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Payer/Provider Parity: Beyond Just Being Fair

By Eric Logue and Richard Bajner

When a small payer consolidates with a large one, contracting hospitals could see revenues from those two payers (now one) decrease by as much as 10 percent as a result of the unit reimbursement decrease resulting from lower per unit reimbursement from the larger payer. Here's how to develop a long-term parity strategy.

In our experience, unit reimbursements commonly vary by 30 percent or more between commercial payers within a single provider's set of payers. However, recent consolidation of smaller payers (with high unit reimbursement) with larger payers (with lower unit reimbursement) is putting financial pressure on many providers that have historically made their margins on these smaller payers.

Key Takeaways:

- Create a three-year plan designed to move payment rates toward "competitive levels" based on volumes, but keeping unit reimbursements within 15 percent to 20 percent between payers to minimize risk of payers exiting the market.
- Move payment increases to balance value with rates, such as pay-for-performance-based contracts.

How can providers minimize margin risk as payer consolidation continues? To fully answer these questions, we need to understand the following key questions:

- What is an acceptable range of rates for payers within the market?
- When is parity more or less important in a market?
- What factors, within the market, encourage or discourage rate parity, such as:
 - Market share of providers
 - Market share of payers
- Should hospitals be willing to give up higher reimbursement levels to maintain parity?
- What are the positive or negative effects of having payer parity?

Parity Defined

For the purposes of this discussion, we will measure parity by comparing the prices paid by two payers for the same services.

- MRI payment example:
 - Largest payer pays 25 percent of charge
 - The second tier payers pay 50 percent of charge
 - Parity difference is 200 percent

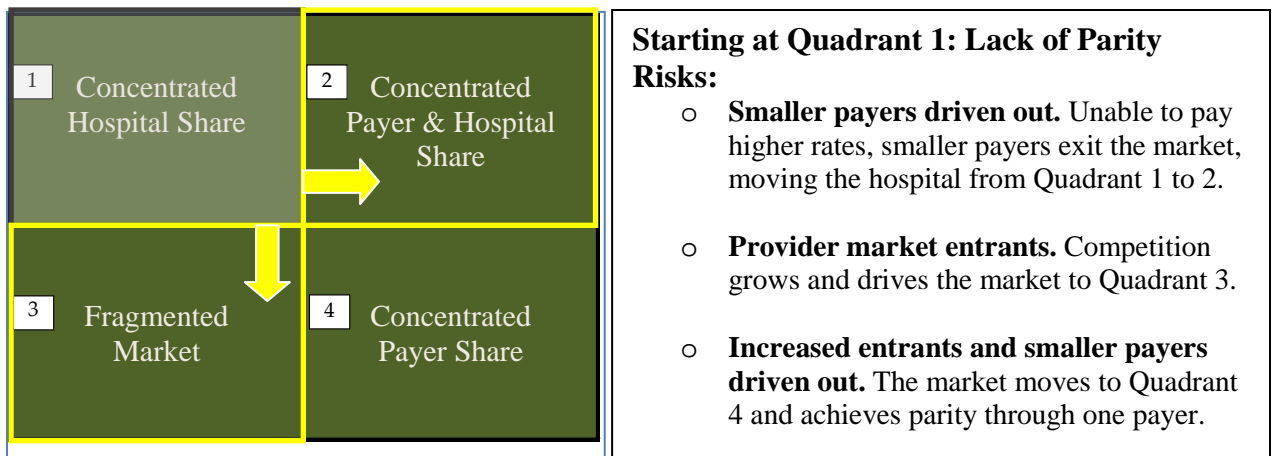
Market Dynamics Affecting Parity

The lack of parity within individual markets is affected by several dynamic elements, including:

- Lack of transparency
- Disconnect in health care among those who pay for services, those who provide services, and the patients who receive services
- The lack of competing choices in a market
- Barriers to entry, such as certificate of need

To assess a hospital's market, it is often useful to use analytics to frame the hospital's position. One tool is the four by four matrix that shows varying degrees of market share concentration between payers and providers (see the exhibit below).

Four by Four Matrix: Market Share Concentration



Source: Navigant Consulting, Inc.

Consider the example illustrated in the exhibit:

- Quadrant 1: Concentrated hospital share
- Quadrant 2: Concentrated payer and hospital share
- Quadrant 3: Fragmented market
- Quadrant 4: Concentrated payer share

Hospitals in Quadrant 1 have the dominant market share within a relatively fragmented market. The central issue with this enviable hospital position is that the market is dynamic and can quickly change due to increasing competition from non-hospital sources, such as free-standing imaging, ambulatory surgery centers, etc. Hospitals that begin in the advantaged position of Quadrant 1 often quickly slip into Quadrants 2, 3, and 4, if the hospital does not develop an active parity strategy that aligns value with payments.

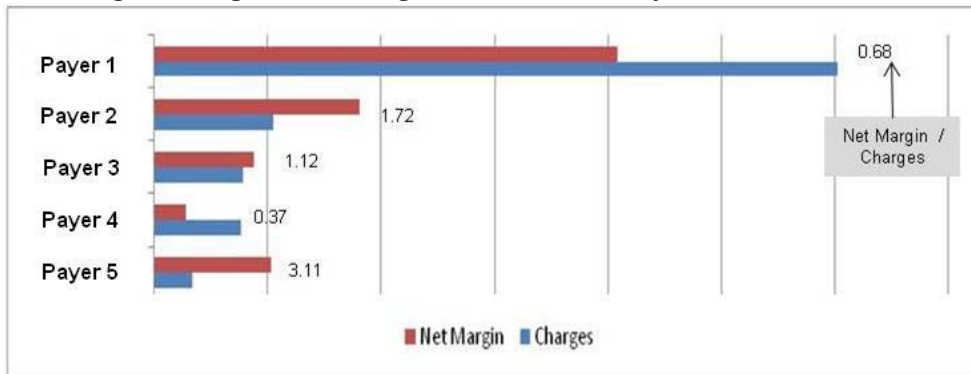
The greatest level of parity will generally be seen in Quadrant 3 because this quadrant has comparatively more choices for both the payers and the providers. Therefore, it operates more like a free market, where supply and demand determines price; however, few markets exist where the payer and provider markets are both fragmented.

How Parity/Lack of Parity Effects Providers

Our research indicates that two thirds of the 87 markets that we have analyzed have a payer concentration level of “highly concentrated” (based on FTC guidelines) using the Herfindahl-Hirschman Index (HHI) score, a commonly accepted measure of market concentration. The HHI score is calculated using the number of plans active in a given location and their relative market shares. The highest scores would be given to pure monopoly markets. Generally, the dominant payer maintains and increases its ability to keep its market share through advantageous discount rates to providers, which in turn, results in providers generating a disproportionate percentage of their margins from smaller payers through higher per unit reimbursements.

The exhibit below shows that the largest payer’s net margin/charges factor of 0.68, while smaller payers account for more than three times their margin share. Healthcare finance leaders must be cognizant of the risk that these smaller payers may exit these markets, resulting in the additional lives being driven (now even more) to the dominant payer at a lower unit reimbursement.

Net Margin/Charges from Large Versus Small Payers



Source: Navigant Consulting, Inc. Data based on client case study.

Article 2: Payer / Provider parity.

In our recent experience, the impact of a smaller payer exiting a market and the majority of lives shifting to the dominant payer resulted in an overall decrease in revenue from the two payers (now one) by more than five percent to 10 percent because of the lower unit reimbursement enjoyed by the dominant payer.

Due to this effect, providers that enter into contracts with payers that allow substantive discounts to select payers without receiving an increased level of tangible service are:

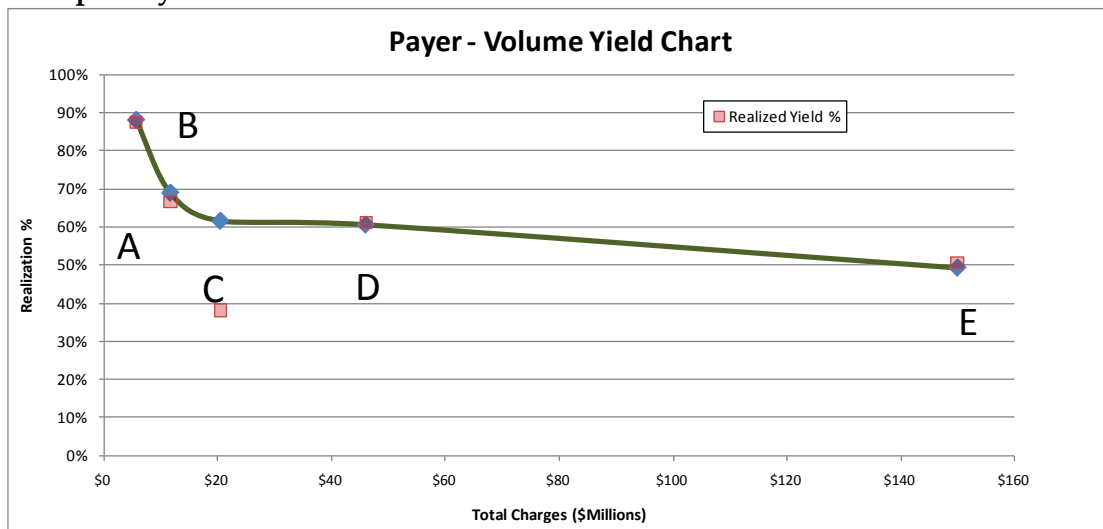
- Setting a challenging future negotiating environment as disadvantaged payers discover they are overpaying through a market analysis
- Pushing less competitive payers out of the market

Devising a Long-Term Parity Strategy

Managed care executives need to balance the optimal parity strategy with the realities of staying within budget, as well as recognizing that some payers drive a higher volume of business. It may not be feasible to instantly move all payers in a market to parity; however, managed care executives should implement a three-year plan to move closer to parity.

Step 1: Measure parity. Plot the difference between payers on a trend line using total charges and percentage of yield. The exhibit, below, represents the typical payer volume to yield graph where the largest payer has some discount advantage.

Example Payer Volume to Yield



Source: Navigant Consulting, Inc. Data based on client case study.

Step 2: Target outliers. Identify tier two outliers. (For example, see payer C in the exhibit [Net Margin/Charges from Large Versus Small Payers.](#)) Immediately negotiate rates upward, especially with those payers that have a history of denials, late payments, and a general lack of partnership with providers in the market.

Article 2: Payer / Provider parity.

Step 3: Consider targeted payer partnering initiatives. Open discussions with tier 2 and 3 payers and present shared cost reduction initiatives, narrow networks, and other methodologies for increasing overall yields. (It is important to note that partnering initiatives should be considered with all payers; however, smaller payers are frequently more motivated to consider alternative payment structures.)

Step 4: Measure and monitor. Review payment levels and market share on an ongoing basis to determine if targets are being met.

The Bottom Line

Many providers may look to drive even larger margins from smaller payers, especially in the short term, given decreased reimbursements from Medicaid, stagnant Medicare payments, and slow commercial enrollment growth. However, in doing so, providers may be setting the stage for continued payer consolidation. Providers that do not proactively manage their markets, through measuring parity and aligning value with payments, risk having parity forced on them through the consolidation of the payers within their markets.

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