-00-97-054 DATE February 26, 1998



Harvey D. Thorp
Assistant Inspector General for Audits

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OFFICE OF THE INSPECTOR GENERAL
OFFICE OF PERSONNEL MANAGEMENT

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I. INTRODUCTION AND SUMMARY OF RESULTS

As a result of interest initially expressed by Chairman Mica, House Subcommittee on Civil Service, Committee on Government Reform and Oversight, the Office of Personnel Management (OPM), Office of the Inspector General (OIG) has performed a review of the use of "silent" and "non-directed" Preferred Providers Organizations (PPOs) in the Federal Employees Health Benefits Program (FEHBP). The committee expressed the concerns of the American Hospital Association and American Medical Association who suggested that health care providers are being victimized by schemes that create payment discounts for payers who are not entitled to them. These schemes are purportedly carried out by "silent PPOs." Thus, the principal purpose of our review was to determine whether "silent PPOs" were used by FEHBP carriers to capture discounts to which they were not entitled. Our review did not disclose any evidence that FEHBP carriers used "silent PPOs" to capture discounts or that health care providers were otherwise victimized by FEHBP carriers. Nevertheless, we observed that for 1.3 percent of the claims we tested, discounts taken were inconsistent with agreed upon contract terms. We do not consider these errors to be material nor are they indicative of a systemic problem.

At the committee's request, we also determined how wording in OPM's annual carrier call letter, which encouraged carriers to seek discounts on providers' bills, came to be included in the call letter. We found that the wording was included as a result of discussions between the House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A detailed discussion of our review objectives, scope, and methodology is presented in Section IV. Substantive comments made in response to a draft of this report from several affected parties are included in the appendix.

II. BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance

benefits for federal employees, annuitants, dependents, and others. OPM's Retirement and Insurance Service has overall responsibility for administration of the FEHBP. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations which are codified in Title 5, Chapter I, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers that provide either service benefits, indemnity benefits, or comprehensive medical services. Health insurance carriers provide these benefits on either a fee-for-service or a prepaid basis. For calendar year 1997, there were 14 fee-for-service plans and about 460 prepaid plans in the FEHBP. In a fee-for-service plan, the medical provider is paid a fee for the specific service provided. The size of the fee will vary depending on the complexity of the service. The subscriber's group insurance premiums reflect the composite cost of all fees paid to medical providers on behalf of all subscribers in the group. In a prepaid plan, the providers are generally paid a fixed amount which is intended to cover all the services required by individual subscribers. Because of the fixed nature of the payment, the providers are at risk of not recovering all their costs. This risk is an incentive for prepaid plans to control their costs.

During the last decade, the health insurance industry has been undergoing rapid change in response to rising costs. The rapid growth of prepaid health carriers, generally referred to as Health Maintenance Organizations (HMO), who, through their ability to better control costs via utilization control and managed care techniques, have caused fee-for-service carriers to seek better ways and means to control their costs so that they can remain competitive. One cost control method used by fee-for-service carriers is known as a Preferred Provider Organization (PPO). A PPO is a group of medical providers who agree to provide medical services to the subscribers of an insurance carrier at a lesser cost than would have been otherwise charged. The perception is that in a traditional PPO, the PPO would employ some method of controlling benefit utilization by subscribers and would manage medical care more cost effectively. They might also establish controls to improve the quality of care. In exchange for a preferred status, lower fees, and better care, the carrier would attempt to steer its subscribers to the PPO's medical providers through such methods as financial incentives, ID cards, and preferred provider lists. Thus, significant savings could be achieved by the carrier which would reduce its premium costs.

In recent years, a new variation of the PPO concept appeared. This variation is known as a "non-directed" PPO as distinguished from the traditional PPO which has become known as a "directed" PPO. The terms "directed" and "non-directed" are references to the steerage or lack of steerage of patients. As explained above, in a traditional directed PPO arrangement, subscribers are steered to the PPO to take advantage of the lower costs. In a "non-directed" PPO, even though the medical providers have agreed to charge a lower fee, the contract the PPOs enter into do not require that the carrier's subscribers be steered to them. In some non-directed PPOs, the PPO may benefit from this arrangement as a result of prompt payments or advances. In other non-directed PPO arrangements, the benefits to the provider may be less clear.

In the case of both the directed and non-directed PPOs, the terms of the arrangement are committed to a contract between the parties. Also, there may be intermediate organizational

layers between the insurance carrier and the providers of medical service. In a typical non-directed arrangement in the FEHBP, an insurance carrier contracts with a third party vendor for non-directed PPO services. The vendor assembles the network of non-directed PPO providers by either contracting directly with individual medical providers or by contracting with networks of medical providers who in turn contract with individual medical providers (Exhibit 1). Very frequently, the vendors and the provider networks also contract with other carriers for directed PPOs. Therefore, non-directed PPO services may be provided to FEHBP carriers while directed PPO services may be provided by the same provider or provider network to non-FEHBP insurance carriers.

Concurrent with the evolution of non-directed PPOs, a new term, "silent PPO" became commonplace. The term, "silent PPO," means different things to different people. Initially, the term "silent PPO" was merely a reference to a non-directed PPO where the contract was "silent" with regard to the steering of patients to the provider's facilities. However, in more recent times, the term has acquired a more restrictive meaning. As a result, to some people, "silent PPO" describes a payment scheme used to obtain illegal discounts for payers who are not entitled to them. In discussions with interested parties and in industry literature, the terms "fraud," "illicit," "manipulation," "falsely," "unethical," and "scheme" are frequently used to describe silent PPOs. Consequently, the term "silent PPO" has come to mean an unethical and/or illegal practice, and the term has been loosely extended to inappropriately encompass non-directed PPOs. For the purpose of our review, we have differentiated between the terms "non-directed PPO" and the more restrictive term "silent PPO." Since "silent PPO" activity would be inappropriate for the FEHBP, we were concerned with the implication that it may exist in the FEHBP.

A "silent" PPO is distinguished from a "non-directed" PPO by the nature of the contractual relationship between the parties. As stated above, in a "non-directed" relationship, discounts are taken pursuant to contractual arrangements that can be traced from the payer (i.e., the insurance carrier) to the medical provider. In a "silent PPO," a contractual relationship can not be traced from the payer to the medical provider from whom the discount is taken. Typically, in a silent PPO arrangement, another PPO will sell its medical provider's names and discounted fee information, often without the provider's knowledge and permission, to a secondary market of vendors. These vendors then access the information on behalf of their payer clients, recalculating the provider's fee based on the discounted fee information. It has been alleged that sometimes, the payer may claim a non-existent affiliation with the provider by inaccurately declaring that the patient is a member of a PPO to which the provider is a member.

In 1993, when the distinction between a non-directed PPO and a silent PPO was less clear, OPM became aware of market place arrangements that resulted in the capturing of discounts from provider bills. As a result, in its March 1993 call letter to FEHBP carriers providing rate and benefits instructions for the 1994 contract year, OPM stated, "In addition, OPM is aware that price concessions are available from non-network providers, e.g., hospitals, so carriers are expected to obtain the lowest price available for all goods and services, including non-PPO

providers." The committee is concerned that this OPM requirement may have encouraged the use of improper payment discounts thereby causing an FEHBP provider to grant a discount to a payer that it is not contractually obligated to give.

III. DISCUSSION OF RESULTS

Our review disclosed that substantial savings have been and can be achieved by both directed and non-directed PPOs. We further found these saving can be achieved in an ethical manner; in that, we found no evidence in the FEHBP that "silent PPOs" were a factor or that provider discounts were otherwise taken on the basis of any schemes to victimize medical providers. In addition, we found FEHBP carriers and their vendors were, except for some minor exceptions, accessing discounts in accordance with the terms of their contracts with providers. Based upon the aggregate of our observations, we believe given the complex environment in which PPOs operate, it is understandable why the expectations for patient steerage by medical providers is not always fulfilled. With regard to OPM's call letter, we found that language which encouraged carriers to seek discounts on providers' bills was the result of discussions between the House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

A. Substantial Savings Can Be Achieved through both Directed and Non-directed Preferred Provider Arrangements.

As we indicated earlier, a principal reason why carriers enter into preferred provider arrangements is to reduce their costs. Lower costs translate into lower premiums for the FEHBP, the federal government, and its employees. In our survey of FEHBP carriers, we asked carriers how much the FEHBP saved by using directed and non-directed PPOs. Carriers reported substantial savings (See Exhibit 3). The great majority of the savings were realized under directed PPO arrangements. For the six-month period ending June 30, 1997, six carriers reported gross directed PPO savings totaling \$390.5 million. This represents 19.7 percent of premiums for those carriers. For the same period, a different mix of six carriers reported gross non-directed PPO savings totaling \$25.5 million representing 2.2 percent of premiums. We conclude that substantial sums can be saved through directed and non-directed PPO arrangements. In view of the fact that directed PPOs provide for steerage of patients, as would be expected, directed PPO savings are significantly larger than non-directed PPO savings. While non-directed PPO savings are substantially lower than directed PPO savings, in absolute terms, they too are significant and offer additional opportunities to reduce FEHBP costs that should not be overlooked, assuming they can be achieved in an ethical and lawful manner.

B. No Evidence Found to Confirm the Use of Payment Schemes that Victimize Health Care Providers in the FEHBP.

Based on our test of insurance benefits paid in August 1997 by FEHBP carriers, we found no evidence that "silent PPOs" were used as a method of capturing discounts or that providers were

being otherwise victimized.

The Committee on Government Reform and Oversight has expressed the concern that medical providers are perhaps being victimized by an alleged practice which accesses provider discounts using subterfuge or misrepresentation. As explained previously, this practice involves the selling of provider names, and the discounts they provide to their directed PPO clients, to third parties who access the discounts by misrepresenting their subscribers as members of the provider's directed PPO. This report uses the term "silent PPO" to describe this practice. In these cases, there is no contractual relationship between the payer of insurance benefits (or their subcontractors) and the medical providers who are providing the medical services to the payer's subscribers. Such misrepresentation, in our opinion, would constitute, at the very least, an unethical practice in the FEHBP. OPM regulations set forth the minimum standards for health benefit carriers. The standards provide that carriers must perform the contract in accordance with prudent business practices which include, "Legal and ethical business and health care practices." (48 CFR 1609.70(b)(2)). Failure to adhere to minimum standards could be cause for terminating a carrier contract. Consequently, the principal focus of our review was to determine whether any FEHBP carriers, or their subcontractors on behalf of FEHBP carriers, participated in the above described practice.

As explained in the background section, the terms "non-directed PPO" and "silent PPO" have been used interchangeably. Therefore, it was generally thought that those vendors who offer non-directed PPOs also made use of "silent PPOs." Consequently, to search for the use of silent PPOs in the FEHBP, we focused our attention on the vendors who subcontract with FEHBP carriers to provide non-directed PPO services. As a result, we identified five FEHBP carriers who contracted with four (as a result of an acquisition, to become three) vendors to provide non-directed PPO services (See Exhibit 2). [Note: These same vendors may also provide directed PPO services to other clients.] We sampled and reviewed 600 claim lines representing 120 claim lines for each carrier that were repriced by these vendors. The purpose of our sample was to determine whether the discount taken on each claim was pursuant to the medical providers membership in the non-directed PPO and was otherwise consistent with their contract. We found that in each instance, a series of contractual agreements were in place. These agreements were between the carrier and the vendor, the vendor and provider network or the provider, and the provider network and providers. Consequently, we found no evidence that the FEHBP carriers through their vendors used "silent PPOs" to access discounts.

C. With Minor Exception, Discounts Were Accessed in Accordance with Contract Terms.

In addition to ensuring that there was a contractual relationship between all the parties who participated in arranging for the discounts from non-directed PPOs, we also verified that discounts taken were consistent with the contract terms. While the great majority of the claim lines tested were processed in accordance with contract terms, we observed in a few instances, that the FEHBP carrier was not entitled to the discounts taken. We found that the vendors accessed provider discounts in 8 of the 600 claim lines (or 1.3%) that were inconsistent with

contract terms. These improperly taken discounts totaled \$675.27 representing 1.24 percent of the \$54,370 of discounts taken in our August 1997 sample of 600 claim lines. If our findings for the month of August 1997, were representative of the six-month period ending June 30, 1997, then out of carrier reported non-directed PPO savings of \$25.4 million, about \$315 thousand was improperly taken. In each case, to access the discount, the contract between either the vendor and provider network or between the provider network and the provider required the steering of the patient to the provider through some form of financial incentive. In each case, the patient was not steered to the provider in accordance with the contract terms. Our review at each vendor is further discussed below:

National Preferred Providers Network (NPPN), Inc.

The NPPN is located in Middletown, New York and offers provider networks to its clients. Its network consists of 3,000 hospitals, 18,000 ancillary facilities, and 280,000 physicians. The NPPN contracts with the National Association of Letter Carriers Health Benefit Plan (NALC) to provide a non-directed PPO network. Their agreement provides that NALC is under no obligation to notify participants of the availability of NPPN's network providers.

During our review of the NPPN claim line sample (60 claim lines out of a universe of 33,848), we determined that there were contractual agreements in place that made the medical providers members of NPPN's network. However, we found that NPPN extended some discounts to NALC that we determined were improper. NPPN's contract with one provider network required steering in order for the discounts to be given to the insurance carrier. This contract covered three claim lines or 5 percent of the claim lines reviewed in our NPPN sample (See Exhibit 4). For the three claim lines, \$55.77 in discounts were taken.

Multiplan

Multiplan is located in New York, New York. It is a facility-based preferred provider organization with a network of over 30,000 hospitals and other facilities located throughout the United States. Multiplan contracts with the NALC to provide a non-directed PPO network. Multiplan also provides directed PPO services to other clients. (See appendix for Multiplan comments.)

During our review of the Multiplan claim line sample (30 claim lines out of 6,081), we determined that there were contractual agreements in place that made the medical providers members of Multiplan's network. Generally, we also found that Multiplan agreements with provider networks did not require the steering of patients, but instead required Multiplan to use its best efforts to encourage appropriate incentives to the Providers. However, we found that Multiplan extended an immaterial discount to NALC from one provider network that we determined was improper (See Exhibit 4). Multiplan's contract with one network required steering in order for the discounts to be given to the insurance carrier. The contract covered one claim line or 3.33 percent of the lines reviewed. The discount totaled \$1.87.

United Payors & United Providers (UP & UP)

The UP & UP is located in Rockville, Maryland. UP & UP provides non-directed PPO services to the following five FEHBP carriers: Foreign Service, APWU, NALC, Rural Carriers, and SAMBA. In September 1997, UP & UP acquired America's Health Plan, Inc.. AHP previously provided non-directed PPO services to FEHBP carriers. (See appendix for UP & UP comments.)

During our review of the UP & UP claim line sample (510 claim lines out of 40,704), we determined that there were contractual agreements in place that made the medical providers members of UP & UP's network. We observed that UP & UP periodically provides its provider networks with a list of client payers. They also provide their hospitals with a cash prepayment. We also noted that UP & UP agreements state that it will use its best efforts to require each payer client to create financial incentives for covered persons to utilize their providers.

Our review disclosed that UP & UP accessed discounts for four APWU claims that we determined were improper (See Exhibit 4). For the four APWU claim lines, one contract between a provider network and its providers required steerage of subscribers through financial incentives in order for the discounts to be given to the insurance carrier. In all four cases, the carrier did not provide the financial incentives required by the contract. In three of the four cases, the APWU paid 100 percent of the claim. Had co-insurance been applicable to these specific claims, the cost sharing provision of UP & UP's contract with its providers would have been operative thereby authorizing the discounts taken. These four claim lines represent less than one percent of the claim lines reviewed in our sample. The discounts taken total \$617.63.

Conclusion

While we found no evidence that silent PPO's were a problem in the FEHBP, we noted that in eight instances, FEHBP carriers were given access to discounts by their vendors to which they were not entitled. In these instances, the contracts with either the provider networks or the providers required a financial incentive to steer patients to the provider's facilities and the subscribers were not so steered. We believe it is the obligation of the vendor to ensure that it does not give FEHBP carriers access to discounts to which they are not entitled. To the extent that these circumstances exist, providers would have cause for concern. However, the number of instances in our sample were not material.

While the evidence of our review suggests little cause for concern, this conclusion is inconsistent with the level of concern expressed by the medical community. While we found that in the great majority of the cases, discounts taken were consistent with the contract terms, the complex environment and sometimes vague contract terms under which PPOs operate leave expectations on the part of providers that perhaps are not being fulfilled. First, we observed that many of the vendor contracts with provider networks and providers state that the vendor will make a reasonable or best effort to encourage payers to provide incentives to its subscribers to use the vendor's providers. Best efforts do not always translate into actual steerage. Second, the

contractual relationship between the vendor and the provider sometimes also involves an intermediary, a regional provider network. These regional network agreements insulate the provider from the true nature of the agreement that exist between the regional networks and the vendor. Third, some payer clients use the vendors for directed PPO services and thus share the same providers with other payer clients who use the vendor's non-directed PPO services. Since the vendor may have only a single contractual agreement with the provider, some of the patients are steered and others are not. Thus, we can visualize how these three factors can combine to cause perhaps false expectations and confusion on the part of providers who may be expecting steerage but in fact entered into an agreement that does not require steerage. We would suggest that the best solution to these factors is education within the industry. We have observed that both the American Medical Association and the American Hospital Association have already begun such an effort.

D. Use of Non-directed PPOs Encouraged by Appropriation Committees.

Our review determined that language in OPM's annual carrier call letters, which encouraged carriers to seek discounts on providers' bills, was a result of discussions between House Appropriation Committee's staff and OPM's former Associate Director for Retirement and Insurance.

Each spring, OPM issues its annual carrier call letter to health benefits carriers. The call letter is a solicitation to current FEHBP carriers for proposed rate and benefit changes for the upcoming contract year which begins January 1. The letter generally provides overall direction and sets the parameters for acceptable rate and benefit changes. Recognizing that in the market place, price concessions were available from non-network providers (meaning providers who do not belong to directed PPO networks), the March 1993 call letter for the 1994 contract year included a new provision which encouraged carriers to obtain price concessions from providers including non-PPO providers (again meaning providers who do not belong to directed PPO networks). The provision read as follows:

"Carriers are to actively establish or promote the expansion of existing PPO arrangements in terms of availability to enrollees as well as coverage provided. In addition, OPM is aware that price concessions are available from non-network providers, e.g. hospitals, so carriers are expected to obtain the lowest price available for all goods and services, including non-PPO providers." (Underline added)

A similar provision was included in the March 1994 call letter for contract year 1995. It read as follows:

"We continue to encourage expansion of PPO arrangements, in terms of availability of PPO providers to enrollees and coverage provided. In addition, carriers are expected to obtain the lowest price available for all goods and

services, including those of non-PPO providers. All carriers must put in place procedures to capture discounts from all bills presented and/or contract with vendors to do this. (Underline added)

The call letters for contract years 1996, 1997, and 1998 continued to encourage carriers to expand and strengthen their existing PPO arrangements and the services provided under such arrangements. In addition, they each contained the following pertinent provision:

“We also expect carriers to put in place procedures to capture discounts from bills presented, where cost effective to do so.”

The committee was concerned that the call letter language may have encouraged, perhaps inadvertently, the use of improper payment discounts. By “improper,” they meant any system of payment discounts for payers who are not entitled to such discounts. They believed that the result of any such improper discount would be to cause an FEHBP provider to grant a discount to a payer that it is not contractually obligated to give. The committee was also concerned that the call letter seems to have had the effect--intended or not--of spawning efforts on the part of some network managers and/or brokers to require the use of non-directed PPOs by statute. As a consequence, the committee asked us to determine what prompted the language in the OPM call letter.

The former Associate Director for Retirement and Insurance recollected that in 1993 the House Appropriation Committee was considering either report or statutory language which would require FEHBP carriers to take advantage of provider discounts available in the market place. The former Associate Director indicated that he opposed any language which would regulate the market place. Consequently, as a compromise he agreed to include language in OPM's call letter which would encourage FEHBP carriers to take advantage of whatever discount arrangements were available in the market place. In 1993 (for the FY 1994 appropriation) and again in 1994 (for the FY 1995 appropriation), both the House and Senate Appropriation Committee reports on OPM's appropriation bill applauded OPM's action. The House report for the FY 1994 appropriation stated:

“The Committee feels that, in addition to the cost savings obtained by HMO's and PPO's, all FEHBP carriers should endeavor to obtain the lowest price available for the goods and services they provide. The Committee has learned that while price concessions are available from most providers, not all FEHBP carriers are receiving such discounts. Many carriers in the FEHBP merely pay the billed charges or the usual and customary rate.

The Committee is aware, however, that some carriers are utilizing large discount networks that have negotiated more favorable rates with providers. The Committee feels there could be significant savings realized through a more concerted effort by carriers to pay the lowest price available for billed medical

charges, and applauds the Office of Personnel Management's reference to such potential efforts in its Letter to Carriers dated March 31, 1993. The Committee believes these efforts should in no way disrupt benefits or attempt to direct patients if they choose not to be directed to specific providers."

Based on our interview with the former Associate Director for Retirement and Insurance and our review of the Appropriation Committees' Report for the Treasury, Postal Service, and General Government Appropriation bills for 1994 through 1995, we conclude that the call letter language was prompted by the House Appropriation Committee.

IV. OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to determine whether FEHBP carriers were taking advantage of health care providers by using payment schemes that create payment discounts for payers who are not entitled to them. In performing our review, the committee staff requested that we also:

1. Identify organizations that contract with FEHBP carriers to reprice provider bills to obtain a discount where the FEHBP carrier does not have a directed PPO with the provider or the patient has not been given a financial incentive to use the provider from whom the discount was obtained.
2. Determine whether any discounts were taken by FEHBP carriers to which they were not contractually entitled.
3. Identify providers that have a contract with vendors based solely on the possibility of becoming a part of that vendors network.
4. Identify providers that have a contract with a vendor based solely on the concern that they need to do this to remain competitive.
5. Determine what prompted the language in the OPM call letter to encourage the use of non-directed PPOs by FEHBP carriers.

Our review was performed in accordance with generally accepted government auditing standards for performance audits. The review was performed at the Government Employees Hospital Association, Kansas City, Missouri; United Payors and United Providers, Rockville, Maryland; Multiplan, New York, New York; and National Preferred Providers Network, Middletown, New York during the period June 1997 through December 1997. Additional work was performed in our offices in Washington DC. Our review entailed the following review procedures:

- We conducted an initial review at the FEHBP's Government Employees Hospital Association (GEHA) plan to gain an understanding of the subject. We interviewed carrier officials and traced 34 claims, which were repriced by non-directed PPO vendors,

to contractual agreements between the GEHA, vendors, and providers. We found no evidence of questionable conduct or contract inconsistencies; that is, in each case, we found that contracts were in place and that discounts were taken pursuant to the contract terms.

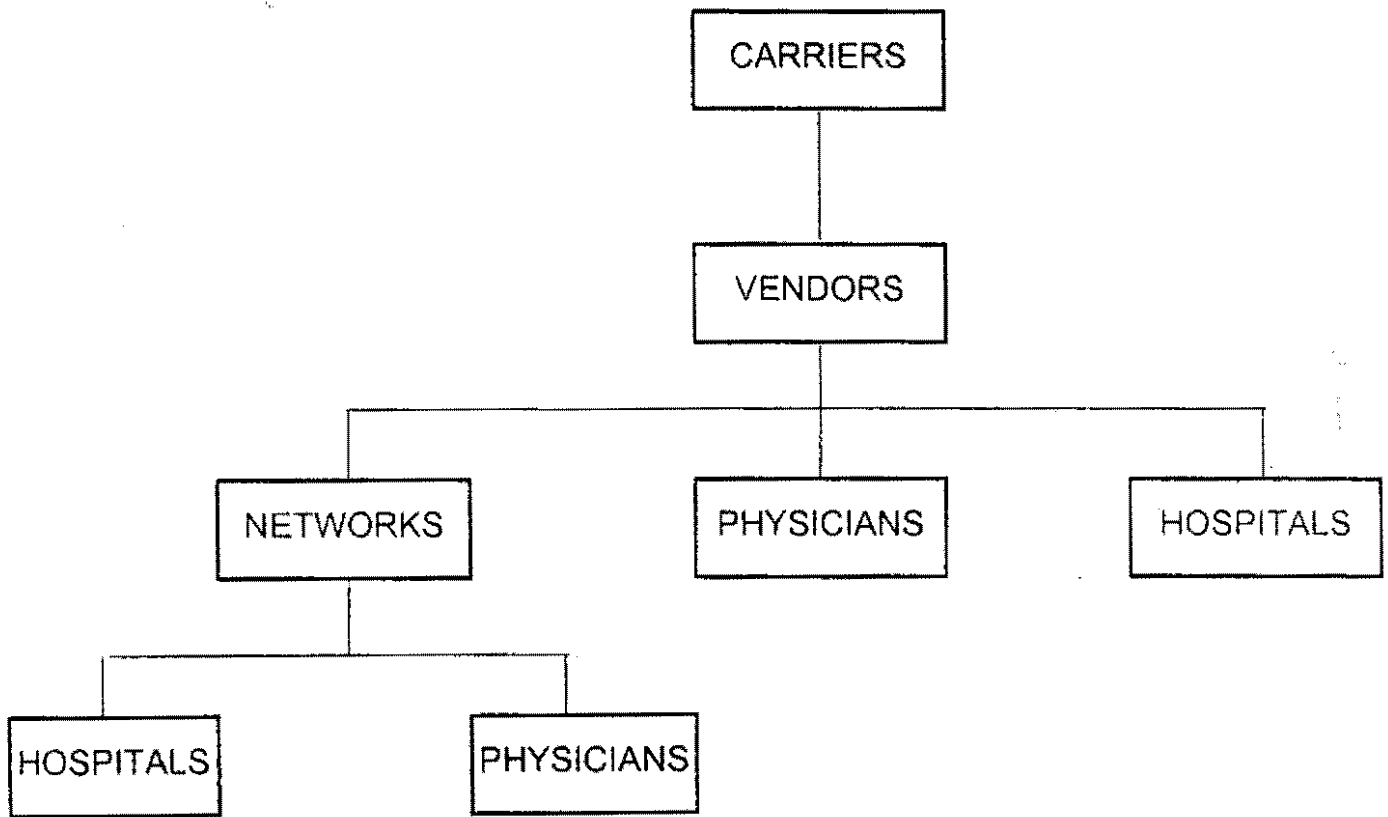
- We surveyed 9 of 14 FEHBP fee-for-service carriers to identify which carriers used directed and non-directed PPOs and to identify the non-directed PPO vendors used by the carriers. We did not survey: Blue Cross Blue Shield (has its own PPO networks), GEHA (covered in survey work), Association Benefit Plan (requires extraordinary security procedures), Panama Canal Area Benefit Plan (out of country), and Secret Service (underwritten by BCBS who has its own PPO networks).
- Of the nine carriers surveyed, we found that five carriers used non-directed PPO arrangements. They were:
 1. American Foreign Service Protective Association (Foreign Service),
 2. American Postal Workers Union Health Plan (APWU),
 3. National Association of Letter Carriers Health Benefit Plan (NALC),
 4. Rural Carriers Benefit Plan (Rural Carriers), and
 5. Special Agents Mutual Benefit Association (SAMBA).
- We identified four vendors that provided non-directed PPO services to the five carriers (See Exhibit 2). They were:
 1. United Payors and United Providers (Up & Up), Rockville, Maryland,
 2. America's Health Plan (AHP), Rockville, Maryland (Acquired by UP & UP),
 3. Multiplan, New York, New York, and
 4. National Preferred Provider Network (NPPN), Middletown, New York.
- From each carrier, we acquired a computer tape of all benefit payments during August 1997. From these tapes, we extracted 80,633 claim lines representing \$2.7 million in discounts paid by the five carriers and repriced by one of the four non-directed PPO vendors.
- From the extracted claim lines, we sampled 600 claim lines (120 per carrier) representing \$54 thousand in discounts.
- For each of the 600 claim lines, we reviewed the carrier's Explanation of Benefits, when available, traced claims to carrier contracts with vendors and further traced claims to vendor contracts with provider networks and/or providers.
- We reviewed the carrier and provider network contracts at the vendors' offices to determine whether contracts were in place and to determine whether the contracts

required steerage in order to access the discounts. When present in the vendors file, we also examined the provider network's contracts with providers to determine whether steerage was required.

- We recalculated a sample of discounts to verify that discounts were calculated consistent with contract terms.
- We met with representatives from the American Medical Association and the Federation of American Health Systems.
- We did a literature search and reviewed the articles identified.
- We surveyed 30 hospitals that complained to OPM about its call letter provision regarding the capture of discounts.
- With regard to the call letter issue, we reviewed OPM's call letter files for the period 1991 through 1997 and interviewed both the former Deputy and Associate Directors for Retirement and Insurance Services to determine who or what influenced OPM to include in its annual call letter a statement which would encourage carriers to capture discounts from non-PPO medical providers. We also reviewed the House and Senate Appropriation Committee Reports for the Treasury, Postal Service, and General Government Appropriation bills for 1993 through 1995.

Due to time constraints, we were not able to perform sufficient procedures to identify health care providers that entered into a non-directed PPO contract arrangement with a vendor based solely on the possibility of becoming a part of that vendor's directed PPO network or to remain competitive. While we did make some limited inquiries, those inquiries were insufficient to either confirm or deny whether these were substantive reasons for entering into a non-directed PPO arrangement.

FLOW OF DISCOUNT ARRANGEMENTS



PREFERRED PROVIDER ORGANIZATIONS

Employee Organization	Multiplan, Inc	National Preferred Provider Network	United Payors & United Providers and America's Health Plan
American Foreign Service Protective Association			✓
American Postal Workers Union Health Plan			✓
National Association of Letter Carriers Health Benefit Plan	✓	✓	✓
Rural Carrier Benefit Plan			✓
Special Agents Mutual Benefit Association			✓

Vendors:

Multiplan, Inc.
 115 Fifth Avenue
 New York, NY 10003
 Phone: (212) 780-2000

National Preferred Providers Network, Inc.
 407 East Main Street
 Middleton, NY 10940
 Phone: (914) 343-1600

United Payor and United Providers/America's Health Plan
 2275 Research Boulevard, Sixth Floor
 Rockville, MD 20850
 Phone: (301) 548-1000

PREFERRED PROVIDER ORGANIZATIONS REVIEW

**PREMIUM PAYMENTS
FOR PERIOD ENDING JUNE 30, 1997
(UNAUDITED)**

DIRECT PPOs			
CARRIER	PREMIUM PAYMENTS	SAVINGS	RATIO
APWU	203,027,700	29,825,317	14.69%
GEHA	477,451,392	106,799,463	22.37%
MHBP	903,996,936	179,148,767	19.82%
NALC	323,256,494	58,873,579	18.21%
POSTMASTER	29,373,621	5,007,328	17.05%
SAMBA	41,255,807	10,839,047	26.27%
Gross Fees	1,978,361,950	390,493,501 <u>29,854,245</u>	19.74%
Net	<u>1,978,361,950</u>	<u>*360,639,256</u>	<u>18.23%</u>

NONDIRECT PPOs			
CARRIER	PREMIUM PAYMENTS	SAVINGS	RATIO
AFSPA	18,858,169	392,495	2.08%
APWU	203,027,700	2970380	1.46%
GEHA	477,451,392	7573843	1.59%
NALC	323,256,494	12,573,249	3.89%
RURAL	85,536,527	1,630,669	1.91%
SAMBA	41,255,807	311,073	0.75%
Gross Fees	1,149,386,089	25,451,709 <u>4,345,450</u>	2.21%
Net	<u>1,149,386,089</u>	<u>21,106,259</u>	<u>1.84%</u>

* Amounts saved may be further reduced as a result of financial incentives given to subscribers.

Results

Vendors	Arrangement between Vendor/Network	Arrangement between Network/Provider	Total Number of Errors	Total Amount of Sample Errors
National Preferred Provider Network	3		3	\$55.77
Multiplan	1		1	\$ 1.87
United Payors & United Providers		4	4	\$617.63
Total Errors	4	4	8	\$675.27
Number of claim lines reviewed			600	\$54,370
Error Rate			1.3%	1.24%

APPENDIX

SIGNIFICANT RESPONSES FROM AFFECTED PARTIES

1. William E. Flynn, III, Associate Director for Retirement and Insurance, Office of Personnel Management
2. Richard G. Miles, President, Government Employees Hospital Association, Inc.
3. Carroll Midgett, Chief Operating Manager, Health Plan Department, American Postal Workers Union, AFL-CIO
4. Calvin Engel, Assistant Administrator, National Association of Letter Carriers Health Benefit Plan
5. S. Joseph Bruno, Chief Financial Officer, United Payors & United Providers
6. Sidney L. Meyer, Executive Vice President, MultiPlan



Office of
Personnel Management

Washington, D.C. 20415

In Reply Refer To:

Your Reference

MEMORANDUM FOR PATRICK E. MCFARLAND
INSPECTOR GENERAL

FROM: WILLIAM E. FLYNN, III *W. E. Flynn*
ASSOCIATE DIRECTOR
FOR RETIREMENT AND INSURANCE

Subject: Silent PPOs, Report Number 99-00-97-054

Thank you for sharing your "Report on the Use of Silent PPOs in the Federal Employees Health Benefits Program" with us. We were impressed with the rigor and thoroughness of the report and are gratified that it confirmed our belief that the carriers which contract with us engage in lawful and ethical practices in obtaining discounts from health care providers.

We were pleased that the small number, only 13 percent, of discounts that occurred in a manner inconsistent with agreed upon contract terms were inadvertent errors which were neither material nor indicative of any systemic problem in need of correction. While much concern has been expressed about "silent PPOs" which take inappropriate discounts from health care providers, your report definitively shows that if "silent PPOs" exist at all, they clearly do not exist in the Federal Employees Health Benefits Program. What do exist are legitimate non-directed PPOs which produce material savings for the carriers that employ them. While these savings do not approach those obtained by the same carriers from their directed PPO networks, they still constitute savings which would not otherwise have been achieved.

We hope that your report will put to rest the need that some parties have expressed for action on our part to address a "silent PPO" problem that does not exist.

RECEIVED
OFFICE OF
INSPECTOR GENERAL
90 FEB 23 AM 9:26



The Health Plan for Federal Employees

February 16, 1998

Office of the Inspector General
Office of Personnel Management
Attention: Sanders Gerson
Room 6400
1900 E St. N.W.,
Washington, D.C. 20415

Subject: Draft Copy of Report on Silent PPOs

Dear Mr. Gerson:

I have reviewed the report and was relieved to see that the conclusions supported our position on this matter. As a matter of editorial comment only I have a couple of observations from reading the report.

The report discusses the concept of an "ideal" PPO. I believe that the term "ideal" used in this context is too subjective and creates the impression that one type of network is better than another. In reality, what may be desired by a provider may not be ideal from a payor standpoint or from that of another provider.

Although many PPOs do provide services related to controlling utilization this is not universal and the savings derived from utilization controls is minor in comparison to the savings from contractual agreements with providers. In my opinion, whether or not a PPO provides utilization controls is not relevant to the subject matter. I might also suggest that you substitute "traditional" for "ideal" to describe directed networks in the second paragraph on page 2.

I thought the report language could be strengthened to note that although a small number of errors were detected there did not appear to be a systematic practice of deception nor were any of the errors made of a material nature.

Government Employees Hospital Association, Inc.

P.O. Box 1096 • Independence, MO 64051-0596 • Telephone (800) 821-6136

www.geha.com



Overall, I was very pleased with the conclusions reached and am hopeful that this report will put the issue to rest so we can all devote our efforts to more substantive topics. Thank you for giving me the opportunity to review the draft report and to provide comment.

Sincerely,



Richard G. Miles
President



Health Plan Department American Postal Workers Union, AFL-CIO

P.O. Box 420, Burtonsville, MD 20866

February 17, 1998

Chief Operating Manager

Carroll E. Midgett, Jr.
(301) 622-5554

**Health Plan
Board of Directors**

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Central Region

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Eastern Region

Elizabeth "Liz" Powell
Northeast Region

Terry Scapleton
Southern Region

Raydell R. Moore
Western Region

Mr. Sanders P. Gerson
Deputy Assistant Inspector General for Audits
Office of Personnel Management
1900 E. Street NW - Room 6400
Washington, D.C. 20415

Dear Mr. Gerson:

We appreciate the opportunity to comment on the Office of Inspector General's report on "Silent PPOs" before its release to the House Committee on Government Reform and Oversight.

Based on a review of the draft report dated February 6, 1998 and discussions with the OIG audit staff, it is our understanding that the four APWU claim lines in question (out of 120 claims reviewed) involved agreements between the hospitals and a network which required steerage of subscribers through financial incentives in order for the discounts to be given. While the contract between APWUHP and UP & UP did not require steerage and the contract between UP & UP and the network did not require steerage, the contract between the network and the providers apparently required steerage.

Currently, the APWUHP is working with UP & UP to determine what alternatives are available to eliminate the conflicting language in the provider - network contracts.

Additionally, the 4 claims lines out of 120 claims reviewed represents a 97% processing accuracy rate which is well above the 95% processing accuracy standard set by the Office of Personnel Management.

February 17, 1998

If you have any questions regarding the enclosed information, you can reach me at
(301) 622-5554.

Cordially,

Carroll Midgett

Carroll Midgett
Chief Operating Manager

NATIONAL ASSOCIATION OF LETTER CARRIERS
HEALTH BENEFIT PLAN

20547 Waverly Court, Ashburn, Virginia 20149 • 703-722-2477
Vincent R. Sombrotto, President • Thomas H. Young, Jr., Treasurer



Delivered via Facsimile and U.S. Mail

February 17, 1998

Office of the Inspector General
U.S. Office of Personnel Management
Room 6400
1900 E Street, N.W.
Washington, DC 20415

Attention: Sanders Gerson, Deputy Assistant Inspector General for Audits

Dear Mr. Gerson:

Thank you for the opportunity to review the Office of the Inspector General's (OIG) preliminary report on silent and/or non-directed PPO type programs. As this report indicates, PPO arrangements are defined and applied by FEHBP carriers with differing methodologies. Because of this, it is difficult to draw a parallel between the FEHBP carrier's PPO type applications.

Reviewing this OIG draft suggests that OIG is only releasing aggregate fees (i.e. the amounts paid to PPO contractors for savings on discounted services) for the FEHBP program. The NALC Health Benefit Plan believes that OIG's final release should not disclose individual negotiated fees with any given vendor - being that they are competitively derived. Releasing these fees will violate the Plan's disclosure terms of PPO agreements and may jeopardize our capability to obtain future competitive bidding with PPO and discounted provider groups.

Again, thank you for giving the NALC Health Benefit Plan an opportunity to review and comment on this report before its final release.

Sincerely,

Calvin Engel
Assistant Administrator

Board of Trustees

Lawrence D. Brown, Jr. John W. DiTollo, Ch. Luc E. Bosveld

UNITED PAYORS & UNITED PROVIDERS

February 17, 1998

Sanders P. Gerson
Deputy Assistant Inspector General for Audits
U.S. Office of Personnel Management
Office of Inspector General
1900 E Street, N.W., Room 6400
Washington, DC 20415

Dear Mr. Gerson:

Thank you for the opportunity to meet with you and Mr. Gibbons on Friday afternoon regarding the results of the Office of the Inspector General's Review ("OIG Review") of the use of Preferred Provider Organizations ("PPOs") in the Federal Employees Health Benefit Program ("FEHBP"). We, the management team at United Payors & United Providers, Inc. ("UP&UP"), want to reiterate to the OIG that:

- (1) The review was performed in a professional and efficient manner with knowledgeable staff.
- (2) The OIG's extension of their FEHBP Review to include PPO provider contracts was an important element of examining the benefits derived by the FEHBP. The Review validated the importance of the PPO networks in obtaining savings for not only the FEHBP but also for the individual plan members.
- (3) The OIG's Review was an important step in determining that there was "no evidence found to confirm the use of payment schemes that victimize health care providers in the FEHBP". Further, we appreciated your comments at our meeting which indicated that a reader of your Review report should determine that (a) there was no evidence of "Silent PPO" activity, (b) the FEHBP derived significant benefits from PPOs, and (c) there is no need for further audit work by the OIG or any other oversight body regarding the use of PPOs.

We believe that if the FEHBP were to be subjected to a further review, it would be imperative for the OIG, or other agency of the Federal Government, to audit all vendors (so-called Directed and non-Directed PPOs) that provide financial intermediary services between FEHBP payors and health care providers. These intermediaries (PPOs) offer identical products that are utilized by the commercial payor community (i.e., major insurance companies). From our perspective, it is important to note that discounts enjoyed by the FEHBP through so-called Directed PPO products are also supported by a similar

Mr. Gerson
February 17, 1998
Page Two

commercial contracts. In fact, if such Directed PPO arrangements were not supported by a valid contract, there would be evidence of a "Silent PPO" and an abusive provider relationship. Specifically, we believe that all other so-called Directed PPOs should be subjected to the same contractual scrutiny that other FEHBP financial intermediaries have experienced. To drive this point home, if there is a need to expand your Review, we believe it should be expanded to the other PPOs serving the FEHBP.

Audit/Review Conclusions Should Be Clearly Stated

We are pleased with the results of your Review and we recommend that your report consist of an opinion paragraph (presented on page 1 of your report) that indicates the scope of your Review and the results obtained as noted in your headline comments A and B on page 6 of your draft report. The substantial background information section of your report inadvertently allows the reader to believe that unverified industry data and processes represent the results of your Review. Specifically, we believe that there is no support for the following health care terminology used in your Report:

- Financial incentives
- Ideal PPO
- Steerage
- Directed PPO
- Non-Directed PPO

If the reader of your Review report requires background information, we suggest an appropriate Appendix which describes how the \$1 trillion health care industry operates including the Blue Cross and other so-called Directed PPOs. This write-up should also include common health care terminology and not "hearsay" comments which you describe as anecdotal information from the Committee staff and other special interest groups.

UP&UP is a public company required to make disclosures to the Securities and Exchange Commission, therefore, we are confident that our business would be characterized using the following informational points:

- ✓ UP&UP's clients include all major insurance carriers — Aetna, Cigna, John Hancock, United HealthCare, Prudential, Mutual of Omaha, etc. These clients use the same national health care network as the FEHBP.
- ✓ UP&UP is a financial services company that supports the health care industry. Insurance companies and other major payors design health plans for a full range of large and small group employers, unions and other Government employees that utilize the UP&UP network.
- ✓ UP&UP regularly communicates with its provider clients by describing how the beneficiaries of our payor clients use the provider network.

- ✓ UP&UP's contracts with its providers offer tangible benefits such as a prepayment of one month (1/12) of medical claims represented by all of UP&UP's payor clients. As of December 31, 1997, UP&UP has prepaid approximately \$17 million in medical claims.
- ✓ UP&UP has contracted with hospitals, ancillary facilities and physicians that represent "high utilization" providers of the beneficiaries that are covered by the health plans of UP&UP's payor clients.
- ✓ UP&UP's national network product is based on certain principles:
 - UP&UP does not assume underwriting risk
 - UP&UP prepayments to providers do not require the provider to assume business risk (capitated payments do shift risk to the provider)
 - UP&UP facilitates the continued use of the health care provider by the beneficiary through positive communication (directories, 800 numbers, ID cards). "Steerage" to hospitals is done by physicians and UP&UP believes that it is inappropriate to interfere with the doctor-patient relationship.
- ✓ The UP&UP network savings are always shared with the beneficiary. UP&UP believes that the waiver of a "co-payment" is a financial technique that is negative for the following reasons:
 - Interference with the patient's relationship with their physician.
 - Increase in health care costs, i.e.:

	UP&UP Relationship	Co-Payment Waiver Financial Technique
Hospital Bill	\$1,000	\$1,000
Contractual Allowance	<u>(200)</u>	<u>(200)</u>
Net Billing	<u>800</u>	<u>800</u>
Co-Payment Waiver (20%)	<u>N/A</u>	<u>160</u>
Total Health Care Cost to Payor (80/20 plans)	<u>640</u>	<u>800</u>
 Increase Health Care Cost Shifting		 <u>20%</u>

Further, as noted above, we believe that when a co-payment waiver is required to "so-called direct" a patient to a specific hospital, the FEHBP actually incurs a significant cost in addition to the PPO network access fee in order to achieve "steerage" (if one actually believes that anyone or anything steers a patient other than a physician).

Full Disclosure of Background Information is Needed to Make the OIG Report Complete

There are references to Chairman Mica, House Subcommittee on Civil Service, in your report. We believe that it would be important background information for Congressman Mica's comments on October 22, 1997 to be included in your report. An excerpt of his comments are:

"The second major revision in the amendment deals with the most controversial matter in the bill: the question of 'silent PPOs'. Everyone acknowledges that Preferred Provider Organizations (PPOs) play an important role in today's health care market. Frequently, these PPOs negotiate discounted rate schedules with health care providers in exchange for certain incentives. The incentives may include an agreement to steer patients to the provider, in the case of so-called "directed PPOs", or they may include financial incentives such as prepayment or prompt payment in the case of so-called 'non-directed PPOs'. Both directed and non-directed PPOs provide legitimate and valuable benefits to health care providers, carriers, and patients.

However, many believed that the original language placed non-directed PPOs at a competitive disadvantage. That was not Chairman Burton's intent, and it is certainly not the intent of this subcommittee.

'Silent PPOs', however, are another matter. These organizations take advantage of health care providers by arranging for a carrier to obtain access to discounted rates it is not entitled to. The first victims of this practice are the Doctors and Hospitals. But in the end, all of us will pay the price as the losses incurred by these providers are shifted to other consumers of medical services."

Also, an October 16, 1997 letter to John Mica from Constance A. Morella, M.C., Thomas M. Davis, M.C., Elijah E. Cummings, M.C. and Harold E. Ford, Jr., M.C. indicated that:

"We are writing to express our collective concerns about Section 5 of H.R. 1836. Currently, fee-for-service plans in the Federal Employees Health Benefits Program (FEHBP) are saving the government millions of dollars a year through their utilization of various savings initiatives, including non-directed efforts. Section 5 of H.R. 1836 would cost the FEHBP these savings and create an administrative burden that would increase administrative costs.

We are concerned about these increased costs to FEHBP, which would be borne jointly by the federal government and federal employees. Already, next year's premiums are rising, on average, by 8.5%. Increased costs caused by this legislation would almost certainly need to be addressed in both authorizing and appropriating legislation if Section 5 is enacted. The Office of Personnel Management (OPM) and carriers within the program have expressed concern over these additional costs. In the Congressional Budget Office's (CBO) first approximation, FEHB costs could increase by between \$10 and \$50 million a year after 1998 if Section 5 of H.R. 1836 were enacted. The government's share would be approximately 70 percent of that amount, split roughly equally between additional agency costs and government payments for annuitants.

Section 5 would legislate a mandate on the FEHBP, instead of leaving these issues to the marketplace to sort out. Our job is to protect the federal treasury and federal employees - not to become involved in private sector disputes."

Finally, you indicated during a telephone conversation with UP&UP that Congresswoman Morella had asked the OIG a series of questions concerning your Review and the scope of your work. We believe that the entire OIG response to Congresswoman Morella would represent important background data as an Appendix to your report.

Hearsay, Anecdotal Comments and Unsubstantiated Data Do Not Constitute a "Review Opinion"

We previously noted that your background data could easily be confused by a reader of your report to be the results of your Review. We reinforce our comments on the efficiency and effectiveness of your Review and we believe that your "Review Opinion" included in the second paragraph of page 7 of your report should be on page 1, paragraph 1 of your report. Your opinion includes these important factual statements:

"Our purpose was to determine whether the discount taken on each claim was pursuant to the medical providers membership in a non-directed PPO and was otherwise consistent with their contract. We found that in each instance, a series of contractual agreements was in place. These agreements were between the carrier and the vendor, the vendor and provider network or the provider, and the provider network and providers. Consequently, we found no evidence that the FEHBP carriers through its vendors used silent PPOs to access discounts."

The conclusion section of your report includes many industry statements that may not be universally accepted, terms without an appropriate definition and a conclusion sentence that is inconsistent with your Review opinion on page 7, paragraph 2. Specifically, your conclusion in the first paragraph on page 10 states:

"Thus, these three factors combine to cause perhaps false expectations and confusion on the part of providers who may be expecting steerage but in fact entered into an agreement that does not require steerage."

The word "confusion" has a negative connotation. Of course a \$1 trillion industry has "complex" elements. The providers in question are organizations with billions of dollars in revenue, sophisticated financial staffs and legal counsel representation. It is difficult to believe that they do not understand contractual relationships entered into.

Specific Comments Concerning UP&UP's Review Items

With respect to the four UP&UP "errors" as presented in Exhibit 4, we believe that three of the four items noted are not errors. Our support is as follows:

Monongalia General Hospital

This contract states on page 4, section 3.4, the following regarding incentives:

Mr. Gerson
February 17, 1998
Page Six

"HPO will offer most favorable terms to payors that provide the greatest financial savings for Covered Subscribers to utilize the HPO network. All HPO Network payors provide financial incentives for covered subscribers that utilize the network. Financial incentives range from shared saving arrangements, to reduced or waived co-insurance/deductibles, to benefit differentials and planned design."

This section addresses two items:

- (a) Most favorable terms to payors, and
- (b) Financial incentives for covered subscribers.

Item (a) refers to offering the payor client a lower fee if they provide greatest incentives to their covered subscribers; while item (b) refers to financial incentives for covered beneficiaries. The contract specifically defines the range of financial incentives from "shared savings to benefit differentials". Our Payor clients utilize "shared savings" to meet the financial incentive contract requirement, **therefore, this does not constitute an "error"**.

Baptist Hospital of East Tennessee (page 4, section 3.4)
East Jefferson General Hospital (page 4, section 3.2)

These contracts state the following regarding incentives:

"HPO will offer most favorable terms to Payors that provide the greatest financial savings for Covered Subscribers to utilize the HPO network."

The respective sections address "most favorable terms to Payors" and refers to offering the Payor client a lower fee if the Payor provides greatest incentives to their covered subscribers. There are no contractual requirements regarding financial incentives for covered subscribers, **therefore this does not constitute an "error"**. Notwithstanding this, all our Payor clients utilize the "shared savings" financial incentive program for their covered subscribers. If the Payor client implements additional methods of financial incentives such as waived co-insurance and deductibles, benefit differentials, etc., then the fee paid by the payor client to access the network would be reduced.

Specific Comments Regarding Exhibit 3

As currently presented, Exhibit 3 does accomplish the objective stated at our meeting to "demonstrate that utilization of both Directed and non-Directed PPOs benefit the FEHBP program". However, the method in which the information is presented, and certain elements of the information, are unclear, inaccurate and misleading. The unclear, inaccurate and misleading elements are as follows:

- (a) Net Direct PPO savings do not reflect the "actual" additional cost to the FEHBP of the financial incentives (reduction or waiver of co-payments/deductibles, etc.); and

Mr. Gerson
February 17, 1998
Page Seven


- (b) Non-Directed PPOs' savings ratio calculations are misleading. Specifically, the amount of premium payment is significantly overstated due to the fact that the premium payment must be reduced by the actual amount applicable to Directed PPOs to avoid double counting.

We have revised Exhibit 3 to reflect a clearer presentation of the data and it is included as an attachment to this letter for your consideration. We believe the revised Exhibit 3 reflects your stated objective "to demonstrate that utilization of both Directed and Non-Directed PPOs benefit the FEHBP program".

In closing, we apologize if the tone of our comments indicate any displeasure with the Review process by the OIG. In fact, we are pleased that the matter seems to be resolved since your Review indicated that there was no evidence of any "Silent PPO" activity. As a public company, we are sensitive about comments made concerning our business. We operate with strong business principles and our national health care network is used to process approximately \$3 billion of medical claims for all major insurance carriers. As a public company, we know we are subject to public scrutiny and we are satisfied with the results of your Review. We do not believe, however, that government oversight should extend into a matter that is clearly governed by contractual relationships.

Thank you again for allowing us to comment on your draft Review report. Of course, we would be pleased if our response (or portions of our response) is included as an Appendix to your final report as background information on the health care industry.

Very truly yours,



S. Joseph Bruno
Chief Financial Officer

SJB/aiw
Attachment

PRELIMINARY REPORT: FOR DISCUSSION PURPOSES ONLY
 NOT FOR PUBLIC RELEASE

EXHIBIT 3
 (revised)

PREFERRED PROVIDER ORGANIZATIONS REVIEW

PREMIUM PAYMENTS
 FOR PERIOD ENDING JUNE 30, 1997

<u>Carrier</u>	<u>Premium Payments</u>	<u>Net Savings</u>	<u>Ratio</u>
APWU	\$ 203,207,700		
GEHA	477,451,392		
MHBP	903,996,936		
POSTMASTER	29,373,621		
SAMBA	41,255,807		
AFSPA	18,858,169		
NALC	323,256,494		
RURAL	85,536,527		
Total	<u>\$ 2,082,936,646</u>		
Net direct PPO savings (1)		\$ 360,639,256	17%
Net non-direct PPO savings		21,106,259	1%
Total		<u>\$ 381,745,515</u>	<u>18%</u>

(1) Directed PPO's by definition must utilize a direction mechanism in the form of financial incentives (reduction or waiver of co-payments and/or deductibles for the federal employee). These financial incentives are not included in this analysis as they were not available from the FEHBP Carriers. The impact of these financial incentives would be to reduce net savings since the FEHBP paid a larger portion of the premium payments (i.e., the reduction or waiver of the co-payments or deductible for the federal employee is borne by the FEHBP Carriers).



Stanley L. Meyer
Executive Vice President

February 19, 1998
Via Fax: 202-418-0630

United States Office of Personnel Management
Office of the Inspector General
1900 E Street, N.W., Room 6400
Washington, DC 20415
Attention: Sanders P. Gerson
Deputy Assistant Inspector General for Audits

Re: Silent PPO Review

Dear Mr. Gerson:

I am writing on behalf of MultiPlan, Inc., in response to the draft, preliminary Report (the "Draft Report") that you prepared on completion of your review of the use of "silent" and "non-directed" preferred provider organizations ("PPOs") within the Federal Employees Health Benefits Program ("FEHBP"). We appreciate the OIG's hard work on this complex and sensitive issue and the opportunity to comment on the Draft Report.

As an initial matter, we concur with your view that giving health payers access to provider discounts through subterfuge or misrepresentation would constitute, at the very least, an unethical practice in the FEHBP. MultiPlan, Inc. strongly opposes these so-called "silent" PPOs. We also are pleased, but not surprised, that OIG's review has confirmed that MultiPlan is not a silent PPO and does not engage in such practices. Indeed, OIG's review, which was performed in accordance with generally accepted government auditing standards for performance audits, demonstrates that MultiPlan had written contracts in place in every case reviewed and that all but one of the MultiPlan claims reviewed were processed in accordance with MultiPlan's provider contracts. In the case of that one claim, MultiPlan inadvertently extended a discount to the FEHBP plan of \$1.87 -- a trivial error. As this example illustrates, MultiPlan's claim payment accuracy far exceeds the FEHBP's own standard for accuracy of payment. See Office of Personnel Management, *Financial Statements Fiscal Year 1996* at 56-57.

America's Managed Care Partner

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New York NY 10003-1004
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smeyer@multiplan.com



February 19, 1998

Page 2

We therefore ask that you expressly state in the final Report that MultiPlan is not a "silent" PPO and does not engage in "silent" PPO practices, and that all of MultiPlan's claims reviewed were processed under written contract administered in a manner that exceeds FEHBP standards for accuracy of payment.

The OIG has conducted a careful and professional review of this matter. The Draft Report, however, includes some language that is inconsistent with the OIG's data and conclusions as presented in the Draft Report. It also uses some terms in a manner that is misleading and inaccurate. We ask that you correct these points, which are described below, in your final Report.

First, on pages 6-7, the Draft Report states that "anecdotal evidence" may justify concern on the part of the Committee on Government Reform and Oversight that medical providers are perhaps being victimized. This "anecdotal evidence," however, is not disclosed. And, in any event, the OIG's factual investigation refutes this "evidence" and dispels any basis for concern. We urge that this passage be deleted, less it be quoted out of context in support of a conclusion directly contrary to that reached in the OIG's review. For the same reason, the discussion of claims payment should be deleted from section B, on pages 6-7. Rare instances of inaccurate payment under written contracts is a separate topic from "vitalization" of providers under "silent" PPOs, and is fully addressed in section C.

Second, the Draft Report inaccurately implies that surveyed vendor's contracts with network providers are "vague" and create expectations on the part of providers that are not being fulfilled. This unsupported conclusion is in stark contrast to the conclusion regarding contract compliance, which is supported by a detailed claims audit. The report does not cite a single instance in which the OIG concluded that a provider had reason to be confused regarding the terms of its contract with MultiPlan or one of the other vendors or in which a specific provider's reasonable contractual expectations were not met. For these reasons, the Draft Report's discussion regarding allegedly vague contract terms and unmet provider expectations should be deleted.

Third, the Draft Report's use of the terms "directed PPO" and "non-directed PPO" is inaccurate. MultiPlan is classified as "non-directed", but MultiPlan does provide varying degrees of direction in its work with FEHBA plans.





MultiPlan requires, for example, that its clients share with subscribers the savings realized from its provider discounts by calculating the subscriber's coinsurance payment on the basis of the discounted rate. This results in a direct reduction in out-of-pocket expenses for FEHBP subscribers who use MultiPlan network providers. If, as some suggest, financial incentives are essential to a directed PPO arrangement, then MultiPlan meets this definition.

But financial incentives are not the only effective way to steer subscribers to network providers. For example, MultiPlan maintains a web site referral service on the Internet that is so extensive and accessible that it won an award from USA Today. We encourage you to review the site, which is at <http://www.multiplan.com>. Similarly, MultiPlan operates a 24-hour-a-day toll-free referral line staffed by nurses, and the FEHBA plans have been notified of this referral line. MultiPlan also offers a transfer assistance program that arranges for patients that are in a non-network hospital to be safely transferred to a network hospital.

Finally, steerage is not the only reason providers agree to extend discounts to MultiPlan. For example, MultiPlan's arrangements result in much better cash flow for network providers. MultiPlan requires its clients to make timely payment to providers and offer pre-audit payments and prepayment programs as a deposit or guarantee for bed days or for specific procedures. These programs provide concrete, financial benefits to MultiPlan's network providers. MultiPlan also provides quality support for network providers through its rural health care support, credentialing and certification, discount purchasing programs for medical services and supplies, and an extensive library of critical pathways that are shared with all of our network providers. These programs directly benefit our network providers. Equally important, however, they encourage high quality of care for FEHBP subscribers.

For these reasons, we urge you to revise the Draft Report to note that benefit differentials are not the only appropriate form of steerage, and that PPOs such as MultiPlan *do* direct subscribers to providers in their networks. In addition, we ask that the final Report state that steerage is not the only benefit that FEHBP providers can gain from membership in a PPO network.

Fourth, the Draft Report does not scrutinize the practices of entities that operate PPOs that the Draft Report labels "directed." Many of these entities, for example, contract with hospitals for an EPO rate, and/or HMO rates and/or for a PPO rate. The OIG review did not examine whether the directed PPOs accessed the correct rate in accordance with the contract term. To provide a more balanced assessment of whether health care providers are being "victimized" by FEHBP payers -- the stated purpose of the Draft Report -- the OIG's review should be expanded to



include the practices of so-called "directed" PPOs. If this is not practical at this time, the report should note a minimum that there is also the potential for abuse by the PPO's that the Draft Report labels "directed," and that the OIG has not reviewed their practices.

Fifth, the Draft Report should note that OPM's 1993 call letter encouraging FEHBP carriers to obtain the lowest price available for all goods and services is entirely consistent with existing legal requirements. See 48 C.F.R. § § 1600 *et seq.* OPM obviously did not intend for the carriers to do this through unethical or illegal means.

In summary, Provider discount arrangement with PPO's exist today for a variety of reasons. These reasons include direction of patients, collection and cash flow advocacy and quality support. The depth of discount vary as does the reason for providing them. This is all part of the process that helps keep health care in America self regulated as to price and the world leader as to quality.

Again, we appreciate the opportunity to comment on the Draft Report.

Please call Harvey Sigelbaum or me if you have any questions, or if we can be helpful to you in any way.

Very truly yours,

A handwritten signature in black ink, appearing to read 'Sidney L. Meyer'.

Sidney L. Meyer

Executive Vice President

Chief Legal and Legislative Affairs Officer