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Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition

Contracts with insurers allow hospitals to hide prices from consumers, add fees and discourage use of less-expensive rivals.

By Anna Wilde Mathews Sept. 18, 2018

Last year, Cigna Corp. and the New York hospital system Northwell Health discussed developing an insurance plan that would offer low-cost coverage by excluding some other health-care providers, according to people with knowledge of the matter. It never happened.

The problem was a separate contract between Cigna and NewYork-Presbyterian, the powerful hospital operator that is a Northwell rival. Cigna couldn't find a way to work around restrictive language that blocked it from selling any plans that didn't include NewYork-Presbyterian, according to the people.

Dominant hospital systems use an array of secret contract terms to protect their turf and block efforts to curb health-care costs. As part of these deals, hospitals can demand insurers include them in every plan and discourage use of less-expensive rivals. Other terms allow hospitals to mask prices from consumers, limit audits of claims, add extra fees and block efforts to exclude health-care providers based on quality or cost.

The Wall Street Journal has identified dozens of contracts with terms that limit how insurers design plans, involving operators such as Johns Hopkins Medicine in Maryland, the 10-hospital OhioHealth system and Aurora Health Care, a major system in the Milwaukee market. National hospital operator HCA Healthcare Inc. also has restrictions in insurer contracts in certain markets.

The U.S. spends more per capita on health care than any other developed nation and will soon spend close to 20% of its GDP on health. Americans aren't buying more health care overall than other countries. What they are buying is increasingly expensive. Among the factors driving spending is the opaque way the price of health care is set, a problem exacerbated by the hidden details in agreements between insurers and health-care providers.

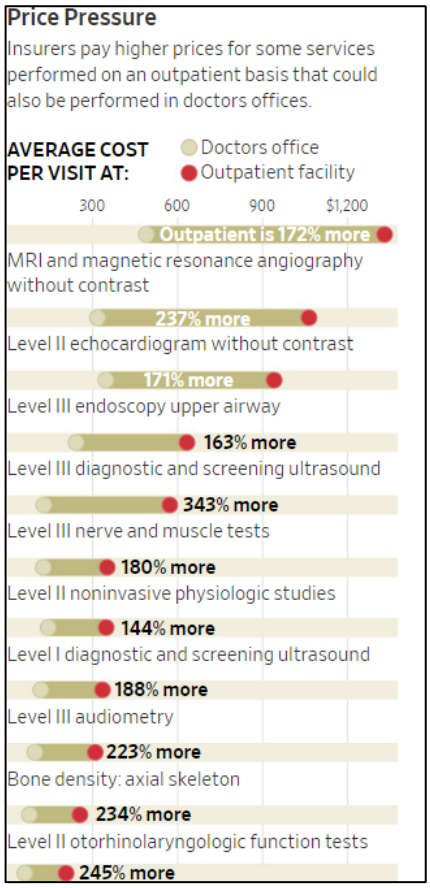
"No hospital system should be able to exercise market power to demand contract agreements that prevent more competitively priced networks," said Cigna's chief medical officer, Alan Muney, in a written statement provided by the company.

A health plan that excludes a costly system can be more than 10% less expensive for consumers and employers, according to insurance-industry officials. A plan that includes all providers but steers patients away from the costlier ones can save 3% to 7% or more, these people said.

Restrictive hospital-insurer contracts have helped prevent even big employers, including Walmart Inc. and Home Depot Inc., from moving forward with plans they were exploring to try to lower costs and improve quality for their workers.

Price Pressure

Insurers pay higher prices for some services performed on an outpatient basis that could also be performed in doctor's offices.



Note: Medical services listed were identified by the Medicare Payment Advisory Commission as frequently performed in doctor's offices but also offered on an outpatient basis. Prices are for 2016.
Source: John Hargraves and Julie Reiff of the Health Care Cost Institute

A Northwell spokesman said "negotiations and other conversations with our insurers are confidential." Aurora, which is now part of a larger system called Advocate Aurora Health, said in a statement from Carrie Nelson, a vice president, that it approaches "all of our contracts through the same lens that guides all of our clinical and operational decisions: what will ensure the highest quality of care at the lowest cost for our patients." HCA said it "provides patient access to health care in a variety of settings and contracts with health-care payers for all of its services and sites of care in the communities it serves."

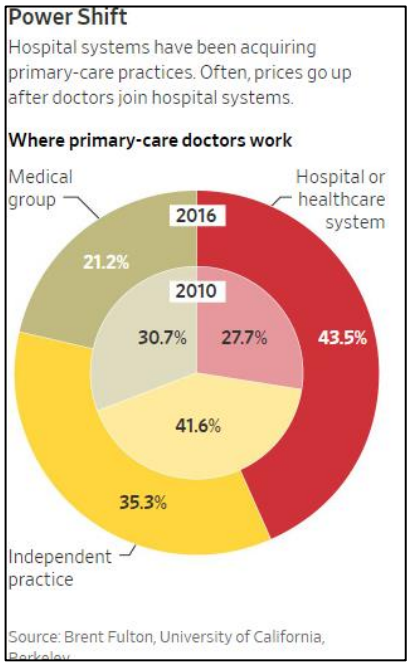
NewYork-Presbyterian, Johns Hopkins and OhioHealth declined to comment on their contracts. Hospital-industry officials said patients should be able to choose their health-care provider without financial pressure from their insurers or employers. Insurers are focused on their bottom lines, not necessarily the best care for patients, they said. "Allowing the patient to make the best decisions for

them and their family and their health is the central goal," said Matt Gove, chief consumer officer at Piedmont Healthcare, a large system in the Atlanta area.

This article is based on dozens of interviews with current and former health-insurance executives, employer executives, hospital officials, researchers and other experts.

Certain hospital systems are able to command advantageous terms because they have grown through years of deal-making, shifting the balance of power between hospitals and insurers. In 2010, the year the Affordable Care Act passed, the annual number of hospital mergers shot up 40% to 59, and the number of deals has remained above 60 every year since, according to Irving Levin Associates, a research firm that tracks health-care transactions.

About 77% of Americans living in metropolitan areas are in hospital markets considered highly concentrated, ranging from Modesto, Calif., to Trenton, N.J., according to a Wall Street Journal analysis of 2016 data from researchers at the University of California, Berkeley. The analysis excluded areas with more than three million people, which economists believe are too large to be considered single markets.



Hospital systems have been acquiring primary-care practices. Often, prices go up after doctors join hospital systems.
Source: Brent Fulton, University of California, Berkeley

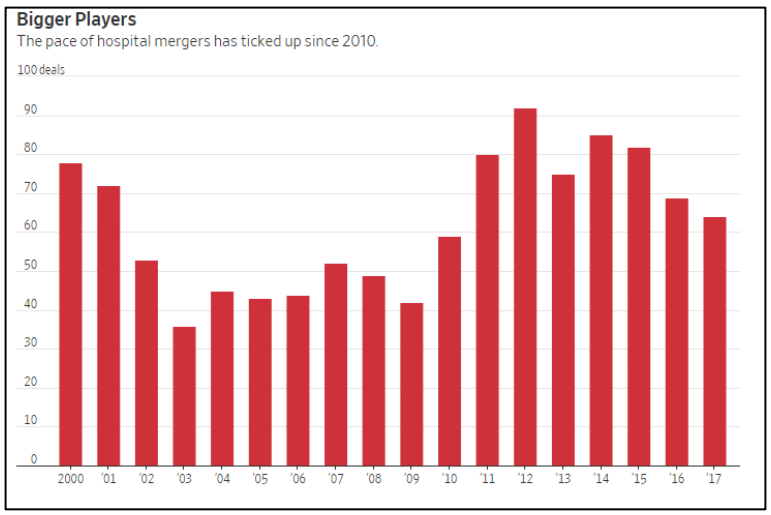
"If you're the single hospital system in an area, you essentially can set your price, because you're a monopoly," said Patrick Conway, the chief executive of Blue Cross and Blue Shield of North Carolina. "We literally have to have them in network." Even in a region with more than one hospital system, "if they are the dominant player in part of the geography, they can charge higher rates," Mr. Conway said.

Hospital care is the largest single component of health-care spending in the U.S. It accounts for more than $1 trillion a year—roughly three times what is spent annually on prescription drugs, the third-largest category. The second largest is physician and clinical services, many of which are now provided by hospital systems as well.

Hospital prices grew at about three times the rate of economywide inflation between 1960 and 2016, according to data from the Centers for Medicare and Medicaid Services and Altarum, a nonprofit health systems research and consulting group in Ann Arbor, Mich.

"The marketplace is just not working," said Gerard Anderson, a health-care economist at Johns Hopkins University. Insurers that must negotiate reimbursement with health-care providers for plans offered by employers pay roughly 50% more than Medicare on average, he said, and those rising costs are "the main culprit for why the U.S. spends so much on health care."

Hospital-industry officials said that hospital-system consolidation hasn't driven higher costs, pointing to an industry-funded analysis that said revenue per admission dropped at hospitals that were acquired, compared to non-merging hospitals, a finding that contradicted other studies. "It's the insurers that retain the greatest leverage," said Melinda Hatton, general counsel of the American Hospital Association. The hospital association also said that hospitals must rely on private-insurer payments to sustain themselves, because they lose money on uninsured patients and those covered by government programs. Ms. Hatton said hospitals' mergers aim to reduce expenses and improve quality and efficiency.



The effect of contracts between hospital systems and insurers can be difficult to see directly because negotiations are secret. The contract details, including pricing, typically aren't disclosed even to insurers' clients—the employers and consumers who ultimately bear the cost.

Among the secret restrictions are so-called anti-steering clauses that prevent insurers from steering patients to less-expensive or higher-quality health-care providers. In some cases, they block the insurer from creating plans that cut out the system, or ones that include only some of the system's hospitals or doctors. They also hinder plans that offer incentives such as lower copays for patients to use less-expensive or higher-quality health-care providers. The restrictive contracts sometimes require that every facility and doctor in the contracting hospital system be placed in the most favorable category, with the lowest out-of-pocket charges for patients—regardless of whether they meet the qualifications.

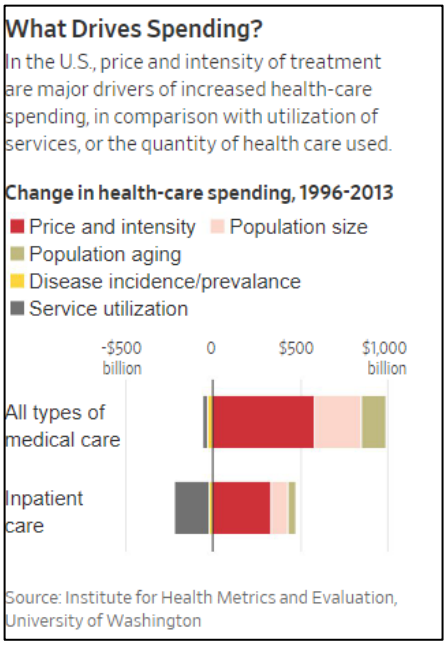
The restrictions in some hospitals' contracts mean "you must always include them," said Chet Burrell, former chief executive of CareFirst BlueCross BlueShield, which offers coverage in Maryland and the D.C. area. "If their costs are 50% higher for the same service, you have to include them. That cost is directly built into premiums…in the end the buyer of the service pays that."

Hospital systems with restrictive language in their contracts can also protect their position by limiting rivals' ability to draw patients based on lower prices, insurance executives said.

In some cases, contract clauses prevent patients from seeing a hospital's prices by allowing a hospital operator to block the information from online shopping tools that insurers offer. Because of such restrictions, some health-insurance enrollees can't find prices for hospital systems, including BJC HealthCare in St. Louis and NewYork-Presbyterian.

The gaps frustrate consumers such as Bob McKitrick, a teacher who lives near St. Louis and has insurance with a $5,400 family deductible. Mr. McKitrick checks prices carefully before getting care, he said, and he finds them for most providers. The website for his insurer, UnitedHealthcare, a unit of UnitedHealth Group Inc., doesn't include information about hospitals owned by BJC, the parent of the well-known Barnes-Jewish Hospital and 14 others.

"How can we keep costs down if we can't even get an estimate for care?" he said. "If you're buying a car, they don't say, 'with this one, you won't know how much it costs until you check out.' "
J.C. McWilliams, a vice president at BJC, said insurers' tools sometimes offer inaccurate information and generally give a narrow picture that doesn't reflect the total cost of care. Patients can get cost estimates from BJC directly, he said.



Hospital systems have also been snapping up other types of providers, including doctor practices, clinics and outpatient surgery centers, and raising these providers' prices. A study published in April in the Journal of Health Economics found that doctors' prices increased on average by 14.1% after they became part of hospital systems.

In many cases, insurer-hospital contracts allow hospitals to move these new acquisitions immediately to the hospitals' reimbursement rates—which are typically far more generous for the same services. That leads to a fast markup in prices.

In addition, hospitals often receive extra charges, known as "facility fees," that are supposed to cover the extra costs associated with care given in a hospital setting, including regulatory and safety standards that apply to hospitals. Hospitals can often impose these fees after they acquire an off-site clinic or office.

"It's just paying more for the same services," said Mark Weinstein, chief executive of the Independent Colleges and Universities Benefits Association, which provides health coverage for employees at 27 schools in Florida. Last year, the group heard complaints from employees about unexpected extra fees for visits to doctors owned by hospitals, he said. Ultimately, the group began paying the extra cost itself, to spare workers. "Our leverage is little," he said.

American Hospital Association executive vice president Thomas Nickels said facility fees, which are also paid by Medicare, are needed to cover the extra costs that hospitals must shoulder, including treating any patient who needs care. "We have far more regulatory requirements, legal requirements, facility and structural requirements" than other providers, he said.

The Justice Department is suing Atrium Health, a system with huge market share in the Charlotte, N.C., area, arguing that the hospital operator "uses its market power to impede insurers from negotiating lower prices with its competitors and offering lower-premium plans." The California attorney general is suing Sutter Health, a 24-hospital operator in Northern California, citing anticompetitive practices.

Atrium Health said it "has neither violated any law nor deviated from accepted health-care industry practices for contracting and negotiation." Sutter said "the California Attorney General's lawsuit gets the facts wrong and mischaracterizes how Sutter Health serves patients and communities."

Insurer Anthem Inc.'s agreement with NewYork-Presbyterian restricts its ability to exclude the hospital system, which includes the prestigious Columbia University Irving Medical Center and Weill Cornell Medical Center, from its health plans. To help win the New York area business of the Health Transformation Alliance, an employer group, Anthem partnered with a small company called Brighton Health Plan Solutions, which had its own plans that don't include NewYork-Presbyterian. Simeon Schindelman, chief executive of Brighton, said the company is "very open to strategic alliances that help us bring lower cost, better quality health care to even more families." Anthem declined to comment on its contracts.

Companies have been thwarted from developing new plans for workers. A few years ago, officials at Home Depot asked Anthem, which administered its coverage, to create a plan for employees around the country with a more-limited network of health-care providers. The retailer wanted to include only hospitals and doctors with the lowest costs and highest-quality care.

The insurer turned down its client's request, and a major reason was restrictive contracts with hospital systems. A spokeswoman for Home Depot confirmed the account of the situation and declined to comment further.

Officials at Walmart a few years ago asked the insurers that administered its coverage—Aetna Inc., UnitedHealthcare and Arkansas Blue Cross and Blue Shield—if the nation's largest private employer could remove from its health-care networks the 5% of providers with the worst quality performance. The insurers told the giant retailer their contracts with certain health-care providers didn't allow them to filter out specific doctors or hospitals, even based solely on quality measures.

A spokesman for Walmart confirmed the company had explored such an approach. Aetna, UnitedHealthcare and Arkansas Blue Cross and Blue Shield declined to comment.

Stuart Piltch, chief executive of Cambridge Advisory Group, a health-care consulting and data firm, approached Anthem and UnitedHealthcare a few years ago on behalf of an employer in the Milwaukee region. The employer was considering a network that would let employees pay less out of their pockets if they chose doctors and hospitals selected based on quality and cost for particular types of care.

The insurers said they couldn't deploy such a plan "due to their contracts with the dominant player, which is Aurora," Mr. Piltch said, so the employer wasn't able to move forward. "The free market has been distorted in an unhealthy way," he said.
Advocate Aurora Health's Dr. Nelson said in the statement, "We are relentless in our pursuit of high quality and low cost in tandem, not [as] an either/or proposition."

—*Melanie Evans contributed to this article.*
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