AAPPO has the answers.
WHAT are PPOs?

A Preferred Provider Organization (PPO) is a healthcare delivery system where providers contract with the PPO at various reimbursement levels in return for patient steerage into their practices and/or timely payment. PPOs differ from other healthcare delivery systems in the way they are financed, including providing more choice, benefit flexibility and enrollee access to providers and medical services both in and out-of-network.

There are two types of PPOs:

- **A non-risk** PPO’s primary focus is to contract with providers in a geographical area to form an interconnected network of providers and services. The non-risk PPO network leases and/or "rents" its network for a fee to insurance companies, self-insured employers, union trusts, third-party administrators (TPAs), business coalitions and associations.

- **A risk** PPO assumes the financial risk for an enrollee’s medical costs. Traditionally, insurance companies offer a risk PPO that includes a benefit plan and network services either provided by the risk PPO or leased from a non-risk PPO network.
WHY PPOs Exist

For consumers, the impact becomes very personal when trying to access and pay for healthcare services — they want what they need, when they need it — for their families and themselves. As Americans seek a more active role in their health care, they demand more choice and greater flexibility in accessing provider services.

PPOs have responded by offering:

- **additional choice** in provider selection, including direct access to many specialists,
- **greater access** to medical services, and
- **tremendous flexibility** in obtaining benefits in or out of network.

Because PPOs allow patients to choose their doctors, long-term doctor-patient relationships are solidified, resulting in the delivery of a higher level of care.
WHO Benefits from PPOs?

The proven benefits of PPOs are demonstrated by the 644 million individuals enrolled in PPOs. PPOs benefit consumers by supporting their need to take a more active role in their health care. These benefits are actualized through key components of the PPO delivery system that allow consumers to:

- Take control in selecting the provider of choice when accessing medical services they need, when they need them.
- Receive benefit coverage when selecting a provider outside the PPO network (however, benefits are less than in network).

PPOs provide consumers exactly what they want — more choice, greater access and flexibility in selecting providers and medical services.

PPOs benefit providers, respecting the sanctity of the doctor-patient relationship by…

- Separating provider quality from provider reimbursement levels.
- Balancing the delivery of most appropriate care with most reasonable cost, but not necessarily at the lowest cost.

The financial considerations of the PPO healthcare delivery model do not override patient care decisions, but rather work in conjunction with PPO providers in delivering patient care. Through the co-pay mechanism, the PPO model has allowed unprecedented steerage of patients and doubled billable encounters per family unit for participating PPO providers.
WHERE to Turn for Facts on PPOs

AAPPO recognizes that policymakers confront critical and often difficult decisions that impact how health care is financed and delivered to consumers. AAPPO is dedicated to being a resource for policymakers and their staff and is committed to providing the information and expertise necessary to foster an understanding of PPO issues and the industry.

AAPPO provides a complimentary online PPO Primer as an educational tool for the public policy community. The “PPO Primer” is an easy-to-access resource providing a detailed and comprehensive overview of the PPO industry.

AAPPO also serves as a resource to the PPO industry with a goal to ensure consumers continue to benefit from more choice, flexibility and greater access to providers and medical services made possible by PPOs.

To that end, AAPPO has developed industry positions and guidelines to establish best practices and is a critical resource for the industry. Some examples of the standards and best practices developed by AAPPO:

- Timely payments to providers
- Opposition to silent PPO activity
- Support for health savings accounts
- Improving diabetes care and outcomes.

These are available to policymakers and their staff on request.
WHEN Talking PPOs, Know the Terms

Benefits Coverage
Entitlement inclusion in an insurance policy. Payers generally customize the range of benefits provided. The PPO ensures the right types of providers are available for the specified benefit.

Benefits Determination
Benefits coverage based on state and federal requirements, group contracts or subscriber agreements.

Broker/Agent
Individual licensed by the state to sell insurance and receives compensation via commissions paid by insurance companies, HMOs, TPAs, PPOs or medical management organizations.

Claims Processing
Complex and systematic series of actions related to the adjudication of health insurance claims according to an employer’s benefits plan.

Explanation of Benefits/Remittance (EOB)
A statement sent via mail or electronically to enrollees describing how and why a claim was paid or not paid.

Grievance Procedure Mechanisms
Grievance systems offered by a PPO to address a full range of problems, including customer complaints, review of denial of benefits based on medical necessity determinations, benefits coverage and network provider complaints.

Insurance
Coverage by contract whereby one party (the insurance company) undertakes to indemnify or guarantee another (the contract holder or patient) against loss by a specified contingency (the cost of care for injury, illness and routine care).

Leased/“Rental” PPO Networks
A PPO network that leases or “rents” its network for a fee to insurance companies, self-insured employers, union trusts, third party administrators (TPAs), business coalitions and associations.

Network Adequacy
Measurement to determine if a network has an appropriate number of providers, in a wide range of specialties, that are geographically located near where enrollees live or work.

Non-Risk PPO
Sometimes referred to as leased or “rental” PPO network. A non-risk PPO’s primary focus is to contract with providers in a geographical area to form an interconnected network of providers and services. The non-risk PPO network leases and or “rents” access to its network for a fee to insurance companies, self-insured employers, union trusts, third party administrators (TPAs), business coalitions and associations.

PPO Network Access Fee
Fee charged by a PPO network to its customer for network services. The primary service provided is network access. Additional services may include claims repricing, medical management, educational services and customer support. Fees are traditionally based on a per employee per month (PEPM) basis for all employees enrolled in a PPO network.
Payers
Payers include both entities reimbursing providers for services rendered to a covered life, as well as those entities that pay for healthcare coverage. Payers may include PPOs, TPAs, and insurance companies. Those who purchase healthcare coverage on behalf of a group such as employers, multiple employer welfare arrangements, government employers and entitlement programs may also be considered payers.

Physician Discount
A reduction of a provider’s charge.

Point of Service (POS)
Hybrid HMO/PPO plan which allows enrollees to select network or non-network services each time they utilize medical care. While using network providers, POS plan functions more like an HMO, typically with significant preventative care coverage and the requirement of a gatekeeper. At any time, enrollees may choose to go out of network and receive more conventional indemnity coverage, usually with deductibles and coinsurance.

PPO Services
PPOs can provide many services to purchasers. At a minimum, PPOs provide a network of contracted providers. Other services can include provider credentialing, claims payment, utilization management or case management.

Preferred Provider Organization (PPO)
Healthcare delivery system through which providers contract to offer medical services to enrollees at various reimbursement levels in return for more patients and/or timely payment. PPOs differ from other healthcare delivery systems in the way they are financed, including providing more choice, benefit flexibility and greater access to providers and medical services both in and out-of-network.

Provider Contracting
Process of obtaining a contractual agreement between provider and PPO. The contract should describe the mutual contractual obligations of provider and the PPO, including financial terms.

Provider Credentialing
Screening and verification of providers’ medical credentials, malpractice insurance, and delivery of medical services that contract with PPOs.

Provider Reimbursement
Amount of payment, as defined by contract between PPO and provider, accepted by providers for medical services rendered to members of PPO.

Provider Relations
Good provider relationships are important to the success of a PPO. PPOs need to perform several functions to ensure good provider relationships, including provider contracting and provider servicing. Provider servicing includes any activity that helps provider work with PPO, for example, claims concerns or provider directory issues.

Quality Reporting
Some PPOs provide performance-based or quality information using standardized tools such as Health Plan Employer Data and Information Set (HEDIS) or Consumer Assessment of Health Plans Survey (CAHPS). Reports are usually provided to specific customers so they can examine data used by the PPO to determine the quality of providers.
Resource Based Relative Value System
The Resource Based Relative Value System (RBRVS), used by the Medicare program, is widely accepted as the basis for fee schedules developed by PPOs.

Repricing
Process whereby PPO network prices claim based on contracted reimbursement level agreed to by provider and forwards repriced claim to payer for payment.

Risk PPO
Assumes the financial risk for enrollee’s medical costs. Traditionally, insurance companies offer a risk PPO that includes a benefit plan and network services either provided by the risk PPO or leased from a non-risk PPO network.

Self-Funded
When the purchaser, typically an employer, assumes financial risk of medical costs. Self-funded plans usually contract with TPAs or insurance companies to administer benefits.

Silent PPO
PPOs that apply discounts for provider services without appropriate contractual agreement and disclosure to the provider. Silent PPOs do not have a mutual contractual/financial agreement with a provider nor do they provide network identification, access and steerage to the physician's practice.

Steerage
Process of providers contracting with a PPO to accept a lower reimbursement level in exchange for the directing of patients to the providers’ practice.

TPA
Third-party administrator. Entity that performs administrative functions, such as claims processing or membership.

URAC
Independent, non-profit organization that promotes healthcare quality through accreditation and certification programs. Health Network Accreditation, for PPOs and similar networks, assesses network management, quality management and improvement, provider credentialing and consumer protection. Health Plan Accreditation, for fully integrated PPOs, is a comprehensive assessment of performance of the plan.

UCR
Method of calculating reimbursement for medical services based on usual, customary and reasonable charges by similar providers in local marketplace. Most likely used for paying out-of-network providers.

Utilization Management
Program assisting covered patient, provider and payer in assessing whether course of treatment is medically necessary, appropriate and a covered benefit.

This glossary defines common terms used to explain the operational components and processes within the PPO industry. For a more comprehensive glossary of healthcare and insurance terms, contact AAPPO at 502-403-1122, ext. 100.
About AAPPO

The American Association of Preferred Provider Organizations (AAPPO) is the leading national association of preferred provider organizations (PPOs) and affiliate organizations and was established in 1983 to advance awareness of the benefits — greater access, more choice and flexibility — PPOs bring to American healthcare system.

AAPPO is the only association advocating solely on behalf of PPOs and continues to lead the way in the promotion, support and advocacy of the PPO industry. The association’s vision is to continue to be the most-valued trade association for organizations that use, develop and support PPO networks and products. Our mission is to advance and promote the PPO industry for AAPPO members and their stakeholders, providers and consumers by…

• Informing and educating the public policy community about the PPO delivery model.

• Facilitating PPO best practices by developing and advancing PPO industry practices and guidelines.

• Promoting PPO networks and benefit products as the preferred healthcare solution.

• Supporting professional growth through comprehensive PPO training programs to meet ongoing employee needs for organizations that use, develop and support PPO networks and products.

For the past 74 years, AAPPO has researched and responded to many of the critical issues affecting its constituency and continues to advocate and promote the PPO value proposition. AAPPO is constantly working to serve as a resource for its members and policymakers on issues surrounding the PPO industry. The association facilitates initiatives to support the business needs of all PPOs and releases an assortment of information on many important topics impacting the PPO industry.

Working to provide our members with valuable information and activities that support their internal business needs, AAPPO and the Disease Management Association of America (DMAA) announced in January 2007 a strategic alliance to significantly enhance benefits for members of both associations. This alliance will allow us to work in tandem with the medical community to support the education of consumers in their effort to take a more active role in their personal health care.

AAPPO HAS THE ANSWERS.