

Hospital Dominance: A Growing Problem?

TWO HIGH-PROFILE SETTLEMENTS INVOLVING HUGE HOSPITAL SYSTEMS RAISE CONCERN ABOUT EFFORTS TO CURTAIL ANTICOMPETITIVE PRACTICES, SPOTLIGHT NEED FOR BETTER DUE DILIGENCE

Written By Bruce Shutan

From President Trump and foot soldiers in his administration to at least two state attorneys general, government officials have tried to rein in dominant hospital systems whose business practices raise antitrust concerns. A related worry is balance billing, aka “surprise” bills, which have drawn ire in countless conversations from kitchen tables to boardrooms across the nation.

While two high-profile court cases at the state level have put behemoths on notice from coast to coast within the past two years, critics warn that multimillion-dollar settlements have done nothing to move the needle on these systemic issues. Industry leaders, meanwhile, implore the self-insured community to pursue any number of increasingly popular strategies to avoid price gouging, improve health outcomes and ultimately lower costs.

HIGH CONCENTRATION OF PROVIDERS



Suzanne Delbanco

More than half of the nation's major metropolitan areas are highly concentrated in terms of providers, reports Suzanne Delbanco, Ph.D., executive director of Catalyst for Payment Reform. There's also a lot of consolidation among third-party administrators (TPAs), which she says means "there's only so many choices."

A growing body of evidence suggests that hospital industry consolidation "almost always leads to higher prices and very rarely improves quality, and may in fact lead to worse quality, which impacts the total cost of care," she observes.

The number of primary care physicians and specialists acquired by hospitals in the U.S. nearly doubled between 2010 and 2018 to where nearly half of all physician practices are now owned by a hospital. So said Richard Scheffler, a health economics and public policy professor at the University of California, Berkeley's graduate school, during a lively panel discussion on health care market concentration at SIIA's 2019 national conference in San Francisco.

FROM ATRIUM TO SUTTER

Sutter Health, Northern California's largest hospital chain, was poised for a court trial expected to last three months that would have been the latest litmus test for high-level antitrust scrutiny of health care market concentration at the state level.

While the nonprofit giant reached a tentative settlement to avoid damages of up to \$2.7 billion, details of which were still being worked out as this issue went to press, it faces a separate federal antitrust lawsuit tentatively slated for the spring. The hospital system, which reported \$13 billion in operating revenue in 2018, has 24 hospitals, 34 surgery centers, 5,500 physicians and 12,000 affiliated doctors across Northern California.

A 2014 civil suit initially filed on behalf of a health plan run by the United Food and Commercial Workers International Union & Employers Benefit Trust was later certified as a class action representing roughly 1,500 employer-funded health plans across California. The state's attorney general joined the lawsuit two years later.

A civil antitrust case involving another dominant industry player accused of anticompetitive practices was settled in 2018. One of the nation's largest nonprofit healthcare systems was prohibited from using so-called steering restrictions in contracts between commercial health insurers and its providers.

Atrium Health, North Carolina's largest healthcare system with more than 40 hospitals in the Carolinas, was sued for restricting access to information on the cost and quality of alternative health benefit plans that would help health care consumers seek better value. The hospital system reported \$11.1 billion net operating revenue in 2018, which included joint venture and affiliated enterprises.

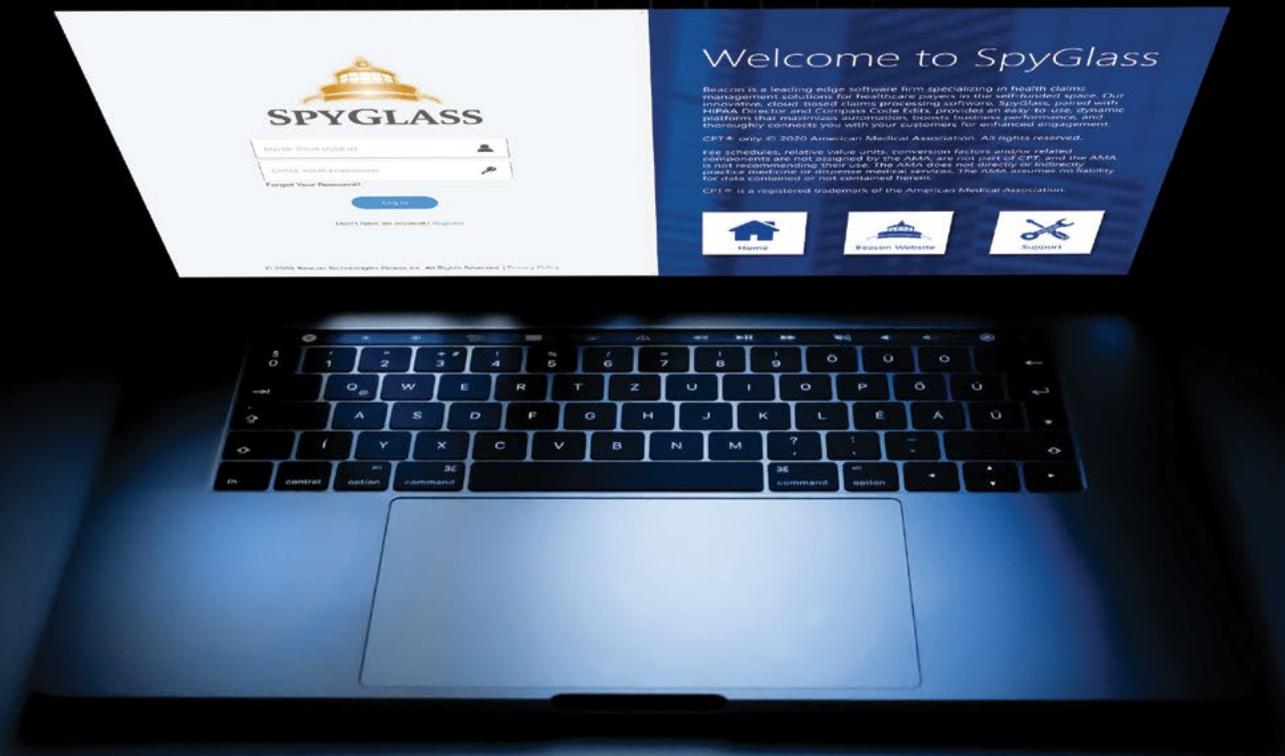


Jaime King

Jaime King, J.D., Ph.D., associate dean and professor of law at the UC Hastings College of the Law, describes the Sutter Health lawsuit as "a landmark case that could have brought to light a lot of the issues surrounding massive health systems in states and the strategies they use to increase prices." Once settlement details are announced, she predicts they will "end up being very important for setting the tone for other states and AGs about what kind of practices will be allowed in those contracts going forward."

Sutter Health has a reputation for highly aggressive pricing strategies – a practice that King believes other health systems watched and then mirrored. The chain also was one of the first players

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of its kind to aggressively acquire other entities to increase its market power.

Scheffler alluded to a recent study by the Nicholas C. Petris Center at the University of California-Berkeley about the impact of Sutter Health on health care prices in California. What the state-led court case suggests for self-insured employers is the importance of reviewing hospital pricing practices, Elizabeth Mitchell, CEO of the Pacific Business Group on Health, suggested in reaction to the high-profile court settlement. Her region pays 50% more on average for health care than in the Los Angeles metropolitan area.

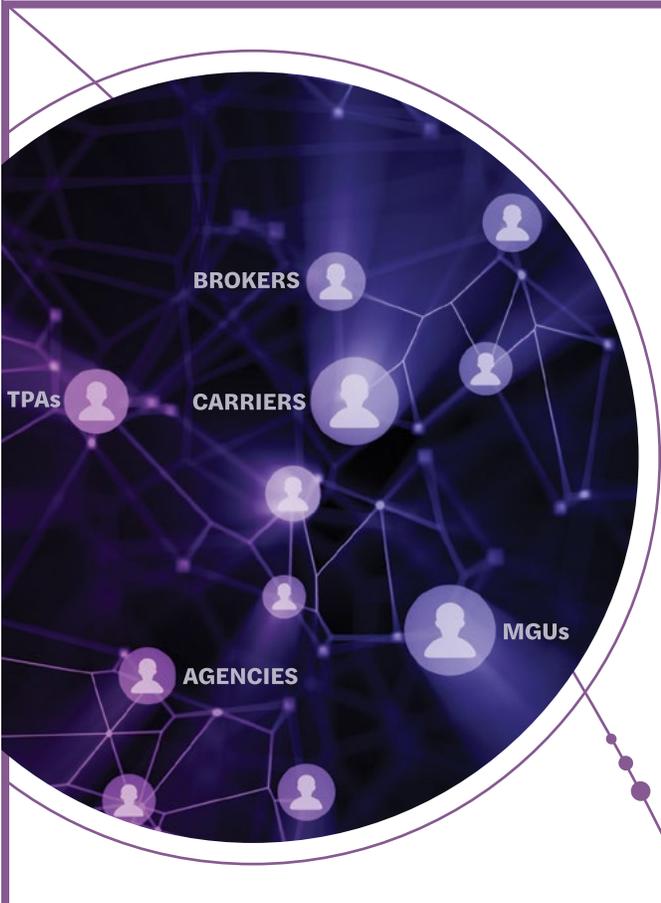
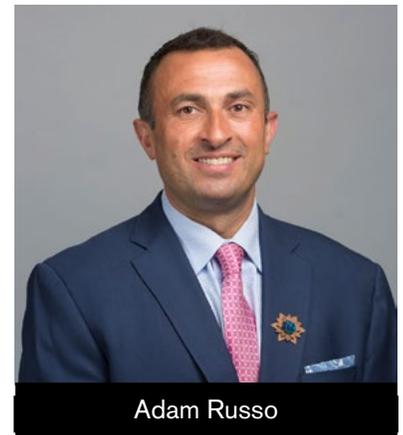
Knowledgeable observers agree that going to trial could have been a public relations nightmare for Sutter Health and that airing details in a courtroom is

almost always a slippery slope for all hospital operators. "There is story after story about hospitals bringing their prices down in the face of public shaming, or coming back to the table after walking away to negotiate for a better deal," King noted during SIIA's 2019 national conference.

Delbanco assumes all parties to the suit, including California Attorney General Xavier Becerra, received the remedies they were looking for. Although most of the Atrium settlement terms are under seal, King says what's known is that anticompetitive contract terms were not enforced and some amount of money was paid to North Carolina.

NO-FAULT SETTLEMENTS

But will these antitrust settlements actually change long-standing practices that have been the bane of existence for employers and the public at large? "There's no reason to think these practices won't continue," laments former SIIA Chairman Adam Russo, Esq., CEO of the Phia Group, LLC.



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He says the deals represent an ominous sign and will continue to hurt the self-insured industry, including employers, employees and their dependents, because they don't determine any liability. Russo even referenced a Sutter Health statement that explained its settlement was not an admission of wrongdoing.

Indeed, he says these actions are merely a slap on the wrist and that they won't produce any meaningful change in how nearly every major hospital system across the U.S. negotiates prices with self-funded employers, insurance companies and networks. When large facilities continue to gobble up smaller hospitals, specialty practices and physician groups, Russo says it tightens the screws on self-insured employers who are beholden to overpriced network contracts.

Recalling a 2009 whistleblower case involving a close friend, Russo notes how then-California Insurance Commissioner Dave Jones lauded a \$46 million settlement as a historic change in how facilities bill for anesthesia charges. But he says not much has changed since that deal, which was made to settle allegations that claims were triple billed. He describes most network contracts as not only anticompetitive, but also anti-democratic and anti-American.

DIRECTING CONTRACTING AND POOLED PURCHASING POWER

There are several steps employers and other purchasers of health care can take to combat anticompetitive practices. "The most immediate is to connect plan



members with providers who deliver the highest value," Delbanco says. Others include steering members into narrow or tiered networks, centers-of-excellence programs, reference-based pricing "or even just basic transparency around healthcare provider prices and quality," she adds.

However, these strategies aren't possible if a TPA has contractual agreements with hospitals that prevent employer clients from tiering or steering health plan members, or pursuing transparent practices that would be considered detrimental to the dominant, powerful health system, Delbanco cautions. She says they also would be undermined if high-priced health systems are allowed into a top-tier or narrow network where they don't belong.

Her organization provides employers with a model health plan with request-for-information and contractual language. "We think being thoughtful about the sourcing and contracting process is really critical," she observes.

As a result of hospital consolidation, Delbanco expects more direct contracting and carving out specific services and procedures with the help of third-party vendors, as well as engagement with alternative TPAs that use more precision in building provider networks. She also sees a rise in retail clinics and urgent care facilities, as well as onsite or near-site clinics that employers share, or even telehealth and more careful referrals to control utilization of overpriced services.

Reputation is also a factor in determining a hospital's market share or domination. Delbanco notes that this phenomenon is often seen with academic medical centers whose impressive reputation gives them clout.

The biggest lesson or takeaway of these high-profile antitrust cases is that “the more employers can band together, the stronger and better they will be in negotiating and getting their point across,” according to King, referencing smaller and midsize companies.

Examples include joining a local business group on health or coalition or captive insurance group. She says other winning strategies include setting reference-based prices, bundling services with crystal-clear pricing strategies and establishing onsite or near-site health clinics.

In the face of continued marketplace dominance, Russo says self-insured employers still have several options. They include direct contracting with the help of a TPA, joining a large network, regional narrow network or using no network at all. The trouble with large networks, he explains, is that it’s nearly impossible to avoid facilities owned by dominant chains that come with a much higher price point and lack transparency.

CAVEAT EMPTOR

If details of Sutter Health’s settlement end up favoring employees and employers alike, then King believes it “will demonstrate to major health systems the power that these unified employer groups can have, and that might give them much more leverage in contracting.”

But there also is an important caveat to consider. Since self-insured employers have long relied on third-party beneficiaries to negotiate in their best interest, she says these lawsuits demonstrate a need to pay closer attention to contractual details, hold those organizations more accountable for the services they provide and generally become more savvy health care purchasers.

“A lot of the contract terms that have been agreed to pretty systematically over the years may not be in the best interests of employers and consumers,” King cautions.

Many industry observers say it’s vital to carefully vet contracts with health care facilities because it makes good business sense and can produce better health outcomes, but there’s also another reason. Russo and others warn against a wave of litigation alleging a breach in fiduciary duties under ERISA if health plan assets are mismanaged, which mirrors a trend in the 401(k) arena.

What needs to change is the mindset among many employers that believe they cannot fix the health care system and, therefore, accept rising premiums, copays, deductibles and coinsurance, Russo opines. “They don’t realize that they can empower the plan to actually lower costs,” he says. His own firm ended out-of-pocket costs for employees starting January 1, 2020, setting an example that employer clients may well follow. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.



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