2011 National Payor Survey

The More Things Change, the More They Stay the Same

Analysis by Revive
Survey sponsored by The Godbey Group

Introduction

Numerous factors have fundamentally altered the playing field for hospitals and insurance companies. This report presents the findings from Revive's fifth annual National Payor Survey and provides insight into the current hospital contracting landscape, hospital executives' expectations for what may occur in the future, and how hospitals can best prepare for the road ahead.

We carefully examined the latest economic issues facing hospitals and payors, and present an overview of the economic reality impacting the business of health care today. We surveyed executives from hospitals across the U.S., who offered their perspectives on how negotiations with payors have changed following the passage of the Patient Protection and Affordable Care Act in early 2010. Finally, based on our experience providing strategic guidance to more than 200 hospitals and health systems, we've distilled the key areas hospital leaders must bring into focus as they prepare for the post-reform health care world.

What have we found? Despite changes requiring hospitals and payors to change the way they deal with their customers, they continue to relate to each other in very familiar ways: hospitals continue to focus on private payor contract rates and volume, and payors continue to focus on pushing down rates to maximize profit. Hence the title of this report.

About the Author

Launching Revive is the latest move in a long career in PR and marketing for founder Brandon Edwards. Brandon brings more than 20 years of experience in health care and a track record that includes 170 successful PR engagements, more than 50 crisis situations, and nine political campaigns. From 2002 to 2009, Brandon served as the President/COO of Davies and senior strategist for the firm's health care practice. Prior to joining that firm in 2002, Brandon oversaw crisis communication for Tenet Healthcare. Brandon worked in litigation support, medical malpractice issues, union issues, CON battles, hospital closures, M&A, managed care contract disputes, and other high stakes, defining issues. Brandon also oversaw Tenet's corporate strategy and venture group, which managed the corporate venture fund and analyzed large strategy opportunities for the company.

Brandon is a featured speaker for PR trade groups, as well as SHSMD, AHA, ACHE, Healthcare Roundtable, The Governance Institute, HASC, BAHCCA, and VHA. Married with three children, Brandon calls Santa Barbara home.

Survey Methods

Survey implemented by the nationally recognized research firm Fabrizio, McLaughlin & Associates, an international survey research firm based in Alexandria, Va. Interviews were conducted with respondents on telephones and on the web via a survey host portal. Respondents were screened to ensure they were responsible for negotiating contracts with major health plans. Potential respondents were contacted via email, U.S. postal mail, fax, and/or telephone and were asked to complete the survey anonymously. Respondents represent all 50 states. Data was collected from December 6, 2010, through January 20, 2011. Final survey results included 258 interview respondents representing 28 percent of all hospitals in the U.S.

The Current State:

The Great Recession has not been kind to hospitals, health systems, or physicians. The burdens have been numerous — rising bad debt, reduced outpatient volumes, pressure from payors for lower rates, and growing uninsured population, among others. Many hospitals and physicians are providing care to a growing pool of underinsured and uninsured patients, taking a significant loss on the cost of care. Approximately 87% of hospitals report significantly more bad debt and charity care volume than a year ago, with 74% reporting decreased operating margins for the same period.[1]

On top of this, the U.S. population is aging: The U.S. Medicare patient population grew by more than three million since the start of the Great Recession in 2007.[2] The vast majority of hospitals lose money treating Medicare patients, and those margins are expected to drop further with the implementation of health reform. In fact, the average hospital margin for Medicare business is -7.2%.[3]

The economic downturn has taken a toll on commercial membership enrollments for payors, yet these huge companies have benefitted from increased Medicare Advantage and managed Medicaid enrollment, as well as declining utilization by members who are saddled with an increasingly large out-of-pocket burden (and therefore less financial risk for the payors). Payors have experienced significant margin expansion over the last three years, despite eroding commercial enrollment, which demonstrates they are successfully raising prices and shifting risk onto members faster than rates and utilization are rising.

The period of 2007 to 2010 may mark one of the most significant transfers of wealth from employers and policyholders to private health insurance companies ever.

At the same time, stock market volatility and rising shareholder expectations have pushed payors to seek new ways to generate revenue and maximize profit. How have payors managed in this environment? Every payor has sought to improve its financial performance by squeezing hospital and physician contracts, cutting payment rates, and introducing more restrictive contract language. These payors claim — despite all evidence to the contrary — the era of cost shifting is coming to an end.

In the face of these pressures, hospitals have continued to hang tough, making difficult decisions to restructure their operations and cut costs to stay in the black. Hospital administrators find themselves in the position of cutting costs, but have also been forced to make improvements to infrastructure and quality to keep up with regulatory and payor requirements. The capital requirements in the hospital industry have only accelerated with EMR deployments, physician employment trends, and clinical integration needs.

In this section we will examine the following trends:

Trend #1: Payor financial success grows despite weak member enrollments

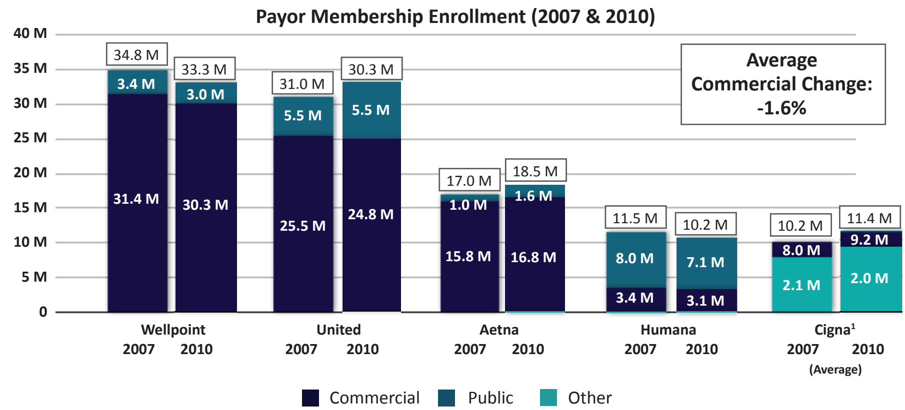
Trend #2: Hospital financial performance is positive, but margins remain vulnerable in challenging times

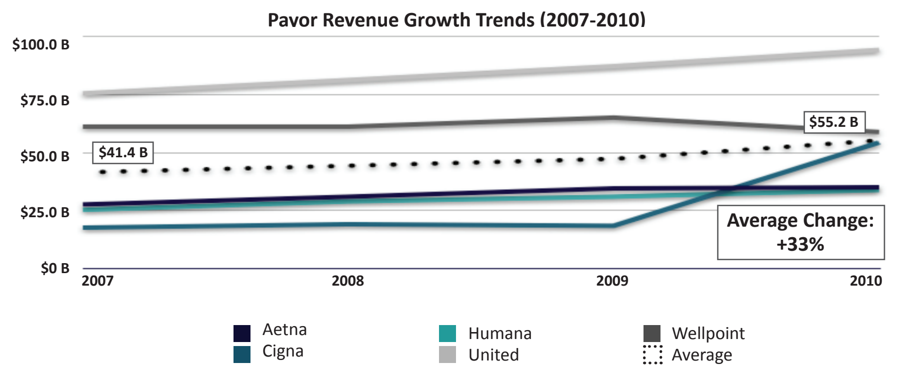
Trend #3: Hospital-payor negotiations reach fever pitch for negotiations

The Current State:

Trend #1: Payor financial success grows despite weak member enrollments

Across the industry, insurance companies have achieved financial success in spite of deteriorating conditions in the United States economy. One would assume that, in the face of high unemployment rates in 2008 through 2011, the financial performance of insurance companies would have deteriorated during the same period. Quite the opposite.





[1] "Other" includes self-insured plan administration for commercial and senior plans. Totals include "Other" category; "Other" may not be shown due to relative size.
Note: Estimates are based on analyst expectations for FY2010. Actual data was not released at the time of this presentation.
Source: Morningstar, company income statements, Revive analysis

Commercial enrollments are down for nearly all of the largest payors, enrollments for government sponsored (Medicare and Medicaid) members have increased. For the top five publicly-traded largest payors, commercial membership enrollment fell by 1.6% since 2007. At the same time,

The Current State:

managed Medicaid and Medicare Advantage enrollments have risen by nearly 12% in the same time period. Independent Blue Cross Blue Shield plans, however, have taken advantage of this market dynamic by using accumulated reserves to underprice Wall Street payors, grow commercial market share, and push for greater leverage in provider negotiations.

Collectively, the top five Wall Street payors have memberships in excess of 100 million patients, representing about 42% of the entire insured population today, nearly double the level in the mid-1990s.[5] For certain states, the consolidation has left employers with few insurance choices.[4]

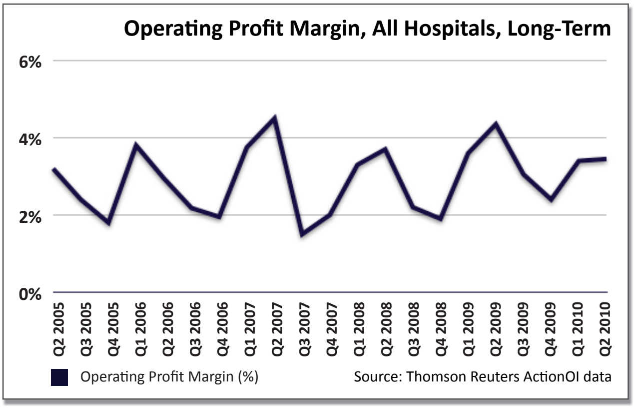
State	Health Insurer	Market Share %
Arkansas	BCBS AR	75%
Kentucky	WellPoint, Inc.	59%
Michigan	BCBS MI	65%
Missouri	WellPoint, Inc. (BCBS)	68%
Vermont	BCBS VT	77%

Despite falling enrollments for their most profitable members, the largest payors have seen their revenue streams steadily rise during the same period. From 2007 through 2010, revenue grew 33% to an average of $55.2 billion. Margins for certain payors — Humana, Cigna, and Independent Blue Cross Blue Shield plans — have grown considerably. United alone reported $11.3 billion in 2010 EBITDA — more than the combined EBITDA of all for-profit health systems in the U.S.

What does this mean? All signs point to payors becoming more aggressive in contract negotiations and reimbursement rates to increase profitability and shareholder returns.

Trend #2: Hospital financial performance is positive, but margins remain vulnerable in challenging times

While payors have experienced steady increases in profitability over the last four years, the hospital sector has also incrementally improved its financial position, largely recovering from losses incurred during the initial stages of the U.S. economic downturn.[6] There are, however, still winners and losers in the sector: one-third of hospitals are on the verge of bankruptcy (usually smaller community hospitals), while large health systems and regional integrated delivery networks have achieved better results. In the future, the base of commercially-insured patients is expected to shrink, leaving hospital profitability vulnerable to pressure from payors.

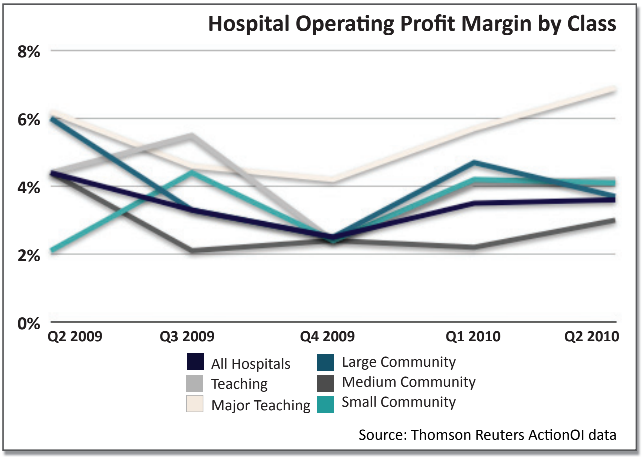


During tough economic times, hospitals reined in expenses to maintain profitability levels like never before to ensure modest profit levels. Hospitals have taken steps to minimize cost and reduce waste, but there will likely be a point at which

The Current State:

hospital administrators can no longer cut expenses without negative impacts to patient satisfaction, quality, safety, or the opportunity for future revenue growth.

Given slim margins, however, hospitals are vulnerable to economic fluctuations and changes in payment rates. Hospitals should continue to look for ways to communicate their value to stakeholders and the community at large to best position themselves for contract negotiations now and in the future.



Trend #3: Hospital-payor negotiations reach fever pitch

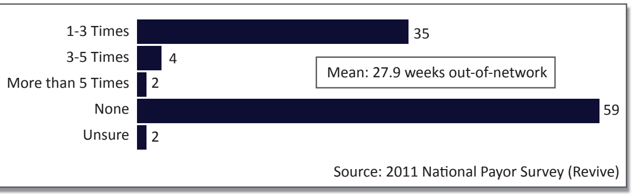
While the implications of health care reform are not entirely clear, one thing is certain: Payors appear to have shifted their contracting strategies, taking a harder line on negotiated rates in provider contract renewals. As tough as it's been in the past, the environment for hospitals and physicians has become even more difficult when it comes to payor negotiations.

The following findings from Revive's 2011 National Payor Survey reflect the dim view of hospital executives on their relationships with payors, who they perceive as squeezing rates to boost profits. With five years of history to examine and benchmark, the 2011 National Payor Survey reveals some clear changes and troubling trends.

The number of contract disputes reported by hospital respondents is up

Increased instability in the economic environment appears to have filtered into the hospital contracting environment: More than 40% of hospitals surveyed reported having a dispute with a payor that resulted in the hospital being out-of-network.

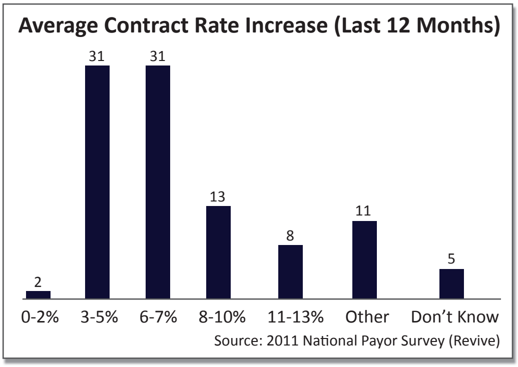
Q In the past five years, how many times have you had a contract dispute that resulted in your hospital being out of network?



These disputes, when they occur, are long-lasting and result in real impact. The average duration of a reported contract dispute and resulting non-participation is seven months — a long time for a hospital to live without the patient volume and revenue that come from being in-network with a private payor.

The Current State:

Rate increases are small... and may get smaller in the future



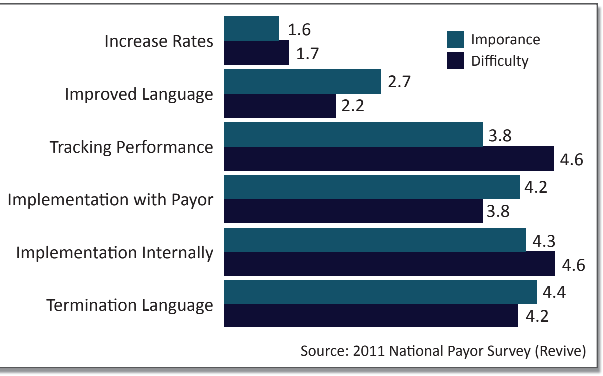
For negotiation contracts with payors, the majority (62%) of hospital respondents reported annual rate increases between 3% and 7%. About 21% indicated obtaining contracted rates of 8% or higher, and 33% reported increases below 5%. Clearly, the economic reality of the last three years has depressed rate increases for hospitals, who are now forced to do more with less from private insurance companies.

Hospitals face rising health care expenses due to changes in the composition of insured patients in their markets. Nationwide, hospital margins for patients who are not commercially-insured are on the decline: In 2002, hospitals had positive margins on Medicare patients (2.2% overall); by 2008, Medicare margins were in the red after years of decline (-7.2%).[3] Hospitals depend on private insurance rates to supplement losses incurred while caring for public payor patients.

Rate increases are most important factors in contract negotiations

The divide between hospitals and payors appears to be widening: The majority of respondents cited increasing rates as the most important goal of managed care contract negotiations. The majority of hospitals surveyed, however, received rate increases less than the rate of medical inflation. While there are many important issues in contract negotiations — contract language, denials protection, dispute resolution, termination terms — the rates hospitals receive from the biggest payors still takes precedence over all other issues.

Q Thinking about when when you negotiate your managed care contracts, please rank the following list of goals from the most important to achieve to least important to achieve using a scale of 1-6 with 1 being THE MOST important and 6 being THE LEAST important.



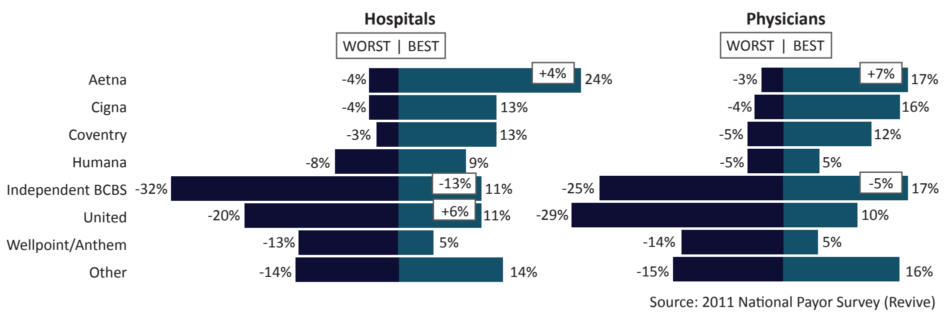
The Current State:

Independent BCBS, United pay the lowest rates; Aetna the highest

Hospitals. Aetna garnered the highest marks for the highest hospital contracting rates (24% of respondents, an increase of 4% from one year prior). Independent BCBS plans received marks for the lowest rates (32% of respondents, a decrease of 13% from one year prior). Interestingly, later questions in the survey will reveal that Aetna's reputation among hospitals is eroding <u>despite</u> paying the highest rates.

Physicians. Independent BCBS and Aetna garnered the highest marks for the highest physician group contracting rates, with 17% of respondents citing that each had the best rates. It's important to note that this does not include rates for independent physicians, just for physicians contracted as part of a health system. Also interesting, praise for Independent BCBS plans fell by 5% from the prior year, with respondents citing these plans as having among the worst rates (25% of respondents). United lead payors with the worst rates, with nearly one-third (29%) indicating that the company provides the lowest rates for physician groups. United has clearly been following a strategy of offering high hospital rates and low physician rates.

Best/Worst for Payment Rates

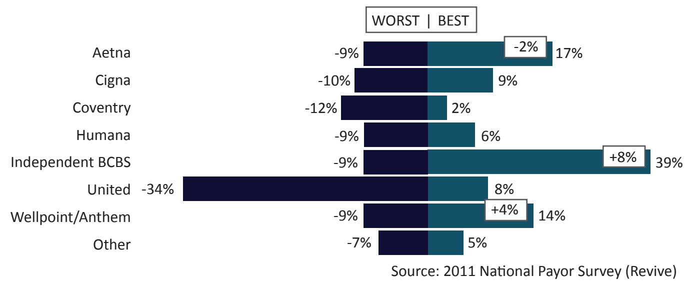


Proper payment of claims: United among the worst offenders

In addition to leading the pack in offering the worst rates among the largest payors, United also received the worst marks for proper payment of hospital claims (34% of respondents cited United as having the worst rates).

Interestingly, Independent BCBS plans, who were deemed to be among the worst in terms of contracted rates, were cited as the best at paying claims promptly. This is part of a trend for Independent Blue Cross plans when we

Best/Worst for Paying Hospital Claims Promptly

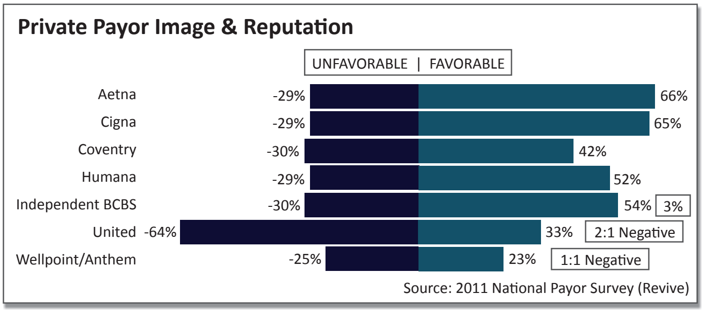


examine multiple questions in the survey: Independent Blue Cross plans are big, they leverage their size to pay low rates, but they also have the infrastructure to process claims accurately and promptly. One survey participant said, "One thing I appreciate about Blue Cross in my state: They may not pay fair rates, but they pay quickly and without hassle. Of course, the Blue Card program is a different story..."

Hospital executives' opinions of private payors on the decline

As the playing field for hospitals has become more challenging, executive opinions on payor relations, strategies, and tactics have tanked. For 2011, negative opinions are up across all payors.

Overall, payors garnered more negative opinions and ratings in all categories compared to last year's survey results. In particular, Independent Blue Cross plans saw a 10% rise in negative opinions since last year's survey and Aetna saw an 8% increase. These results are consistent with the increasing number of public contract battles between these payors and hospitals.

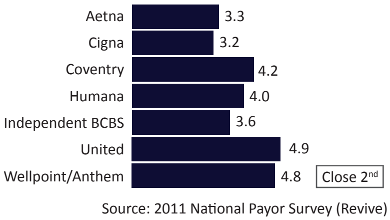


Remarkably, Independent Blue Cross plans slipped from the second best rated plan overall to near the bottom of the ratings in a year's time. Nationally, we've seen Independent Blue Cross plans pushing much harder on rates and negotiations. It's not a phenomenon limited to Independent Blue Cross plans, however; Aetna, who pushed hard on reimbursement rates in provider contracts last year and announced it intended to take a harder line in negotiations, saw significant increases in negative ratings from survey respondents.

Worst hospital/physician relations: United Healthcare and Wellpoint

Survey respondents rated United and Wellpoint as the worst payors overall, receiving low marks in their treatment of both hospitals and payors. Yet, Independent Blue Cross plans and Aetna both moved down the ladder from the last year's survey.

Q From your personal experience or what you've heard from colleagues, please rank the following health plans from best to worst when it comes to dealing with HOSPITALS/PHYSICIANS using a scale of 1 to 7 with 1 being the best and 7 being the worst.



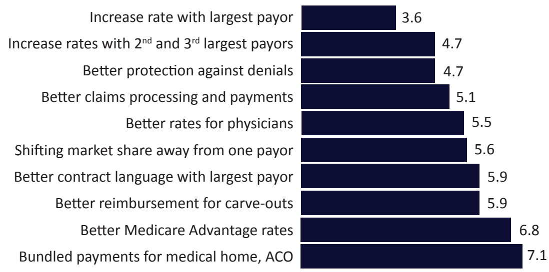
The Current State:

For 2011, hospitals are concerned with increasing near-term payment rates

In the near-term, hospital executives appear to be primarily focused on increasing rates during contract renegotiations, reflecting continuing concern with hospital financial performance. Three of the five top priorities are directly related to payment rate increases. Respondents also indicated protecting against denials and better claims processing as top priorities.

These results are consistent results from previous National Payor Survey data. Essentially, hospitals don't view their relationships with payors through the lens of quality in any way — it's all about payment and ensuring protection from payor bureaucracy and business practices. Providers know that payors don't really care about quality when it comes to provider contracts.

Q Thinking about your health plan contracting priorities over the next year, please rank each of the following issues in the order of importance to your organization's success. 1 is most important and 10 is least important.



Source: 2011 National Payor Survey (Revive)

The Road Ahead:

In 2010, health insurance reform legislation was passed, in part, to improve access to care for the uninsured and level the playing field between payors and hospitals. Our survey results, however, reveal hospital executives' growing negativity at what the future may hold as details and regulatory definition emerges.

Health reform is creating a pretty bleak picture — hospitals perceive that payors are gaining power while rates are getting tighter, with any benefits of health reform offset by additional risk and investments needed to effectively deliver care.

In this section, we will examine the following findings from the survey:

Finding #1: Hospital executives see payor leverage increasing, with challenges to reimbursement rates ahead

Finding #2: Even with fewer uninsured patients, respondents don't believe their hospitals can stay afloat with lower private payor rates in the future

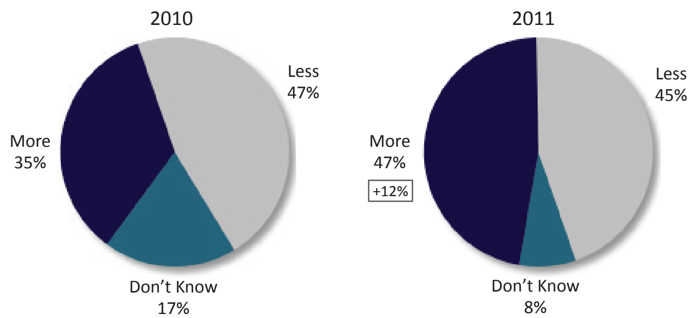
Finding #3: The new models of care are threatening, not rewarding — new care delivery models are expected to be, in reality, devices to reduce hospital profitability

Finding #4: Hospitals are ill-prepared when it comes to benchmarking rates and preparing for negotiations

Finding #1: Hospital executives see payor leverage increasing, with challenges to reimbursement rates ahead

Across the board, hospital executives surveyed believe that, through 2014 payors will continue to aggressively challenge hospitals in contract negotiations. What's more, hospitals appear to believe that payors will have more, not less, leverage in contract negotiations during the next 2-3 years: nearly half of respondents felt that payor leverage will increase, a 12% increase from one year prior.

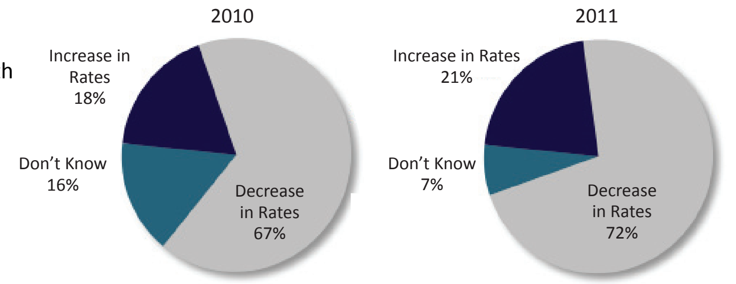
Q Will health reform legislation create MORE or LESS negotiating leverage for private payors over the next 2-3 years?



Source: 2011 National Payor Survey (Revive)

The Road Ahead:

Q In your opinion, will health care reform INCREASE or DECREASE your private payor rates?

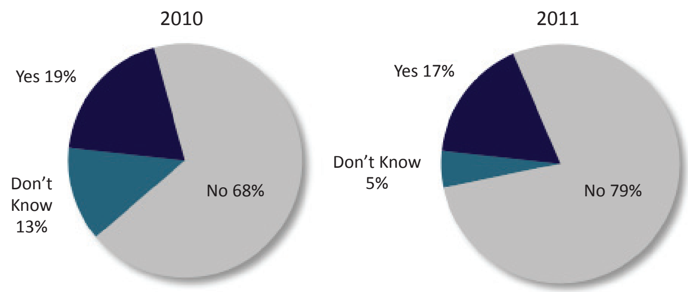


Source: 2011 National Payor Survey (Revive)

Finding #2: Even with fewer uninsured, no one believes their hospitals can stay afloat with lower private payor rates in the future

By an overwhelming margin (4-to-1), hospital respondents think that the cost savings resulting from seeing fewer uninsured patients will not make up for lower private payor rates. Simply put, health reform may grant access to people who were previously outside the health care system, but it's expected to be a significant financial takeaway for hospitals.

Q Do you think that the reduction in the amount of care for the uninsured will make up for any lower private payor rates over the next 2-3 years?



Source: 2011 National Payor Survey (Revive)

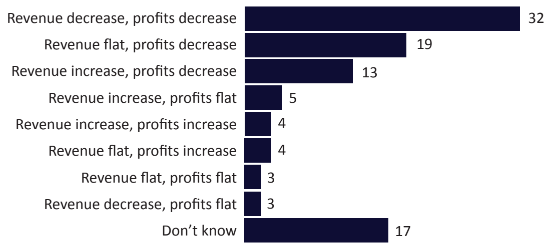
Finding #3: The new models of care are threatening, not rewarding — new care delivery models are expected to be, in reality, devices to reduce hospital profitability

Respondents don't appear to believe in the benefits of the brave new world of post-reform care delivery. Three out of four (74%) respondents have a negative view of potential financial impact of impending care models, such as medical homes and ACOs. Of those surveyed, 64% believe hospital margins will fall as a consequence of new models of care, and 35% believe hospital revenues will drop.

The Road Ahead:

For all the industry press and discussion about ACOs as the strategy-du-jour, the overwhelming hospital executive opinion is negative and getting worse. ACOs are a “passive-negative” issue for hospitals executives: the more they know, the less they like the idea.

Q Which phrase best describes the financial impact to hospitals you expect from medical home and ACO strategies in the future?



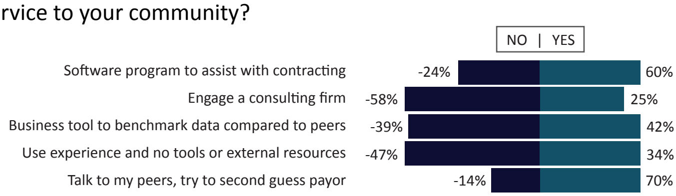
Source: 2011 National Payor Survey (Revive)

Finding #4: Hospitals are ill-prepared when it comes to benchmarking rates and preparing for negotiations

When it comes to taking proactive steps to remain financially stable in light of impending changes related to health care reform, the majority of respondents surveyed indicated that they have talked to executive peers and have engaged in gamesmanship with payors. One-third of respondents indicated that they do not use tools or resources of any kind, and wholly rely on experience to ensure continuity of performance and operations.

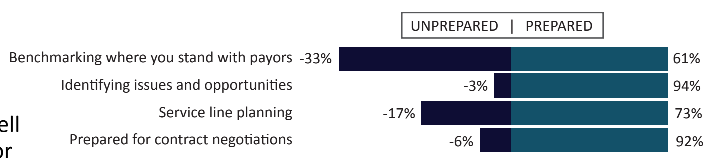
About one-third of hospitals surveyed are unprepared to benchmark where they stand with payors — a startling finding in light of the data that’s available through consulting firms and from sources like Thomson Reuters, Premier, and Milliman. Payors present significant data to support their negotiating positions, and hospitals must do the same.

Q What have you done to ensure that your hospital/system is prepared for the new health care reform and that you will remain financially stable to provide quality care and optimal service to your community?



Source: 2011 National Payor Survey (Revive)

Q When you think about your managed care capabilities, how well are you prepared for accomplishing the following:



Source: 2011 National Payor Survey (Revive)

Where Do We Go From Here?

As 2014 and the full impact of health reform approaches, don't delay. Providers must take steps now to prepare for what the future may hold.

Administrators should draw upon all resources and expertise available to effectively evaluate, measure, and plot a course for the future:

1 **Evaluate the performance today.** Analyze, compare, and assess payor contract rates and your organization's financial performance. Know where you stand with every payor, and compare revenue and costs against hospitals within the state and across the country. With the right data, you can determine the best story to tell at the negotiating table, what your organization really needs, and how to activate your position to the board, physician leadership, and the business community.

2 **Be proactive.** Revenues derived from providing care in the future will be valued based on relative cost, quality, safety, and efficacy. CMS and payors are moving forward with solidifying future payment mechanisms and incentives. Providers who have taken a proactive stance in providing care at a better value are at a distinct advantage when it comes to telling their stories across the spectrum of stakeholders, from payors and regulators, to business leaders and patients, leading to better financial results.

3 **Set the short-term priorities and long-term strategies**. Short-term priorities — like operational improvements that improve quality, negotiations with medical device manufacturers and physicians to reduce costs, and setting charges across contracts — can only be effective if it falls into alignment with a long-term strategy. The sooner the long-range strategy is determined, the quicker short-term priorities can be brought into focus.

4 **Execute, engage, communicate.** After the hospitals tackle the hard work of evaluating performance, undertaking a proactive approach, and setting priorities and strategies, the real fun can begin. Hospitals can use their the collective learnings and a strategy plan as a platform for engaging with stakeholders to drive change. Hospitals must engage their employer communities and explain the value they provide to change the dynamic with payors.

Endnotes

1. "Telling the Hospital Story Survey," American Hospital Association, 2010.

2. "Medicare Chartbook 2010," Kaiser Family Foundation.

3. "Data Book 2010," MedPAC.

4. "2007 Update: Competition in Health Insurance, A Comprehensive Study of U.S. Markets," American Medical Association.

5. John K. Iglehart, Health Affairs, "Improving Tomorrow's Health Care with Today's Tools: A Conversation with Larry C. Glasscock," November 2006.

6. "Hospital Operating Trends Quarterly (December 2010)," Thomson Reuters.

About Revive

Revive is a national health care public relations firm specializing in crisis communications, mergers and acquisitions, payor contracting disputes, union issues, and reputation management issues of all stripes. Named "New Agency of the Year" in 2010, Revive is among the 15 largest health care PR firms in the country. Revive's clients include major hospitals and health care systems, academic medical centers, physician organizations, health care industry associations, health care I.T., and health & wellness companies. With 17 professionals on staff, Revive has offices in Santa Barbara, Calif., and Nashville, Tenn. To learn more, visit www.revivepr.com.

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The Godbey Group is the leader in managed care contracting and reimbursement strategy with more than 300 clients in 38 states. The firm's unique combination of senior negotiators, industry knowledge and proprietary data enhances the clients' ability to successfully negotiate contracts. The Godbey Group works with single hospitals, entire systems, and managed care teams to optimize managed care contracting and reimbursement strategies. The Godbey Group helps you create a healthier bottom line and all that comes with it, including the ability to provide a higher quality of health care. Learn more by visiting www.TheGodbeyGroup.com.

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