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The Payer Paradox: When Higher Rates Don't Mean Higher Reimbursement

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Executive Summary

With a select few payers dominating the commercial reimbursement landscape, variations in contracted rates have become increasingly consequential for physician practices and health systems. However, contracted rates represent only one component of reimbursement reality: **with insurance denials on the rise**, the gap between what is promised on paper and what is ultimately paid continues to widen, reshaping the financial performance of every payer relationship. These differentials impact specialties inequitably, as denial frequency and reimbursement variance disproportionately burden certain service lines, altering payer mix strategy, practice sustainability, and access to care in ways that are often overlooked in traditional contracting analyses. As recent policy shifts have made strides toward reimbursement transparency, we urge for continued efforts to provide more insights into the prior authorization and denial process to bring greater clarity to the entire commercial payer lifecycle.

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Introduction

Four health insurers, Aetna, Blue Cross Blue Shield (BCBS), Cigna, and UnitedHealthcare (UHC), collectively known as BUCA, **dominate the commercial realm across the United States.** With such market concentration, BUCA's pricing behavior dictates revenue variation across healthcare entities, leaving providers, medical groups, and even regional health systems with limited negotiating leverage. This imbalance not only shapes contracting outcomes, but also care delivery patterns, physician practice stability, and ultimately the sustainability of the broader healthcare financing ecosystem.

Commercial insurance reimbursement plays an increasingly central role in the financial viability of physician practices, particularly as Medicare cuts accumulate and workforce shortages intensify. Over the past decade, BUCA's consolidation has accelerated, reducing meaningful competition in many regions and leaving providers with fewer contracting alternatives. This concentration not only shapes the economics of care delivery but also influences access, administrative burden, and practice sustainability. **As margins tighten across specialties,** understanding how payers differ in both reimbursement magnitude and payment reliability has become essential for medical groups, health systems, and policymakers.

Methodology

The included specialties are Allergy & Immunology, Anesthesia, Cardiology, Dermatology, Diagnostic Radiology, Emergency Medicine, Endocrinology, Family Medicine, Gastroenterology, Internal Medicine, Oncology & Hematology, Neurological Surgery, Neurology, OBGYN, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pediatrics, Psychiatry, Surgery, and Urology. Mean rates were calculated for each specialty for each BUCA payer for the CPT billing codes 99213, 99214, and 99215. These rates represent universal evaluation and management codes assessed in an outpatient fashion. The codes vary in complexity with 99213 corresponding to a low complexity clinic visit for an established patient, 99214 as moderate complexity, and 99215 as the highest complexity. To quantify a comparison of payers regardless of specialty, Trek Health created the Payer Generosity Index (PGI). The PGI is calculated as the mean reimbursement for each payer across all specialties divided by the overall mean reimbursement for each billing code.

> `Payer Generosity Index (PGI) = Mean reimbursement for each payer across specialties / overall mean reimbursement for billing code`

Payer Winners (And Losers)

UHC ranks best in reimbursement for all assessed specialties except Emergency Medicine, where Cigna dominates. Cigna most often ranked second, BCBS third, and Aetna consistently ranked last. Though UHC appears to be the most generous in terms of physician reimbursement overall, it fails to take vast denials into consideration. **Physicians often cite insurance rules as one of the most draining parts of clinical work,** largely due to the burden of preauthorizations and the influence insurers exert through denials. UHC tops the commercial giants with the most aggressive denial rate of 33%, whereas Aetna has a reported 22%, BCBS at 20%, and Cigna with 21% across all specialties. To account for these denial rate differences, we've created the adjusted PGI (aPGI) consisting of the PGI*(1-Denial rate).

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Adjusted PGI (aPGI) = PGI * (1 - Denial rate)
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When using the aPGI, the rankings change drastically: UHC falls to third place overall, with Cigna in first, BCBS in second, and Aetna still in last. Despite having much lower denials compared to UHC, it cannot compensate for the largely suppressed reimbursement.

Payer	99213	99214	99215	Denials Percent
Aetna	$87.56	$127.95	$178.08	22%
BCBS	$107.20	$155.99	$217.83	20%
Cigna	$118.00	$172.38	$243.90	21%
United	$126.30	$183.35	$250.58	33%
Average	$109.78	$159.92	$222.59	24%

Figure 1: Commercial Payer Variation by Billing Code

Medicare & Medicaid

While the vast majority of physicians accept some percentage of Medicare patients, a growing number are **refusing to see this population due to lower reimbursement.** This frustration affects both physicians and patients: physicians are at arbitrary whims of Medicare cuts, not receiving adequate payment for their labor, and patients are left in healthcare deserts without access to care. This phenomenon compounds the already growing physician shortages faced nationally, amplifying the importance of commercial reimbursement in sustaining viable practice economics. This, in turn, also makes commercial reimbursement that much more important.

Despite low reimbursements universally compared to commercial, government programs offer greater predictability and lower denial rates, **with Medicare averaging 6% and Medicaid averaging 12%.** As a result, while Medicare and Medicaid produce lower PGI scores, their adjusted PGI (aPGI) values are comparatively stronger, reflecting the reliability of payment once a claim is submitted. Unlike commercial payers, Medicare does not differentiate by specialty taxonomy, relying instead on geographic adjustment factors to reflect regional cost of living. This structural simplicity reduces administrative friction but also eliminates the nuanced pricing flexibility seen in the private market.

Highest rate ≠ highest revenue reliability

Payer Mix Strategy

The interplay between contracted reimbursement rates and payer denial behavior creates a negotiation paradox that significantly influences a provider's financial reality. High-rate payers with aggressive denial practices, such as UHC, may appear lucrative in contract summaries but often generate volatile and unpredictable cash flow because a substantial portion of claims never materialize into paid revenue. As a result, providers must approach payer mix optimization with a far more nuanced lens, one that weighs not only nominal fee schedules but also denial propensity, coding friction, authorization hurdles, and the administrative load imposed by each payer. Practices heavily concentrated in a single high-denial payer may experience significant cash-flow instability despite seemingly favorable contracted rates, underscoring the importance of diversification and data-driven negotiation strategies that consider both price and payment reliability.

Specialty Specific Findings

While payer specific findings may inform payer mix strategy, this analysis provides a different perspective: a glimpse into service line strategy. **Neither reimbursement nor denial rates are universal across specialties**, meaning that the financial performance of a payer can vary dramatically depending on the composition of a practice's service lines. With surgical specialties typically facing higher denial rates, the gap between contracted rates and realized collections can become disproportionately wide, making certain payers far less profitable for procedural groups than they appear on paper. Additionally, reimbursement does not necessarily correlate with physician salary: we see that higher paid physicians are not reimbursed more generously, and vice versa. This has meaningful implications for administrative resource distribution and service line optimization, as practices must strategically allocate billing support, authorization teams, and denial management workflows to the specialties most affected by payer variability. Understanding these specialty-level variations provides a more nuanced view of payer behavior that is essential for optimizing contracting, staffing, and long-term strategic planning.

Specialty	BUCA 99213	BUCA 99214	BUCA 99215
Allergy	$103.78	$151.86	$210.46
Anesthesia	$115.21	$166.23	$228.82
Cardiology	$109.83	$159.96	$222.98
Dermatology	$98.79	$144.47	$201.30
Diagnostic Radiology	$111.56	$162.69	$226.77
Emergency Medicine	$120.87	$176.60	$246.06
Endocrinology	$112.39	$163.84	$228.55
Family Medicine	$102.50	$149.08	$207.99
Gastroenterology	$110.01	$160.95	$223.79
Internal Medicine	$109.85	$159.89	$223.07
Medical Oncology	$121.58	$176.06	$246.11
Neurological Surgery	$116.86	$170.05	$235.81
Neurology	$113.62	$166.25	$230.97
OBGYN	$109.00	$158.86	$221.24
Ophthalmology	$96.72	$140.79	$196.37
Orthopedic Surgery	$109.48	$159.85	$221.51
Otolaryngology	$112.84	$164.29	$229.54
Pediatrics	$112.91	$164.47	$228.70
Psychiatry	$95.74	$138.81	$194.08
Surgery	$111.58	$162.27	$225.98
Urology	$112.02	$163.54	$227.72
All Specialties Average	**$109.78**	**$159.92**	**$222.59**

Figure 2: Specialty Variation Across Commercial Payer Aggregates

Policy Implications

These findings represent significant implications for contracting strategies, practice economics, and patient access. For providers, the key lesson is that commercial contract rates must be interpreted in conjunction with denial trends, authorization requirements, and downstream administrative barriers; evaluating rates in isolation no longer reflects the true economic value of a payer relationship. From a regulatory standpoint, ongoing CMS initiatives, including annual updates to the Medicare Physician Fee Schedule and reforms to prior authorization processes, are placing pressure on commercial insurers to justify or reduce their own denial practices. As Medicare reimbursement continues to stagnate in real terms, commercial insurers increasingly shoulder the responsibility for sustaining physician practice economics, elevating the importance of transparent contract structures and predictable claims processing. Policymakers may ultimately need to address denial transparency and administrative burden as central drivers of healthcare inefficiency, recognizing that payment reliability, not just payment amount, plays a critical role in maintaining access to care and stabilizing the physician workforce.

Conclusion

The analysis of BUCA reimbursement patterns reveals a structural paradox at the core of commercial healthcare financing: higher contracted rates do not reliably translate into higher realized revenue. When denial behavior, administrative friction, and payment consistency are incorporated into reimbursement evaluation, the apparent hierarchy of payer generosity shifts in ways that have meaningful operational and strategic implications for providers. The PGI and adjusted PGI (aPGI) highlight this reality, demonstrating that a payer's value lies not only in the rates it publishes, but in the dollars it ultimately delivers.

As physician groups and health systems navigate tightening margins, rising practice costs, and growing pressure from both commercial and governmental payers, understanding this paradox becomes essential for sustainable contracting. The findings underscore that payer mix strategy must evolve beyond rate benchmarking alone and instead prioritize predictability, authorization burden, denial trends, and the administrative cost of getting paid. At the same time, the stagnation of Medicare reimbursement and the expanding strain on access to care further amplify the importance of commercial payer performance in maintaining the economic viability of medical practices.

Ultimately, aligning payment policy with practice reality will require greater transparency, tighter guardrails on denial practices, and renewed attention to the administrative machinery that dictates physician cash flow. By illuminating the differences between contracted rates and realized reimbursement, this report offers a more accurate framework for payer evaluation: one that empowers providers, informs policymakers, and advances Trek Health's mission to bring clarity, data, and accountability to the healthcare economics landscape.

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