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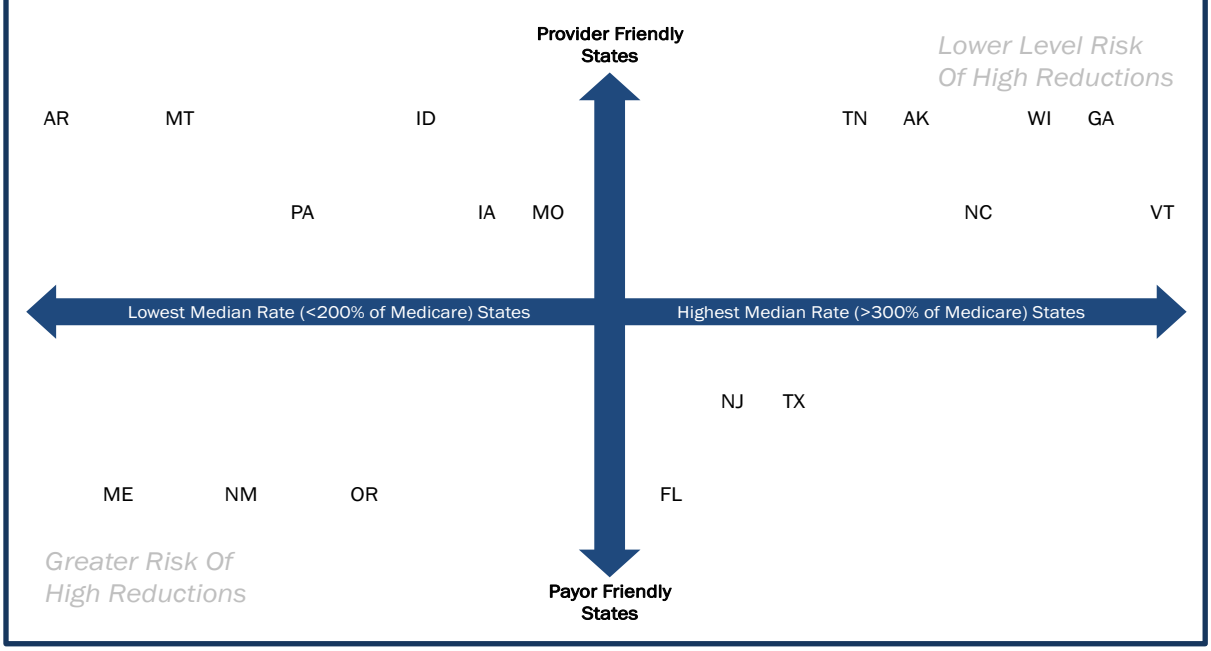
Payor Contracting Strategies and the Impact of Surprise Billing

Executive Summary

- The focus of federal policy makers on "surprise billing" has acted as a catalyst to change the contracting dynamics between payors and in-network outsourced physician groups, leading to pressure on reimbursement or contract terminations for large groups of scale with rates above the median in a given market
- Some payors, such as United Healthcare, have already begun to implement changes, while others are likely to wait until federal legislation passes before making changes to reimbursement
- However, as Marwood explores below, the scale of potential reductions varies by state based on differences in median in-network rates
- Additionally, mitigating factors such as provider-friendly state legislation, network adequacy requirements, and provider market share will likely have an impact on payor contracting strategies over the next few years

Impact Of Federal Surprise Billing Legislation On Providers in States Based On Median In-Network Rates And Existing State Legislation



Median In-Network Rate Data Source: HCCI Commercial Claims Data 2017, covering over 40 million commercial lives. Data show above is the average for ED, Anesthesia, and Radiology claims

Marwood's analysis notes that there are significant differences in the median in-network rate by state due to market factors such as provider competition, payor market share, and relative levels of aggressiveness in terms of contracting strategies; typically states in the Southeast, as well as Texas tend to have higher medians.

Background on Surprise Billing Legislation

Surprise bills, which arise when an out-of-network provider sends a consumer the balance of a bill after failing to reach an agreement with the consumer's insurer for the full price of the bill, have been a concern at the state level for over a decade and at the Congressional level for the last several years. Surprise bills typically occur in two primary situations: first, when a consumer receives emergency care at an out-of-network facility (or is transported by an out-of-network ambulance) and lacks the time or capacity to discern the network status of the providers, and second, when a consumer is treated by an out-of-network provider in an otherwise in-network hospital, most often through specialties with less patient contact, such as anesthesiology, radiology, and pathology, among others.

Over the last several years, states have increasingly sought to impose legislative solutions to surprise billing. 29 states have implemented surprise billing legislation, including 15 that have implemented comprehensive solutions and 4 that have new or expanded legislative solutions for 2020. These restrictions have typically sought to either set a rate for reimbursing out-of-network claims or use a binding arbitration process. While states have been active in restricting surprise bills, these legislative efforts are limited by ERISA pre-emption, which prevents states from regulating self-insured plans. As a result, state surprise billing laws only apply to individual market and fully insured plans, which typically make up less than half of the commercial covered lives in a given state.

With that backdrop, and at the behest of health insurers and employers, Congress began considering surprise billing legislation in 2018. Almost from the start, the two primary policy options have been a statutory rate-setting approach and an arbitration approach. As Congressional committees dug into the issue in 2019, the policy decisions were further colored by the secondary effects of surprise billing: even when a provider went in-network with a payor, the possibility of remaining out-of-network and sending surprise bills drove even in-network rates higher than would otherwise be expected.

As a result, the Congressional approaches with the most support have not only sought to ban surprise bills, but also save money by bringing the mean in-network rate towards the median. The Senate HELP and House Energy & Commerce Committees came to a compromise that was nearly included in end-of-year legislation in 2019. That compromise would automatically pay out-of-network claims at the median in-network rate, as defined based on the in-network rate for the region, payor, and service as of January 2019. Certain claims could go to arbitration, but only if the median rate was above $750. Due to the out-of-network rate being restricted, the expectation is that payors would gain negotiating leverage in in-network negotiations and push those rates towards the median, reducing provider rates overall. In early 2020, the House Ways & Means Committee, which was instrumental in blocking the HELP/E&C compromise in late 2019, released their proposal, which would preserve post-service negotiations and use binding arbitration to resolve lingering disputes. However, while this general framework has been supported by providers throughout the process, arbitration in this case uses the median in-network rate as the initial factor, which the Congressional Budget Office projected would similarly work to push provider rates towards the median over time.

While the legislative process has been long and arduous, there is every indication that a surprise billing fix remains a bipartisan political priority, and we expect there will be a push to pass legislation by the end of 2020, and otherwise relatively soon in 2021. The flurry of Congressional activity required to respond to COVID-19 has slowed the Congressional negotiations required to find a legislative compromise and advance a surprise billing package to the President's desk. Throughout the COVID-19 efforts, the White House has presented a new surprise billing fix, an outright ban on surprise bills without any back-end mechanism for payments. That would carve the patient out of the middle and leave negotiations to the provider and payor. We believe this would still swing power in

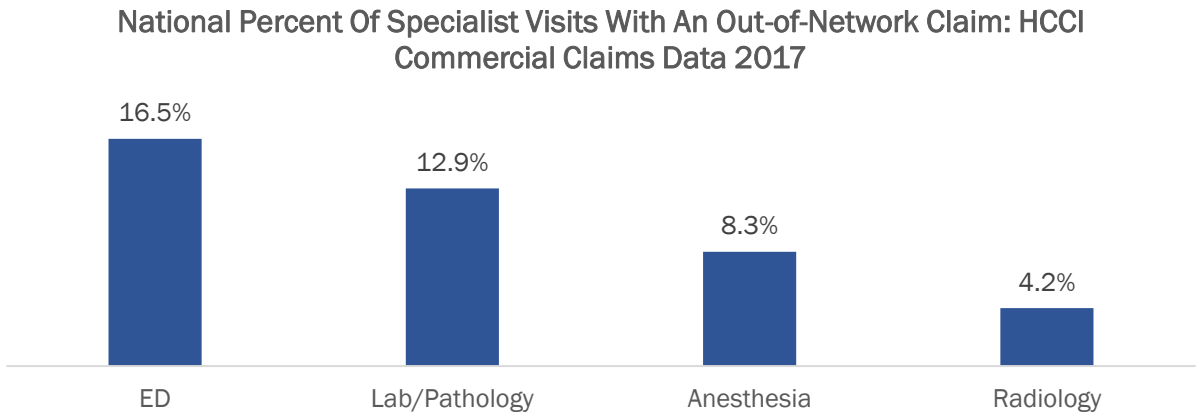
the payors' direction, but without a specific rate-setting mechanism, the overall impact would be much more modest.

The White House approach has gained only mixed approval in Congress, but the COVID-19 pandemic has likely shifted negotiating leverage towards providers somewhat, particularly hospitals. Overall, this likely improves the legislative outlook for providers, but it is not clear to this point how far Congressional leadership will allow the bill to move in a provider-friendly direction.

Impact on the Market

Out-of-network utilization for outsourced physician specialties such as ED, anesthesia, radiology, and pathology remains a concern for payors and is typically higher than other physician specialties. However, over the last 5 years, more of these physician groups have moved in-network as a combination of payor strategies and state legislation around surprise billing have led to a less favorable out-of-network environment. Many payors have exerted pressure on hospitals to contract with in-network groups and some payors have shifted away from a discount off of billed charges payment approach for out-of-network claims, thereby reducing the out-of-network reimbursement that is collected from the payor, though the vast majority of out-of-network claims continue to be reimbursed at levels much higher than in-network rates.

Even in 2017, the out-of-network utilization for these specialties was below 20% at the national level. There are some states where out-of-network utilization is more prevalent; for example, Florida and Texas out-of-network utilization was over 25% for ED in 2017.



Source: HCCI Commercial Claims Data 2017, covering over 40 million commercial lives

The use of a median in-network rate, either through statutory rate setting, or through a binding arbitration approach, is likely to drive remaining out-of-network physicians servicing hospitals in-network by removing the incentive for those providers to be out-of-network (i.e. the ability to balance bill patients and the ability to collect higher out-of-network reimbursement from payors). This transition is likely to result in a substantial discount in reimbursement for these providers, especially if they are balance billing patients.

Today, hospital outsourced physician groups, and particularly those of scale, have been able to use the threat of going out-of-network to negotiate high rates with commercial insurers. As a result, in-network outsourced physician groups are among the highest reimbursed physician specialties as a percent of Medicare, with some of the large ED and anesthesia groups receiving upwards of 400% of

Medicare in certain markets. Outsourced physician radiology and pathology rates are typically lower, though certain providers may still be receiving over 300% of Medicare. Most payors consider these rates to be egregious as other physician specialties are typically reimbursed below 200% of Medicare.

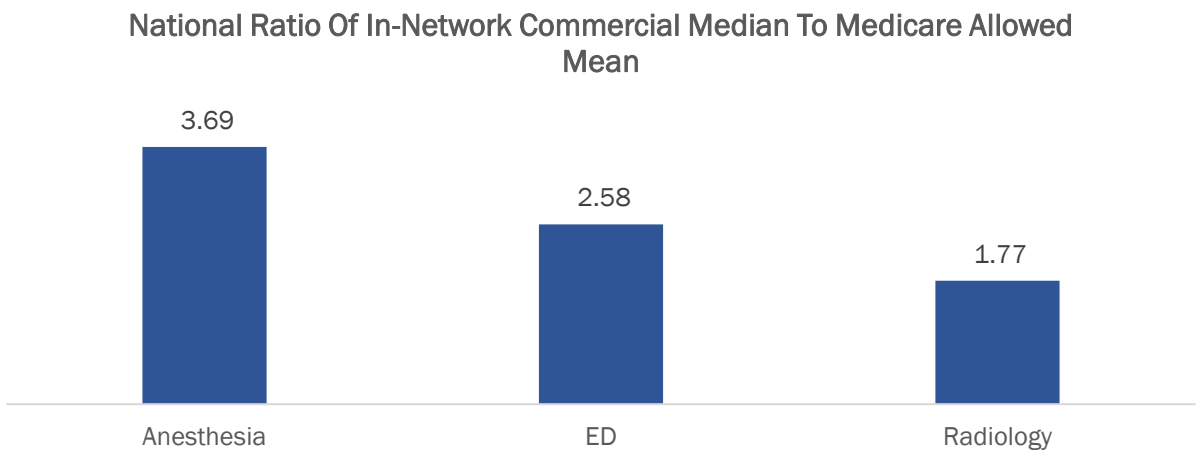
Federal surprise billing legislation is likely to result in pressure on above average in-network reimbursement, as use of median in-network rates for out-of-network provider groups changes the contracting leverage dynamics between in-network physician groups and payors. If a provider group is paid above the median on an in-network basis, the payor would have leverage to either renegotiate reimbursement with the provider at a rate close to the median, or terminate that provider from their network and reimburse them at the median in-network rate without concern that the provider would balance bill their member.

Some payors have already begun to implement reductions in in-network reimbursement for large physician groups. In 2018, UnitedHealthcare (UHC) renegotiated contracts with Envision, one of the larger outsourced physician groups in the country. Eventually UHC and Envision were able to come to an agreement at a substantially lower in-network rate. Subsequently, in 2019 and 2020 UHC has had further disputes with TeamHealth, US Anesthesia, and Mednax. In some cases, UHC asked for a discount of upwards of 40%, when the provider and the payor were unable to come to terms, UHC terminated those providers from their networks. Starting in 2019, Anthem began making substantial reimbursement cuts (above 50% in some cases) to pathology groups across states as a result of anticipated changes in leverage dynamics and UHC implemented a similar approach in April 2020 in the Texas market.

Most other payors are likely to wait until federal legislation passes before being more aggressive in contracting with these provider groups, but if legislation does pass with a statutory rate setting using the median in-network rate or if legislation passes using the median as the benchmark for arbitration, there will likely be additional pressure from payors on high-end reimbursement for these specialties. The larger the market share of the payor and the wider their network for ED, anesthesia, radiology, and pathology, the greater the probability is that they will implement cuts. It is less likely those located in rural areas with limited providers will implement significant cuts and less likely that smaller payors with more limited networks will implement cuts.

COVID-19 likely has a limited impact on payor contracting strategies for outsourced physician groups currently being paid substantially above the median, as payors continue to be concerned around current in-network reimbursement levels for the large groups. In some cases, COVID-related concerns may cause smaller payors to delay cuts to in-network providers if they feel those will cause significant network adequacy issues.

Marwood's analysis of HCCI's commercial claims data from 2017 offers some insights into what the median in-network rates may look like. Since the median benchmark will likely be based on reimbursement rates as of January 2019, one consequence of the UHC and Envision negotiations in 2018 is that the median rate for UHC was likely reduced in areas with substantial Envision market share. As the other reductions from both Anthem and UHC largely occurred post- January 2019, they will likely have limited impact on the median.



Source: HCCI Commercial Claims Data 2017, covering over 40 million commercial lives

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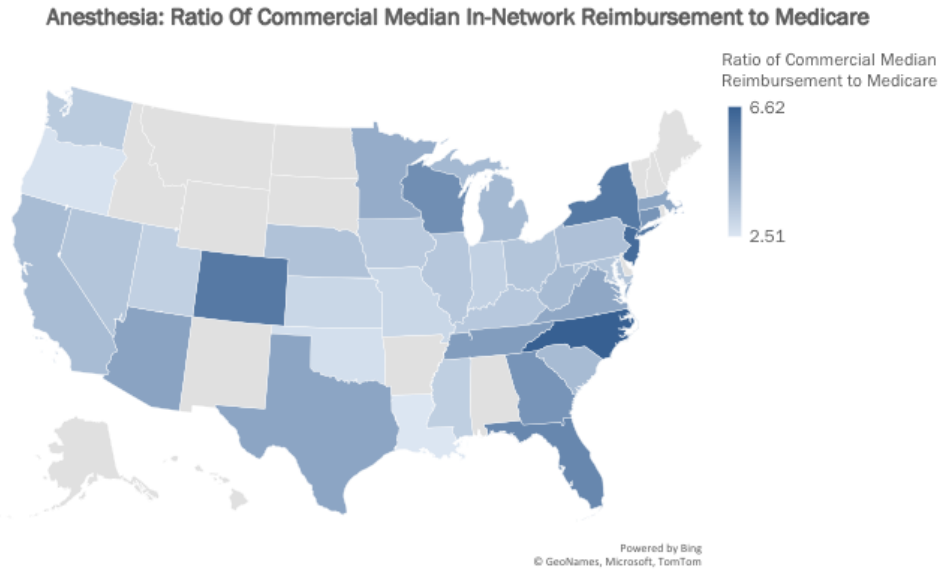
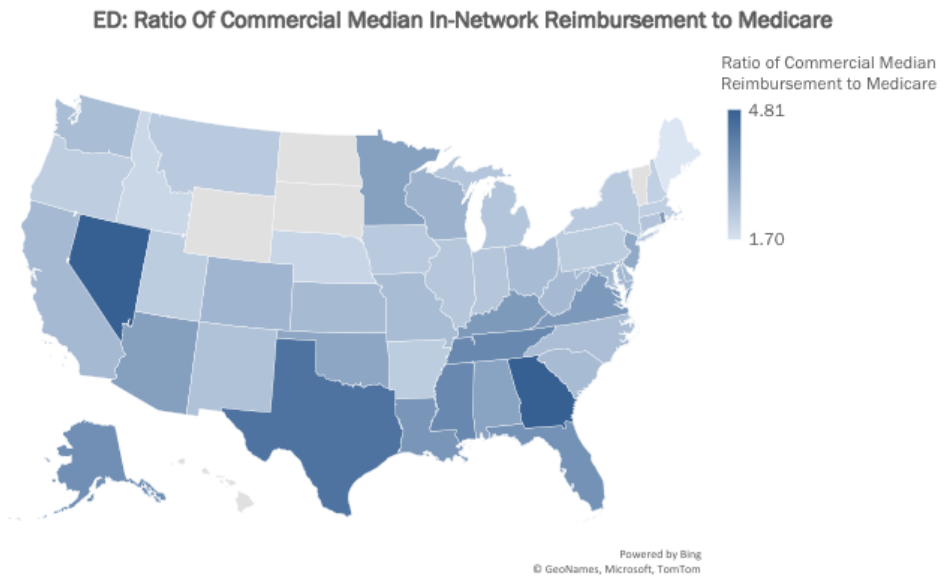


Source: HCCI Commercial Claims Data 2017, covering over 40 million commercial lives. Median in-network rates were unavailable for grey states



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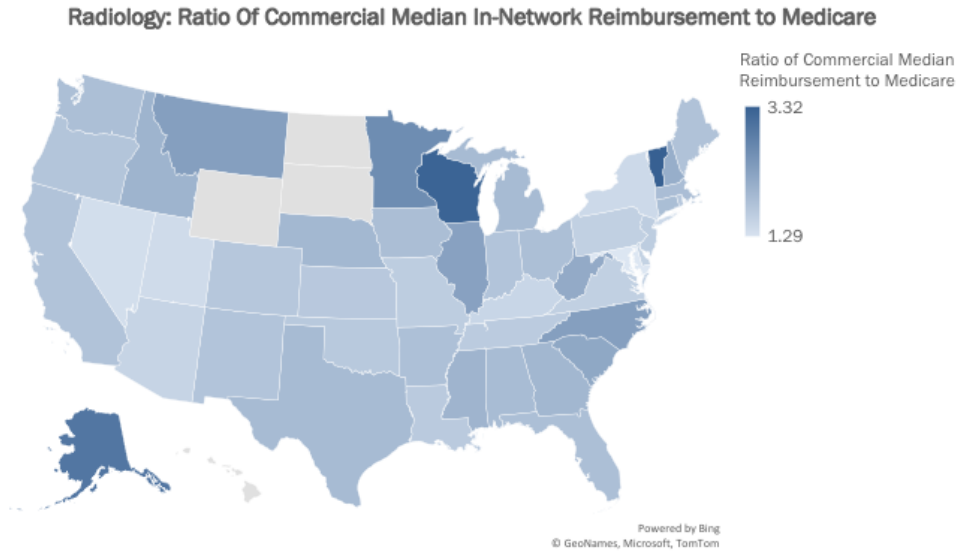

Source: HCCI Commercial Claims Data 2017, covering over 40 million commercial lives. Median in-network rates were unavailable for grey states

Mitigating Factors

State legislation will continue to control fully insured and individual markets, which will limit the downside risk somewhat in several states with more provider-friendly approaches, so long as states continue to leave current approaches in place. All of the bills that have gained traction in Congress to this point have preserved state laws in the appropriate markets. States could also pass new legislation that would affect the fully insured market in coming years if there is concern the federal approach is too harmful to providers. In general, this mitigating factor may be limited by state willingness to use two separate systems for handling surprise bills, but in the short term it could soften the initial blow. Payors located in states with more provider-friendly approaches that have a high portion of their commercial enrollment in fully insured and individual markets are more likely to take a measured approach in provider negotiations than those with a high portion of their enrollment in the self-insured market.

Another factor that is likely to help providers in these negotiations is state network adequacy requirements. Network adequacy requirements ensure that payors are able to deliver benefits by providing reasonable access to enough in-network care included under the terms of the contract. State laws vary in their stringency, the breadth of provider types and payor products to which they apply, and the degree of enforcement. Some payors have expressed concern that being too aggressive in contracting with specialists in the wake of surprise billing legislation may lead to providers dropping out of their networks and, subsequently, issues meeting network adequacy requirements, which could result in fines. A recent example of this occurring was a $700,000 fine issued by the Texas Department of Insurance to Humana, related to their anesthesia network.

Additionally, relative market share in a given area can influence the median rate and have an impact on the size of reductions that payors are able to implement. If a given provider has over 50% market share by claims and was still receiving high in-network rates in January 2019, then it is likely the median rates would be at or close to that provider's contracted rate, so surprise billing legislation would not likely have an impact on reimbursement.

Demonstration or willingness to be a partner to the payors could also lead to more favorable contract negotiations in some cases. Depending on the amount a provider is above the median, payors may be willing to phase-in reductions over a number of years or implement a smaller reduction if the provider demonstrates a willingness to participate in value-based payments or other initiatives the payor is pursuing to improve the quality and cost of care.

Surprise billing legislation could lead to some upside for those outsourced physician groups that are currently receiving reimbursement below the median, as they may be in a position to negotiate more favorable reimbursement with the payors or else go out-of-network and receive the median in-network rate. This could also be a strategy for some of the larger groups to pursue as they evaluate additional acquisitions.

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