Health Insights

How will inflation drive payer strategy in 2023?

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The healthcare industry is facing unique economic headwinds caused by high inflation, unrelenting workforce shortages and provider consolidation. While responses to these challenges differ from sector to sector and organization to organization, health plans are stuck in the middle. Health plans must understand these various headwinds and determine the best strategies to respond to them.

During a Becker's Healthcare roundtable discussion sponsored by Merative, a panel of health plan executives discussed how their organizations are adapting their strategy and operations to address this turbulent environment.

Health plans are starting to see price increases in their provider contract negotiations

Higher costs across the entire healthcare industry have led to compressed operating margins, which are likely to endure for at least the next two to three years. To cope, hospitals and provider networks are attempting to negotiate higher prices with their health plans.

"There may be hospitals looking to pass on to commercial payers the cost and increases that may not be picked up by public payers," said Mahil Senathirajah, Industry consultant at Merative. He added that the vertical and horizontal consolidation taking place in the hospital sector is adding market power, enabling and emboldening hospitals to command higher prices.

Commercial payers in turn are beginning to ponder how to share the burden of cost increases with their clients. The cumulative effect of all this does not bode well for affordability and access. "Employers are starting to see that increase come from the health plans and ultimately it's going to start flowing to the consumers," said Brandi Hodor, Senior Healthcare Analytics Advisor at Merative.

An internal poll found:

63%
of health plan executives expect average provider price increases by 6-10% over the next 12 months

42%
of respondents expect employers to encounter premium increases of 6-10%

16%
of respondents expect premiums to employers to increase by 11 percent or more for the 2024 contracting year

Difficult conversations are taking place with an eye on preserving relationships and affordability

Health plans are aware of the economic and business challenges providers face and are attempting to accommodate higher rate requests, while also maintaining access and affordability. A concern for the impact of premium increases on individually insured plan members and on self-insured employers passing on those increases to employees was mentioned repeatedly during the discussion.

In this fraught context, as multi-year contracts come up for renegotiation, some health plans are willing to accept moderate price increases, in some cases even before contracts are due for renewal to avoid drastically sharper increases later. "That way we can keep it more measured versus some 20 percent increase [two years] down the road," said the CFO of the health insurance arm of a 45-hospital integrated health system.

The vice president of provider networks and contracting for a regional affiliate of a nationwide health insurer emphasized that the goal is to maintain positive relationships. "While we may not always be able to give the increase from a fee-for-service standpoint, we try to meet providers where they are, providing opportunities in value-based care," he said.

Several health plans are already leveraging value-based reimbursements as a way to help providers — and themselves — limit price increases by streamlining functions and reducing administrative burden.

> Almost 80 percent of our members are in some type of value-based reimbursement arrangement. Everyone is looking at quality metrics and how best we do the reimbursement tied to that."
>
> Vice President and Market Chief Medical Officer of a large Medicaid managed care plan in the Midwest

Tackling administrative inefficiencies points to a need for broader collaborative efforts

The group recognized the opportunity to improve efficiency as a response to inflation. To reduce administrative waste, some payers are helping providers identify areas ripe for automation. "What we're trying to do is identify solutions that will automate mundane tasks to extend the workforce and start to get overhead down," said the Chief Medical Officer of a large, integrated payer-provider health system in the Southwest.

But addressing waste and inefficiencies must be part of broader strategic efforts that health plans and health systems ought to undertake together. This suggests a need for improved trust and transparency.

The Medical Director of a nationwide health plan's Alabama affiliate cited prior authorization as a prime example of a process that is ripe for automation because, while required by payers to prevent overutilization of health services, it represents a huge administrative burden and cost for providers. Yet, to get authorization requests approved on first pass and realize savings, providers must be willing to share EMR data with payers, which many are still uncomfortable doing.

Plans are steering care to lower-cost settings and reevaluating payment models for specialty care

Because the cost of care is influenced by where care is delivered, shifting services from inpatient and clinic-based settings to outpatient, office-based and even home-based settings is one effective way to reduce care costs. Surgeries and infusions are two common types of procedures for which payers are increasingly tying reimbursement to lower-cost environments.

In thinking about ways to drive affordability, some health plans are also re-evaluating how they reimburse providers for costs occurring in specialty areas such as otolaryngology and orthopedics. The Executive Medical Director of a nationwide health plan's affiliate in the Northwest said his organization is in the midst of setting up quality metrics that differ by specialty and engaging physicians in developing the quality metrics that they believe have the highest impact on both costs and outcomes.

> "If you're looking at using value-based care to drive cost savings, you need to move away from primary care and move toward the specialists, requiring threshold quality measures to get into your network."
>
> – Clinical Leader from Alabama

"For example, with joint replacement, [relevant metrics would be] infection rates, readmissions and DVT rates. Use those as entry criteria and start excluding some low-performing hospital systems and lowperforming providers."

Nevertheless, roundtable participants cautioned that while quality metrics can be useful for conditioning provider entry into a health plan's network, they should not be used as standalone incentives for reimbursement because then health outcomes may suffer. "Any good measure ceases to become a good measure or metric once you use it as an incentive," the clinical leader from Alabama said. "We see that all the time and we see providers retreat to the metrics they're being judged on."

In summary, roundtable participants reinforced the profound impact that inflation is likely to have on affordability in the next 2 -3 years and the importance of actively monitoring that impact. At the same time, there is opportunity to not only mitigate those impacts but also to make meaningful improvements in quality and efficiency.

Learn more about how Merative supports health plans with healthcare analytics and program strategy.

About Merative

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