

REPORT | September 2020

California's Sutter Health Settlement

What States Can Learn About
Protecting Residents from the
Effects of Health Care
Provider Consolidation

By Rob Waters



Executive Summary

Hospital mergers have been rising steadily for the past decade. From 2010 through 2014, 451 mergers were completed in the United States, an average of 90 a year. From 2015 to 2019, the number rose to 511, a rate of 102 a year. Numerous studies have shown a strong relationship between concentrated ownership of hospitals and physician practices on the one side and higher prices for procedures and insurance premiums on the other. Among the privately insured, hospital costs account for 44% of health care spending and explain virtually all of the increases in spending in recent years.

Over the past 20 years, Sutter Health, a nonprofit hospital chain based in Sacramento, California, made numerous acquisitions and reported an operating revenue of \$13.3 billion in 2019. In 2014, a group of large payers sued Sutter in a case that was later joined by the California attorney general. Plaintiffs argued that Sutter had used its dominance to force insurers to place Sutter facilities in favored positions in health plan networks and to withhold from payers information about pricing.

In October 2019, the parties reached a tentative settlement, with Sutter agreeing to pay \$575 million and to refrain from engaging in a set of specific behaviors that had given the health system an unfair advantage. Among the key settlement provisions, Sutter agreed:

- To end its “all-or-nothing” practice of requiring health plans to contract with all Sutter hospitals and facilities if they wanted to get access to any Sutter facility.
- Not to interfere with or block health plans from establishing tiers—rankings of providers that assign more favorable positions to those offering better pricing or quality. Plans charge patients lower copays or deductibles when they use providers in favored tiers.
- To limit what it charges when health plan members are treated out of network, including for emergency room or trauma care, helping ensure that members don’t receive surprise medical bills from out-of-network providers.
- To increase transparency by ending the practice of preventing health plans from giving insurers, employers, and self-funded payers access to pricing, quality, and cost information.

- To allow health plans to freely designate as centers of excellence those providers that deliver high-quality care and to exclude Sutter providers from these centers if they don't meet predetermined criteria.

"The Sutter settlement was a landmark," said Shawn Gremminger, a Washington, DC-based health policy analyst who tracks federal issues for Pacific Business Group on Health, an alliance of employers and public purchasers of health insurance. "This is really the first time where we've actually seen success getting a major system to cease and desist."

The provisions agreed to by the parties may now help inform other efforts around the country to control the behavior of large health systems with dominant positions in health care markets. Health law scholar Jaime King said the Sutter case may act as a guide for policymakers and litigators in other states—once they are able to turn their attention to issues other

than COVID-19. "I think the provisions in this case can directly lead to a road map," she said.

In addition, states may want to pursue broader policies such as antimerger legislation, rules requiring health care price transparency, and the imposition of price controls to help reduce health care consolidation, create a more competitive playing field, and limit the power of hospitals to dominate markets and increase prices.

In the era of COVID-19, the vast disparities in outcomes that have long been a feature of the US health system have never been more apparent. If state and federal policymakers, along with health care payers, wish to reverse these trends and create transformative change, they will need to pursue new strategies to impede and roll back consolidation in the health care industry and the power of dominant hospital systems. The successful litigation against Sutter Health may offer a useful guide.



INTRODUCTION

The coronavirus pandemic has exposed the inadequacies of the US health system and the massive health disparities that have long existed in the United States in ways that are clearer and more damning than ever. Perhaps the biggest issue is the one that's visible from 10,000 feet. The United States now spends \$4 trillion on health care—far more than any other country—and gets a decidedly poor return on that investment.¹

In addition, almost 18% of gross domestic product is spent on health care—nearly twice as much on average as the 36 members of the Organisation for Economic Co-operation and Development (OECD). That figure is projected to rise to almost 20% by 2028, according to the US Centers for Medicare and Medicaid Services (CMS).² All of this spending delivers mediocre outcomes, as is shown by the United States ranking last or near last on numerous health metrics compared with other high-income countries.³

The biggest driver of rising US health care costs is hospital care. Of the \$4 trillion that will be spent on health care this year, hospital expenditures account for one-third—\$1.3 trillion—far and away the biggest category of health spending.⁴ Among the privately insured, hospital costs account for 44% of health care spending and explain virtually all of the increases in spending in recent years, according to a 2020 report from the Urban Institute and UC Hastings College of the Law in San Francisco.⁵

Meanwhile, the minuscule portion of health spending devoted to public health activities has fallen from 2.76% in 2012 to 2.46% of spending in 2020.⁶ This is money that in normal times is devoted to activities that can help keep people healthy and prevent chronic disease—and could now be spent on contact tracing and helping people protect themselves from COVID-19. In 2017, Trust for America's Health reported that from 2008 to 2017, 55,000 positions in public health departments had been eliminated—one-fifth of the total—and that funding for the Centers for Disease Control and Prevention declined 10% from 2010 to 2019.⁷

Spending on hospitals, though, keeps rising. And one of the biggest reasons is the steady expansion of health

systems and their increasing domination of local and regional health care markets. Starting in 2010 and intensifying throughout the decade, large hospital systems went on a buying spree, acquiring other hospitals as well as physician practices. In the process, many gained enough market power to demand higher prices, which also pushed up insurance premiums.

Elizabeth Mitchell, president and chief executive officer of Pacific Business Group on Health, an alliance of employers and public purchasers of health insurance, said hospitals' thirst for acquisitions reinforces investment practices that pursue revenue, not better care or improved public health.

"History has shown that these large systems invest in ways that reinforce their existing market power without investing in the things that the community may need," Mitchell said. "They raise prices, they build new buildings, add capacity. They buy up primary care practices so they get all the referrals. They become monopoly owners of a specific specialty."

Perhaps nowhere was the linkage between consolidation and price as dramatic as in Northern California. This report is a case study of how one such system, Sutter Health, came to dominate the Northern California hospital market, fueling price and premium inflation, and the effort by employers, payers, and litigators to rein Sutter in.

The Push for Market Power

Because local health care markets in the United States are largely unregulated, health care prices are largely a function of the relative market power of insurers and providers. Consumers using employer-sponsored insurance are partly insulated from the costs and have limited reason to be cost conscious. When their out-of-pocket costs do rise, they have little ability to influence—or even understand—their complex and confusing bills.

Employers, who pay most of the bills, have an incentive to keep costs down. But even large employers often lack the clout to exercise significant market leverage. That leaves insurers and providers battling over quality and price, with the balance of power shifting with their standing in the marketplace.

In the 1990s, employers began moving large numbers of people to managed care plans that limited their choice in

selecting providers, “a market-based response to rapidly rising health care costs,” according to a 2015 report.⁸ This gave health plans greater leverage over doctors and hospitals—for a time. Hospitals fought back with a flurry of mergers, purchasing other hospitals, physician practices, and health care facilities and increasing their bargaining clout with insurers. While many of those mergers unwound, a new wave of mergers began in the aftermath of the 2010 passage of the Affordable Care Act, which encourages coordination of care—though not necessarily through consolidation.

From 2010 through 2014, 451 mergers were completed in the United States, according to the consulting firm Kaufman, Hall & Associates, an average of 90 a year. From 2015 to 2019, the number rose to 511, a rate of 102 a year (Figure 1). The average size of each deal ranged from \$189.6 million in 2010 to \$408.5 million in 2018.⁹

“Market Power Has Shifted”

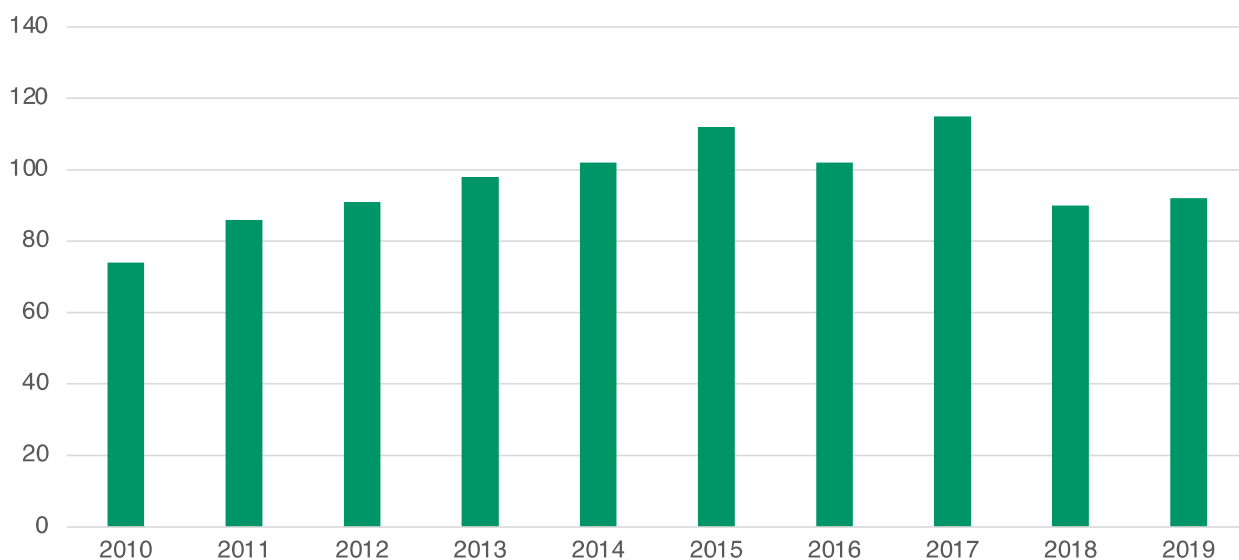
Today, 95% of hospital markets are highly concentrated, as defined by the standard metric for characterizing market concentration, known as the Herfindahl-Hirschman Index.¹⁰ As a result, “market power has shifted from payers to providers as reflected in the relative leverage that the parties bring to the negotiating table over prices,” says the 2020 Urban Institute/Hastings Law

report *Addressing Health Care Market Consolidation and High Prices*.¹¹ The report also notes that hospital costs account for 44% of health care spending in the United States for the privately insured and explain virtually all of the increases in spending in recent years.

The unwillingness of state and federal government to meaningfully regulate the hospital industry has led to huge price disparities. With little control over health care mergers, hospital systems like Sutter have grown enormously. And with no price controls, health care providers with market power have strong leverage as they negotiate rates with commercial payers. One result: big hospital chains command the highest prices.

From 2004 to 2013, a nine-year span that included a major recession, overall inflation rose only 25%, yet actual charges at California’s two largest hospital systems, Sutter and Dignity Health (now CommonSpirit Health), grew by 113%, compared with 70% in all other hospitals, according to a study led by Glenn Melnick, director of the Center for Health Financing, Policy and Management at the University of Southern California.¹² Another Melnick report noted that out-of-pocket health spending for a family with employer-sponsored insurance increased by 142% from 2003 through 2018, while median household income in California grew 43%.¹³

Figure 1. Annual Number of Hospital Acquisitions, 2010 to 2019



Source: Kaufman, Hall & Associates

One result is that the gap between what hospitals charge for patients enrolled in Medicare—where the federal government uses its power to set prices—and what they charge for patients with private insurance has continued to grow. A study last year by the West Health Policy Center found that hospitals in California were paid, on average, more than twice as much by private insurers as they were by Medicare for similar services; a Sutter hospital in San Francisco was paid almost three times as much.¹⁴

THE SUTTER HEALTH STORY

Today, Sutter Health is California's second-largest health system, with 24 hospitals, 36 surgery centers, and 12,000 physicians working in hospitals or practices it owns. Its 2019 operating revenue of \$13.3 billion would have placed it roughly in the middle of the Fortune 500, if it weren't organized as a nonprofit. It is the dominant health care system in Northern California, but not always the only player in town. Its influence stems not just from the number of entities it owns, but also from its strategic acquisitions and willingness to leverage that ownership in forcing health plans to include Sutter facilities and doctors at preferred positions in their networks.

Sutter has been pursuing a strategy of acquiring hospitals and physician practices to expand its footprint in Northern California since the mid-1980s. In 1996, it acquired California Health System, the parent of California Pacific Medical Center in San Francisco; Alta Bates Hospital in Berkeley; Marin General Health Systems in Marin County; and Mills-Peninsula Health Services in San Mateo County. Two years later, it announced its intent to acquire Summit Medical Center in Oakland, giving the health system a virtual monopoly in Alameda County.

California Attorney General Bill Lockyer went to federal court in 1999 seeking to block Sutter's purchase of Summit, and the case surfaced a number of internal memos suggesting that Sutter wanted to use acquisitions to boost its leverage with health plans. In one, Sutter's former head of Bay Area operations suggested the company should "hire a very aggressive negotiator and take no prisoners on pricing" if it obtained enough market share.¹⁵ Another outlined a goal of increasing market share to obtain a "critical presence" in each of four geographic markets, making Sutter "indispensable

for the major health plans." Nonetheless, the judge in the case ruled in favor of Sutter and allowed the acquisition to proceed.

In 2004, Blue Shield of California performed a cost analysis on behalf of CalPERS, the pension fund that administers health and retirement benefits for more than one million public employees and dependents. The analysis found that CalPERS was paying, on average, 73% more for hospital claims at Sutter hospitals than at other hospitals. CalPERS president Sean Harrigan said, "Every citizen in the state of California should be outraged by Sutter Health" for using its "monopoly hold on some markets to extort high prices."¹⁶

"Out of the Park" Price Increases

When Catherine Dodd took over as director of the San Francisco Health Service System in 2009, the city's health care purchasing agency was in the middle of negotiating rates with three health plans that provide health insurance for the city's 100,000 or so employees, retirees, and family members. Blue Shield was proposing rate increases that were "out of the park," Dodd recalls.

Then, as now, most of those 100,000 were enrolled in Kaiser Permanente, which provides care in its own clinics and hospitals. But a significant number chose Blue Shield, which contracted with doctors and facilities affiliated with Sutter Health. Over the next few years, Dodd and her team of actuaries and analysts tried to determine why Blue Shield's rates kept rising and worked on strategies to control them. "I'd pull in Blue Shield and try to negotiate, but we'd get nowhere," Dodd recalls.

The insurance representatives explained that hospital charges were rising, and premiums needed to keep pace. Dodd would ask to see bills itemizing the charges Blue Shield was paying, but her requests were denied—because Sutter had required Blue Shield to sign agreements keeping the cost of services secret.

"I'd go to Blue Shield and say, 'What are they charging us? Why are these premiums so high?'" Dodd recalls. "And they'd say, 'We can't tell you that because it's a contractual trade secret.'" Sutter, Dodd explained, wouldn't sign a contract with a health plan unless it contained a so-called gag clause forbidding disclosure of prices. As

the person responsible for paying the bills and protecting taxpayer money, Dodd was outraged. “The example I’d use is: ‘This is my credit card, and I want to know what you’re charging on it.’” But she couldn’t get the information directly.

The contract did allow for a year-end lookback at claims over \$50,000 and Dodd’s team found one surprise. According to Dodd, the cost of knee replacement surgery in Sutter facilities went from \$35,000 to as much as \$65,000 over a two-year span. Many were performed in same-day surgery centers Sutter had acquired.

In an effort to control costs, Dodd had the city switch to a hybrid payment model. She negotiated a capitated contract with the Blue Shield medical group affiliated with Sutter, paying a fixed amount per enrolled member for all outpatient services, while acting as a self-insured entity to pay hospital bills directly. Dodd thought that would increase transparency—but it didn’t.

“I’d come in on Monday morning and have to sign checks for Sutter hospital services that had happened over the weekend,” she said. “We’d get bills for like \$2 million, basically for services rendered and no other details. They didn’t tell us what the bills were for. I was appalled.”

“All or Nothing”

Sutter didn’t have a monopoly in San Francisco, but in the Oakland-Berkeley area of Alameda County, east of San Francisco, it owned both major acute-care hospitals (not counting public hospitals or those owned by Kaiser, which serves only members of its own health plan). When Dodd tried to create a narrow network there that would exclude Sutter’s high-priced hospitals and physician’s groups, she was stymied by Sutter’s lock on the Alameda County market.

Many San Francisco employees and retirees live in Alameda County and if Dodd and her colleagues wanted them to have access to Sutter’s hospitals there, they had to agree to keep Sutter hospitals and doctors in its network. “It was all or nothing,” Dodd said. “There was nothing we could do.”

Sutter also purchased or created affiliations with multiple groups of doctors, increasing the number of affiliated physicians from around 5,000 in 2010 to more

than 12,000 today. These purchases, too, were strategic, said Elizabeth Mitchell. Acquiring primary care doctors brings referrals and controlling different specialties offers leverage, she said.

“Sutter may not have been in every region, but they basically controlled maternity care across the Bay Area,” Mitchell said. “To get the right maternity access, you would have to have Sutter in your network. They didn’t have to own all the hospitals in the area, they just had to be strategically dominant.”

Arminé Papouchian, a retired insurance executive who worked as a senior vice president of provider contracting for Blue Shield of California from 2007 to 2019, said negotiations with Sutter were “very contentious,” with Sutter representatives employing strategies she’d never seen before. They refused to use standard contract templates that Blue Shield developed, she said, insisting on agreements Sutter drew up. Among other things, Blue Shield was barred from placing Sutter facilities in anything but favored positions, or tiers, in health networks, and was prohibited from disclosing to employers Sutter’s actual charges.

“Sutter was trying to get the highest reimbursement level and were also pushing to grow their network over time to create this kind of monopolistic environment,” Papouchian said. “They wouldn’t allow health plans to have agreements with some, but not all, of their hospitals.”

“The Larger They Became, the More Leverage They Had”

In some cases, acquisitions led to immediate price hikes, Papouchian said. “When Sutter would purchase ambulatory surgery centers where we had agreements, the prices would immediately escalate substantially,” she said. Sutter’s assertiveness “got worse as they expanded their network. The larger they became, the more leverage they had.” Over time, other health systems began insisting on the same kinds of contract language Sutter used. “Other large systems would tell us, ‘We understand Sutter has this language, so we want the same,’” Papouchian said.

In 2012, a class action lawsuit, *Sibide v. Sutter Health*, was filed in federal court on behalf of members of health plans that contract with Sutter hospitals. The suit

alleged that Sutter used its market dominance in some geographic markets to force the plans to contract with Sutter in all other markets where it operated hospitals, forcing members to pay higher copays and premiums.

In areas including Berkeley, Oakland, and rural parts of Northern California, “Sutter is the only game in town,” Matthew Cantor, the plaintiffs’ lead attorney, said in an interview. “Basically Sutter said to the health plan: ‘If you want my monopoly hospitals and you can’t live without them, you’re going to have to contract with me for all my hospitals on the terms and prices that I dictate.’”

The case was dismissed three times by a federal magistrate judge and sat in limbo for years, but it was reinstated in 2016 by the Ninth Circuit Court of Appeals. In July 2020, it was certified as a class action and a trial was set for March 2021.

In 2014, another case was filed, this one in state court, on behalf of self-insured employers and unions who pay directly for their own health care. That case, *United Food & Commercial Workers (UFCW) and Employers Benefit Trust v. Sutter Health*, also accused Sutter of using its dominant market position to bend health plans to its will and inflate the prices paid by employers.

In March 2018, Richard Scheffler, director of the Nicholas Petris Center on Health Care Markets and Consumer Welfare at the University of California, Berkeley, released a report detailing just how uncompetitive California hospital markets had become. It found that 44 of California’s 56 counties had “highly concentrated” hospital markets¹⁷ and that the more concentrated the market, the higher the prices charged by hospitals and the higher the premiums paid by consumers.

Though the report did not mention Sutter by name, it found that Northern California, where Sutter dominates, had the greatest concentration and highest prices. On average, Scheffler found, hospital charges in Northern California were 20% to 30% higher for the same procedure as in the south, after adjusting for cost-of-living differences. Suffer a heart attack in East Los Angeles, the report said, and the cost to treat it was about \$15,000, compared to \$25,000 in San Francisco. The average price of an inpatient procedure in Southern California was \$132,000; in Northern California it was \$223,000.

Scheffler announced the study in a telephone press briefing joined by California Attorney General Xavier Becerra. Four days later, Becerra filed an antitrust action against Sutter. In a press statement, he accused the hospital chain of “throwing its weight around in the health care market, engaging in illegal anti-competitive pricing.” The case was soon joined to the four-year-old UFCW case.

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Shawn Gremminger, Washington, DC-based health policy analyst

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A “Game-Changer” of a Settlement

In October 2019, after months of negotiations and on the cusp of a jury trial, the parties announced a stunning tentative agreement. Details of the deal—which Becerra called a “game-changer”—were announced two months later. Sutter agreed to pay \$575 million in damages and accept a suite of restrictions on its future behavior, with a court-appointed monitor ensuring compliance for 10 years. Among the key settlement provisions, Sutter agreed:

- To end its “all-or-nothing” practice of requiring health plans to contract with all Sutter hospitals and facilities if they wanted to get access to any Sutter facility.
- Not to interfere with or block health plans from establishing tiers—rankings of providers that assign more favorable positions to those offering better pricing or quality. Plans charge patients lower copays or deductibles when they use providers in favored tiers.

- To limit what it charges when health plan members are treated out of network, including for emergency room or trauma care, helping ensure that members don't receive surprise medical bills from out-of-network providers.
- To increase transparency by ending the practice of preventing health plans from giving insurers, employers, and self-funded payers access to pricing, quality, and cost information.
- To offer a stand-alone price for providers whose services previously were only available if a health plan agreed to purchase bundled services from multiple providers.
- To allow health plans to freely designate as centers of excellence those providers that deliver high-quality care and to exclude Sutter providers from these centers if they don't meet predetermined criteria.

"It's not overstated to say the Sutter settlement was a landmark," said Shawn Gremminger, a Washington, DC-based health policy analyst who tracks federal issues for Pacific Business Group on Health (PBGH). "There have been lots of efforts to try to curb aggressive pricing and aggressive market consolidation in different places. But this is really the first time where we've actually seen success getting a major system to cease and desist."

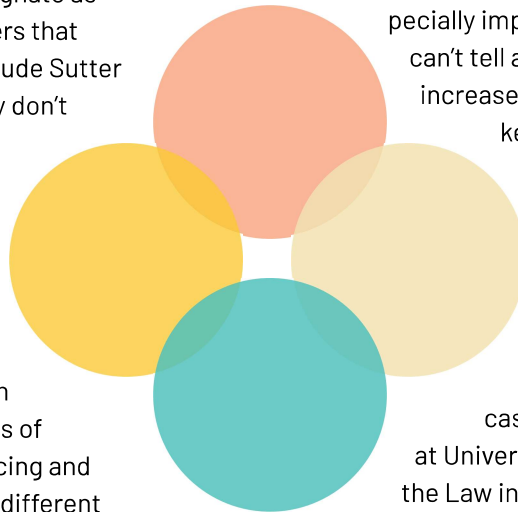
The measures agreed to by Sutter are the most important part of the settlement, said Elizabeth Mitchell, PBGH's president and chief executive officer. Her group was not a formal party to the litigation, but she and her members tracked it closely because of its direct impact on the costs they paid.

"We were way more excited about the injunctive relief than even the settlement dollars, because we think those will have much more significant economic impact over the 10 years that they're in place," Mitchell said. "It requires Sutter to basically stop the behavior that was so egregious. If employers leverage these new rules of the road, we think there are meaningful opportunities to change the market."

The settlement provisions "could reduce Sutter's market power substantially, preventing the health system from imposing all-or-nothing contracts on health plans and allowing insurers to create tiered products," said Glenn Melnick, the USC health economist. The limitation on emergency out-of-network charges may be especially important, he said. "It means Sutter can't tell an insurer, 'If you don't give us a 20% increase, we'll pull out of the network and keep half your patients anyway, and you'll pay us even more.'"

Jaime King, a health law scholar recently appointed as the John and Marylyn Mayo Chair in Health Law at the University of Auckland in New Zealand, followed the Sutter case closely during her 12-year tenure at University of California, Hastings College of the Law in San Francisco. She said that what made Sutter's strategy so powerful was its use of multiple contract terms, each reinforcing the other.

"The 'all-or-nothing' is most important," King said. "The gag clauses are also important because they prevent insurers, government, employers, or anyone else from recognizing what's happening. But it's really how the contract provisions fit together. The sum of these provisions is greater than its parts."



CALIFORNIA DREAMING? PROSPECTS FOR APPLYING THE SUTTER SETTLEMENT IN OTHER MARKETS

If the settlement was indeed a landmark, it raises a number of questions: What lessons can be taken from the settlement and ongoing efforts in other states to constrain hospital behavior? Does the settlement offer guidance to other states struggling to control rising prices in an era of market domination by hospitals? Can the settlement provisions truly constrain the behavior of Sutter and other hospitals given the high concentration of ownership that already exists in the industry? And what kinds of policy initiatives could states take to rein in hospital pricing?

King believes that with time, the settlement will reverberate around the country, especially among the coalitions that employers and public payers have created to increase their leverage with health systems. She predicts that new litigation and legislative initiatives will emerge in other states, as attorneys general, legislators, and private plaintiffs study the strategies Sutter employed.

“A Great Road Map” for Other States

“I think the provisions in this case can directly lead to a road map, because Sutter was one of the most sophisticated in how it set up its contracts,” King said. “I think that a lot of states were watching the Sutter case very closely but then the world sort of stopped in early March with COVID.” She believes policymakers and litigators can examine Sutter’s strategy and look for its correlates in their locales. “It allows them to say: ‘Okay, these are the kinds of contract provisions that you might want to enjoin in another health system that is engaging in that behavior.’ It’s a great road map, but each market is different.”

Interviews with health care payers in other states suggest this is beginning to happen.

In Indiana, the use of Sutter-style anticompetitive contract language has been “rampant,” said Gloria Sachdev, president and CEO of Employers’ Forum of Indiana, an employer-led coalition that works to improve the quality and reduce the cost of health care for payers.

“Such language prohibits fair market principles from being applied [and] supports the adage ‘where there’s mystery, there’s margin,’” Sachdev said. “We need transparency up front so we can shop for health care based on quality and price like we shop for everything else.”

Her group supported a bipartisan transparency bill, [Senate Bill 5](#), that passed the state legislature this year and was signed into law by Governor Eric Holcomb. It requires health care facilities to post on the Internet the “weighted average negotiated charges” for services it provides and bars the use of gag clauses in health care contracts—clauses that prohibit health providers from disclosing claims data to employers.

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Sue Birch, director of the Washington State Health Care Authority, which purchases health insurance for 2.5 million public and school employees, said her team has been “poking and prodding” to see if providers in Washington “have done a Sutter” by using similar strategies to push up prices. “We’re very intrigued about using the Sutter [settlement] scenario” as a way to keep hospitals’ pricing and contracting strategies under control.

BROADER STRATEGIES FOR REINING IN HOSPITAL PRICE INFLATION

Sutter, like many health care systems, took advantage of a largely unregulated health care marketplace to acquire facilities and physician practices and use market power to dictate contract terms and push up prices. The Sutter settlement offers guidance to policymakers and purchasers who want to contain dominant health systems through litigation, contract terms, law, or regulation. But these steps are incremental and inherently limited. What does a broader agenda to rein in hospital price inflation look like? In this section we propose three principal areas where strengthened state or federal policies might help reduce health care consolidation, create a more competitive playing field, and limit the power of hospitals to dominate markets and increase prices.

Antimerger Legislation

When Sutter announced in 1998 that it would buy Summit Medical Center in Oakland and combine it with Alta Bates, a nearby hospital Sutter had acquired two years earlier, the Federal Trade Commission (FTC) took no action. Seven years later, the FTC conducted a review and found that the merger had led to price increases of 28% to 44% at Summit, “among the largest of any comparable hospital in California.”¹⁸ These price increases affected a diverse community with large numbers of Asian, African American and Latino residents in which 17% of all residents and 19% of children live below the poverty level.

In the years since the Summit acquisition, the Department of Justice and the FTC have, with some notable exceptions, done relatively little to block hospital acquisition of other hospitals and even less to block so-called vertical mergers—when hospitals acquire physician practices.

The Perils of Consolidation: A Look at the Midwest

Northern California may be the most expensive hospital market in the country, and one of the most consolidated, but concentrated ownership of hospitals and health care services has become a feature of life in every part of the country, including the Midwest. Some markets have a single dominant health system and no real competition to constrain what that hospital charges. But markets with two competing systems present their own set of inflationary problems.

Jarrold McNaughton has worked for both a health provider and insurer. Today he runs the nonprofit Inland Empire Health Plan in Southern California. He also spent almost five years, from 2013 through 2017, as an executive at Kettering Health Network in Dayton, Ohio, one of two hospital systems competing head-to-head in southwestern Ohio that, he said, “controlled just about everything in the market.”

The competition didn’t necessarily constrain prices. In fact, it fueled an “arms race” as each system sought to acquire local physicians to bring business to the hospitals, McNaughton said. In that atmosphere, “physicians and

their patients almost become commodities. And hospitals start to think, ‘How can I have a competitive edge against that other system and create a scenario where I own those physicians?’”

He offered an example: “Say you have a cardiothoracic surgeon, they’ve been on your medical staff for 10 years, they have good, solid quality scores and do good work. Now all of a sudden you want to own them—which means buy their practice assets and make them part of your group.” Such moves, aimed at ensuring that a continuing stream of surgeries will be performed at your facility, often trigger a bidding war, McNaughton said, pushing physician compensation so high “you’re now paying three or four or five times what they were making as a private physician.”

If the physician was already in the hospital’s network, such a transaction may increase the hospital’s expenses without bringing in much new business. Hospitals are moved to do it as a defensive measure, McNaughton said; the alternative may be losing the surgeon and their patients altogether. Expensive hires like this may push hospitals to cut programs, lay off people, or search for new revenue. One way to do that, McNaughton said, is to charge inpatient rates at outpatient centers.

“You could have an MRI done at your outpatient center, and the charge might be \$5,000, while the stand-alone MRI down the street charges \$800,” he said. “That’s how hospitals make up for that massive change in expense.”

In Pittsburgh, the sprawling health system operated by the University of Pittsburgh Medical Center (UPMC) has long been a dominant player in the city’s health care market and in recent years has expanded throughout western Pennsylvania and into Maryland. In 2011, a local health insurer, Highmark Health, facing steep increases from UPMC, decided to branch into the hospital business by purchasing a failing health system and creating its own health network. UPMC retaliated by saying Highmark’s members would be unable to use UPMC providers. The two systems, each with their own health plans and hospitals, moved to create separate silos and were headed toward a deeper clash that would have kept patients from seeing providers from the opposing system starting in 2019.

Pennsylvania Attorney General Josh Shapiro intervened, threatened legal action, and forced the two to the bargaining table. They negotiated a 10-year contract that restored the ability of enrolled members in one of the systems to use providers from the other. The market and many patients “breathed a sigh of relief,” said Jessica Brooks, CEO and executive director of the Pittsburgh Business Group on Health, an association of employer-purchasers of health care.

But Brooks said the agreement has done little to control rising health care prices and contains provisions that bar “tiering and steering.” These provisions keep employers who buy health coverage for their workers from giving priority

to providers whose care may be higher quality or less expensive. PBGH employer-members believe those provisions may make it difficult for national health insurers to compete in the market, she said.

That’s because the Highmark and UPMC health plans each offer narrow networks that entice members to use their own health systems, while national plans like Aetna are precluded from mixing and matching facilities owned by Highmark and UPMC in favored, lower-cost tiers. That makes these plan less competitive and keeps them from incentivizing the use of providers that have better quality scores or offer preventive services—steps employers believe can improve health and lower costs.

“They can’t say, ‘We can provide you total cost-of-care savings because we can provide data analytics and mental health and well-being programs,’” Brooks said. “And we’re going to hold hospitals who are lower quality accountable by making patients pay more to go to them based on real data.’ We can’t do those things based on the contractual arrangements, and I think that was a fail in the picture.”

As with Sutter, self-insured employers in Pittsburgh—companies like the Kraft Heinz Company and First National Bank—have no ability to see the actual prices charged by hospitals. “They signed away those rights in their contracts,” Brooks said.

And so far, she said, the employers in her organization have been unwilling to go to the next level of collectively purchasing health coverage for their employees as a coalition, giving them more leverage. But it could be a trend that’s coming.

In California, Attorney General Becerra followed his success in the Sutter case by drafting legislation that would extend to other hospitals some of the settlement provisions agreed to by Sutter. Senate Bill 977 would require health systems that own multiple hospitals, as well as private equity firms and hedge funds, to notify and obtain the permission of the attorney general to acquire a health care facility or provider. It also establishes a Health Policy Advisory Board to analyze health care

markets and advise the attorney general. At the end of June, the bill had passed the state Senate but it did not make it out of the Assembly in the 2020 session.

Not surprisingly, the legislation was opposed by Sutter and the hospital industry, which led the effort to stop or weaken it.

“The bill is dangerous because it would vest unprecedented power and authority over these partnerships and relationships with a single office,” said Carmela Coyle, president and chief executive officer of the California Hospital Association, in a statement. “That will inhibit the development of integrated delivery systems that can buoy financially challenged doctors, keep open hospitals that might otherwise shutter in rural communities and inner-city urban areas, and preserve access to care throughout California.”

Price Transparency

A large body of research has documented wide variation in hospital charges based on geography and the degree of concentration in a particular market, as well as a huge gap between what the public insurance system—Medicare, Medicaid, and the Department of Veterans Affairs—pays compared with what commercial insurers pay. That data is revealing at a meta level, but it still leaves payers in the dark about the actual charges at any particular hospital.

The Trump administration recently released new rules requiring hospitals to publish on the Internet the actual prices negotiated and paid by insurers. The new rule is scheduled to go into effect on January 1, 2021. The American Hospital Association argues that forcing hospitals to publish their negotiated rates violates their First Amendment rights and asked a federal judge to block the rule. In June, District Judge Carl Nichols refused to do so, ruling in favor of the government. The association said it would appeal the ruling.

Many states have created all-payer claims databases based on data from public and private payers showing what is actually paid, giving payers more insight into what hospitals are charging to others. Several states, including Massachusetts, Colorado, Maine, and New Hampshire, have used this data set to create publicly accessible cost-comparison websites that show what different providers charge for different procedures. These tools can increase awareness and might allow public shaming of hospitals that overcharge, but overall, they have done little to control hospital prices, according to an October 2019 report by Massachusetts Attorney General Maura Healey.¹⁹ That report also found that payers’ efforts to improve

health and lower the costs of patient care are hampered by insurance “churn”—the frequency of patients switching health plans.

State Price Controls

One state, Rhode Island, imposed price controls on hospitals back in 2010, capping price increases to the rate of increase in the Medicare program plus 1% and creating a cost-containment commission to collect data and review costs. A 2019 study published in *Health Affairs* found that the Rhode Island scheme succeeded in reducing the quarterly fee-for-service spending by \$76 per enrolled member of commercial insurance plans, after adjusting for inflation, and that the drop was driven by lower prices, not reduced utilization. The study found that the state-imposed price controls “appear to have shifted the negotiation dynamics between commercial insurers and providers in favor of insurers” and represent a way to “effectively leverage state regulatory power to reduce health care costs.”²⁰ Data from CMS shows that from 2009 to 2014, health care spending in Rhode Island grew more slowly than any other state—2.5% a year compared with 3.9% nationally.²¹

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Matthew Cantor,
lead attorney in the
Sibide v. Sutter class action

Three other states attempt to control prices in other ways. Oregon controls prices and premiums for its Medicaid program and allows health plans covering public employees to impose caps on hospital prices. Maryland regulates hospital prices and budgets for

all hospitals and payers. Massachusetts sets a target growth rate for health care costs each year and can require health systems that exceed it to submit improvement plans.

Matthew Cantor, the lead attorney in the *Sibide v. Sutter* class action, said that short of establishing a single-payer system, approaches that regulate costs may be needed to rein in hospital prices.

“As much as we want health care to be based on competition, there’s a real question as to whether this is the kind of product that is amenable to competition,” Cantor said. “The reality is that the only way to deal with repeated market failure is regulation. The problem is that regulation is often deemed to be anti-American and it requires a sophisticated understanding of these markets—and these markets are complex as hell. From a political standpoint, it’s hard. But it’s the only way to do it.”

In 2019, a bipartisan bill, the [Lower Health Care Costs Act](#), emerged from the US Senate Committee on Health Education, Labor and Pensions. Key provisions include limiting surprise medical bills by keeping hospital emergency departments and air ambulances from charging out-of-network rates and banning gag clauses in contracts between health plans and providers. The bill was approved by the committee but has gone nowhere since, said PBGH’s Shawn Gremminger. Its fate will await a new Congress and the results of the November election.

“*We’ve been building moneymakers and investing billions and billions of dollars in high-dollar cancer treatment centers and eye hospitals and other specialties. But we have communities right up the street that are a food desert and lack adequate transportation. The community has been collateral damage.*

*Jessica Brooks, president and CEO,
Pittsburgh Business Group
on Health*”

CONCLUSION

When the COVID-19 pandemic exploded in the United States in March, ownership of the country’s health care system had never been more concentrated. Twenty years of nearly unrestrained consolidation has pushed the cost of health care to unsustainable heights and fueled a pattern of investment that prioritizes the building and acquisition of new facilities and hospitals while starving public health and community-oriented systems of care of the resources they need.

The vast disparities in outcomes that have long been a feature of the US health system have never been more apparent, making African Americans, Latinos, and Native Americans far more likely to be sickened and to die than whites.

“COVID-19 shed a light on those inequities,” said Jessica Brooks, CEO and executive director of the Pittsburgh Business Group on Health, an association of employer-purchasers of health care. “We’ve been building moneymakers and investing billions and billions of dollars in high-dollar cancer treatment centers and eye hospitals and other specialties. But we have communities right up the street that are a food desert and lack adequate transportation. The community has been collateral damage.”

If state and federal policymakers, along with health care payers, wish to reverse these trends and create transformative change, they will need to pursue new strategies to impede and roll back consolidation in the health care industry and the power of dominant hospital systems. The successful litigation against Sutter Health may offer a useful guide.

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Rob Waters is an award-winning journalist, researcher, editorial consultant and author who focuses on health, mental health, and health policy. He is a contributing writer for *Health Affairs* and for the California Health Care Foundation blog. In recent years, he has written for Kaiser Health News, STAT, EdSource, the *Atlantic* and many other publications.

Waters was West Coast health, science and biotechnology reporter for Bloomberg News, covering science and business news in the pharmaceutical and health care industries. He also has worked as a staff writer at Time Inc. Health, assigning editor at WebMD, contributing editor at *Psychotherapy Networker* magazine and editor of the *Tenderloin Times*, a four-language San Francisco community newspaper.

Waters' articles have also appeared in *Politico*, Bloomberg BusinessWeek, San Francisco magazine, the *San Francisco Chronicle*, *Pew Trust* magazine, the *Washington Post*, the *Los Angeles Times*, Salon.com, and numerous other outlets. He co-authored *From Boys to Men*, published in 2004 by Simon & Schuster. Among other honors, his 2005 Mother Jones investigation, "Medicating Amanda," won the Casey Award for magazine writing and he was awarded fellowships by the Rosalyn Carter Fellowships for Mental Health Journalism and the University of Maryland Journalism Fellowships in Child and Family Policy. He is a member of the San Francisco Writers Grotto.



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