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The California Competitive Model: How Has It Fared, And What's Next?

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ABSTRACT **California became very successful in controlling rising health care costs by promoting price competition through market-based, managed care policies. However, recent data reveal that the state has not been able sustain its initial success in controlling growth in hospital prices. Two powerful trends emerged in California that eroded the conditions needed to sustain price competition. To ensure timely access to emergency hospital services, government regulators enacted regulations that had the unintended effect of giving hospitals tremendous leverage when contracting with health plans. Also, antitrust authorities allowed hospitals to consolidate into multihospital systems by adding members that were not direct competitors in local markets. The combined effect of these policies and consolidation trends was a substantial reduction in the competitiveness of provider markets in California, which reduced health plans' ability to leverage competitive provider markets and negotiate lower prices and other benefits for their members. Policy makers can and should act to restore competitive conditions.**

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Nearly two decades ago an article published in *Health Affairs* by some of the current authors reported that California had been very successful over the previous decade in controlling rising health care costs by promoting price competition through market-based managed care policies.[1] California was the earliest US adopter of such a model for controlling rising health care costs.[2] In the summer of 1982 the California State Legislature passed what turned out to be groundbreaking legislation that spurred national growth in managed care plans and the use of selective contracting by commercial health plans to leverage competitive market conditions and keep prices low. Subsequent research showed that this new model was working well in California and other states where managed care and selective contracting had taken hold.[3–9] We concluded our 1996 article[1] with a challenge to policy makers to promote and support competitive provider markets, and we underscored the importance of stimulating price competition to control rising health care prices.

Since we made that recommendation, more recent data have revealed that California has not been able to sustain its initial success in controlling hospital spending. Based on data reported to the state, prices paid by commercial health plans to California hospitals declined consistently from 1995 to 1999, for a cumulative reduction of 26 percent. However, beginning in 2001 hospital prices in the state began a sustained and rapid rise: Between 2001 and 2016 hospitals' revenue from commercial health plans grew from $13.2 billion to $40.2 billion, despite a 10 percent decline in total volume of care for commercially insured patients over the same period—resulting in a 238 percent increase in prices.[10]

Comparing California to the rest of the nation paints a similar picture. In 1998 hospital prices to commercial payers in California (measured as a percentage of Medicare prices) matched the national average.[11,12] However, by 2012 hospital prices in California were well above the national Medicare average (203 percent versus 175 percent of Medicare prices).[11,12]

In this article we present data covering the past twenty-five-plus years to focus on some key market developments and governmental policies during that period that undermined the effectiveness of California's competitive, managed care–based model. We conclude that health policy in California did not keep pace with changes in the hospital market, resulting in an erosion of the competitive structure of the market needed to sustain and support a model that relies on competitive forces for controlling health spending.

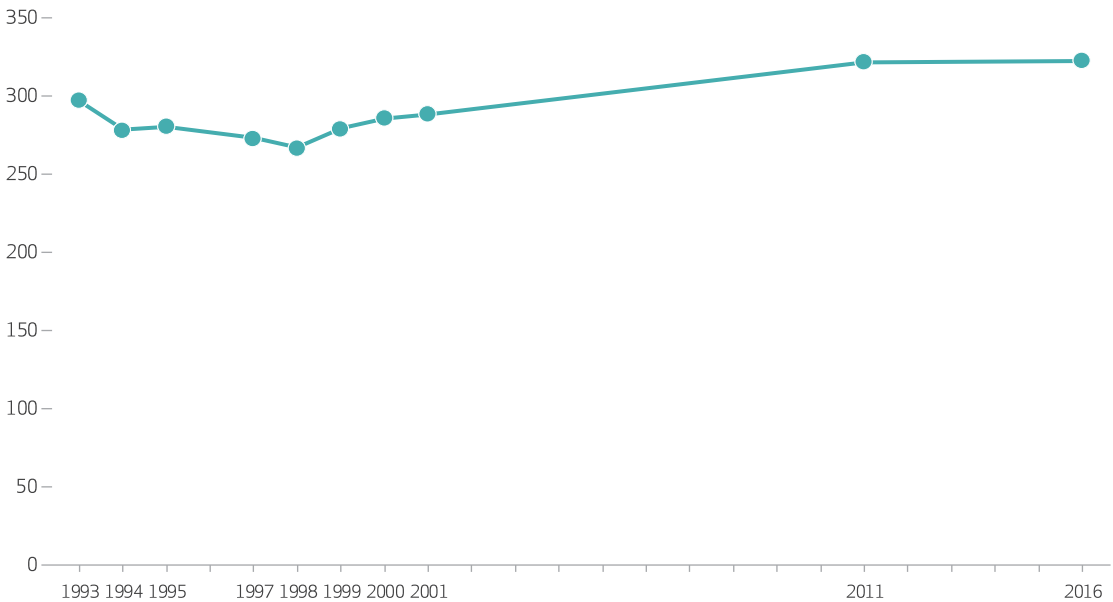
'Managed Care Backlash' Affects Emergency Care And Hospital Billed Charges

As managed care plans in California and the rest of the country became more aggressive in managing utilization and limiting prices through selectively contracting for narrower "preferred" provider networks, a so-called managed care backlash emerged across the country.[13–16] Patients and employers expressed concern that managed care plans had gone too far in limiting access to needed care, especially emergency care. Governments responded by enacting regulations that made it more difficult for commercial health plans to exclude hospitals from their preferred networks. One such policy was adopting the "prudent layperson" rule for emergency care, which requires health plans to pay for their members' emergency services (both inpatient and outpatient) received from all providers, even those out of network.[17] California adopted a prudent layperson regulation in 1999, mandating that health plans instruct their members to go to the nearest emergency room (ER) in the case of a medical emergency, even if it is not on the health plan's contracted, preferred list, and requiring the health plan to pay for it.[18,19] To assess the effects of this rule change, we calculated ER visit rates per 1,000 population before and after the change in 1999 (see the online appendix for data and variable construction).[20] Before 1999 ER visit rates were declining (exhibit 1). In the period after 1999 we found an increase in the rate of hospital ER use in California. This trend continued even before the expansion of health insurance coverage related to the Affordable Care Act (ACA) in 2014.

Along with the increase in ER visit rates came increases in patients admitted as hospital inpatients through the ER (exhibit 2). Those in-

EXHIBIT 1

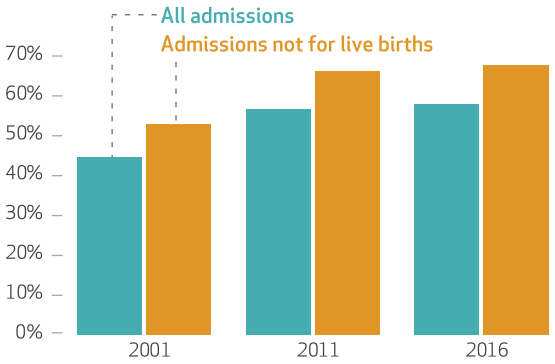
Emergency room visits per 1,000 people in California before and after implementation of a prudent layperson regulation, selected years 1993–2016



SOURCE Authors' analysis of hospital financial disclosure pivot data for 1993–2016 from California's Office of Statewide Health Planning and Development. **NOTE** California enacted a prudent layperson rule for emergency care (explained in the text) in 1999.

EXHIBIT 2

Percentages of inpatients admitted via hospital emergency rooms in California, with and without admissions for live births, selected years 2001–16



SOURCE Authors' analysis of hospital annual utilization data for 2001, 2011, and 2016 from California's Office of Statewide Health Planning and Development.

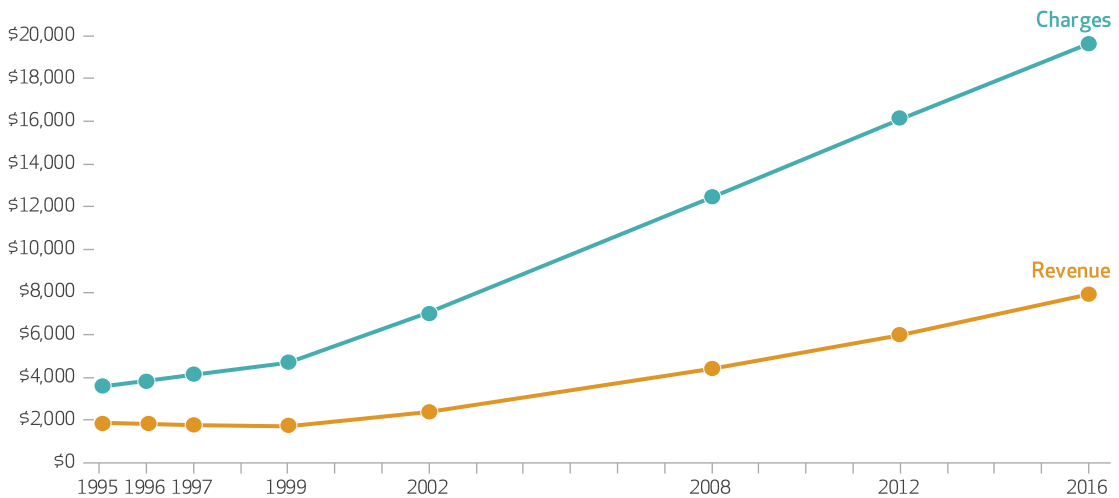
creases also followed the adoption of the prudent layperson rule and have continued over time: The number of ER-based admissions grew from 1.26 million in 1993 to 1.92 million in 2016, an increase of 52 percent—compared with a population increase of 25 percent, according to Annual Utilization Reports for selected years from the Office of Statewide Health Planning and Development.

These changes have proved valuable to hospitals since health plans must pay for all emergency visits, even when patients go to the nearest hospitals that have not signed a contract with a given health plan. The prudent layperson rule guarantees that hospitals will still receive a portion of all medical emergencies that occur in their local markets, even in the absence of a contract. Furthermore, they are permitted to submit bills to health plans at billed-charges rates. The specific proportion of medical emergencies treated at a given hospital without contracts depends on local emergency medical transportation routes and other local factors. Typically, emergency medical transport companies do not consider a patient's insurance coverage restrictions but instead follow local protocols based on travel time, medical necessity, and local hospital ER capacity.

Simultaneous with enactment of a prudent layperson rule in California and the acceleration of ER use, hospitals began substantially raising their billed charges, and they have continued to do so throughout the period we examined (exhibit 3) (see the appendix for variable construction).[20] The enactment of the rule, along with differential payments tied to billed charges from Medicare and commercial health plans for patients with extremely long lengths-of-stay or high costs (so-called outlier patients), provided hospitals with strong incentives to increase their billed charges, without any market constraints on the amount of increase. Before 1999 billed charges grew relatively slowly, from $3,590 per day in 1995 to $4,675 in 1999 (an increase of 30 percent). By 2002, however, billed charges per day had increased to $7,071 (an increase of 51 percent from 1999). This inflationary trend has continued and accelerated, with billed

EXHIBIT 3

Hospitals' net revenue and billed charges for commercial payers per day in California, selected years 1995–2016



SOURCE Authors' analysis of hospital financial disclosure pivot data for 1995–2016 from California's Office of Statewide Health Planning and Development. **NOTE** Billed charges and net revenue were adjusted for outpatient volume.

charges per day reaching $19, 649 in 2016 (an increase of 178 percent since 2002). Exhibit 3 also shows average amounts paid to hospitals by health plans, calculated as net revenue per day. Before 1999 that amount trended downward, from $1,851 in 1995 to $1,713 in 1999, and then it began trending upward. This is consistent with the robust price competition among hospitals in the early period and reduced competition in the later period.

Hospitals Respond To Price Competition By Consolidating Into Hospital Systems

Health care providers reacted to the introduction of managed care price competition in several stages. Initially, as reported in our earlier article,[7] managed care enrollment grew rapidly, and providers were forced to compete for managed care contracts based on price (for the first time) and other factors. This contributed to a slowdown in health care spending in California.[2,7,21] However, competition based on price presents real difficulties for hospitals as it imposes market forces that require constant efforts to manage and control costs while delivering acceptable levels of quality and service.California hospitals soon began seeking ways to lessen competitive pressure. One of their first responses to intense price competition was consolidation, which included a combination of hospitals exiting the market, mergers or acquisitions, and the expansion of multihospital systems. Based on data reported to California's Office of Statewide Health Planning and Development, between 1995 and 2016 the number of acute hospitals in California declined nearly 20 percent (from 345 to 282, including new hospitals entering the market and existing hospitals closing), while at the same time the proportion of hospitals (and beds) in multihospital systems increased substantially (from 39 percent to almost 60 percent).

Reducing the number of hospitals and increasing consolidation into systems can affect the degree of competition hospitals face in their local markets. To examine this, we computed Herfindahl-Hirschman Indexes (HHIs) for each hospital and averaged across all hospitals over time. A standard measure of local market competition, the HHI ranges from 0 (perfect competition) to 1 (a monopoly market); see the appendix for more details.[20] Average HHIs grew from 0.24 in 1995 to 0.30 in 2001 and then remained stable until 2016. This early change followed by stabilization indicates that consolidation, mergers, and expansions of multihospital systems that involved local competitors happened early in the period and that continuing expansion of multihospital systems likely focused on adding hospitals in different geographic markets (which would not affect HHIs). The expansion of hospital systems by adding hospitals beyond local geographic markets is important, since antitrust regulators historically have not intervened in this type of consolidation.

Hospital Systems Can Employ Anticompetitive Contracting Practices To Gain Market Power And Raise Prices

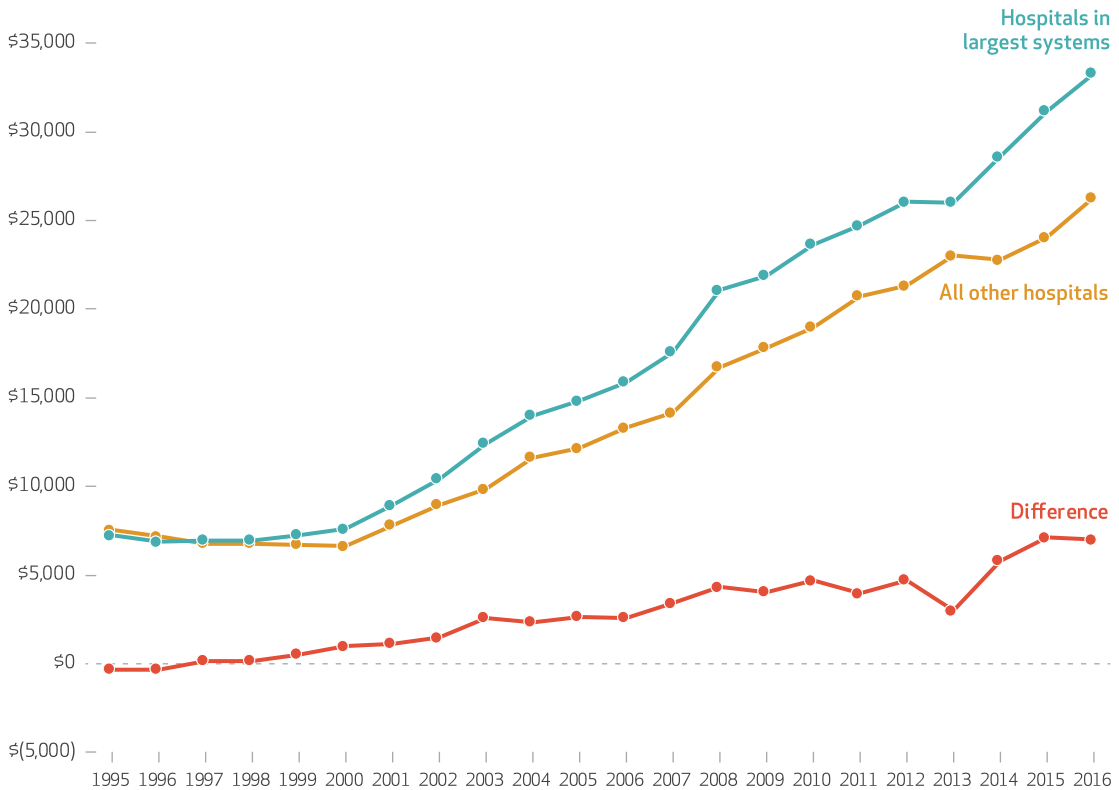
As hospital systems have grown in number and size in California, they have developed strategies to enhance their leverage when contracting with health plans. One reported strategy is to link, when possible, all system-member hospitals into a single bloc for contracting purposes and to demand contracts with commercial health plans that include all system hospitals (an approach known as systemwide, or all-or-none, contracting), even when particular member hospitals would otherwise be excluded because they had higher prices or lower quality than other alternatives in their local markets.

To illustrate the potential impact of all-or-none contracting by systems, we examined price trends in 1995–2016 in the two largest multihospital systems compared with trends in other California hospitals. According to reporting by news media in California, these two systems employ all-or-none contracting practices—threatening to pull all of their member hospitals out of a health plan's network when contract negotiations break down.[22,23] These news reports suggest that both systems adopted this practice at about the same time, and recently filed court documents allege that one of the systems implemented all-or-none contracting practices in the early 2000s, "insisting that all contract negotiations for any of its providers be conducted on a system-wide basis."[24]

Exhibit 4 shows that the average price per admission (adjusted for differences in hospital case-mix and cost of labor and outpatient volume) for hospitals in the two largest systems was about the same as the average price at all other hospitals in California at the beginning of the period (see the appendix for price construction).[20] While prices in both groups grew substantially over time, prices at hospitals that were members of these two systems increased more rapidly, compared to prices at other California hospitals. By 2016 the average adjusted price per admission in large-system hospitals was almost $7,000 higher than that in all other California hospitals. It should be noted that this widening price difference was not related to differential

EXHIBIT 4

Adjusted average prices per admission at hospitals in the two largest systems and at all other hospitals in California, 1995–2016



SOURCE Authors' analysis of hospital financial disclosure pivot data for 1995–2016 from California's Office of Statewide Health Planning and Development. **NOTE** Prices were adjusted for differences in hospital case-mix, cost of labor, and outpatient volume.

changes in either patient severity (case-mix) or local wage rates (Centers for Medicare and Medicaid Services wage indexes), as these effects were adjusted for in the price measure in exhibit 4.

In addition, because there are other factors beyond hospital system membership that may affect hospital prices, we conducted a sensitivity test using a statistical model (see the appendix)[20] that contained thirty-nine factors, including local market competition; payer mix; and eighteen measures of the availability of specialized hospital services, technology, satisfaction, and quality. The test generated adjusted differences between large-system hospitals and all other California hospitals that were of similar magnitude. That finding indicates that the higher prices observed in the data for large-system hospitals (a difference of $6,985 in 2016) cannot be not explained by differences in other factors (that we can measure).

This is important because hospital systems often defend their need to accumulate market power and charge higher prices to offset the effects of other factors, including the need to cross-subsidize Medicare and Medicaid patients and rural hospitals in their systems or pay higher wages in their local markets. All of these factors, along with measures of quality and the availability of specialized services, were included in the sensitivity test model, and they did not substantially reduce the higher prices observed in the largest systems by the end of the period.

Failure Of Policy To Keep Markets Competitive Derails The California Model

Research has shown that health care prices are consistently lower in markets where there are more competing hospitals for health plans to contract with.[25] An essential element of the price competition model is health plans' ability to exclude high-price or low-quality hospitals from preferred provider contracted status, which could result in lost volume, revenue, and net income for excluded hospitals. However, as shown by the data above, developments in California eroded these conditions needed to sustain price competition.

In an attempt to ensure timely access to emergency hospital services, regulators in California and across the country enacted rules that had the unintended effect of giving hospitals tremendous leverage in contract negotiations with health plans. Prudent layperson rules enabled hospitals to continue receiving ER patients even if the hospitals did not have a contract with those patients' health plans, weakening health plans' bargaining power with the hospitals. Regulators in California also enacted minimum geographic access rules and limitations on transferring health plan members from one provider to another when a hospital threatened to withdraw from a plan's network.

Simultaneously, hospitals began substantially raising their billed charges and applied them to ER patients not covered by a health plan contract. The result was that hospitals gained a guaranteed flow of local patients with a medical emergency for whom they could charge above-market prices. This makes it much more expensive for a health plan to exclude a hospital from its preferred contracted network, and during contract negotiations it weakens any threat of selective hospital exclusion and strengthens potential all-or-none contract demands from hospital systems.

At the same time, government antitrust authorities allowed hospitals, with little regulatory intervention, to form multihospital systems and expand them by adding members that were not direct competitors in local markets. Hospitals join systems for a variety of reasons: Systems offer the potential to improve quality and efficiency, but they also may accumulate market power that can restrain contractual freedom, resulting in higher prices and other anticompetitive outcomes. Additionally, it has been reported[26] that once systems are able to demand all-or-none contracts, they add other anticompetitive language to contracts to protect or expand their market power. Similarly, we have seen hospital systems acquiring medical groups and other services, which can further enhance market power and raise prices for other services.

The combined effect of these policies and consolidation trends was a sustained and substantial reduction in the competitiveness of provider markets in California. This resulted in a significant loss in health plans' ability to negotiate lower prices and other benefits for their members. The outcome has been sustained increases in health care spending in California.

Our data provide a quantitative example of the impact on prices when systems accumulate enough leverage to impose anticompetitive demands on health plans. The data show that the price per adjusted admission of the two largest systems in California grew faster than those of other hospitals (in 2016 the average price at the system hospitals was27 percent higher than the average price at other hospitals).

Policy Implications

The California experiment has not sustained its initial success, but there might still be the opportunity to change course. Our data provide important lessons for policy makers in California and other states. Markets are dynamic, so the competitive conditions needed by health plans to generate price competition increasingly need to be understood, monitored, and protected.

It is not clear where needed changes will come from. Legislation was introduced in California (SB-538) in 2016 to limit anticompetitive provisions by hospital systems in contracts with health plans. SB-538 sought to level the playing field in health care contracting by preventing dominant provider systems from engaging in five coercive and unfair practices: requiring all-or-none contract terms; forcing employers to be bound by undisclosed terms of a hospital-plan contract; mandating that payers bring antitrust claims on terms that are exceedingly favorable to the dominant provider group; requiring that a health plan provide coverage to its enrollees at the same level of cost sharing regardless of underlying value; and requiring that rates be kept secret from parties that are or will become liable for payment. This proposed bill was withdrawn on June 27, 2018, without explanation.[27]

There are two ongoing private class-action antitrust lawsuits (one certified) that challenge all-or-none and other contracting practices as unlawfully anticompetitive.[28,29] The California Office of the Attorney General recently filed a lawsuit alleging anticompetitive conduct by one of California's largest hospital systems and is seeking to join the existing class-action cases.[30] The attorney general's complaint outlines a broad range of anticompetitive behaviors that are used to drive up prices—including the use of all-or-none contracting; gag clauses that do not disclose prices; and other contract provisions that hinder competition, such as limiting a health plan's ability to create products with incentives for members to use more cost-effective providers (so-called anti-tiering language).[31]

Policy makers across the country can and should learn from California. The wave of hospital consolidation happened earlier in California, but other states are catching up.[32–35] States could enact a variety of policy changes to restore, maintain, and protect competitive forces in their markets.

Antitrust regulators at the state and federal levels could expand their scope beyond transactions within local markets to oversee consolidation involving multihospital systems that span broader geographic markets. This is important because, as has been seen in California, much consolidation has involved hospitals that are in different markets.

Policy makers should also consider new approaches to limit the use of prudent layperson rules by providers to undermine competition. The California State Legislature has adopted rules limiting the use of out-of-network prices for some hospital-based physicians. Similar regulation could also cover hospital-based emergency care to limit monopoly pricing for out-of-network emergency care. Some states have limited hospitals' ability to collect full billed charges for out-of-network emergency patients, but this approach often ends up relying on the courts to interpret broad regulatory language. It increases both uncertainty and the costs of challenging full billed charges by health plans. Some states allow providers to balance-bill patients for the difference between full billed charges and amounts collected from the patient's health plan.[36] This does not solve the problem of monopoly pricing of emergency services but just shifts more of the costs to the patient. One state, Maryland, offers a potential model, as it has the most administratively simple and comprehensive approach: limiting health plan payments to a fixed percentage of what Medicare pays without balance billing patients.[36] A more market-based approach could tie prices for out-of-network emergency care to negotiated, contracted prices for the same services in local markets.

Health insurance premiums in the United States for a family of four cost nearly $27,000 in 2017, and they continue to grow much faster than general inflation.[37] A growing body of research shows that rising provider prices are the driving force behind rising premiums.[38] This article has identified two sets of policy changes that could help restore competitive conditions to health care markets and immediately slow the growth in prices. First, the formation of integrated delivery systems needs to be supported, yet these consolidated entities must be prevented from accumulating market power that can affect prices, quality, and service levels.Second, access to needed emergency care should continue to be assured, while at the same time regulations are needed to limit prices when there is no contract in place. ■

NOTES

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11 Hospital prices were calculated by the authors (based on hospitals' financial disclosure reports filed with OSHPD) as the ratio of the commercial payer paid-to-charge ratio divided by the Medicare paid-to-charge ratio. This price measure adjusts for hospital case-mix, Medicare wage index, and differences in hospital charges for the same service.
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medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist."

20 To access the appendix, click on the Details tab of the article online.

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24 The documents state: "Shortly after its Alta Bates–Summit market expansion in 2000, Sutter began bundling together and using the leverage of the market power of its various affiliated hospitals, medical groups, and other providers, insisting that all contract negotiations for any of its providers be conducted on a system-wide basis with a single termination date for all of its providers." See People of the State of California ex rel. Xavier Becerra, Plaintiff, v. Sutter Health, Defendant, Superior Court of the State of California for the City and County of San Francisco, CGC-18-565398.

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26 See People of the State of California ex rel. Xavier Becerra, Plaintiff, v. Sutter Health, Defendant (note 24).

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28 UFCW & Employers Benefit Trust, Plaintiff and Respondent, v. Sutter Health et al., Defendants and Appellants. Superior Court of the State of California for the City and County of San Francisco,CGC-14-538451).

29 Djeneba Sidibe and Diane Dewey et al., Plaintiffs, v. Sutter Health and Does 1 through 25, inclusive, Defendants, District Court, Northern District of California, San Francisco Division, C 12-04854 LB.

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