Payer Negotiations in the New Healthcare Environment: How to Prepare for and Succeed in a Value-Based World

Ron Howrigon*

Because of their involvement with the Affordable Care exchanges, the national insurance companies have reported significant financial losses. As a result, there will soon be significant payer pressure to reduce medical expenses. To succeed in future negotiations with the payers, medical practices must understand the needs of the payers and then play to those needs. The author is a former managed care executive with more than 25 years of experience managing provider networks and implementing payer strategies for some of the largest payers in the United States. In this article, he outlines important things medical practices should be doing to prepare for the new world of value-based contracting. Medical practices that embrace this change and work hard to evolve with the future are the ones that are going to survive and succeed.

KEY WORDS: Payer negotiations; value-based contracting; pay for performance; Affordable Care Act; insurance exchanges.

*President, Fulcrum Strategies, 1340 Sunday Drive, Suite 101, Raleigh, NC 27607; phone: 919-436-3380; e-mail: r.howrigon@fsdoc.com.

You may remember back in 2010 when Nancy Pelosi, referring to the Affordable Care Act, was famously quoted as saying: "But we have to pass the bill so that you can find out what's in it."[1] The insurance company executives completely understood and related to that statement. Many of them knew that they would have to wait and see what kind of members and risk they got once the Affordable Care Act was fully implemented. Then they would know its true impact. Well, here we are, a couple of years into this experiment, and the results are worse than anyone had predicted.

When the Affordable Care Act was passed, the payers expressed concern about the severity of illnesses in people who would be attracted into the exchanges. The national payers—Cigna, Aetna, United, and Humana—were very timid in their entry into this new market. These companies chose to offer their products in very few markets to limit their potential exposure. The fact that these for-profit companies did not flock to the opportunity to sell their product to a market of over 7 million customers should have been a major indication as to how bad this business was going to be for the insurance companies.

RESULTS OF THE AFFORDABLE CARE ACT

We now have two full years of ACA experience, and the results are staggering. Cigna, Aetna, and United have all issued earnings warnings because of their involvement in the ACA. Several of the national carriers have also indicated that they may withdraw from some or all of the ACA markets they participate in as soon as 2017. The results for the Blue Cross Blue Shield plans across the country are even worse. The combined financial statements for the 30 nonprofit Blue Cross Blue Shield plans are projected to show a net loss for 2015. That has not happened since the late 1980s. In my home state of North Carolina, Blue Cross Blue Shield has released some truly disturbing results. Blue Cross Blue Shield of North Carolina has around 250,000 members from the ACA exchange products. Those members, on average, cost 70% more than the non-ACA members they cover. Blue Cross Blue Shield is projecting a $400 million loss on those members for 2014 and 2015. These kinds of losses are simply not sustainable. At some point, the carriers will either exit the market altogether or

be forced to figure out a way to stem the losses. Since politically it would be very difficult for Blue Cross Blue Shield plans around the country to exit the exchanges, the most likely outcome of all this will be significant payer pressure to reduce medical expenses. Remember, what they call "expense" is what you call "revenue."

IMPACT ON PHYSICIANS AND MEDICAL PRACTICES

Unfortunately, the business of practicing medicine is going to get even harder. The payers have already started gearing up for the future with the recent rash of consolidations. Last year, Anthem agreed to buy Cigna, Aetna agreed to buy Humana, and Centene agreed to buy Health Net. If you look at the top four payers now as United, Anthem/Cigna, Aetna/Humana, and Centene/Health Net, these payers have combined revenue of $367 billion. To put that in perspective, the entire Medicare budget is only $505 billion. That means we will have four very large and very powerful national payers when all of these mergers are completed. The CEOs of these companies have been very candid about their reasons for consolidation; they want to be able to gain leverage on providers of care in order to reduce medical expenses. In light of all this, we know that it will become increasingly difficult to negotiate higher fee schedules in the future. Simply contacting the payers and demanding a raise when they are already losing money is not likely to be met with success. The market is shifting, and physician practices must change as well.

The bottom line is that the game has changed, and being able to routinely negotiate annual increases to your fee schedules will soon be a thing of the past. The payers are getting hurt financially, and they just do not have the appetite for fee schedule increases anymore. In many markets, large payers are significantly reducing fee schedules. I am not saying that contract negotiations will be impossible. I am just saying that negotiations will be more difficult than ever before. The environment is different, and a new approach is necessary. To succeed in future payer negotiations, physicians must understand the needs of the payers and then play to those needs.

THE FUTURE OF PAYER NEGOTIATIONS

The future of payer negotiations will involve showing the payers how you can reduce medical expenses and then negotiating for a portion of those savings to be returned to your practice. Although this may seem daunting, physician groups with the right negotiation and analytical expertise are uniquely positioned to do this work. It is my firm belief—and I think the data support this—that payers and the government have been minimally successful at controlling healthcare costs. The only people who can truly bend the cost curve are physicians. Consequently, you are well positioned to do that work and then negotiate for a portion of the savings you are producing. This new approach is more complicated than simple fee schedule negotiations, but it is critical to your success in the new world and also produces the proverbial win-win.

Allow me to give you two real-life examples. One of my clients negotiated with a major payer an agreement to switch the specialty drug it was using to treat a specific condition. The drug it switched to is clinically equivalent and less expensive. In return, the payer agreed to remove all prior authorization requirements from the group. This reduced the group's overall administrative costs and made the doctors much happier. Again, a win–win scenario. Another client negotiated a multiyear agreement with a payer where future year increases would be tied to four specific performance metrics. The group was confident that it could meet these metrics, which allowed for annual increases in the fee schedules. The payer was happy to know it had a partner in utilization management and cost control.

PREPARING FOR THIS NEW APPROACH

So how do medical practices prepare? The key is to get started now. The sooner you engage, the sooner you can execute new agreements. To be successful in the new world of value-based contract negotiations, there are several important things medical practices should be doing:

- **Data, data, data:** The need for data and analysis for this kind of negotiation is critical. You need to be able to analyze and track your utilization patterns by diagnosis, procedure, and payer. You will need to be able to run "what if" analyses to determine the amount of cost reductions produced if your physicians change the way they practice. In the example I gave earlier, the group that changed the drug it was using first ran the calculation on how much money the change would save the payer. This kind of data tracking and analysis is new and is critical for these types of payer negotiations.
- **Physician participation:** Unlike fee schedule negotiations, this new approach will require a much more active role by physicians. Physicians will play a key role in finding cost savings and making sure that any recommended initiatives are also good patient care. It is crucial that the physicians "buy in" to the programs or they just will not work. The worst outcome would be devoting precious time and resources to a shared savings program only to have it fail because the physicians weren't engaged in the process.
- **Performance tracking:** Another new issue with value-based or pay-for-performance contracting is the ability

to continuously track performance. For the group that agreed to switch to a lower-cost drug, it is now imperative that it has a process to ensure compliance and track performance. For many practices, this will be a new function that will need to be developed.

- **Skilled and educated negotiator:** Before entering into these kinds of negotiations, the practice should make sure that its negotiator is equipped to succeed. Contracts of this nature can be incredibly complex; it is more than just negotiating a percentage of the Medicare fee schedule. Your negotiator will need to have a firm grasp on the analyses and the mechanisms necessary to finalize this type of agreement. He or she will also need to understand the potential system issues the payers face so that mutually beneficial common ground can be achieved. It does not do any good to negotiate a contract that the payer cannot implement in its systems. If you do not feel your negotiator is up to the task, make sure you either get him or her the necessary training or seek outside help.

Once you have completed these preparations and are ready to proceed, it's time to engage the payers. The best way to get their attention is to have a plan already in place. Right now, if you call payers and let them know you have a detailed plan on how you can save them money and you have already calculated the potential savings, they will be very interested in talking with you. The payers are under significant pressure, and they don't have time for concept meetings with no details. If you have specific ideas and data to share, it will help move things along.

CONCLUSION

Remember, you don't have to solve *all* the problems in the first discussion. You should walk first before you run. Do not rush out and try to negotiate a full risk capitation contract as your first foray into the new world. Pick something that is feasible and meaningful but is also easy to do, and work on that first. As you get more experience and the payers understand your abilities, then you can move on to broader agreements. The best way to do this is to look at your practice as a payer would. What diagnoses make up most of the money they spend with your group? What diagnoses or procedures do you think you can impact? In a recent analysis for one of my neurology clients, we discovered that almost 50% of all the money spent with the group was for multiple sclerosis, headaches, and sleep issues. We realized that if we focused on these three areas, we could make a huge impact on payers' costs.

Yes, the healthcare industry is in flux, and yes, everyone is facing challenges right now. But the future isn't all gloom and doom. Healthcare and the need for care are not going away. We are facing difficult times, but I firmly believe that physicians are the only true answer to the healthcare cost issues we face. The medical practices that embrace this change and work hard to change with the future are not only going to survive, they are going to succeed.

REFERENCE

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