

Issue Brief

Findings from HSC



GETTING ALONG OR GOING ALONG? HEALTH PLAN-PROVIDER CONTRACT SHOWDOWNS SUBSIDE

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Although contract negotiations between health plans and providers have remained tense during the past two years, overt impasses have declined, according to findings from the Center for Studying Health System Change's (HSC) 2002-03 site visits to 12 nationally representative communities. The balance of power stabilized during the period, with providers, particularly hospitals, solidifying their dominant negotiating positions and securing concessions from plans in the form of significant payment rate increases and more favorable contract terms. Many plans have recognized and accepted their weaker position relative to providers, suggesting the recent lull indicates plans have found it in their interests to accommodate provider demands for higher payments, rather than resist them and possibly trigger a contract showdown. Though no immediate change is likely in this environment, there are emerging forces that could swing the power pendulum back toward plans.

Providers Retain Upper Hand Over Health Plans

A number of forces converged in the late 1990s to give certain providers—particularly hospitals—significant bargaining leverage over health plans. By 2000, many providers were pushing plans for large payment rate increases and more favorable contract terms, such as reimbursement based on a percentage of charges, to recover ground previously lost to health plans. Providers also experimented with more aggressive bargaining tactics, such as contract terminations or threatened terminations, to seek new contracts. Negotiations in a number of cases degenerated into bitter public disputes. Providers' negotiating success emboldened other providers to push back and contract showdowns became

commonplace across the country during 2000-01.¹

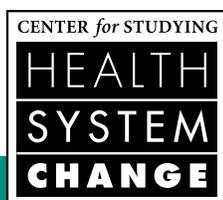
Providers have since solidified their negotiating clout, with many of the factors behind the shift in the balance of power two years ago continuing to shape local health care markets:

- Despite double-digit health insurance premium increases and increased consumer cost sharing, consumer demand for broad provider networks remained strong and continued to undermine plans' threat of network exclusion as an effective negotiating tool.
- Both physicians and hospital systems have pursued consolidation and used the resulting solidarity

to strengthen their negotiating leverage.

- Certain providers—particularly those perceived to have strong clinical reputations—continued to enjoy “must-have” status in health plan networks.
- Hospital capacity constraints persisted in some markets, reducing hospitals' incentive to accept discounts to maintain or increase patient volume.

Nevertheless, the contracting environment has evolved beyond the acrimony that characterized the first two years of the decade. Across the 12 markets, contract showdowns were considerably less prevalent and network



instability was less of a concern in 2002-03, as plans accommodated providers' demands to avoid the negative consequences of bitter and protracted disputes (see Data Source).

The lull in showdowns reflects, in part, a growing recognition by plans that the balance of power now clearly favors providers. Indeed, while contract negotiations remain difficult, most plans now cautiously approach potential showdowns with a better understanding of the formidable odds they face in trying to win them. At the same time, health plans have seen little serious resistance to premium increases from employers—many of whom have chosen to pass on more costs to employees—which has further diminished plans' willingness to oppose providers. Only in the rare instances when plans had steadfast purchaser support have they resisted provider demands and engaged, sometimes successfully, in the kind of brinkmanship that was common in 2000 and 2001.

Plans Meet Provider Demands

HSC profiled plan-provider contract showdowns in three markets—Orange County, Calif., Seattle and Boston—following its 2000-01 site visits. Just as these showdowns were representative of disputes occurring across the country at the time, their aftermath illustrates both the painful consequences that all parties experienced, particularly plans, and how plans altered their contracting strategy throughout 2002-03 as providers strengthened their bargaining leverage.

The Orange County market has stabilized since the 2001 showdown between PacifiCare of California and St. Joseph Health System. In the aftermath of the split between these two local powerhouses, St. Joseph reportedly retained three-quarters of its PacifiCare patients as they switched enrollment to competing health plans. Market observers generally viewed PacifiCare as having suffered more as a result of the dispute, even though one of the area's largest and most respected physician groups severed its affiliation with St. Joseph after the dispute because of plummeting health maintenance organization (HMO) enrollment and capitation revenues.

Possibly influenced by the showdown's consequences, most other plans in Orange County have avoided challenging providers publicly. Plans have largely acceded to providers' demands for double-digit payment rate increases while experimenting with new approaches—such as tiered-provider networks and financial incentives for medical groups—that could strengthen plans' bargaining leverage in the future. Notably, PacifiCare recently announced that it signed a new contract with St. Joseph, two years after they parted ways.

Since the bitter contract disputes and significant network disruption that rocked Seattle in 1999 and 2000, the two largest health plans in the market—Regence Blue Shield and Premera Blue Cross—have sought to improve relations with providers. In the round of negotiations that followed, both plans offered higher payment rates, more flexible payment methods and a more collaborative approach to negotiations. For example, Premera created physician advisory boards to provide feedback on contracting policies and payment rates. Both of the Blues abandoned confrontational negotiations to stabilize their broad provider networks, turning to tactics like tiered networks. Other Seattle plans saw the Blues' conciliatory strategy as driving the market's medical cost trends higher.

In Boston, Partners HealthCare System remains the area's dominant hospital system because of its prestigious academic medical centers and physician organization. In 2000, Partners engaged in heated public disputes with each of the top three local plans, coming away with large payment increases that forced the plans to raise premiums significantly. The plans indicated they hope to avoid controversy during the next contracting round by moving to more collaborative contracting strategies and turning their efforts to approaches that include tiered networks and incentive-based compensation. Tufts Health Plan, the firmest negotiator of the three plans in 2000, and Partners recently came to a multi-year agreement that includes quality-based incentives for providers, though the specific terms of the agreement were not released.

Plans in other markets showed a similar desire to avoid protracted public disputes. For example, Anthem Blue Cross and Blue

Shield, the undisputed market leader in Indianapolis, faced a challenge in 2002 from one of the area's four major health systems, which threatened to terminate its contract with Anthem over payment rates and contract terms. Rather than engaging in a public debate about the terms, Anthem quietly and successfully defused tensions by negotiating a quality-based incentive system that conditions a portion of a hospital's negotiated rate increase on how well the hospital performs on a quality scorecard. Some view the use of payment incentive systems as a useful means to promote better cooperation and sustained collaboration between plans and hospitals, and perhaps with other providers as well.

Purchaser Support Aids Plans

Although a shift toward fewer overt clashes was generally observed, plan-provider contracting still produced isolated showdowns during 2002-03. In Lansing and Seattle, plans fought to thwart providers' intransigence by using purchaser support to pressure providers to retreat from their hard-line stances.

The two market giants of Lansing, Sparrow Health System and Blue Cross and Blue Shield of Michigan (BCBSM)—who control two-thirds of the Lansing hospital market and 70 percent of the private health insurance market, respectively—squared off in a bitter public dispute in 2002. Likened to a “sumo-wrestling match,” Sparrow threatened to terminate its BCBSM contract at the end of 2002 if it didn't receive a much higher payment increase than the 3 percent increase Blue Cross offered to most Michigan hospitals in its most recent contracting cycle.²

Several large employers in the market, hoping to curb premium trends and maintain access to Sparrow's services, supported BCBSM through public and private actions. Some announced they would refuse to reopen enrollment periods for employees who might wish to switch from BCBSM to another plan if Sparrow were dropped from BCBSM's network. Many observers commented that Blue Cross was, in effect, the voice of employers who wanted to keep health care costs down, and one public

official went so far as to say, “The battle is really between Sparrow Health System and large, self-funded employers.”

As the contracting deadline neared, Sparrow and BCBSM reluctantly agreed to extend the existing contract for six months. Following subsequent negotiations, an agreement was finally reached. While the final terms remained confidential, most observers believe BCBSM, with the help of strong purchaser backing, successfully withstood Sparrow’s challenge.

Despite attempts by several Seattle health plans to improve relationships with the area’s most powerful providers, the market still experienced a major contract dispute in late 2001. Swedish Health Services, one of the area’s most popular hospital systems, terminated its contract with Aetna after the national insurer refused requested rate increases. Because Aetna was a leading plan for some of Seattle’s largest self-insured employers, including Microsoft, Boeing, Starbucks and Nordstrom, these businesses—which would see cost increases more directly and immediately—became involved in the fray. Some employers applauded Aetna for aggressively fighting price increases for its clients, while others blamed Aetna for the network disruption. Some, including Microsoft, subsequently switched plans in part because of the dispute.

The sides ultimately reached an agreement but did not publicly reveal the terms. The dispute underscored the potential for employers to play an active role in negotiations, particularly by using the media as a conduit for their cause.

Will the Pendulum Swing Back?

While providers, particularly hospitals, generally appear to be in the driver’s seat in contract negotiations and many plans have altered their contracting strategy to be more accommodating of provider demands, a number of recent trends could shift the balance of power back toward plans.

Rising prices may force purchasers to reconsider the positions they have typically staked out in plan-provider disputes. Traditionally, employers have been more supportive of providers to protect their employees’ interests—namely choice of

provider and access to medical services—and thereby undermined plans’ negotiating leverage with providers. But large payment rate increases for providers translate directly into premium increases for purchasers, and employers have been hit hard with double-digit premium increases over the past three years.³ While purchaser roles in contracting disputes remained uneven and unpredictable during 2002-03, showdowns in Lansing and, to a lesser extent, Seattle illustrate how purchaser involvement can influence negotiations and help plans hold the line against payment rate increases. Nevertheless, increased patient cost sharing has softened the consequences of premium increases for employers, and few have yet to show an interest in resurrecting tight network products, so it is unclear how much purchaser allegiances will shift in the near term.

Having to respond to growing community pressures can constrain providers’ ability to request large payment rate increases. For example, Partners in Boston, which prevailed in negotiations with all major plans in the market and attracted the attention of joint Federal Trade Commission and U.S. Department of Justice hearings,⁴ has tried to dispel perceptions that its recent proposed payment increases were excessive. Meanwhile, hospital pricing practices have come under greater scrutiny in the wake of controversies that have befallen Tenet and HCA.⁵ Some market observers in Orange County, where Tenet owns 11 hospitals, viewed the recent controversies around Tenet’s pricing practices as an indication of how overly aggressive hospitals have become and a signal that public sentiment is turning against hospitals in reaction to their excessive financial demands.

While plans have been limited in their ability to refuse provider payment demands, they have increasingly pursued initiatives to reduce tensions with providers and engage consumers more directly. For instance, the growth of preferred provider organizations (PPOs) has signaled an interest by employers both to broaden choices and transfer more responsibility to consumers while promoting more price sensitivity. PPO options with coinsurance, where patients pay a percentage of the total bill, can offer considerable transparency

to consumers about covered benefits, provider networks and level of coverage based on the site of service. This process relieves plans of some decision-making burden and absolves them of some blame for high health care costs. Likewise, plans’ increasing interest in consumer-directed health plans is consistent with the industry’s attempt to engage consumers directly through similar cost-sharing mechanisms as PPOs. Consumer-directed plans place even greater decision-making responsibility in the hands of the consumer and, with it, more exposure to price differences among providers.

Another plan initiative that is being employed on a limited basis to alter the balance of power is tiered-provider networks, where consumers face different payments based on the cost or quality of providers.⁶ These products may increase plans’ flexibility in determining rates they can offer providers and generate new leverage for plans in price negotiations. For example, in Orange County, some hospitals agreed to lower payment rates to ensure placement in the preferred tier of Blue Shield of California’s tiered hospital network product. Nevertheless, while plans in nearly all of the 12 markets have explored the use of tiered networks, many have faced a number of barriers to implementation. Providers often vehemently object to tiered networks, and in some markets, dominant providers have successfully precluded the networks’ development by refusing to participate. Purchaser ambivalence toward tiering also has prevented these products from gaining traction. Ultimately, tiered-provider networks, as well as other plan initiatives such as consumer-directed plans, will require greater purchaser and consumer acceptance to significantly alter the balance of power between plans and providers.

Finally, plans have tried to improve relations with providers by offering more favorable payment methods, notably incentives based largely on quality-related measures. Providers have been attracted to these pay-for-performance initiatives largely because they typically involve little downside risk and may provide rewards for high-performing providers. Performance-based compensation schemes



Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. HSC researchers interviewed key individuals in each community, including representatives of health plans, providers, employers and other stakeholders. This Issue Brief is based on an analysis of these individuals' assessments of plan-provider negotiating practices and contract negotiations in the 12 markets.

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for physicians and/or hospitals are being developed in Orange County, Boston, Indianapolis, Lansing and other markets.

Implications

The last two years revealed few contracting disputes in the 12 markets tracked by HSC researchers. Although the contract negotiations remained tense, providers—particularly hospitals—overwhelmingly received the terms they sought. The future of health plan-provider relationships, negotiations and the balance of power remains uncertain, but two key issues may influence these trends.

First, plans and providers may be displaying more mature approaches to contracting. The fact that only two major disputes surfaced over the last two years across the 12 markets may indicate that dissatisfied parties have moved beyond hostile tactics or exercises in one-upmanship. Efforts by plans and providers to negotiate more privately also lend credence to this interpretation, and a mutual recognition of the negative fallout for both parties may create more reluctance to go down the impasse road.

Second, regulatory interventions could challenge provider ascendancy. Through consolidation and disciplined negotiating strategies, more providers are gaining “must-have” status in plan networks and using it to their advantage. Such status confers extraordinary power to these providers and has triggered intensified pleas from plans, purchasers and consumers for regulatory intervention. The Federal Trade Commission has indicated its intent to revisit previously approved hospital mergers in response to health plans' complaints about the heavy concentration in the hospital market. The threat of regulatory scrutiny could force providers to temper their bargaining demands.

Finally, as providers gain large payment increases and plan profitability improves because of their ability to pass on the increases through higher premiums, purchasers and consumers appear to be the ultimate losers of

the current contracting environment. Many purchasers and consumers view the current cost trends as untenable. Pricing pressures—especially if combined with a continued sluggish economy—could provoke a more forceful backlash, possibly leading into the public policy arena with stronger demands for rate regulation or more comprehensive health reform. ●

Notes

1. Strunk, Bradley C., Kelly J. Devers and Robert E. Hurley, *Health Plan-Provider Showdowns on the Rise*, Issue Brief No. 40, Center for Studying Health System Change, Washington, D.C. (June 2001).
2. *Bitter Contract Dispute Reaffirms Blues' Dominant Position in Lansing*, Community Report No. 5, Center for Studying Health System Change, Washington, D.C. (Spring 2003).
3. Gabel, Jon, et al., “Health Benefits in 2003: Premiums Reach Thirteen-Year High as Employers Adopt New Forms of Cost Sharing,” *Health Affairs*, Vol. 22, No. 5 (September/October 2003).
4. The joint hearing related to Partners was held on Feb. 28, 2003. The agenda is available at: <http://www.ftc.gov/ogc/healthcarehearings/healthcareagenda.htm>.
5. Modern Healthcare, “Tenet's Turn,” Nov. 18, 2002.
6. Mays, Glen P., Gary Claxton, and Bradley C. Strunk, *Tiered-Provider Networks: Patients Face Cost-Choice Trade-Offs*, Issue Brief No. 71, Center for Studying Health System Change, Washington, D.C. (November 2003).

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