Hospital Consolidation Across Geographic Markets: Insights from Market Participants on Mechanisms for Price Increases

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Abstract

Context: Consolidation among health systems has resulted in increased prices and has caused the cost of employer-sponsored health benefits to increase much faster than inflation over the past few decades. Earlier quantitative research shows small but significant price increases resulting from transactions that expand the geographic footprint of health systems, but the mechanisms by which these cross-market acquisitions raise prices is not completely resolved.

Methods: In this qualitative study, the authors interview market participants to elucidate the experience of employers, insurers, and others when negotiating with large health systems.

Findings: The respondents report that employer demand for broad, stable provider networks and a lack of employer support for insurers when negotiating with large health systems undermined insurers' ability to negotiate lower prices. Additionally, the interviews identified the widespread use of restrictive contract terms by health systems and misaligned financial incentives between employers and consultants engaged to act on their behalf.

Conclusions: Without government action, employers will be unable to restrain price increases that result from increasing market power of consolidated health systems. The authors identify policy levers that regulators can use to increase competition, but the oligopolistic nature of many health care markets in the United States suggest that even more significant government action may be needed.

Keywords hospital consolidation, cross-market merger, employer-sponsored insurance, health care costs

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Decades of mergers among hospitals have resulted in large health systems that span multiple geographic markets (Gaynor 2021; Goldberg and Nash 2021; King 2021). Unlike earlier rounds of hospital merger activity that followed the rise of managed care in the 1990s and the financial incentives for coordinated care in the Affordable Care Act in the 2010s, many of the more recent mergers involved hospitals in geographic markets outside those of the acquiring health systems (Feyman and Hartley 2016; Fulton et al. 2022; Kocher 2016; NIHCMF 2020). For example, Advocate Aurora Health and Atrium Health completed their merger in December 2022, resulting in a health system with 67 hospitals across Wisconsin, Illinois, North Carolina, South Carolina, Georgia, and Alabama (Kacik 2022).

Numerous studies have shown that hospital consolidation within markets leads to price increases without consistent increases in quality, and that hospital systems that have vertically integrated with physicians are associated with higher hospital prices and spending (Baker, Bundorf, and Kesser 2014; Cooper et al. 2019; Harris et al. 2024; Liu et al. 2022). In addition, evidence is emerging that cross-market hospital mergers lead to higher prices, with the most recent study finding that higher prices did not lead to a commensurate increase in quality (Arnold et al. 2024; Beaulieu et al. 2020; Dafny, Ho, and Lee 2019; Lewis and Pflum 2017).

This project aims to inform state and federal antitrust enforcers, regulators, employers, and the public about how consolidated health systems may leverage a presence in multiple markets to increase prices (Schmitt 2018). Through a set of semistructured interviews, this research explores how employers with employees in multiple markets may be affected by cross-market mergers. We investigated how insurers and third-party administrators (TPAs) negotiate with health systems to form networks and set prices for health care services, and then how employers assess these options when choosing which plans to offer to their employees. Our results are consistent with previous literature describing how provider monopolies in health care exacerbate provider pricing problems (Havighurst and Richman 2010). This study adds to that knowledge base by providing firsthand accounts from experts in this industry that describe the challenges employers face, including (1) employer preferences for stable, broad networks even when that leads to higher prices, (2) the difficulties in obtaining relevant information to make informed, considered decisions about health insurance coverage, and (3) the fact that consultants hired by employers have financial interests that may not be aligned with those of the employer.

We conclude this report with a discussion of the policy implications of our findings and suggest that while employers may be able to better

leverage their bargaining power, market forces may prevent them from evaluating and purchasing cost-effective coverage for their employees. Consequently, we argue that government action is likely necessary to address underlying market inefficiencies, and we suggest multiple policy avenues that state and federal lawmakers may consider.

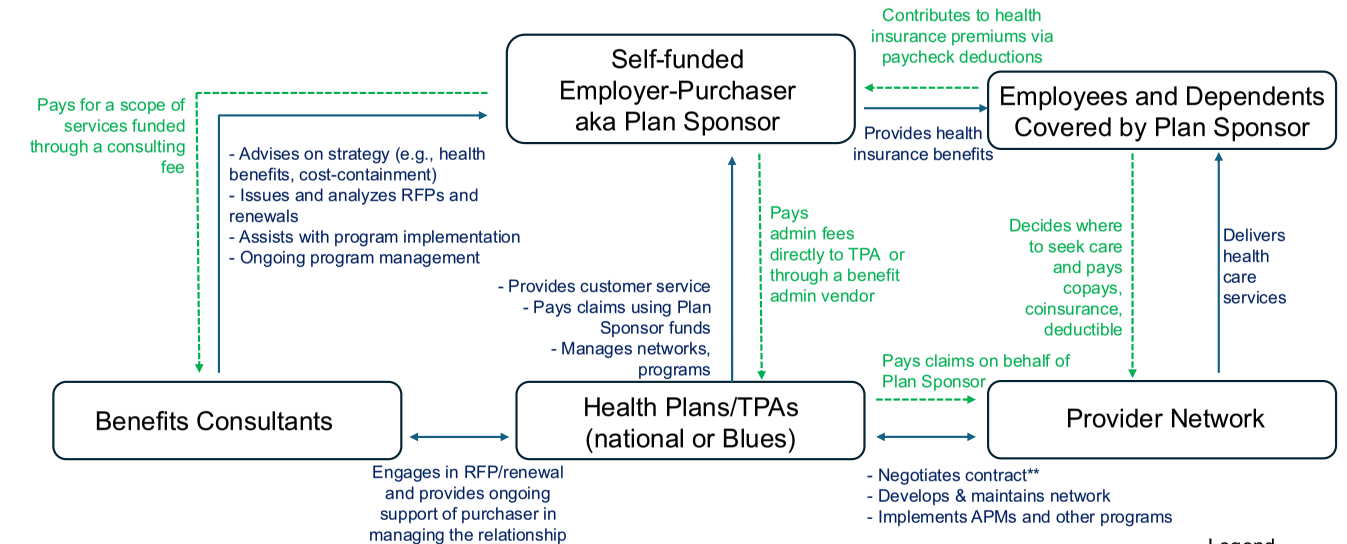
The Market for Private Health Insurance in the United States

Many types of entities, including insurers, TPAs, and benefit consultants, support the employers that provide health insurance benefits to nearly two thirds of Americans younger than age 65 (fig. 1) (Claxton, Rae, and Winger 2024; Pestaina, Wallace, and Long 2024).[1] Some employers, typically smaller employers, purchase an insurance policy offered by a health insurer. This "fully insured" approach means that the employer pays monthly premiums to the insurer for a standardized product, and the insurer bears the risk for all claims. Alternatively, most large employers, typically those with more than 100 employees, choose to "self-fund" or "self-insure," meaning that employers bear financial risk for their health plans, although it is common for such employers to purchase reinsurance to limit the risk. Self-funded employers typically use an administrative services only (ASO) contract with a TPA to manage employee enrollment and employee benefits, process claims, provide customer service, and manage a network of providers. TPAs, especially those serving large employers, are often separate divisions or business units of large health insurers.

In addition to TPAs, self-funded employers often engage benefits consultants to assist them in procuring health care benefits. Most, if not all, self-funded employers/purchasers who do not have in-house expertise use benefits consultants. Benefits consultants' roles typically involve comprehensive advisory services, including facilitating and interpreting responses to requests for proposals from health insurers, TPAs, and point solution vendors;[2] analyzing an employer's workforce demographics and providing actuarial support; designing innovative benefit solutions; strategizing how

1. Of the 164.7 million people covered by employer-sponsored insurance in March of 2023, 84.2 million had insurance from their own job, 73.8 million were covered as a dependent by someone within their household, and 6.7 million were covered as a dependent by someone outside their household (Claxton, Rae, and Winger 2024).

2. The term *point solution vendor* refers to a health care organization that offers a product or service to employers' and/or other health care purchasers' benefits programs that supplements a health plan/TPA product or addresses a gap that the health plan/TPA cannot fill. Examples of point solution vendors include but are not limited to care navigation support, disease management support (e.g., diabetes, cancer, weight management), and telehealth and other virtual benefits.



**There are more services between health plans/TPAs and provider networks than depicted in this flow chart.

Figure 1 Participants in the market for self-funded employer-sponsored insurance.

to contain costs; navigating regulatory compliance; and advising on upcoming industry trends. Theoretically, benefits consultants can improve competition among TPAs and insurers because they can assist employers in selecting the most appropriate plans; however, they may also offer products in which they have their own interests, such as pharmacy benefit products, or other programs that can compromise their objectivity for their self-funded clients.

Insurers negotiate prices for health care services, and insurers with large market shares (i.e., covered lives in both fully insured and ASO products) should theoretically be able to obtain lower prices from health systems. Research suggests that insurers with dominant market share may result in lower private-sector hospital prices (Scheffler and Arnold 2017; Trish and Herring 2015). However, any savings generated by lower prices may not be passed on to patients through lower premium payments because of the limited competition in most insurance markets.

Over the last 20 years, the health insurance market has consolidated, largely removing significant regional players. A study by Meiselbach and colleagues found that the number of employees covered by self-funded plans (as opposed to fully insured plans) has increased substantially in the past few years and that collectively, the five largest insurers—HCSC, Elevance, Cigna, CVS Health (formerly Aetna), and UnitedHealth Group—enrolled 71% of the self-funded employer-sponsored insurance (ESI) market in 2021 (Meiselbach, Marr, and Wang 2024). The researchers also found that between 2015 and 2021, the percentage of enrollees in self-funded plans grew significantly for both CVS Health and Elevance (from 68% to 81% for CVS Health and 62% to 76% for Elevance).

Over this time, commercial hospital prices have increased much faster than inflation and have outpaced prices for public payers, demonstrating significant insurer market power (CBO 2022; Moriya, Vogt, and Gaynor 2010; White and Whaley 2021). A few studies found that fully insured plans—those for which the insurer bears the financial risk—have lower hospital prices than ASO contracts, although part of the difference may be that networks in ASO plans tend to be larger than those for fully insured, often HMO-type plans (Craig, Ericson, and Starc 2021; Sen, Chang, and Hargraves 2023). Furthermore, TPAs are sometimes paid as a percentage of overall claims, and under these arrangements, the TPAs get paid more when hospital prices are higher (Jeng 1996).

In short, the financial incentives of TPAs may not always align with those of self-funded employers, and consolidation among insurers has left employers with restricted choices for health insurance. Furthermore, the lack of strong competitive forces in the insurance market leaves employers more susceptible to increased market power of health systems because

insurers, especially their affiliated TPAs, do not have strong financial incentives to negotiate lower price increases.

Methods

We conducted semistructured interviews with at least one representative of most of the types of organizations described above, including insurers, traditional TPAs affiliated with large insurers, alternative TPAs, benefits consultants, and labor unions.[3] A convenience sample of interview subjects was selected through extended networks of contacts from the individual authors. In total, we conducted 16 interviews with 20 interviewees. The interviewees included managers, executives, consultants, and actuaries, and their roles included network development and maintenance, contracting, negotiating with provider groups, price modeling, and designing employee benefit packages. Most of the interviewees had been working in network negotiations for more than 10 years. These interview subjects had senior executive status and were responsible for network negotiations across large regions of the country or consulting for very large clients, but two subjects that were employed by large employers were relatively early-career professionals. These interviewees were selected to give a perspective of current negotiation dynamics at the regional and individual hospital levels. We interviewed representatives from multiple benefits consultants and asked them to reflect on the broad experience of their employer and labor union clients. The authors also reached out to at least two different executives at each of the 10 largest health systems through email and social media. While no one currently working in these positions agreed to be interviewed, three of the interviewees were former health care providers: two physicians and one allied provider. All interviewees were assured that no personal or organizational identifiable information would be disclosed. To further protect anonymity, we the use the pronoun "she" for all interviewees. Some quotations were edited for clarity and brevity.

Study Limitations

The respondents in this study were selected for inclusion in the sample because they were known to the authors, were identified through other interviews, or were contacted directly as a result of their current employment. The responses may not be representative of the experience of

3. This study was reviewed by the Office for Protection of Human Subjects at the University of California, Berkeley, which determined that the study did not meet the threshold of research involving human subjects.

employees of other organizations or the industry generally. Furthermore, our sample of representatives of health systems was extremely limited; no current employee of a health system or former employee with significant contracting responsibility agreed to an interview. Additionally, potential interview subjects from all the large employers we contacted were unable to get approval from their legal or compliance departments, so no firsthand accounts from large employers are included in this study.

Results

We asked all interview subjects about their experiences with ESI, including their experiences negotiating contracts between insurers and health systems or their experiences advising employers in evaluating or choosing insurance products. The respondents described a market for self-funded health insurance in which employers experience a dearth of information and rely on advisors with incentives that did not always align with their own. In addition, other factors, including federal tax exclusions for contributions to health insurance premiums, and the fact that employees only pay for a portion of health insurance premiums, dampen the effect of hospital price increases on employee demand for health insurance (CBO 2024). The absence of critical information on price and dampened price effects lead employers and employees to demand very broad and stable provider networks.

Employers Demand Broad Hospital Networks That Inhibit Insurer Negotiations to Restrain Prices

One of the most consistent themes that emerged from our interviews was that employers demand broad, stable networks that made inclusion of as many hospitals as possible the primary goal for insurers when creating networks. Not surprisingly, the respondents reported that most hospitals and virtually all health systems were already in network in at least one line of business (e.g., fully-insured products, ASO contracts, or Medicare Advantage plans) for all large insurers. For example, a former employee of a large insurer with responsibility for contracting in New York, Connecticut, and New Jersey said, "In the tri-state area, we were contracted with every hospital and physician group, other than super specialist physicians like neurosurgeons or plastic surgeons."

A few respondents described how negotiations around removal of a hospital from a network would proceed, at least historically. For example,

one former employee of a large health insurer described the situation when she first started at the insurer, about 20 years ago:

> [The insurer] might instigate a divorce [with a hospital] because the contract we were operating under was just not competitively viable. The rates we were paying might have been out of line with what other payers were paying, and it made our insurance products not as competitively priced. So, if you're in a market with three hospital systems, you might be contracted with two of the three and switch which of them was in network to try to bring more of a competitive dynamic. That kind of thing happened around the early 2000s. As time went along, there was more and more pressure to have all the key hospitals in your network, and it was really a problem in most markets if you didn't.

She described how currently, the need to contract with all hospitals negatively affected the terms of the contracts, including rates and other terms and conditions, and she concluded: "Having as broad a network as you can is critical, because the benchmark competitor in most markets is the Blue Cross Blue Shield system, and their networks are very, very broad. Having a network that was materially different from them is not sustainable in most places."

In fact, contrary to the perception that insurers should push back on excessive rate increases by threatening to take a high-priced hospital out of their network entirely or out of some of their products, another interviewee from a large insurer who was in charge of negotiating networks in one region of the country explained that, in practice, the opposite was true—the threat to go out of network was a tool health systems used to demand higher rate increases: "The leverage any health system has in terms of the rate negotiations is their ability to go to termination because then the health system and the insurer have to send an 'Intent to Terminate' letter out to every enrollee who had been to that hospital or seen the providers within the last year. Insurers don't want to stir the pot."

The respondent then gave an example of a health system in her region that expanded over time through acquisitions, with the result that the insurer she worked for could no longer reasonably threaten to take the health system out of network in any negotiation: "At a certain point, I think it was like 2018, we couldn't even threaten to terminate them because they were so large. If we had terminated them, we would lose our ability to sell any lines of business in the state because of network adequacy requirements and employer demand. When they got to a certain size, then the health system pretty much had all the leverage, which was unfortunate."

Other interviewees echoed the difficulties with removing any hospital from a network, even if that meant acquiescing to large rate increases from health systems. For example, a current employee of a large insurer described how their sales department would get complaints directly from an employer every time the network negotiation team tried to remove or threaten to remove a hospital from their network, and very few employers were focused on prices:

> I'm not exaggerating when I say that any person who was dissatisfied was important to the employer. Imagine if you have a hospital where the contract lapses and your client has a number of employees in that locality. If that hospital is a key maternity provider, and even one of their employees or employee's wives is pregnant, I can't begin to tell you how much pressure there is to not allow that hospital contract to lapse.

Another former employee of a regional health insurer talked about a time in the early 2000s when a large health system in her region threatened to terminate their contract:

> I was at [regional health plan] when [large health system] delivered over 5,000 physician termination notices to us. At the time, we thought naively that the employers that told us to hold a hard line and to not let health care costs go up would support us. We were totally wrong. The employers basically said, "open enrollment is coming up, and if you don't resolve this, we're not including your [health plan] in our offerings." People want lower costs, but the HR people don't want employees complaining. Having last-minute contractual high jinks and having providers carved out of the network because they're just too fricking expensive is really hard to manage.

Finally, another respondent, a former employee of a different large insurer, described what happened with an employer client when that insurer faced termination with a health system in their network:

> [Large employer with a large, multistate account] is a great example. Yes, they cared a lot about price, but they really cared more about disruption, access, and customer service. We had a very difficult provider negotiation on the East Coast, and we were about to have a termination with a health system. It was right when [large employer] was renewing their contract with us, and they happened to have a whole lot of employees concentrated in that market. They were coming unglued. You can imagine the pressure that we were under to close that provider deal.

The respondent went on to explain that the insurer could not ignore the large employer's demand to have this provider in network without risking losing that employer's business across the entire country.

Every interviewee that had worked for an insurance company uniformly described the need to contract with essentially all hospitals. The conventional picture of an insurer negotiating with multiple hospitals in a market and choosing only the most cost-effective facilities to be in their managed care network was inconsistent with the respondents' experience in commercial ESI products. While employers are reasonably responding to employee pressure, the demand for broad networks undermines the incentive of insurers or TPAs to bargain aggressively with health systems, especially in markets with concentrated insurer markets. As a result, insurers only need prices that are slightly lower than their rivals to be competitive.

Employer Demand for Stable Coverage Also Inhibits Competition Among Insurers

In addition to describing employers' reluctance to support insurers in confrontations with health systems, respondents also reported that employers preferred to maintain the current health benefits and would consider changing carriers only if another carrier offered *significantly* better price or contract terms. Keeping a specific carrier over time ensures that employees, who are insulated from the full cost of insurance, remain satisfied and less likely to voice complaints.

An employee at a benefits consulting company explained that historically, large employers used different strategies to administer health care benefits, and those strategies seem to evolve over time.

> Twenty years ago, the strategy was [to choose the] best in class [carrier] for each market. And so large companies would have contracts with 20 different companies in 20 different markets. Maybe even more than that. [For example,] in Boston, they might have a contract with Tufts Health Plan, and a contract with Harvard Pilgrim,[4] and a contract with Blue Cross. And that's just in Boston alone. Things have moved on. Now most large employers have a single national carrier.

She went on to say that large employers typically have only one TPA administering health plans, and that most large employers stay with an existing TPA, even if they might get slightly lower prices by switching

4. Tufts Health Plan and Harvard Pilgrim Health Care now operate under the parent company Point 32 Health.

TPAs: "Quite frankly, there is a very heavy-duty status quo bias because it is a pain in the butt to be [changing] health plans. It is usually not 100% about the rates."

Similarly, a former employee of a midsized insurer said employers occasionally approached the insurer she worked for if prices seemed very high in one market, but those conversations were typically limited to only the largest employers with a strong interest in controlling health care costs.

> Some of the larger, more sophisticated clients absolutely got more granular in terms of saying, "Hey, we're really concerned about you guys in this market; you seem really out of whack compared to [our competitors]." I would say, though, that those conversations were restricted to the largest, most sophisticated employers that were working with big, resource-rich consulting houses. They were putting a lot of money into getting all the data and reporting and really understanding where their pricing is relative to where they think the market is. So yes, absolutely there are a few employers like that, but that's pretty restricted to big jumbo accounts that are multisite and have a pretty high degree of sophistication.

The large switching costs associated with changing a TPA are compounded by the consolidation in the insurance industry. Because the large insurers contract with nearly all hospitals and their primary goal is to maintain broad, stable networks to retain their current employer clients, insurers will likely acquiesce to rate increase demands from health systems if they believe their competitors will face similar increases. As the four largest insurers (the Blues, United, Cigna, and Aetna, sometimes referred to as the BUCAs) have near oligopolistic market shares in most regions, employers looking to control costs through innovative benefit designs or excluding high-priced facilities may have very few alternative options. For example, one interviewee who worked at a company designing innovative plans for self-funded employees said, "If you're an employer, it's very difficult to get out of the BUCA jail, because where do you go? What's your viable alternative outside of those four carriers? The employer is just stuck in the jail, and the jail has tightened over the past few years."

Health Systems Ubiquitously Use Restrictive Contract Terms to Thwart Competition

Many respondents also described how health systems demand provisions in their contracts that can prevent insurers, employers, and other entities

from developing benefit design incentives that steer patients to higher-value care. In addition to tying, in which a health system requires insurers that are contracting with a particular hospital in its system (the "tying" hospital) to also contract with another hospital in its system (the "tied" hospital), these restrictive contract terms may include: (1) antisteering clauses—a requirement that an insurer avoid steering patients away from any providers or facilities in the health system; (2) gag clauses—a prohibition on disclosing payment rates or other contract terms from employers or other entities not party to the contract; and (3) all-product clauses—a requirement that an insurer include the health system in all of the plans it offers. These contract terms may hamper competition within a market and may be even more harmful when used across multiple geographies to thwart competition in multiple markets. Many of the interviewees identified contracting practices as a very common way that health systems prevent insurers from controlling costs.

For example, an employee of a TPA-like organization described efforts to save money for employers by creating a network of physicians who are interested in controlling costs through better care management. That organization is not negotiating with hospitals because it sees trying to negotiate directly with the hospitals as a losing proposition.

> What is leading our strategy is to contract with independent primary and specialty care practices. That's because they are happy to do longitudinal care management and site of service differentials—all the things that you would want providers to do on your behalf if you're an employer actually trying to do something to control health care costs. [With hospitals], you're always on the losing end of the battle. If they don't get you on an inpatient [rates], they're going to get you on outpatient rates. Those patterns are incredibly clear, and hospitals are very conscious of how much revenue in total they need. . . . You're set up for failure from the moment you walk into that door. . . . Everything that you would want to do as a purchaser—better outpatient management, better ambulatory care—goes 100% against the grain of the revenue maximization of the hospitals and the health systems. There might be a few health systems out there who are enlightened and are completely changing or tend to change their business model over the next decade, but you can count them probably on one hand in the entire country."

Instead, this TPA-like company's strategy is to lease a network from a large insurer and use its own proprietary physician network to provide better care at lower cost for self-funded employers. However, this interviewee noted that even though one insurer was willing to rent its network to this

TPA-like company, the existing contracts between that large insurer and health systems contain terms that prohibit the insurer from steering patients away from that system.

> I think [restrictive contract provisions] are a problem for [the large insurer]. They've told us they don't know if they can lease their network if what we're going to do is actively steer patients. We have to answer a whole bunch of questions about, is it steering, is it the benefit design, is it the employer's decision around the benefit design, et cetera? The covenants—gag clauses and antisteerage clauses—are supposed to be illegal, but I can absolutely tell you that as of January 2024, they exist, and they continue to exist in carrier contracts. The more a health system spreads itself out across the country, the more it can impose those terms and conditions on a national carrier.

Many other respondents described similar requirements in different regions of the country. Specifically, the former employee overseeing contracting in New York, Connecticut, and New Jersey for a large insurer said simply, "There's a lot of antisteerage language in our contracts. Pretty much every contract we have is antisteerage." She described other contract provisions where health systems inhibited insurers' ability to control costs using medical management or benefit design. For example, she said, "[large health system] forced us to put in contract terms that we couldn't do any utilization or medical management on the front end. We had to approve every inpatient admission and every surgical procedure. At the end of each quarter, we would have the medical directors get together and look on a case-by-case basis, and then negotiate which ones are appropriate or not."

Many of the interviews described contracting practices, including antisteering and gag clauses, as a ubiquitous way that health systems restrict insurers that try to control costs through benefit designs that steer patients to higher-value, lower-cost providers. Health systems that expand into new markets or acquire physician practices can use these contract provisions in even more restrictive ways that drive up prices. Furthermore, the respondents suggested that insurers were sometimes willing to negotiate different contract restrictions for their self-funded and fully funded products in ways that harm self-funded employers.

Self-Insured Employers Are Particularly Hampered by Restrictive Contract Clauses

Most respondents with knowledge about the large insurer and TPA business reported that insurers were primarily concerned with cost-saving

benefit designs (such as smaller networks or the ability to steer patients to lower-cost providers) in their fully funded products and were willing to agree to restrictive contract provisions in their ASO products in exchange. One respondent put it very bluntly, saying, "Let me be really crystal clear on another point here because I think, generally speaking, the carriers don't give a sh*t about self-insured employers."

One interviewee described how restrictive antisteering contract provisions limited the ability of 32BJ, a large labor union in New York State, to try to control costs through their benefit design:

> In 2019, 32BJ began to tier their benefits and created tiers of preferred and nonpreferred hospital systems, based on price. When they did that in New York City, they had to negotiate the ability to tier their network and the hospitals within their network with their ASO carrier. And the reason was because Anthem had contracts with the New York Presbyterian System that deemed that certain hospital systems had to be preferred in any tiered network. They had to be a hospital you were steering to in any steerage program you had.

The interviewee described how 32BJ was successful in getting Anthem and the health system to allow them to create a tiered network, but the union was only allowed to put one of the hospitals in the health system, New York Presbyterian, in the nonpreferred tier. Any of the other hospitals in New York City had to be in a preferred tier because the contract between Anthem and the health system required it. The respondent said, "32BJ went to battle, and they won, they were able to tier the network," but the respondent noted that it was also a short-lived victory.

When the contract between Anthem and the health system was up for renewal, the health system said it would no longer allow the labor union to have an exemption from the antisteering provisions in its contract with Anthem. The respondent emphasized:

> I think this is the part that is really crucial to understand, because Anthem ultimately has to act in Anthem's best interest, which was not in the best interest of 32BJ as a self-funded purchaser. The fact that 32BJ is subject to contracts that they are not party to nor privy to is just a source of angst and the bane of our existence. . . . I think astute purchasers are starting to figure out that self-funded employers are paying all of the bills, and yet they are being held accountable to the contracts between the carriers and the provider systems. Generally, the self-funded groups, the employers, we're all losing.

In short, self-funded employers and labor unions have experienced the effects of restrictive contract provisions that hamper their ability to help their employees or members find the most cost-effective care. While a couple of our respondents described specific situations where they were hampered by these restrictive requirements, many more of the interviewees reported that they suspected these restrictions existed, but they did not know exactly which contracts had them or even what the restrictions were because the contracts between the health systems and the insurers were confidential. The only time the employers or labor unions learned of these restrictions was when the insurer, typically acting as their TPA, told them they could not implement a desired cost-saving mechanism or benefit design because it would violate terms of a contract that the employers had never reviewed.

The Entities Employers Rely On to Advise on Health Benefits May Have Misaligned Financial Motivations and Conflicts of Interest

In addition to the lack of transparency about contracts, employers typically do not have sufficient expertise or scale to efficiently manage health benefits in-house, so they outsource benefits administration and even selection of TPAs to consultants and other companies that offer point solutions, including direct contracting or value-based purchasing agreements. Some of these consultants—especially the large benefit consulting companies like Aon, Mercer, and WTW—provide consulting on a wide range of benefits such as retirement, disability, life, and comprehensive risk. As these consultants serve an array of customers, including health systems, the consultants may not be able to be a strong agent for an employer purchasing health care when evaluating options that would reduce profits for their other clients.

One current employee at a benefits consulting company expounded on the conflicts she faced when trying to determine what was driving increasing health care costs for their clients.

> The reasonable question to ask is, what the hell are employee benefits consultants doing about costs and consolidation? Like, what is my company doing to protect our clients from bad things that come from this? It's a mess. Because if you think about it, health care systems generally are second only to government [as the largest employer in a region]. For us, as employer benefits consultants, a lot of our big

> clients are actually the health care systems. Are we going to Capitol Hill and [arguing that the Federal Trade Commission (FTC)] should come down even harder than [former FTC commissioner] Lina Khan wants to on consolidation of health care systems? Probably not, because somebody at a level higher than me is going to say, well, we have to look and see what our clients say about this. And it turns out a lot of our clients are health systems, because hospitals tend to have pension plans. I don't work in the pension field at all, but companies like mine don't want to totally piss off the hospitals that are their clients because they [the health systems] do health benefits consulting with you, they do talent and reward consulting with you, they do pension consulting with you. We're not proper agents, I'm afraid.

In sum, the interviewees described a market where employer demand for broad, stable networks resulting from employee preferences led to significant price increases. Insurers had little incentive to engage in battles with health systems over price increases, especially with large health systems that could threaten commercially viable networks in multiple geographic markets. Large, multimarket health systems may also be able to impose excessive price increases through tying or other restrictive contract terms.

Discussion: Implications of Health System Consolidation Across Geographic Markets

While many of our findings may not be surprising, the interviews chronicled a market where the players all acted rationally and in their own best interest, but their actions collectively resulted in markets that make payers—particularly large, self-funded employers—vulnerable to price increases that result when a health system acquires a hospital in another market. All of these factors mute price signals for ESI, but the harms may be particularly problematic when insurers are negotiating contracts with large, multimarket health systems. Specifically, if the health system has a must-have facility in any market,[5] it may require an insurer to contract with other facilities owned by that health system as a condition of contracting with the must-have hospital. This ability to "tie" or condition

5. A must-have facility is one that an insurer needs to have in any commercially viable product sold in the region served by that facility. Must-have status can result from network adequacy requirements or because the facility's reputation is so strong that employers will only purchase products for which that facility is in-network.

the participation of a must-have facility with those in other geographic areas may allow the health system to extract surplus profits because of its presence in multiple regions. Furthermore, employers that do not operate in the region where the health system has a must-have hospital may be subject to these restrictive contracts if the health system is able to demand that an insurer include that facility in all of its products if it wants to include it in any of its products (e.g., demands an all-products clause).

As 32BJ's experience demonstrates, employers may even be constrained by contracts signed by their TPA to not steer away from the dominant system, and by the fact that the TPA may be contractually obligated to keep the terms of those agreements confidential from its employer and union clients. All of these factors mean that self-funded employers, who directly pay for price increases as a result of consolidation, may be most harmed by health system mergers across geographic markets. Contractual obligations and consultants with mixed financial incentives contribute to market realities that make it difficult for employers to obtain reliable price information; and even when they do, these factors make it nearly impossible for employers to demand lower prices from health systems.

Earlier research by Eisenberg and colleagues suggests that although self-funded employers have the financial incentive to negotiate lower prices, they lack market power to do so effectively (Eisenberg et al. 2021). Our primary research question was to discover if employers were making decisions that could unwittingly increase the potential harms from cross-market mergers. Our respondents uniformly described the employers' desire for broad, stable networks, even if that resulted in higher prices. Furthermore, insurers risk losing clients if they take a firm stance in negotiations with health systems, especially when the health system has hospitals in multiple metropolitan areas. Insurers know that if the health system demands similar increases from their competitors, they can accede to price increases from health systems without losing a disproportionate share of clients. In this way, a lack of competition leads to unrestrained prices when dominant health systems demand price increases from all insurers.

It seems easy to blame the employer desire for broad networks as a primary factor in giving multimarket hospital systems increased market power; but, importantly, employers are acting rationally and in their own best interest when they demand these broad networks. Employers offer ESI as an employment benefit to attract and retain high-quality employees, so maintaining coverage that employees value, especially to avoid complaints, is logically the employer's primary aim. Additionally, employees are shielded from the full cost of their insurance premiums because

employers pay, on average, about 75% of the premium (Claxton et al. 2024). As a result, employees bear the price effects of hospital mergers in the form of reduced wages, but these impacts are often not immediately transparent to them (Arnold and Whaley 2020). Even if employees prefer lower-cost insurance with a narrower network, there may not be consensus among employees on which providers or hospitals should be in the network. Finally, most individual employers lack market power to effectively negotiate lower provider prices and value-based incentive designs, and even those that have sufficient size are likely constrained by the contracts their TPA signs with the health system for other ESI contracts or lines of business.

Policy Considerations

The many barriers to employers acting as aggressive seekers of value in health care, coupled with highly consolidated hospital and insurer markets, means that government action is likely needed to either strengthen competitive forces or to restrain price growth directly through regulation. While a detailed analysis of regulatory interventions is beyond the scope of this article, our interviews identified three policy areas that merit consideration by state and federal lawmakers. This section outlines these areas and explores actions that policy makers could take to begin to address the concerns identified in our interviews.

A. Improved Merger Review, Especially of Nonhorizontal Mergers

The first step in addressing the harms that can result from mergers is to block mergers that are likely to drive health care costs higher and threaten health care access before they occur. Antitrust enforcement is the standard tool to prevent harmful consolidation. State and federal antitrust laws are designed to arrest anticompetitive tendencies in their incipiency and give enforcers the authority to block mergers that would "substantially lessen competition" or "tend to create a monopoly" (*Brown Shoe Co. Inc. v. United States*, 1962; *Saint Alphonsus Medical Center, et al. v. St. Luke's Health System, LTD, et al.* 2015; 15 U.S.C. §18).[6] In 2023, the FTC and the Department of Justice followed up on the Biden administration's call for

6. Most states have passed similarly worded merger statutes that sometimes deviate in small, but important ways; see Berenson and colleagues (2020).

reinvigorated antitrust enforcement by issuing a revised set of merger guidelines that replaced and combined the former horizontal and vertical merger guidelines (Gudiksen et al. 2021; White House 2023). These guidelines reflect the agencies' recognition that market conditions and economic analyses have evolved to allow the agencies to better analyze mergers beyond those that increase market share in a particular market. In particular, guideline 6 in the 2023 merger guidelines asserts that "mergers can violate the law when they entrench or extend a dominant position" (DOJ and FTC 2023). When applying this guideline, the agencies will evaluate whether a merger may extend the dominant position of an entity into new markets, allow the merged entity to entrench the dominant position through exclusionary conduct, weaken competitive constraints, or otherwise harm the competitive process, and whether the merged firm could leverage its position by tying, bundling, conditioning, or otherwise linking sales of two products.

Although the 2023 merger guidelines clearly demonstrate federal agencies' willingness to challenge mergers that include acquisitions of hospitals in new markets, divestiture of merged hospitals (i.e., "unscrambling the egg") is notoriously difficult, so enforcers need the ability to review transactions before they occur (Baer 1996). As one interview subject said:

> If I were the FTC, I would block every single physician practice purchased by a hospital or health system, period. I'd rather see all physicians be bought up by Optum than be bought up by local hospitals and health systems. That's the killer, because once they've done that, they control the flow of traffic, and you're stuck. The fewer independent practices there are . . . the more prices are going to increase for the employers in those communities. That is absolutely inevitable. Hospital consolidation has been allowed to be out of control for so long that barring the FTC coming in and doing a breakup à la AT&T a few generations ago, what can you do, right?

Some states have supplemented federal agencies' review by passing laws requiring transacting parties to notify the state attorney general or health department of proposed transactions, and some states have given the state attorney general or another agency the authority to block mergers that are not in the public interest (Fuse Brown and Gudiksen 2024). Enhanced merger review may not address existing market power, but antitrust enforcers should prevent future anticompetitive mergers or impose conditions on transactions that limit the way systems can use existing market power to increase prices at newly acquired hospitals (Montague et al. 2023).

B. Limiting the Use of Restrictive Contract Provisions

A second area of concern that our interviews identified as ripe for policy consideration is limiting or prohibiting restrictive contract provisions, such as all-or-nothing contracting requirements or antisteering and antitiering provisions (Gudiksen et al. 2020). The use of these contract clauses has been challenged in multiple lawsuits, and the cases that have been resolved were all settled on terms by which the health system agrees to not use these terms in contracts (*U.S. v. Charlotte-Mecklenburg* 2017; *FTC v. Advocate* 2016; *UFCW*, Complaint 2019; *People of the State of California ex rel Xaviar*, Complaint 2019; *UFCW*, Notice of Motion 2019). Importantly, antitrust lawsuits can be brought by private litigants for treble damages, so employers do not have to rely on actions by state or federal enforcers. For example, the cases against Sutter Health were originally brought by a group of individuals and businesses who were contracted with fully insured plans and a self-funded labor union, whose case was later joined by the California attorney general (*Sidibe et al. v. Sutter Health* 2013; *UFCW and Employers Benefit Trust v. Sutter Health* 2019). While vigilant antitrust enforcement can address the most egregious use of restrictive contract provisions by dominant health systems, the lawsuits can take years to reach a resolution and often fail to address industrywide contracting practices because any settlement terms or court decisions are likely to apply only to the defendant health system(s).

These limitations have led legislators to consider passing laws prohibiting the use of many restrictive provisions—including all-or-nothing, antitiering, and antisteering clauses—in contracts between insurers and health care providers. At the federal level, Congress has considered legislation in each of the last three sessions that would have banned these terms in health insurance contracts, but those bills have so far failed to pass (Bipartisan Primary Care and Health Workforce Act 2023; Healthy Competition for Better Care Act 2021; Lower Health Care Costs Act 2019). At the state level, legislators in Massachusetts, Connecticut, Nevada, and Texas passed laws banning antitiering and antisteering clauses, and two of those states (Connecticut and Nevada) also prohibit all-or-nothing clauses (SHPC n.d.).

Whether these laws effectively reduce health care cost growth or change negotiation dynamics has been difficult to assess. The laws in Connecticut, Nevada, and Texas have been in effect for fewer than two years, so it is too early to observe their impact on prices. The law in Massachusetts was passed more than a decade ago, but it was incorporated in a large package of health reform policies that also required all large insurers to

offer at least one narrow- or tiered-network plan in at least one geographic area in Massachusetts, so isolating the impact of the bans on antitiering and antisteering clauses is difficult. Nonetheless, since that law was passed, the proportion of insurance plans in Massachusetts with tiered networks has grown to 20%, although that percentage has stagnated in recent years (CHIA 2024). Economic analyses by Prager (2016) found that between 2009 and 2012, the presence of tiered networks in Massachusetts led to a moderate decrease in hospital spending (1%–8%) and had a beneficial effect on negotiated rates for hospital services (savings of 2%–4%), with a possible total savings from tiered networks of up to 12% under favorable market conditions. Based on this analysis, the Congressional Budget Office and the Joint Committee on Taxation estimated that a ban on antitiering and antisteering clauses in areas where there was a dominant but nonmonopolistic health care provider would decrease premiums by approximately 5% in those areas and that a nationwide ban on those clauses could reduce total employment-based health care expenditures by 0.05%, amounting to a savings of more than $500 million per year after the effects of the ban are fully realized (CBO 2019). Similarly, an analysis by Melnick and Fonkych (2024) found that the allegedly anticompetitive contracting practices used by Sutter Health, including all-or-nothing and antisteering clauses and excessive out-of-network pricing, led to a 30% increase in prices relative to a control group.

Because respondents in this study reported a widespread use of antisteering clauses and because economic analyses suggest that banning antitiering and antisteering clauses can generate significant savings for ESI plans, state policy makers and enforcers should consider actions to minimize the use of restrictive contract provisions. Furthermore, a ban on these restrictive contract clauses may limit the ability of health systems that span multiple geographic regions to tie those regions together when contracting and may limit the ability of the health system to extend market power from one market to other markets.

C. Disclosure of Conflicts of Interest, or Requiring Entities Acting on Behalf of Employers to Be Fiduciaries

Finally, our interviews uniformly reported that employers rely heavily on consultants and TPAs whose own financial interests may conflict with those of their employer clients. In particular, TPAs that serve jumbo employers in multiple markets are typically part of large, highly consolidated insurance companies that have an incentive to trade off savings in their fully insured

products (where the insurer bears the risk) with their self-funded products (where the employer bears the risk). The Consolidated Appropriations Act of 2021 (CAA) expanded the fiduciary responsibilities of employers who sponsor group health plans from those in the Employee Retirement Income Security Act of 1974 (ERISA) (DOL n.d.). Under the CAA, employers must demonstrate that the health care services they purchase are cost-effective and high quality, and that they align with mental health parity and pharmacy benefit requirements. Employers are also now required to ensure that any broker or consultant be transparent about their compensation, including commissions and fees paid, and that the compensation is "reasonable."[7]

Following the CAA's passage, an employee of Johnson and Johnson filed a class action lawsuit against her employer alleging that the company violated its fiduciary duty under ERISA by failing to ensure that prescription drug prices under their health benefit plans were reasonable (*Lewandowski v. Johnson and Johnson et al.* 2024). Consequently, *employers* may face liability for failing to meet their fiduciary responsibilities to make sure health care prices are reasonable; but our interviews found that employers routinely struggled to know whether their brokers or consultants were acting in their best interest. Additionally, respondents from TPAs and benefits consulting companies acknowledged that they had conflicts of interest and did not always act in complete alignment with the interests of their employer clients.

Some state and federal policy makers have considered additional policies or laws to help employers ensure that brokers, consultants, or other entities acting on their behalf to administer a group health plan are operating in alignment with their interests and those of their employees. For example, the Health Care Prices Revealed and Information to Consumers Explained (PRICE) Transparency Act, which was introduced in the 2023–24 session of Congress but has not yet passed, would require TPAs and pharmacy benefit managers to disclose all health care payment amounts to plan sponsors in a reasonable time, data that employers and labor unions have had to sue to obtain in the past (*Kraft Heinz v. Aetna* 2023; *Trustees of International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund et al. v. Elevance, Inc* 2022; *Massachusetts Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Mass.* 2023). Similarly, in 2025 the Indiana legislature passed S.B. 3, which will impose a fiduciary duty to the plan sponsor on any TPA, pharmacy benefit

7. See Division BB, Title II, Sec. 202, H.R.133—Consolidated Appropriations Act, 2021, https://www.congress.gov/bill/116th-congress/house-bill/133/text.

manager, or insurer acting on behalf of that plan sponsor beginning July 1, 2025 (Fiduciary Duty in Health Plan Administration 2025).

Lawmakers have a range of available policy options to require these entities to act on behalf of the employer, including (1) requiring contractors to disclose all potential conflicts of interest; (2) giving existing fiduciaries, such as an employer administering a self-funded plan, the ability to see and review any contracts signed on their behalf; and (3) requiring all TPAs or benefits consultants to be fiduciaries of the employer. Employers are being held legally responsible for effective administration of health care benefits, yet they are not able to obtain necessary information or have confidence that their consultants or TPAs are always acting in their best interest.

Conclusion

The primary finding of this qualitative study is how employer demand for broad provider networks limits insurers' ability to push back when negotiating contracts with dominant health systems. Paradoxically, some employers view these large, national health systems positively, seeing potential for improved value-based contracting, administrative simplification, and broad, stable provider networks in all markets where they have employees. Health systems and other market players may use gag clauses and intentionally obfuscate employers regarding these market dynamics. This lack of transparency, coupled with weak and sometimes conflicting financial incentives for TPAs and benefits consultants, means that without government action, dominant health systems will have minimal pricing constraints.

Even in the last decade, when the link between health system consolidation and price increases became well understood, antitrust enforcement has failed to protect competition among health systems. Unless enforcers seriously consider dismantling and breaking apart large, national health systems, antitrust law is unlikely to address provider market power. The policy options discussed in this article—improved merger review, prohibiting anticompetitive contract terms, and increasing fiduciary duties for benefit consultants and TPAs—may increase competition in markets where competitive forces still exist; but decades of mergers in both provider and insurer markets have left many areas approaching oligopoly and monopoly levels of consolidation. In those regions, the policy options discussed here are unlikely to meaningfully increase competition, and more significant government action is likely required to address unaffordable price increases. Moreover, many rural areas are natural monopolies for hospital care. In many cases, given the financial pressures on rural hospitals

from uninsured patients and low Medicaid payment rates, policy makers are more concerned with keeping hospitals open than with high prices paid by private insurers. In areas with dominant health systems, more robust government action and increased regulation, including a revision of tax treatment of employee health benefits and price caps, are likely necessary to counter underlying market failures.

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