Health Care Prices Under Scrutiny

Late last month California Attorney General Xacier Becerra filed a lawsuit against Sutter Health, alleging that the health system is charging prices for hospital services that far exceed what the company would be able to charge in a competitive market. "It's time to hold healthcare corporations accountable and bring down illegally inflated healthcare costs that are imposed on California's families," Becerra said.

It is worth noting that the same thing may well be taking place in other markets across the country, including Oregon. In February, the *Network for Regional Healthcare Improvement* (NRHI), of which Oregon is member, released a study showing that while Oregon's health care utilization is lower than in the other regions, our average prices are 16% above the regional average for hospital inpatient services, 11% above the regional average for hospital outpatient services and 15% above the regional average for professional services.

Healthsight Oregon, a nonprofit, community-based organization dedicated to improving health and health care, summarized the NRHI findings this way: "High prices could be attributed to the influential negotiating power between providers and health plans; areas with a high degree of provider consolidation, or with limited competition, often have higher prices."

To the extent that Oregon's high prices are, in fact, due to aggregation and market leverage, the California lawsuit could have far-reaching implications for our efforts to transform the delivery system.

The solution lies in a system that rewards primary care for managing downstream services, thus changing incentives to move specialty and hospital care away from fee for service. This, coupled with a global budget and an integrated, coordinated delivery model accountable for outcomes and quality, can begin to get cost under control. Over the past five years, Oregon used mechanisms similar to these in its Coordinated Care Organizations (CCOs) to significantly slow the rate of medical inflation in the Medicaid program, while expanding enrollment and improving quality, outcomes and patient satisfaction.

The California lawsuit against Sutter is an early warning that excessively high prices generated through aggregation and market leverage are neither sustainable nor justifiable. It should be increasingly clear that these costs *will* be brought under control—the question is not *if*, but *how*. One path is through litigation and regulation; perhaps even a "commercial" fee schedule if providers do not do not take steps to be more accountable. (A case can be made that commercial health insurance is as much a "public good" as Medicare and Medicaid, since the ACA market is subsidized with public funds). The other—and, in my view, preferable—path is through a collaborative effort which engages providers who recognize that they have a stake in the problem and gives them some ownership in the solution.

The creation of the Oregon CCOs demonstrated the value of this kind of a collaborative approach. It is time to begin a serious dialog about how to extend some version of this model to Medicare and the private commercial market. A failure to act on this front will invite reactive regulation and litigation, which rarely produces good public policy. But unless providers *across all payers* begin to take the lead—assuming financial risk and accountability for quality and outcomes in a patient centered, coordinated model that operates in the context of a global budget—we can expect to see a lot more of what is currently taking place in California.