Negotiating From the Payer Side of the Table

Stop Negotiating Rates, Negotiate Value

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If you have ever sat across from a payer's contracting team and wondered what they were really thinking, I can tell you. For seven years, early in my career, I was one of them.

I started at the Central States Health and Welfare Fund, a union health and welfare fund. Every dollar we paid a hospital or a physician was a dollar of a working family's benefits. That experience taught me how the money moves and where it gets stuck. It also taught me something I have carried through the decades since on the provider side: the best way to negotiate with a payer is to understand what they should want, and then deliver it.

The gauntlet

Let me be plain about where things stand today. Dealing with payers has become a well-designed gauntlet, built to say no.

The numbers bear that out. KFF found that Medicare Advantage insurers received nearly 53 million prior authorization requests in 2024 and fully or partially denied 4.1 million of them. Only 11.5 percent of those denials were appealed. But when they were, 80.7 percent were overturned. When most denials that get challenged are reversed, and almost none get challenged, the friction is doing the work. The process itself says no.

The gauntlet extends to prevention. In commercial insurance, both the amounts and the processes for paying for prevention are broken. The 2025 Primary Care Scorecard from the Milbank Memorial Fund found that the average payment for a gastroenterology visit was more than four times that of a primary care visit. Every practice manager also knows the billing maze: a “free” preventive visit becomes a surprise bill the moment a patient mentions a new problem. We underpay prevention, then make it hard to collect even that.

Part of the problem is distance. Payers today are far removed from the office visit, and that is a shame. Over my career, I can count on one hand the number of times a commercial payer has shown genuine interest in primary care. The further you get from the visit, the less you can see the flaws in the system, and the easier it is to build a gauntlet without noticing who has to run it.

The one thing we agree on

Here is what I learned from sitting on both sides. An insurer and a primary care group have very little in common at the bargaining table, except one belief: hospital and specialty care costs too much.

They are not wrong. RAND found that in 2022 employers and private insurers paid hospitals, on average, 254 percent of what Medicare would have paid for the same services. Hospitals dispute parts of that methodology, and they face real cost pressures of their own. But the employers paying the bill feel it either way. KFF reports that the average family premium for employer coverage reached $26,993 in 2025, up 6 percent in a single year.

So the payer and the primary care group agree on the problem. The question is: where are the incentives to fix it?

Where the incentives went missing

They are weaker than you would think, on both sides.

Under fee-for-service, a primary care group that keeps a patient out of the hospital earns nothing for it. The savings go to someone else.

The insurer's incentive is muddier. The Affordable Care Act's medical loss ratio rule requires insurers to spend most premium dollars on care, which caps their profit as a percentage. A percentage of a bigger number is a bigger number. Economists who studied the rule found that many insurers met it by letting claims costs rise rather than by lowering premiums, and a 2025 *Health Affairs* analysis concluded it has driven higher premiums and higher medical spending rather than restraining them. When costs rise and premiums follow, the insurer's dollars can grow too.

That is the conundrum. The two parties who agree the system costs too much are often not paid to fix it.

Stop negotiating rates. Negotiate value.

This is where the payer side of the table taught me the most. Don't just ask what the payer wants this quarter. Ask what they should want: predictable total cost, fewer avoidable admissions, members who stay healthy and stay enrolled, and data they can trust. Then come to the table ready to deliver it.

That changes the conversation. Stop negotiating rates. Negotiate value: who creates the savings, and who gets to keep them. Shared savings, capitation, and direct contracts with employers and union funds all put primary care in a position to profit from keeping people out of the hospital. The Medicare Shared Savings Program shows it can work: CMS reports that its ACOs saved Medicare $2.5 billion in 2024.

It is also the golden rule applied to contracting. Treat the other side's problem as seriously as your own, and you earn the right to ask them to take yours seriously, including the gauntlet.

What to do before your next renewal

Write down the payer's three biggest pressures in their own words. Bring one proposal that solves one of them. And put administrative friction on the table as a contract term: prior authorization turnaround times, exemptions for practices with high approval rates, and a share of the savings you create.

Then test the deal with my two questions. Does it serve the patient? Can it keep doing so?

If you are heading into a renewal and want a second set of eyes from someone who has sat on both sides, I would welcome the conversation. My goal is to help you become your own best consultant.

When it seems crazy out there, and it sometimes is, remember that the patient is still a reliable true north, on both sides of the table.

Sources

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