REVIVE HEALTH

A New Era for Payor/Provider Relations

Combating Distrust in an Industry Myopically Focused on Price

Authors

ReviveHealth is a full-service agency focused on the intersection of healthcare delivery, finance, and innovation. We serve health systems and provider organizations across the country, and have worked on a local and regional basis for clients in 48 states. We are uniquely positioned at the leading edge of healthcare brand innovation, thanks to our decades of experience working with healthcare companies across the industry. This enables us to design effective programs that engage audiences, accelerate buying cycles, and influence decision-making. With a strategy-first approach and distinctive expertise, we pull the appropriate brand, marketing, and PR levers to create momentum and drive clients' business goals.

As a full-service agency, ReviveHealth offers all capabilities necessary to support our clients' marketing communication needs – strategy, creative, and execution. Inside the agency is the industry's only dedicated strategic communication consultancy focused on payor/provider relations and issues management. Headquarted in Nashville, ReviveHealth's team of 90 professionals also work from offices in Boston, Minneapolis, and Santa Barbara.

Acknowledgements

Thank you to the thought leaders, analysts, writers, and countless others who contributed to the making of this report. We are especially grateful to contributors Nate Kaufman of Kaufman Strategic Advisors; Michael Nugent of Navigant; Neil Rao of McKinsey & Company; and Kelly Drosihn of Chancellor Consulting Group. These incredible people work diligently to help us ensure health system leaders and industry watchers have access to a realistic view of the road ahead to inform their strategic planning.

Table of Contents

Executive Summary

When we started 2018, we believed it would be a pivotal year for payor/provider relations. We had witnessed first-hand that negotiations with payors had grown increasingly challenging over the last couple of years. Even single-digit rate increases had been met with obstinate resistance, requiring a level of resilience in health system C-suites and board rooms that was rarely needed just five years ago.

We began 2018 warning about the emergence of a phenomenon we dubbed "terminate to negotiate." As providers wanted to negotiate an outdated contract, the payor required the provider to terminate the contract. When a contract was terminated or scheduled to expire, the payor would simply stall until after the contract expired and the provider was out of network (OON) – only then beginning to negotiate after 30 or 60 days had elapsed. We saw several of these situations unfold a couple of years ago, and at the time it was difficult to tell if this would become a widely adopted strategy. Yet, by the beginning of 2019, it was clear this was no longer an isolated phenomenon. "Terminate to negotiate" had become a mainstream payor strategy.

We believe provider organizations can still get ahead by preparing for payor negotiations in 2019 and beyond. It starts with understanding four key payor/provider trends:

+ Payor/provider conflict is at an all-time high.
+ Payors are targeting market-leading "must-have providers."
+ Payors' and providers' priorities are misaligned.
+ Payors are positioning at the "top of the funnel."

As we turn the calendar to 2019, we survey a very different landscape for payor/provider relations. We have identified four trends covered in the following report. These four trends combine to one clear fact about payor/provider relations: **Payors prioritize (medical loss ratio) MLR over membership, and there is no single lever for providers to pull that will pressure a health plan into a fair contract.**

This simple observation may not seem dramatic. Yet, a fair contract is the product of good faith negotiations and a balanced give-and-take where both sides compromise to maintain a healthy business relationship for the benefit of their customers. If payors care about (MLR) and membership, they will work to keep payment rates to providers at reasonable levels while also maintaining networks of hospitals and physicians that employers and consumers want. However, if an imbalance develops – what we saw in 2018 and expect to continue in 2019 and beyond – payors are willing to shed membership to drive down payment rates (and MLR), which impacts their entire book of business. They focus only on unit price, pushing high-quality and in-demand providers OON unless those providers accept the payors' rate cut demands.

Anthem is the prime example of the new payor priorities. In its recent 10K, Anthem reported commercial membership had declined by one million lives, MLR dropped 210 basis points, and profitability surged 30 percent. In any other industry, a significant drop in membership or volume results in eroded profitability.

This is particularly challenging because providers have very volume-sensitive business models, and they balance a need for healthy commercial patient volumes with the need for appropriate rates that cover the ever-growing losses from treating Medicare, Medicaid, and uninsured patients. If payors focus only on price, and providers focus on both volume and price, who has the natural upper hand in negotiations?

The strange thing, in our view, is that major payors are suddenly very focused on unit price and MLR, and at the very same time their business has shifted heavily to self-insured over fully insured. In a fully insured environment, we expect MLR to be critically important to the health plan, since they are playing with (and paying with) "house money." Yet in a self-insured environment, the health plan's profitability is assured. Perhaps this is all about competitiveness, and the push for health plans to retain large self-insured accounts. Maybe it's something else. Either way, the trend seems clear.

Naturally, every rule has many exceptions. There are definitely payors who still care about membership as much as MLR – mostly not-for-profit Blues. And there are definitely payors who are negotiating in good faith with providers for fair, balanced contracts. Yet the four trends detailed in this report so clearly point to a fundamental shift in the payor/provider landscape that they can't be ignored. This will require providers to approach payor negotiations, and payor/provider relations, with a different attitude and set of priorities.

It is an accepted fact that the world of payor/provider relations and contract negotiations gets a little tougher every year. At the same time, we recognize – and the industry experts we consulted in preparing this report validated – that the hospital industry has experienced a fundamental shift in its financial foundation over the last decade. Three factors stood out; 1) the continual erosion in Medicare and Medicaid margins, 2) the permanent effects of the federal government's budget sequestration, and 3) the continued payor mix shifts caused by the aging population.

We can all agree that the addition of a significant number of employed physicians to any health system's profits and loss (P&L) adds some gasoline to this fire, both in terms of the significant subsidies provided by health systems (and the financial pressure that creates) and the simple fact that physician and outpatent (OP) volume is the first volume affected in an OON situation. To be fair, subsidies may be overstated since the physician enterprise accounting rarely includes the ancillaries and other technical revenue. The addition of a substantial number of employed physicians to the health system enterprise injects a political element, too, which can be difficult to ignore.

We hope this year-end report provides some clarity on the market trends that have emerged and helps provider organizations plan for payor negotiations in 2019 and beyond. Navigating a difficult landscape makes market intelligence all the more valuable. Hopefully, this helps you "see around the corner" a bit as you prepare for the coming year.

Trend 1: Payor/provider conflict is at an all-time high.

The last year has been ugly, building on a series of several difficult years. Conflict between payors and providers is at an all-time high, and contract renegotiations that used to be perfunctory are now protracted, involved, and difficult. In 2018, we saw high-profile disputes between major payors and providers including: Tenet Health, Envision Healthcare, HCA, NewYork-Presbyterian, Mission Health, Montefiore, Mount Sinai, OhioHealth, ProMedica, and Johns Hopkins – just to name a few. In fact, these disputes became so common that, unfortunately, we almost consider them "normal."

We shouldn't.

The Breakdown

Payors recognize short-term OON impacts are felt by the provider – physician unrest, patient confusion, considerable reductions in OP surgical volume and diagnostic imaging, and difficulty collecting patient out-of-pocket (OOP) costs. Then we must consider the challenges of operationalizing OON.

Payors also recognize the long-term OON impacts. It takes months for payors to feel the impact of membership loss; for exchange consumers and Medicare Advantage (MA) members to switch; and for political and regulatory pressure to develop. During that time, the provider is suffering immediate pain and impact, which they naturally want to alleviate as soon as possible. Yet, when a health system concedes and the payor secures desired rate reductions, it sets a precedent that can be used in every other health system contract negotiation. For example, look at the dynamic between Blue Cross and Blue Shield of North Carolina (BCBSNC) and the hospital community in that state.

Before 2017, ReviveHealth developed communication strategies for 872 engagements that resulted in 11 OON situations (1.2%). In 2017 and 2018, we have managed 38 engagements that resulted in eight OON situations (21%). This dramatic change has clearly been a result of "terminate to negotiate."

These intense public battles are not limited to OON situations. Public conflict is increasingly being used by health plans as a signalling mechanism. That's what happened when conflict jumped into the headlines in 2018 with Anthem's 14 medical policies – including "prudent layperson," OP imaging payment, and others. The response that followed was a surge of provider litigation. Now, United Healthcare has announced it will pursue the same OP imaging payment approach, and it's reasonable to expect others to follow.

Implications

Time is of the essence when a health plan issues a termination notice, and providers need to know how and when to respond. Providers also need to know how to handle the communication effort when they issue the termination notice. In either case, inertia is likely to follow the initial notice.

Kelly Drosihn, president of the Chancellor Consulting Group says, "Negotiating thousands of contracts per year gives us a unique view on the market, and we've noticed a pattern of slow response from many payors who seem reluctant to negotiate at all in the traditional sense. Time is on the payor's side unless we put a term on the table and then the vicious cycle/process of the termination and threatened OON status begins."

In our experience, the first organization to publicly comment on the circumstances has the upper hand in establishing the narrative. Successful negotiations require providers to gain advocates and public support by communicating with and educating key stakeholders early and often. Unless providers have effective "ground games" for engaging a range of stakeholders, they will have a difficult time generating the momentum and pressure necessary to win the OON battle.

Compared to payors, who handle difficult contract situations and public conflict with providers continually, most health systems are "one-time players." This means they need a nine- to 12-months ramp-up; negotiating to contracting to create pressure on the health plan for settlement before the contract expires, otherwise they are unlikely to succeed in an OON strategy. Unfortunately, many health systems wait until just four to six months prior to contract expiration to start stakeholder engagement, ultimately ceding precious ground to the payor and losing control of the narrative.

Looking Ahead

The state of payor/provider relations in 2018 was marked by intense conflict and public battles. This was exacerbated by tactics that included a level of social media engagement and point/counterpoint we have never seen before. In 2019, and beyond, we see that trend continuing. As providers are generally the first to relent during an OON situation, payors have decided that conflict is working in their favor. Providers will increasingly have to choose between two scenarios. In the first scenario, providers have to accept lasting, negative impacts of immediate payment cuts. In the second scenario, providers have to endure short-term, negative impacts as they fight for the right rates and contract language.

More than half of U.S. CFOs expect a recession in 2019 or 2020. During a recession, utilization falls, with a 12- to 18-month lag as unemployment rises. With that headwind in the next contract cycle, payors are even more urgently trying to fix lagging contracts and so are providers.

Insights

Provider organizations must consider impacts and benefits that will span across three-, five-, and 10-year time frames.

Think of it this way – a zero percent escalator in any one year has compounding negative effects for many years to come. In the same way that rate increases compound every year, so do rate reductions (in the reverse). Health system executives may have a hard time with this but respond with an anxiety-ridden, "We can't go OON." What they mean is that handling an OON scenario is perceived too complicated to attempt, the unknown and it's too complex to navigate. That's why very few provider organizations have gone OON more than once, whereas payors are negotiating contracts and managing OON situations on a routine basis. Providers will have to change that, bracing for and even leaning into OON situations in favor of longer-term goals.

It is critical that health system executives model benefits and costs with a longer-term horizon. This presents the most accurate picture of the short-term impacts of any OON situation compared to the long-term impacts of any rate reductions.


AXIOS

Bob Herman May 24, 2017

Profits are booming at health insurance companies


NEW YORK POST

BUSINESS DEAR JOHN

Is Montefiore out-of-network for patients with Aetna?

By John Crudele October 27, 2018 | 10:51pm


Dayton Daily News

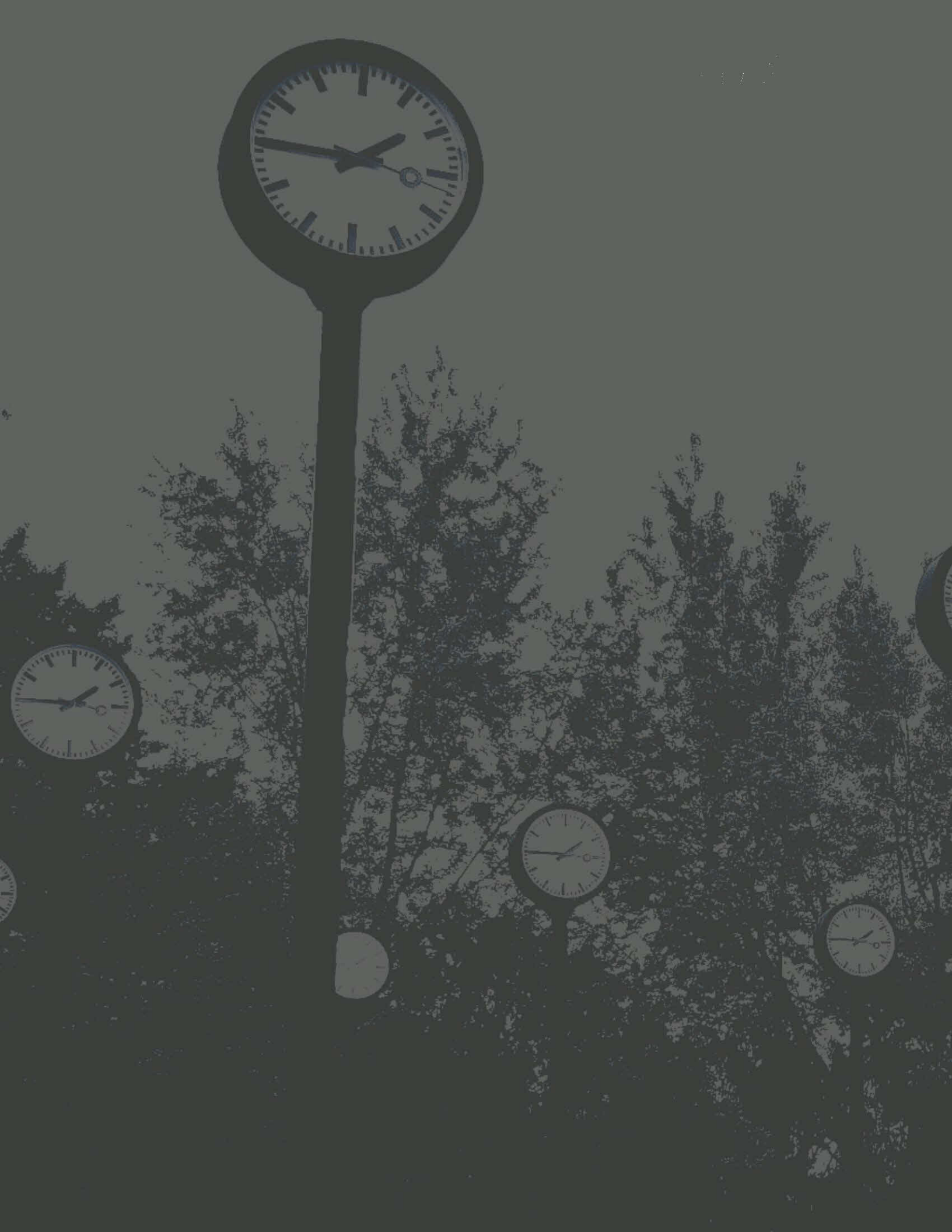
UnitedHealthcare and Premier Health deal: What's really going on?

BOB UNDERWOOD/STAFF

Oct 07, 2017

By Kara Driscoll and Kaitlin Schroeder, Staff Writer

Advertisement



Trend 2: Payors are targeting market-leading "must-haves."

Over the years, payor/provider conflict has frequently been driven by challenger brands and third-tier provider brands asking for significant rate increases. It was rare for payors to engage in conflict with market-leading brands, which used to be called "must-have" hospitals or health systems before the wave of tiered and narrow networks changed the definition of "must-have." These must-have, market-leading brands would challenge payors for rate increases (pre-2008) or the rights to participate in tiered or narrow networks. This was a balance of power that resulted in stable provider networks and few OON situations.

That balance is long gone. In the last two years, the increasingly public conflicts between the largest payors and health systems more commonly involve market-leading "must-haves," rather than challenger brands and third-tier providers. As we look at 2019 and beyond, this trend appears to be intensifying.

The Breakdown

Payors target market-leading brands because their payment rates are often market-leading as well, and other provider organizations shadow-price off of those rates.

Payors also target market-leading brands because they trade in power. Combined with the fact that healthcare is still a two-degrees-of-separation industry, payors know healthcare leaders will inevitably say to one another, "Can you believe [payor] is going after [market-leading provider]? Wow…" This fear-based, word-of-mouth system for even one big negotiation makes every other negotiation with every other provider easier for that payor. In fact, it's easier almost regardless of the outcome, especially when negotiations are based on traditional tactics and perception rather than informed by analytics.

A recent report from Leavitt Partners stated that, "employers express concern about costs but are reluctant to adopt models that might be perceived as limiting employees' choice of providers. With unemployment less than four percent, employers worry how the quality of their insurance benefits impacts recruitment and retention. This fascinating dynamic is now playing out on a rapidly shifting battlefield as payors target market-leading health systems for rate decreases or multiple years of zero rate adjustments."

Implications

The most interesting thing about payor targeting is revealed by recent pricing data which shows how much commercial rate increases have moderated in recent years. It seems that every week, there's a new headline about health insurance costs being driven by price increases for the underlying services. Yet, the 2018 JP Morgan 17th Annual Hospital Survey paints a very different picture – commercial payment rate increases for hospitals were 2.0 percent in 2018, 2.0 percent in 2017, 2.0 percent in 2016, 2.0 percent in 2015, and 2.5 percent in 2014. It's reasonable to expect that 2019 will be similar.

Exhibit 6: Actual commercial medical cost trend has come in at or below the midpoint of UNH's initial outlook in 16 of the past 17 years

		UNH Commercial Medical Cost Trend																
		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018E*
A	Initial outlook**	12.3%	11.5%	10.5%	8.8%	8.0%	7.5%	7.5%	8.0%	8.0%	7.5%	6.0%	5.5%	6.0%	6.0%	6.0%	6.0%	6.0%
B	Actual	12.0%	10.5%	8.3%	7.5%	7.3%	7.3%	8.0%	7.8%	6.0%	5.5%	5.5%	5.0%	5.5%	5.5%	6.0%	5.5%	5.8%
B - A	Delta (in bps)	(25)	(100)	(225)	(125)	(75)	(25)	50	(25)	(200)	(200)	(50)	(50)	(50)	(50)	0	(50)	(25)

*"Actual" reflects revised guidance as of UNH's 11/27 analyst day
**Midpoint of guidance range, which is typically 100 bps wide

Source: Company data, Goldman Sachs Global Investment Research

Considering the medical consumer price index has been hovering between 4 percent and 6 percent for several years, it's difficult to see how this is sustainable. For example, United Healthcare reports a commercial medical cost trend above 5 percent every year for the last 16 years. Rising costs, minimal price increases, and eroding commercial payor mix creates a troubling cocktail.

"The fact that BCBSNC was willing to go out of network for months with Mission Health, a system with over 85 percent market share speaks volumes as to how willing them managed care organizations (MCO) are to take on 'must-have systems,' everywhere," said Nate Kaufman, Managing Director of Kaufman Strategic Advisors.

This makes us wonder – how long can payors use aggressive, public attacks on market-leading must-have health systems and providers? Employers, MA members, and consumers who pay premiums don't want to be excluded from top health system brands. Eventually, something, or someone, has to give, but, if they stay level-headed and rely on analytics, it doesn't have to be providers.

Insights

To avoid the pitfalls of payor targeting, provider organizations should negotiate with a strategy powered by analytics, rather than perception and legacy "beliefs."

Health systems, especially those who have been on evergreen contracts in states with one or two dominant payors, are often not accustomed to negotiating every few years across multiple agreements. While payors may not be issuing terminations to open up those evergreen contracts now, health systems should plan for that to happen in the next 24-36 months as payors attempt to find more soft spots to reduce MLR, especially with acute-care providers. One way to do this is to apply data analysis to mix to the payor base, focus on cost structure, and address the mix payors' demands for lower-cost care. This approach to population health data enables "must-haves" to provide improved specialty care while managing brand reputation and highlighting their offering mix in the process.

Trend 3: Payor and provider priorities are misaligned.

The symptoms of the misalignment between payors and providers are everywhere we look, but show up most visibly in permutations of programs that have taken off in the last few years: value-based care (VBC) and reference-based pricing. The ways in which payors distort and misuse these tools has allowed the divide to widen between what payors prioritize (unit price) and providers prioritize (informed patients and payment reform).

The Breakdown

This isn't how things were supposed to play out when tiered and narrow networks rolled out over the last five years. Tiered and narrow networks were supposed to favor health systems who were willing to accept lower rates in exchange for promised volume VBC was supposed to supplement tiered and narrow networks, but Kaufman said that simply hasn't happened. "Payors are using 'value' as an excuse to pay providers less and generate more profits for themselves," he said. "There is no evidence that value-based payments have done anything but reduce unit prices."

Not everyone is misusing reference-based pricing programs - yet. For example, the State of Montana introduced reference-based pricing in 2016, in a collaborative program that generated state savings and a sustainable financial environment for providers. The State of North Carolina is considering a similar, but more "provider unfriendly" program now.

We see a similar payor approach to reference-based pricing programs. For two years, we've answered client questions about reference pricing, but there's never been much to report. Then, in 2018, it became a reality across the U.S. with certain payors and employers. We've even seen it in the latest employee health benefits for FedEx, albeit only for OON services in certain plan designs. Most notably, the State of North Carolina is promoting a reference-based pricing program that cuts $300 million per year in payments to providers. This program is promoted by the state's largest health plan – BCBSNC – which is the state's partner for state employee health benefits.

Reflector.com

News Obits Opinion Workweek Sports Look Go-Guides Photos & Videos Feed

Battle brewing over state health plan

Vidant estimates cuts will total $40 million; state treasurer says fix is needed

By Bobby Burns
The Daily Reflector

Monday, December 3, 2018

An escalating conflict between North Carolina's treasurer and the state's health care networks is pitting the thin financial margin on which many providers operate against a floundering state health plan, officials said, and exposing a bitter disagreement over the path forward.

A proposal by state Treasurer Dale Folwell aims to restructure how the N.C. State Health Plan for Teachers and State Employees, one of the state's largest purchasers of health care services, pays providers in an effort to produce an estimated savings of $300 million for taxpayers and $65 million for plan members annually.

48 161

1 of 6

The front entrance of the new Vidant Cancer Center Thursday, March 8, 2018.

4 Comments

Officials with Greenville-based non-profit Vidant Health, the largest provider in northeast North Carolina, estimate the plan would reduce the $52.5 million operating margin it had last year by about $40 million, dealing a devastating blow to its ability to reinvest in communities and serve 29 counties from Duplin and Edgecombe east to the Outer Banks. The cuts could force Vidant to shutter facilities and curtail services, in turn limiting access to crucial care for tens of thousands in the region, including state employees who are supposed to benefit from the cuts.

Implications

There are many things we don't know yet about the downstream and long-term implications of payors manipulating VBC and reference-based pricing programs for their own gain. Yet, there are a few things we know for sure. First, unilaterally slashing payments to a provider without regard for the impact on that provider, or the sustainability of the provider's financial situation, is ethically wrong. Second, without substantial policy changes, these do-called VBC programs will continue to lend themselves to exploitation from self-insured employers and payors who would love nothing more than to dictate the rates providers will be paid. Third, the gap in payor/provider priorities is only expanding with every successful "take it or leave it" program that payors launch.

These self-serving payor tactics are significantly more common in markets where a single insurer has dominant market share (e.g., North Carolina, Texas, Tennessee). At the same time, that imbalance creates substantial challenges for employers and consumers purchasing health insurance, as well as providers who must navigate these unstable dynamics. It's hard to imagine this trend continuing – especially when providers start fighting back. For example, we're curious to see how self-insured employers react when providers start suing them for unpaid amounts that result from reference-based pricing schemes.

Insights

Provider organizations must align priorities internally – among board members, leadership, and other stakeholders – to bring a more united front to the negotiating table.

The gap in payor/provider priorities that's been amplified by VBC and reference-based pricing isn't getting any smaller. Why would it? The entire concept of VBC is based on a functional level of consumer engagement and understanding, but that's been all but nonexistent despite massive investments and new technologies deployed to drive engagement. Providers must be prepared for the consequences of these misaligned priorities and focus on Fee for Service rates that will allow for VBC and population health investments. Ultimately, health systems may need to deliver VBC to their communities in spite of payors rather than in partnership with them.

Trend 4: Payors are positioning at the "top of the funnel."

If we asked experts a decade ago to predict which organizations would have the greatest influence over access and provider selection in 2019, many might have picked health plans. We're fairly certain, however, that none of them would have said health plans would actually own many consumer access points. Now, we suddenly find health plans positioning at the "top of the funnel" to provide primary and urgent care services, among others, while also exerting more and more influence over consumer choice of hospitals, specialists and subspecialists.

The Breakdown

Optum – the fastest growing division of UnitedHealthcare, with $250 billion in revenue and double-digit annualized growth – now owns and operates more four percent of the urgent care centers in America. They also own more than 500 OP surgery centers and employ more than 47,000 physicians (approximately double the physicians affiliated and employed by Kaiser Permanente). Their new electronic health record is expected to be used by 50 million people in the next five years. Optum already has all of these assets assembled in more than half of the largest 75 metropolitan statistical areas. Now, with more than $555 billion in addressable healthcare spent in those markets alone, they are on the inexorable march to the remaining markets. In its recent earnings report, United announced that Optum just crossed the $100 billion revenue threshold.

Consider the Federal Reserve Board survey findings: 44% of Americans cannot afford a surprise $400 medical bill because they do not have that much money in savings. That puts a lot of these top-of-the-funnel strategies into focus. It also validates much of the M&A activity we see in the post-acute market and other sectors – Anthem acquiring Aspire; CD&R acquiring NaviHealth; Humana and TPG and Welsh Carson acquiring the component parts of Kindred; Ares acquiring DuPage Medical; and General Atlantic acquiring Landmark Health, just to name a few.

Implications

This trend is particularly interesting in light of a recent Health Care Cost Institute (HCCI) analysis of healthcare spending across nine million people over four years. The report shows that only seven percent of the total healthcare OOP spending is truly shoppable. Regrettably for providers, if it's not shoppable, it's very susceptible to influence. And positioning at the top of the funnel is giving payors that influence.

HCCI's analysis speaks to that as well. Here's what it says about the size of the audience that must be influenced and how critical individual subscribers are to the total healthcare spending equation:

> **"...the top 5 percent of spenders ("top spenders") accounted for more than half of all health care dollars. Within a given year, only a small proportion of people incur very high spending, but there is significant turnover in this group: each year, more than three of the five top spenders were not top spenders during the previous year. These new top spenders faced dramatic changes in year to year spending. In comparison to the persistent top spenders, new top spenders were on average younger and had lower spending – particularly on prescription drugs and professional services."**

The HCCI report continues:

> **From 2013 to 2015, the top 5 percent of spenders accounted for an increasing share of total spending. This increase in concentration coincided with an increase in prescription drugs' share of spending by the top spenders… In 2015, the median member of the top 5 percent had $39,409 in total health care spending and $3,850 in OOP spending. The bottom 50% of spenders accounted for less than 5% of spending in 2015… Per capita spending on prescription drugs by the top 5% of spenders grew to $12,574 in 2015 – almost 50% higher than in 2013.**

What few people have focused on are the impacts for providers if Optum, or any health plan, controls the "top of the funnel." If patients use Optum physicians and urgent care centers, more influence can be brought to bear on the selection of lower-cost hospitals or Optum-owned surgery centers. It's not hard to imagine how tiered networks, narrow networks, and incentives like zero-copay for the use of an Optum ambulatory surgery centers could emerge from this strategy.

Where would this leave hospital-centric health systems who have not pursued top-of-the-funnel strategies of their own? As one of our Wall Street analyst friends said, "Hospitals could end up being very expensive hotels for doctors," or the most expensive care sites for only the sickest (and most expensive to treat) patients. It is difficult to see a path to long-term sustainability in this scenario.

Insights

Payor top of the funnel machines can be combated by provider organizations that invest in improving access and referral integrity with physicians.

United Healthcare may be making big investments to build Optum as the first healthcare system that does not pivot around hospitals – perhaps it will be the first of many. Indeed, CVS/Aetna has referred to itself as the first non-physician centric healthcare system. Regardless, these payors are well on their way to what could be "access point monopolies" and that doesn't bode well for providers. Investing in access and referral integrity gives health systems the opportunity to position themselves as real alternatives to these payor-owned networks.

> **"This is obviously scaring the crap out of hospitals in many markets," Chas Roades, CEO at consulting firm Gist Healthcare. By controlling a greater number of physicians, Optum is not only buffering itself from competitors, but attempting to steer patients toward lower-priced care outs.**
>
> **In some cases, Bloomberg notes, UnitedHealth is directing members toward its acquired physicians. For example, UnitedHealth lists New West Physicians, a Denver-area group of 120 physicians that the insurer purchased last year, as a favored narrow-network plan for commercial members. Some members can see the physicians for 20 percent to 30 percent less in out-of-pocket expenses compared to physicians outside the network.**

Winning health systems will have robust networks of primary and urgent care access points, freestanding emergency rooms, telehealth offerings, and digital health offerings.

Fighting the Trends

Despite the prevalence of the "terminate to negotiate" strategy in the 2019 landscape, it would be unfair to say there are no exceptions to the rule. There are definitely payors who still care about membership as much as MLR – mostly not-for-profit Blues, for example. Also, there are definitely payors who are negotiating in good faith with providers for fair, balanced contracts. Yet there is a clear, fundamental shift in the payor/provider landscape that can't be ignored. It requires providers to approach payor negotiations and relations with a different attitude, set of priorities, and strength of resolve. Negotiations may never be easy again, but providers can level the playing field with well-informed negotiation strategies powered by analytics, market intelligence, and carefully crafted communications.

REVIVE HEALTH