

# Insurer Contract Change Toolkit

*Resources for emergency medicine (EM) physician groups receiving a request for contract termination or renegotiation from a health insurer.*

## **How to Use This Toolkit:**

The following resources can be used to navigate and combat insurer contract termination and renegotiation requests:

1. Responding to insurer contract requests
2. Examples of insurer contract termination and renegotiation requests
3. Sample response letter templates

*NOTE: The materials contained herein are meant to provide general information and are for reference purposes only. These materials do not constitute legal advice, opinions, or recommendations about your legal rights, remedies, defenses, options, strategies, or apply the law to the facts of your situation. Each contract and business arrangement is unique, and no general information or toolkit can address every circumstance. ACEP is not a law firm and may not perform services performed by an attorney. ACEP recommends that you consult with an attorney to ensure adequate consideration of your specific needs.*

While many groups proactively write letters to insurers (either via postal mail or email), the most effective way to renegotiate contracts is to start the process off in person. If you don't have the contracting representative's contact information, you should request it from the insurer's group representative.

## **Responding to Insurer Contract Requests**

To manage an insurer request to renegotiate terms of a contract, consider the following:

### **Understand the Value of the Services Provided**

Before engaging with an insurer, revisit your group's marketing position:

- What services make you stand out?
- What can you do that no one else does?
- What are your group's strengths?
- What have you improved or increased upon since the last time you talked with the insurer?

Market your group's best qualities. Know the local competition and how to differentiate from and position yourself against them. Think about what the insurer wants—the ability to show higher quality for lower cost—and show them how you are doing that. Keep in mind who their actual customer is for the insurance product(s) you are contracted for—it could be the large employer the insurer is most concerned about keeping happy rather than (or in addition to) the individual policyholders you see as patients.

Consider changes in your financial liabilities since your last contract negotiation, including, but not limited to, increased overhead due to added expenses for PPE and staff wage increases. With clear communication and a competitive presentation, part of the negotiation could include increasing the core parts of your business that also provide value to insurers.

### **Collect and Analyze Data**

When renegotiating with an existing insurer, pull all claims-based data for that insurer for the past 12 months, or at least compile the top codes billed. Look at volumes, charges, and current allowed charges at the line-item code level to clearly understand current reimbursement rates.

Model the proposed rates and project how much money the new rates would bring in, assuming volumes and services will be relatively the same in the following year. If cost data is available, ensure costs are covered for each service line. Do not accept rates under the break-even point unless there is a strategic reason.

In addition to claims data, it is also helpful to pull data for the insurer's denial rates, days in accounts receivable, underpayment issues, and coding/bundling issues. You can use this information to evaluate how much time and energy different payers require.

Compile critical data points before your meeting to create your renegotiation strategy, including:

- Desired rates
- Lowest acceptable rates
- Cost coverage
- Insurer performance

Insurers also pull this data when negotiating, so it is imperative you do, too. The more data you have, the better your renegotiation strategy.

### **Renegotiating Contracts**

Sometimes payers will insist the group make the first proposal. Using the data you have collected and analyzed, make an offer.

Setting the proposal at higher rates allows the use of the common negotiation tactic of "bracketing," which creates a range in which there is potential agreement. Typically, this process leads to a middle ground from which the parties can split the difference to agree.

If the insurer is not willing to accept your rates, think about what processes burden your staff. Review your base agreement, amendments, and exhibits to evaluate any language or other requirements that could be changed to provide your practice value, even if it is not monetary.

## **Examples of insurer renegotiation requests**

The No Surprises Act (NSA) bans balance billing for out-of-network (OON) emergency care (provided in hospital EDs and independent freestanding EDs) and for post-stabilization care until the patient can consent and safely be moved to an in-network facility. The physician may only charge the patient for the cost-sharing amount calculated based on the median in-network rate (also known as the Qualified Payment Amount) for same or similar services in a geographic area. [Learn more about the NSA here.](#)

Insurers have sent the following letters to EM physician groups asking for a reconsideration of contracted rates due to the No Surprises Act (NSA):

### **Blue Cross Blue Shield of North Carolina:**

Re: Necessity to amend rate agreement, response needed before November 21, 2021.

Dear Provider:

XXXXXXXXX is likely aware of the passage of the federal "No Surprises Act" in December of 2020, with an impending effective date of January 1, 2021. Under this law, payments from health plans to out-of-network providers in many circumstances will be set at the "Qualifying Payment Amount" (QPA) which is generally calculated at the median in-network contracted rate for the same or similar specialty with n the applicable geographic area. The law applies with respect to out-of-network emergency services, out-of-network professional services at a visit to an in-network facility, and air ambulance services. It applies to our commercial networks (non-Medicare Advantage, non-Medicaid). The QPA paid by health plan to the out-of-network provider constitutes payment in full unless certain limited exceptions apply for a given QPA. These exceptions include express prior patient disclosure and consent, or successful challenge in arbitration.

This new federal law allows a significant change to Blue Cross and Blue Shield of North Carolina's contracting approach with emergency service providers, hospital-based providers, and air ambulance services. Where previous state law could result in an obligation to pay at full charges if no contract is in place, the new law sets reasonable limits on payment at the median in-network rate. Where Blue Cross NC may have previously contracted at what we deemed an inflated rate that is at least somewhat lower than charges in order to avoid paying at full charge, we are now able to seek to contract at a rate more in line with what we consider to be a reasonable, market rate.

We have identified XXXXXXXXXXXX as one of our outliers in-network providers with respect to rates. While the exact, final QPAs are not yet available pending upcoming finalization of the Rules to the No Surprises Act, the Interim Final Rules provide enough clarity to warrant a significant reduction in your contracted rate with Blue Cross NC. If we are unable to establish in-network rates more in line with a reasonable, market rate, our plan is to terminate agreements where the resulting out-of-network QPA would reduce medical expenses to the benefit of our customers' overall premiums.

Our ask of you at this point is as follows. We are seeking an immediate reduction in rates under our commercial agreement, as in interim step to the January 1, 2022, effective date of the No Surprises Act. This interim reduction will buy us breathing room to negotiate the final rates in light of the QPA amounts established in accordance with the upcoming Rules. With the interim reduction in place, we will not need to quickly terminate outlier contracts as a means of avoiding payment levels after January 1, 2022, that are significantly higher than the default out-of-network QPA. Our reduction proposal, for a December 15, 2021, effective date, is -XX%. We ask that you respond to this letter indicating your intention to agree, or providing a specific, comparable counterproposal. If we are able to reach agreement on the rate reduction, we will quickly provide a simple rate amendment for your execution. If we are unable to reach agreement on the reduction, our intention is to proceed with identifying and executing on terminations of outlier contracts where the out-of-network QPA will result in significant savings to the benefit of our customers.

Thank you for your prompt attention to this request and your response before November 21, 2021. We hope and trust that we can update and maintain our ongoing partnership for January 1, 2022, and well beyond. If you have any questions, please contact XXXXX.

Sincerely,

XXXX XXXXX  
Vice President, Provider Networks

**Cigna (Florida):**

Good afternoon,

I hope this email finds you well. Cigna HealthCare of Florida, Inc. continually reviews its fee schedules to ensure competitiveness in a given marketplace. We measure ourselves against the other major healthcare carriers within the state. We accomplish this through the purchase of discount data from an independent consulting firm, public data available from governmental health care bids, claim data analysis, as well as our competitive intelligence and network-based resources. Cigna Healthcare of Florida strives to provide members with access to quality and affordable healthcare. To achieve this, Cigna must ensure our agreements with our provider partners are updated and aligned in the market. As such, our most recent competitive insight shows that our rates with XXXXXXXXXXXX are materially gapped and uncompetitive. By way of this email, I am seeking to open discussions to address the group's current contract and reduction of the contracted rates. We value your participation in the Cigna provider network and hope to reach a mutually acceptable outcome.

**Cigna (Arizona):**

June 2, 2022

Re: Contract Renegotiation for XXXXX

At Cigna, we continuously strive to ensure that our participating agreements with healthcare professionals contribute to making healthcare affordable and predictable for our customers and clients while also remaining competitive in the marketplace. This is an increasingly important effort in today's economy.

Employers and individuals continue to have heightened concerns about the affordability of healthcare services and the lack of reimbursement equity. Cigna has a fiduciary obligation to assist its customers in addressing these concerns. Due to changing market dynamics and our commitment to addressing the affordability challenges that our clients and customers face, we are keenly assessing the performance of our network contracts.

With a greater focus on rate predictability, affordability, and long-term viability, the most recent in depth analysis reveals that the compensation terms of our agreement with XXXX, fail on all accounts.

We are requesting a renegotiation of your reimbursement terms to mitigate our unfavorable position and remedy the market reimbursement disparity. We ask that you contact us within the next 2 weeks to begin discussions. Please contact me directly at XXXXX.

Thank you for your prompt attention to this important matter.

Sincerely,

XXXXXXXXXX  
AVP, Contracting

## **Sample Letter Templates to Respond to Insurers**

How to respond to insurer requests for contract terminations

### **Contract Termination Template**

[Date]

[Attn: Provider Relations Representative or Vice President of Contracting]

[Insurer Name]

[Address]

Re: Group Name:  
Group Tax Identification Number:

Dear [Name],

[Group Name] received your letter from [Insert Date] with the request to terminate the contract with [Insert insurer] effective [contract start and end date]. [Group name] has provided timely emergency medical services to your insured members during the term of the existing contract. According to our records, we have served approximately [Number of patients seen] patients with [Insurer] from [Contract start date] to [Current date].

We request a meeting to discuss quality improvement measures [Group name] has implemented over the last [X] years, which we believe will result in improved care to your insured members:

[Customize the following bullet points to more accurately detail your quality improvements or create more appropriate descriptions]

- Clinical performance measurement implementation
- Patient Satisfaction Improvements (use of surveys, new locations, longer hours, organization of support groups)
- Staffing Improvements
- Technology Improvements

Please respond to [Group contact name, email, and phone] availability for this discussion. We look forward to renewing our contract with [Insurer] and providing uninterrupted high quality medical care through our partnership with your health plan.

Sincerely,

[Signature]  
[Group name]

*Optional Request for Additional Disclosure*

It appears that our office was not provided with the applicable fee schedule related to this contract or the applicable internal procedures for bundling, coding and outlier application which affect reimbursement. Therefore, we request that this additional reimbursement information be sent to us immediately. Disclosure of the information will allow us to more fully prepare for our upcoming discussion regarding this contract.

**Contract Renegotiation Template**

[Date]

[Attn: Provider Relations Representative or Vice President of Contracting]  
[Insurer Name]  
[Address]

Re:     Group Name:  
          Group Tax Identification Number:

Dear [Name],

[Group Name] received your letter from [Insert Date] with the request to reconsider the contract with [Insert insurer] effective [contract start and end date].

We continuously strive to ensure that our participating agreements with insurers contribute to making healthcare affordable and predictable for our patients while also attracting and retaining the best employees. [Group name] provides care to approximately [Number of patients seen] patients with [Insurer] from [Contract start date]. Our ability to provide life-saving care 24/7/365 to your insured members is at risk based on your request to re-negotiate contract terms.

We request a meeting to discuss our fee schedule for the current contractual term. The request to renegotiate our contract will significantly impact our ability to deliver the quality and timely care your insured members for the remainder of the original contracted end date.

Further, [Group name] has implemented quality improvement measures which we believe will result in improved care to your insured members:

[Customize the following bullet points to more accurately detail your quality improvements or create more appropriate descriptions]

- Clinical performance measurement implementation
- Patient Satisfaction Improvements (use of surveys, new locations, longer hours, organization of support groups)
- Staffing Improvements
- Technology Improvements

Our office was not provided with the proposed applicable fee schedule related to this contract or the applicable internal procedures for bundling, coding and outlier application which affect reimbursement. Therefore, we request that this additional reimbursement information be sent to us immediately. Disclosure of the information will allow us to more fully prepare for our upcoming discussion regarding this contract.

Please respond to [Group contact name, email, and phone] availability for this discussion. We look forward to continuing our contract with [Insurer] and providing uninterrupted high quality medical care through our partnership with your health plan.

Sincerely,

[Signature]

[Group name]