

# Issue Brief

Findings from HSC



## HEALTH PLAN-PROVIDER SHOWDOWNS ON THE RISE

by Bradley C. Strunk, Kelly J. Devers  
and Robert E. Hurley

*During the past two years, increasing numbers of contract disputes between health plans and hospitals and physicians have erupted in local markets, according to recent Center for Studying Health System Change (HSC) visits to 12 nationally representative communities. Many providers are taking a hard line in negotiations, threatening to terminate health plan contracts if payment demands go unmet. These contract showdowns signal a shift in the balance of power in local markets toward hospitals and physicians and can potentially disrupt care for many patients, especially when the disputes involve communities' largest and most prominent hospitals and physician groups. This Issue Brief presents case studies of showdowns in Boston, Orange County, Calif., and Seattle, highlighting the changing market dynamics triggering these disputes and the implications for consumers, including rising costs and diminished access to care.*

### Signs of a Shifting Balance of Power

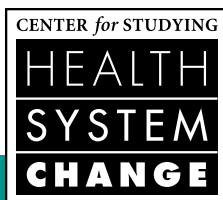
**T**he increasing number of managed care contract disputes over the last two years reflects a shift in the balance of power from health plans to providers. Five years ago, health plans were gaining power as health maintenance organization (HMO) enrollment grew and restrictive provider networks seemed destined to be the standard. Forced on the defensive by plans, providers often agreed to steep discounts in exchange for promises of higher volume. Simultaneously, providers pursued strategies—such as consolidation, geographic expansion and hospital-physician integration—to strengthen their bargaining clout.

Faced with a vigorous backlash, however, managed care plans have lost

ground in recent years. Purchaser and consumer demand for broad provider choice—bolstered by debates about any-willing-provider laws in many states—meant that restrictive networks failed to dominate as expected. Instead, health plans had to develop and maintain large provider networks to compete, diminishing plans' leverage over providers. Indeed, after years of consolidating market share and strengthening their brand names, some providers now enjoy “must-have” status in plans' networks. At the same time, newly developing inpatient capacity constraints<sup>1</sup>—especially among hospitals with strong reputations—have increased hospitals' leverage, leaving them more likely to walk

away from contracts with plans.

Moreover, serious financial pressures have driven providers to be more aggressive in negotiations with health plans. After years of low payments and less volume than expected under commercial contracts, providers have had to deal with Medicare payment reductions and other problems, including higher labor costs because of nursing and other staff shortages. These financial pressures, coupled with greater sophistication in managed care contracting strategies and tactics, have spelled the end of a period when some providers uncritically accepted contract terms. Emboldened by the managed care backlash, providers are testing the waters to see just how far they can





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### **Orange County Standoff Affects 100,000 People**

The contract termination between St. Joseph Health System and PacifiCare in October 2000 shocked many people, given the long and close relationship between the hospital system and health plan. The fact that the termination would last for five years made the news even more startling. A high percentage of St. Joseph's employees were enrolled in PacifiCare's HMO, and, for many employees at PacifiCare's national headquarters less than 15 miles away, St. Joseph and affiliated physicians were providers of choice. In addition, with more than 100,000 people involved—roughly a third of PacifiCare's local enrollment and a quarter of the people enrolled in St. Joseph's affiliated physician practices—the community fallout will be significant.

St. Joseph capitalized on a favorable clinical reputation and strong financial status to build a health care delivery system of three hospitals with nearly 900 beds and a large number of owned and affiliated physician groups housed under an associated foundation. Consistent with HMO contracting practices in southern California, St. Joseph had risk-based contracts for more than 400,000 HMO members across 14 different health plans. Patients received physician services through owned and affiliated practices and inpatient care in system hospitals.

Like many Orange County providers, St. Joseph faced mounting financial pressure under its capitated contracts as medical costs grew more rapidly than expected. In addition, pressure to comply with California's seismic retrofitting standards added to the financial strain. In June 2000—while existing contracts were still in force—St. Joseph unveiled a new contracting strategy. Through a bid solicitation process, the health system proposed sharply reducing the number of contracted plans from 14 to five partner plans. In a bold move, St. Joseph essentially turned the tables on the health plans, threatening to exclude them unless they would

agree to significant payment increases and five-year contracts incorporating new terms, including per diem payments instead of capitation for inpatient hospital services.

Although St. Joseph had demanded payment increases in the middle of existing contracts before and had threatened to terminate contracts if its demands were not met, this was the first time the system had done this to multiple plans simultaneously. Moreover, by deciding to reduce the number of contracted plans at one time, St. Joseph offered selected plans the opportunity for significant membership gains at their competitors' expense. Given St. Joseph's prominence, loss of a contract with the system could be catastrophic to any given plan. The major plans scrambled to meet the new contract requirements, and, ultimately, all reached agreement except PacifiCare.

The showdown could not have come at a worse time for PacifiCare. In fact, some suggested the timing was designed with the plan's vulnerability in mind. As the nation's largest Medicare HMO contractor, PacifiCare was hit hard by the 1997 Balanced Budget Act, which provided most Medicare plans with only a 2 percent annual payment increase. Many of the plan's providers were beginning to refuse risk contracts, leading some Wall Street analysts to suggest PacifiCare's business model was failing. The plan's stock price plummeted in mid-2000, and there was turnover among key senior executives. Then, the St. Joseph bombshell hit directly in the plan's home market.

While some observers suggested St. Joseph always intended to drop PacifiCare to punish the plan for allegedly exploiting the hospital system for many years, St. Joseph claimed it wanted to reach an accord with PacifiCare. The dispute was played out in the community with newspaper reports and advertisements filled with accusations and recriminations, including conflicting claims about the size of expected payment increases. The confrontation's intensity and timing—coinciding with the open enrollment period for many local firms—reportedly appalled employers and consumers and caused great uncertainty and confusion. Informed observers estimate that when the full fallout of the contract termination is known, perhaps half of the 100,000 people involved will end up with other plans or providers, with

both St. Joseph and PacifiCare losing volume and substantial revenue as a result, at least in the near term.

## Specialists Gain in Seattle

In the late 1990s, many Seattle physician groups faced increasingly difficult financial times. Some suffered because of poorly negotiated fee-for-service and risk contracts, while others lost referrals and struggled with lower Medicare and Medicaid payments. Health plans compounded physicians' financial stress by keeping payments relatively flat for several years. Under heightening financial pressure, some large physician organizations successfully pushed back against plan demands and avoided unfavorable reimbursement changes.

One of the most widely publicized disputes occurred in late 1999 between several single-specialty physician groups and Regence Blue Shield, the largest insurer in Washington. At that time, Regence decided to adopt recently enacted Medicare physician fee schedule changes for its commercial products, causing reimbursement for surgical services to decline relative to primary and pre- and postoperative care services.

Although Regence claimed the overall decline would be only 3-5 percent across all specialty services, some surgeons argued payments for certain services would decrease by as much as 30 percent. Unlike large multispecialty groups that could theoretically offset some surgical fee declines with increases for primary care services, single-specialty groups faced significant revenue reductions. In October 1999, about 150 Seattle specialists decided not to renew contracts with Regence effective Jan. 1, 2000, to protest the new payment system.

Several factors converged to give the groups significant leverage over Regence:

- The groups represented a significant portion of Seattle specialists, including a large neurology practice, a large orthopedic practice and the biggest general surgery group. At a time when broad provider choice was highly valued, losing major physician groups was a competitive disadvantage for Regence. In fact, several large employers report-

edly pressured Regence to settle the disagreement, which further undermined the plan's leverage.

- Physicians realized nonrenewal with a particular health plan would not necessarily be a fatal decision. One group with a large Regence membership reportedly was "delighted" that many patients kept coming and paying full charges after the contract ended.
- Finally, the physician groups embarked on a proactive education and advocacy campaign—meeting with insurance brokers, employers and Regence to tell the physicians' side of the story—and succeeded in generating considerable support.

Responding to disgruntled employers and consumers, Regence worked to bring the surgeons back into the plan's network by convening a physician advisory panel, with representatives from the terminating groups as well as other physicians, to discuss payment rates. In June 2000, Regence and the surgeons reached a compromise, ending six months of negotiation and a period when consumers either had to find new physicians or pay higher out-of-pocket costs to see their current physicians. Although the plan did not succumb to all of the physicians' demands, Regence agreed to delay implementation until 2001 and incorporate adjustments to increase payments for surgical services under the new system. Most observers viewed this as a significant victory for the specialty groups.

## Prestigious Hospital System Trumps Major Boston Plan

Partners HealthCare System and Tufts Health Plan announced a parting of the ways in October 2000. Although they eventually came to terms, more than three months of contentious contract negotiations took a toll. Tufts and Partners—which includes the renowned Massachusetts General and Brigham and Women's hospitals and more than 4,000 affiliated physicians—were unable to agree on payment rates. A contract termination could have caused an estimated 100,000 people to lose

access to Partners' hospitals unless they selected another plan that included the hospital system in its network.

Claiming they had lost \$42 million in treating Tufts' enrollees in the previous two years, Partners argued it could no longer accept payments that did not cover the system's costs. According to local news reports, in initial negotiations with Tufts, the system demanded a 29.7 percent increase over three years, or 9.9 percent per year. Partners' previous success in gaining a double-digit payment increase from Blue Cross and Blue Shield of Massachusetts, the largest Boston health plan, also emboldened the hospital system.

Tufts counteroffered with a much smaller increase. To meet Partners' demands, Tufts contended it would need immediate premium increases of 20-25 percent, threatening a loss of business the plan could not afford. In addition to rising medical costs, the plan was recovering from significant financial and membership losses, largely because of an ill-fated regional expansion strategy in the late 1990s.

However, Tufts faced pressure to return to the negotiating table. The timing of Partners' contract termination during Tufts' largest annual open enrollment period left the plan at a disadvantage, because it opened up the possibility of large-scale enrollment shifts if people wanted to maintain access to the Partners system. Moreover, as the impasse played out in the media, consumers and physicians flooded Partners and Tufts with phone calls expressing concern about losing access to Partners' providers, while local employers pressured the two sides to come to some resolution. The state attorney general, though limited in authority to intervene, sent a letter urging the two sides to resume negotiations and avoid disrupting consumers.

Shortly after Partners broke off negotiations with Tufts, the plan attempted to contract directly with some of the large physician groups affiliated with the system. Physicians decided it was in their best interest, however, to remain aligned with the hospital system. With few remaining options, Tufts resumed talks with Partners one week after Partners broke off negotiations, and the two sides settled on a contract several days later.

## Notes

1. Brewster, Linda R., Liza S. Rudell and Cara S. Lesser, *Emergency Room Diversions: A Symptom of Hospitals under Stress*, Issue Brief No. 38 (May 2001).
2. Brewster, Linda R., and Paul B. Ginsburg, *At the Brink: How Harvard Pilgrim Got in Trouble*, Issue Brief No. 33 (December 2000).
3. Short, Ashley C., Glen P. Mays and Timothy K. Lake, *Provider Network Instability: Implications for Choice, Costs and Continuity of Care*, Issue Brief No. 39 (June 2001).

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President: Paul B. Ginsburg  
Director of Public Affairs: Ann C. Greiner  
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Editor: The Stein Group

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While neither side would disclose specifics, Tufts confirmed the deal contained significant payment increases.

The Partners-Tufts showdown was not the end of provider pushback in Boston. In fact, Partners recently won significant payment increases from the third major plan in the market, Harvard Pilgrim Health Care. The attorney general also weighed in on this negotiation, motivated in part by concern about the plan, which the state recently shored up,<sup>2</sup> and the implications of Partners' growing market power.

## Lessons

Much of how these showdowns played out is characteristic of the contentious contract negotiations that HSC has observed in communities across the country. In each case, prominent providers challenged health plans and demonstrated willingness to terminate or simply not renew contracts. Realizing the threat of withdrawal gave them the upper hand with health plans in the current market environment, these providers drew a line in the sand.

At stake in the short run was the threat of considerable consumer disruption. Both providers and plans turned to the news media or made direct appeals to patients to engage them as allies, contributing to a general sense of instability in the health care system. In two cases, final breakdowns in negotiations coincided with plans' open enrollment seasons—a time when the opportunity for enrollees to switch plans leaves those plans most vulnerable. Some large local employers used their clout with plans to push for settlement to avoid disruption for employees. In contrast, state policy makers and regulators were largely absent from these and other disputes because contract disputes among private organizations typically are not within their purview. However, there was one notable exception in Boston, where, despite this limitation, the state attorney general urged the two sides to reach an agreement out of concern about the potential consumer disruption.

In most recent showdowns, plans have largely capitulated to providers' demands.

Events in Orange County vividly illustrate what can happen when they don't—significant disruptions to access and continuity of care.<sup>3</sup> However, plans are quick to point out that the consequences of surrender may be even more serious, particularly if higher provider payments are financed by increased premiums and greater consumer cost sharing.

This dilemma is likely to continue to confront plans in the near future. As providers remain under financial stress from low payment rates, rising costs and slower Medicare revenue growth, more aggressive bargaining with health plans offers one of the few possibilities for relief. Indeed, one of the underlying concerns of the plans involved in the disputes in Boston, Orange County and Seattle was that provider pushback could snowball as others, sensing opportunity, would pattern negotiations after the trailblazers. Although not all providers will achieve better contracts, HSC's observations suggest that organizations with strong reputations and strong physician-hospital relationships are well positioned to prevail.

New market developments could diminish these advantages, particularly if rising premiums and a slowing economy restore interest in restrictive network products. Formal or informal involvement of state and local policy makers also could play an important role in constraining providers' aggressive negotiating tactics in the future. In particular, perceptions that providers have amassed excessive market power and can command inflated prices could trigger antitrust concerns, which might lead providers to rein in aggressive behavior over time.

Ultimately, the degree to which the balance of power shifts back toward health plans remains to be seen. Much of this will depend on the strength of the brand-name status and consolidated market power that providers have developed over the past several years and on the steadfastness of consumer and purchaser disdain for restrictive managed care. In the near term, both sides appear poised to test these positions, which, for consumers, makes the prospect of continued network instability and higher costs likely. ●