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PULSE

Report Highlights Growing Rift Between Health Care Providers and Payers

Eighty-seven percent of CFOs report that current payer dynamics hinder their ability to deliver optimal patient care.

A recent report by the Healthcare Financial Management Association (HFMA), "Bridging the Payer-Provider Divide," reveals a significant decline in relationships between health care providers and payers, with nearly 60% of surveyed health system chief financial officers (CFOs) stating their relationships with health plans have worsened over the past three years.

One of the most contentious issues identified is the increasing number of denials by payers. Eighty percent of CFOs attributed this to an "intentional or systematic effort" by payers to boost denial rates. This has led 75% of respondents to expand their financial services staff to handle the rising complexity of managing denials over the past three years.

Additionally, providers expressed frustration over stagnant fee schedules, which have not adjusted to cover rising costs since the COVID-19 pandemic. HFMA report author Jeni Williams highlighted these static rates as a source of tension.

"Hospitals and health plans engaged in value-based payment initiatives have had some success in developing collaborative working relationships," said HFMA SVP for content and professional practice Richard L. Gundling. "But on the fee-for-service side, the tenor of these relationships has deteriorated as providers' frustration levels with payers' administrative requirements and expectations have increased."

Approximately 87% of CFOs reported that current payer dynamics hinder their ability to deliver optimal patient care. Delays caused by prior authorization denials exacerbate provider burnout and lead to patient dissatisfaction.

"Having to call a patient to say, 'I'm so sorry, but we don't have your authorization here from your insurance company, so we have to reschedule your procedure, and I apologize that you've already taken PTO and arranged transportation,' that becomes a patient dissatisfier. They're not upset with their payer when that happens. They're upset with the provider," said Shannon King, a longtime revenue cycle executive and a board member for HFMA's Arizona Chapter.

A lack of transparency in payer policies was identified by three-quarters of respondents as the primary area needing improvement to rebuild

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trust. Surprisingly, most CFOs are not optimistic about technology or AI as solutions. About 64% stated it is too early to assess the impact of AI on payer relationships, while 29% predicted AI could worsen the situation, citing concerns over AI-driven denials.

What's Next?

The survey, which included responses from 102 hospital and health system CFOs, also highlighted increasing difficulties in contract negotiations. Sixty-one percent of CFOs said these negotiations have grown more challenging in recent years.

Issues with Medicare Advantage (MA) plans are a growing concern. Many providers are opting out of MA contracts due to high denial rates and unfavorable reimbursement structures. Half of Medicare beneficiaries are now enrolled in MA plans, but a separate HFMA survey earlier this year found 16% of health systems plan to stop accepting at least one MA plan within two years, with another 45% considering similar actions.

Tamie Young, vice president of revenue cycle at Stillwater Medical Center, shared her organization's experience, noting that MA plan reimbursements were often lower than regular Medicare or even Medicaid rates, making them financially unsustainable.

Read the report here.

Health Insurer Consolidation Leaves U.S. Consumers with Limited Coverage Options

A recent AMA report found that 95% of commercial health insurance markets were categorized as "highly concentrated" in both 2014 and 2023.

A recent market analysis by the American Medical Association (AMA) highlights the persistent consolidation of health insurance markets in the U.S., resulting in reduced competition and limited consumer choices for medical coverage.

The market analysis examined 382 metropolitan statistical areas (MSAs), all 50 states, and Washington, D.C., revealing that health insurance markets have remained highly concentrated over the past decade.

The study analyzed commercial and Medicare Advantage (MA) market shares for the two largest health insurers in each geographic area, using federal merger guidelines to assess market concentration. The report found that 95% of commercial health insurance markets were categorized as "highly concentrated" in both 2014 and 2023. Additionally, 49% of markets already classified as highly concentrated in 2014 grew even more consolidated by 2023, further eroding competition.

In nearly 9 out of 10 MSAs, at least one insurer controlled 30% or more of the market. In 47% of these markets, a single insurer's market share exceeded 50%. Blue Cross Blue Shield (BCBS) plans dominated state-level markets in 41 states and had the largest MSA-level share in 83% of MSAs. Elevance Health, formerly known as Anthem, held significant shares in 21% of MSAs.

At the national level, UnitedHealth Group emerged as the leading commercial health insurer, while Centene claimed the largest share in the insurance exchange markets.

The report also revealed that MA markets are highly concentrated and have shown little change over time. In 2023, 97% of MSA-level MA markets were highly concentrated, a figure consistent with trends since 2017. UnitedHealth Group was identified as the largest MA insurer nationwide, with a 29% market share—up from 25% in 2017. Locally, the company dominated MA markets in 43% of MSAs.

Broader Implications

The AMA expressed concern about the impact of consolidation on consumers, as reduced competition often leads to higher premiums, limited plan choices, and fewer incentives for insurers

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NEWS & NOTES

Collecting Patient Payments and Patient Access Best Practices

ACA's Healthcare Committee recently put together a series of training videos for you to share with your provider clients. One of their recent videos, "Collecting Patient Payments and Patient Access Best Practices," provides a valuable training resource for frontline staff in health care provider offices. This video focuses on empowering patient access representatives to secure copays and coinsurance early in the process—even when deductibles aren't yet met. Effective scheduling, registration, insurance pre-authorization, and demographic collection are critical first steps that set the tone for a positive patient experience while ensuring your organization's financial health. By mastering these best practices, staff can improve collections, reduce delays, and enhance patient satisfaction, making this an essential tool for your team's success.

Access the video here.

Health Insurer Consolidation cont. from page 2

to innovate or improve service quality. The association highlighted Alabama, Kentucky, Michigan, Louisiana, and Hawaii as the top five least competitive commercial health insurance markets.

Although earlier AMA reports suggested a slight decline in MA market concentration, the 2024 study underscores how mergers and acquisitions, such as Centene's purchase of WellCare, have bolstered national-level shares without significantly altering local market dynamics. This year's findings reaffirm trends identified in previous AMA studies, which have consistently flagged the consolidation of health insurers as a pressing issue. Despite regulatory scrutiny, the share of highly concentrated commercial markets has remained nearly unchanged over the last decade, hovering between 95% and 96%.

The AMA continues to call for policy interventions to address this trend, advocating for measures that would enhance competition and ensure greater consumer choice in health insurance markets across the U.S.

Read more here.

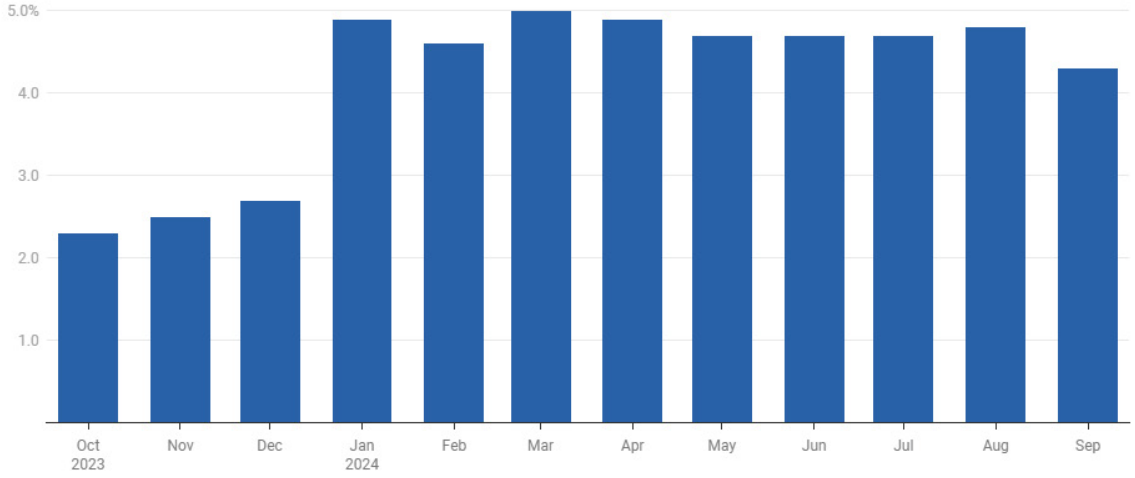
DATAWATCH

Rising Labor Costs Challenge Hospital Sustainability Despite Stable Financial Performance

Hospital and health system finances remained stable in September, but high expenses, particularly labor costs, are pressuring sustainability, Kaufman Hall's latest Flash report revealed. Labor accounts for 84% of medical group expenses, with subsidies per physician surpassing $300,000 for the first time—highlighting the unsustainability of traditional employment models. While contract labor rates have declined, the tight labor market has driven a 3% year-over-year increase in provider compensation.

Physician pay in Q3 averaged $369,392 per full-time equivalent (FTE), while provider compensation reached $305,533. Financial losses and slight drops in hospital margins, from 4.7% to 4.3%, are prompting hospitals to reconsider operations to balance rising costs. Trends like increased inpatient revenue and lengths of stay indicate a shift toward higher-acuity care, requiring organizations to contain costs and adapt to a changing healthcare environment.

Kaufman Hall CYTD Operating Margin Index: September 2024 Data



***Source**: Kaufman Hall National Hospital Flash Report, September 2024 Metrics.* https://tinyurl.com/yrc3v9tx

Note: The Kaufman Hall Hospital Operating Margin and Operating EBITDA Margin Indices are comprised of the national median of our dataset adjusted for allocations to hospitals from corporate, physician, and other entities.

PULSE

is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

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