

# Physician Practice Negotiations with Health Insurers

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## Abstract

American free enterprise drives the healthcare market. Private practice medical offices work in conjunction with health insurance companies to create negotiated terms on pricing for diagnostic studies, laboratory tests, and procedures in providing optimum patient care. These annual negotiations create a potential for uncertainty, and either party may decide to forego future coverage of patients if certain conditions are not met. Insurance companies typically are concerned about physicians they identify as expensive utilizers for underserved patients, while physicians are disconcerted about poor reimbursement rates or denials for patient services. The physician is markedly aware of this delicate equilibrium and proceeds with caution before establishing a diverse portfolio of contractual agreements.

**Keywords:** Physician offices; Private practice; Health insurance companies; Business negotiation; Renegotiation; Health insurers; Practice Management; Medicare reimbursement; Medicaid insurance

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## Discussion

To reach the financial goals of the practice, the physician develops a management style, considers the location of the clinic, patient population, administrative costs, and the financial motivation of insurance companies [1-3]. The first step of the physician is to engage with insurance companies to discuss offering medical services for a multitude of reasons, such as underserved patients in the area or to expand the participating clinician network. In a newly opened practice, the physician will likely reach out to local in-network insurance companies that service the patients in the area and negotiate per patient reimbursement rates per visit and any additional services. On the other hand, if this is a well-established practice with a participating physician in other networks, the insurance companies may reach out to the practice manager. At this point, the practice may have an advantage in the negotiation, since the insurance company is most likely looking for a practice to provide care for their underserved patients or to expand physician membership.

The physician recognizes the advantage of diversifying the practice's portfolio with both for-profit and non-profit insurance companies. Granted, both types of insurers are versed at finding loopholes to boost salaries, although the non-profit executive leaders tax shelter with an internal revenue code (IRC) 501(c) (29) designation to community service by reinvesting in itself without shareholders [4]. On the other hand, for-profit insurance

companies operate to continually maximize their profits by any means necessary, be it through lobbying or raising premiums through exploiting various social determinants of health [5]. Inherently, the physician is capable of aligning the practice business model with certain insurers that provide services and reimbursements consistent with the practice's financial goals that best suit the patients in this specific geographic location. A physician will endeavor to gain a mixed payor profile, likely emphasizing high reimbursement rates from for-profit private insurance companies (eg Preferred Provider Organizations [PPO] and Health Maintenance Organizations [HMO]). Generally speaking, these companies have contractual stipulations where they are required to reimburse within 30 days, and failing to do so incurs added interest [6]. This is an advantage to the practice since comparable non-profit Medicare and Medicaid insurance policies usually process claims in roughly 30 days, and reimbursements oftentimes are paid out in over 60 days. Delays in federal or state reimbursement do not carry similar penalties as private insurers.

Since the inception of Medicare in 1966, the system's approximately 6,200 employees haven't been able to meet the national demands of expansion, and thus, have been utilizing private for-profit and non-profit insurers to assist in processing claims [7,8]. Such subsidiary business relations between the Medicare and health insurance companies result in a higher cost to the federal system. Thus, Medicare does not generally provide

competitive reimbursement rates for medical practices or Physician-Hospital Organizations (PHOs) that provide complete medical services at a discounted rate [9].

Exorbitantly, Medicare costs are compounded with the fact that Medicaid expanded into the Affordable Care Act (ACA) and contracted services with subsidiary companies, which serve to drive up the cost of insurance by specifically targeting geographic and demographic patient populations. The idea is to raise the insurance premiums in lower-income populations where the patients are eligible for Medicaid or ACA subsidized health policies such that the insurance companies profit from both the patient and the federal or state tax dollars [5]. To cap it off, nonprofit brokers are paid by the insurance companies and the fees are built-in as a percentage of the policy purchased by the patient, putting into question their claims of working “for the client.” There are more than 1,300 such nonprofit brokers in the state of California alone [10].

Knowing this, the physician is likely to keep Medicare between 10-30% of the practice’s payor mix, along with ACA top-tier metal affiliations, such as platinum and gold to 20-40%. Such ACA marketplace policies require the insurers to establish premium pricing based on what would cover the cost of essential health benefits (EHBs), administrative costs, and health insurance company profits [11,12]. The ACA would be a good fit for a clinic aiming to capture patients with low cost of care and preventive services, that require prior authorization or referrals for covered benefits with restrictions [12]. Insurance companies typically maintain clientele who are willing to pay higher premiums, subsidized or not. These translate into coverage for higher costs of care where lower-tier companies are more likely to decline claims, such as the silver and bronze ACA or Medicaid policies, which would explain minimizing these in the practice, unless contractually stated otherwise.

Intuitively, the physician may also recognize that nearly six out of ten patients are covered by an employee-based health insurance policy for patients under 65 years old [12]. These group health plans require fundamental knowledge of whether the insurance is HMO or PPO, and if the policies cover benefits and services under most private insurance plans, to what extent cost-sharing (eg deductibles or copays) applies, and if balance billing for out-of-network providers is included. Additionally, in a separate practice where the clientele has more extensive healthcare needs, or where the priority is more novel and expensive, PPO unrestricted referrals are likely recommended, and in combination with HMO policies, may comprise roughly 30-50% of patients in the practice. Considering most practices sustain themselves financially from revenue generated from cash collections before appointments, this places a great value on point of sales (POS) healthcare arrangements, either from co-pays, deductibles, or on average 12% self-pay [9]. As a final consideration, the physician may also consider other third-party payers, such as worker’s compensation and legal liability compensation clients, which would not exceed typically 10% of the practice.

Every year, the contract is either renewed automatically without changes or it is renegotiated. Renegotiation is indispensable in medical practices and foregoing this may end up costing the

practice more. Areas of renegotiation include scenarios where the practice has expanded medical services, increased patient volume, implemented new electronic health records (EHR) system, and cost-of-living increase. These add value to the practice and are justifiable when proposing an increase in reimbursement rates from the insurers [13]. Likewise, reimbursement rates at 100% of recent values may be higher than in previous years. Not to mention, certain ancillary services under Medicare carry up to 42% of reimbursement, although it is also negotiable to upwards of 100%, depending on services provided by the physician and reflected under Medicare’s value rating system [9]. As such, the physician must be a good negotiator, with a keen office manager, medical coder and biller.

With the advent of the Medicare Chronic Care Management (CCM) program in 2015, electively participating physicians or collaborating physician assistants (PAs), may bill for monthly chronic care visits for patients with at least two chronic conditions under the Medicare Physician Fee Schedule (PFS) [14]. This program is available to Medicare A/B, Medicare plus supplemental insurance, and Medicare-Medicaid beneficiaries under a Fee-For-Service (FFS) program with preset non-negotiable reimbursement rates subject to concurrent billing exclusions.

Notwithstanding Medicare’s CCM program, if there's a dispute because the insurance company decreases the reimbursement rates or declines service coverage, then the physician can renegotiate to re-establish the reimbursement rate at a fair number based on market value and practice costs or through fair criteria to cover a particular service. The practice manager would use a formulaic equation to determine what the minimum per patient requirements is to establish the hourly cost to maintain the practice while seeing patients. The office manager’s formula will look similar to this one:  $\text{Income (profits)} - [\text{Expenses (losses from overhead)}] = \text{cost per patient}$ , calculated from the practice’s financial analysis. Now the physician or office manager is equipped to have this discussion with the health insurance companies, and ideally establish contracts with an estimated 20% profit margin in comparison to the 13% nationally [15].

Should the negotiations fail, the contract may be terminated and the office manager is responsible for notifying the staff that no additional patients with that insurance company will be taken. For the remaining patients who are still under the care of the practice, they have to complete treatment as agreed upon. Once finished with the treatment, the patient has an option to use different insurance or pay out of pocket otherwise the practice has a right to discontinue services based on the fact that the insurance company is no longer accepted in the practice.

Medical practices are consistently challenged by annual recurring health insurance companies revisiting policy benefits and reimbursement schedules. In their totality, health insurance companies, whether for-profit or non-profit, regularly monitor data, such as how many people purchase plus-sized clothes, how many cigarette smokers or alcohol consumers, the number of hours of television watched, to determine healthcare costs in America [5]. Their researchers then use statistical tools to objectify and justify maintaining or raising the rates on patient premiums. Nonetheless, the health insurance companies

have a great deal of lobbying power, and consistently attempt to substitute EHBs with less meaningful patient services at a bargain. In the pursuit of revenue surplus from medical economic demands, costly reimbursements and quality provider services are not always a priority for medical insurance companies.

Prepared, the physician, or office manager, will learn to navigate carefully with health insurance company contracts on behalf of the practice's continued cost of patient care, administrative costs, and financial prosperity.

## References

1. New York Times (2021) Burned by low reimbursements, some doctors stop testing for Covid. USA.
2. American College of Physicians. Medical practice types, USA.
3. Shryock T (2020) Budgeting for practice excellence. J Med Econ 97: 16-18.
4. Internal Revenue Service (2021) New guidance for IRC 501(c)(29) qualified nonprofit health insurance issuers. USA.
5. Tabriz A (2020) Health insurance - for-profit or nonprofit. Being well, USA.
6. Health Insurance Companies (2021) Blue Cross Blue Shield Blue Care Network of Michigan. USA.
7. Patel YM, Guterman S (2017) The evolution of private plans in Medicare. The Commonwealth Fund , USA.
8. The Hill (2019) Want to expand Medicare? You'll need to hire the insurance companies, not fire them. USA.
9. Medscape. How physicians get paid. USA.
10. National Council of Nonprofits. California Association of Nonprofits USA.
11. Bennett C (2016) Private Health Insurance and Essential Health Benefits: Premium and Coverage Variations. Nova Science Publishers, USA.
12. Pollitz K (2020) Private health coverage of COVID-19: Key facts and issues. Kaiser Family Foundation, USA.
13. Eramo L (2018) 5 tips to negotiate favorable payer contracts. Medical Economics 95: 42.
14. U.S. Government Medical Store. Chronic Care Management Services. The Centers for Medicare and Medicaid Services (CMS),USA.
15. <https://www.medicaleconomics.com/view/covid-19-vaccines-and-medical-liability>