HCAi
Department of Health Care Access and Information

OHCA
Office of Health Care Affordability
Department of Health Care Access and Information

An Investigative Study of Hospital Market Competition in Monterey County

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Abbreviations, Acronyms, and Definitions

Bay Area	As defined by the California Department of Public Health (CDPH),[1] but with Monterey excluded. Specifically, it includes the counties of San Francisco, Marin, Napa, Santa Cruz, Sonoma, Alameda, Santa Clara, San Mateo, Solano, Contra Costa, and San Benito.
CalPERS	California Public Employees' Retirement System
CHOMP	Community Hospital of the Monterey Peninsula (hospital owned by Montage Health)
CMS	Centers for Medicare & Medicaid Services
GAC	General acute care
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HPD	California's Health Care Payments Data
Montage	Montage Health
Natividad	Natividad Medical Center
NPR	Net patient revenue
SVH	Salinas Valley Health
SVHMC	Salinas Valley Health Medical Center (hospital owned by SVH)
WTP	Willingness to pay

[1] California Department of Public Health. (2024, July 1). *Regional Public Health Office*. https://www.cdph.ca.gov/Programs/RPHO

Executive Summary

A core statutory mandate for the Office of Health Care Affordability (OHCA) is to "monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity." The Director of the Department of Health Care Access and Information (HCAI), who oversees OHCA, is authorized to make investigations concerning "(a) All matters relating to the business activities and subjects under the jurisdiction of the department; . . . and (c)[s]uch other matters as may be provided by law."[2] Elizabeth Landsberg, the Director of HCAI, announced at the October 14, 2024 Health Care Affordability Board meeting an investigative study of hospital market competition in Monterey County. OHCA engaged health care economic experts, Arnold Analytics, LLC (Arnold Analytics) to assist OHCA in the investigative study and produce this report.[3] This report is the culmination of that study.

This report investigates the reasons behind the exceptionally high hospital prices in Monterey County, California, concluding that a significant and structural lack of market competition is the primary driver of these elevated prices, rather than higher operating costs or superior quality of care.

After adjusting for cost-of-living differences across states, RAND's most recent hospital price transparency study ranked California as having the sixth highest hospital prices in the United States. Being among the most expensive hospitals in California often means being among the most expensive nationally. Data reveal that commercial prices at Monterey County's three main hospitals—Community Hospital of the Monterey Peninsula (CHOMP), Natividad Medical Center, and Salinas Valley Health Medical Center (SVHMC)—significantly exceed state and regional benchmarks. New commercial price analyses conducted for this report show Monterey inpatient admission prices for the 10 most common admission types to be 31% above the Bay Area average and Monterey outpatient visit prices for 23 common procedures to be 47% above the Bay Area average. According to publicly available data, these high prices have resulted in consistently strong profits, with operating margins for CHOMP and SVHMC ranging from 10% to 22% between 2018 and 2023, far surpassing the statewide hospital average during that period of 0% to 4%. As evidenced by voluntary, confidential interviews[4], public comments, and local news coverage, the financial impact on the community is severe, depressing wages for workers and leading local unions to encourage members to travel out of the county for common procedures to avoid higher costs.

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[2] Cal. Health & Saf. Code, §127507, subd. (a) and Cal. Gov. Code, § 11180

[3] The Arnold Analytics Team, primary authors of this report, includes *Daniel R. Arnold, PhD*, Senior Research Scientist, Brown University School of Public Health, Affiliated Scholar, The Petris Center, University of California Berkeley; *Paul B. Ginsburg, PhD*, Professor of the Practice of Health Policy and Management, Sol Price School of Public Policy, University of Southern California, and Senior Scholar, USC Schaeffer Institute; *Katherine L. Gudiksen, PhD,* Executive Editor/Senior Health Policy Researcher, The Source on Healthcare Price and Competition, University of California College of the Law, San Francisco; and *Christopher M. Whaley, PhD*, Associate Professor, Department of Health Services, Policy and Practice, Brown University School of Public Health.

[4] All interviews referenced in this report were conducted confidentially by OHCA.

The investigation, conducted by the Office of Health Care Affordability and economic experts, Arnold Analytics, systematically rules out several potential alternative explanations for these prices. While wages for some hospital administrators are notably high, the report finds that overall operating and labor costs are not sufficient to explain the extreme price levels, particularly when compared to other Bay Area hospitals facing similar labor markets. Furthermore, higher prices are not necessarily associated with higher quality of care; federal data from the Centers for Medicare & Medicaid Services (CMS) shows that Monterey hospitals generally receive quality ratings that are similar to, not better than, their peers across the state. The report also considers "cost-shifting"—the idea of subsidizing underfunded public insurance programs with higher commercial rates—as a cause. This theory is generally rejected by economists, and it fails to explain the market's highest prices, as CHOMP's public payer mix is directly in line with the statewide average.

The evidence strongly indicates a market structure defined by a profound lack of competition, a conclusion corroborated by interviews with health plans. Insurers describe all three major hospitals as "must-haves" in their networks due to geographic isolation and network adequacy requirements, giving the hospitals immense negotiating leverage. This market power is amplified by significant physician consolidation, with the county's largest medical group aligned with the hospital systems, thereby controlling patient referrals. This dynamic is compounded by unfavorable contracting practices, such as the use of "percent of billed charges" contracts, which are less common in more competitive markets. The convergence of these factors has created an insulated market environment where high prices can be sustained, lacing a significant and ongoing financial burden on the families and employers of Monterey County.

The California Health Care Affordability Board has already set spending targets for hospitals statewide and lower targets for CHOMP and SVHMC, but there can be a significant time delay between the performance year and the time at which any performance improvement plans or penalties are imposed. This lag helps ensure data accuracy but also translates to a longer time horizon for price to trend downward. Two other policy options—Medicare-based price caps, and global budgets—are described at the end of the report. Each offers a different balance of strengths and limitations. Medicare-based price caps are more straightforward to monitor and can generate faster savings, but they do not give state policymakers much flexibility to make adjustments when the Medicare fee structure does not reflect the relative costs of providing certain services to the commercially insured population and require significant administrative oversight. Global budgets, by contrast, represent a more fundamental shift in payment away from fee-for-service to more value-based arrangements. Global budgets can stabilize hospital finances, incentivize efficiency, and give hospital leaders flexibility in managing costs, though they also require significant regulatory infrastructure and oversight to prevent unintended consequences. With each of these approaches, policymakers will need to weigh ease of implementation and near-term enforcement against the potential for longer-term structural reform that provides hospitals with both stability and incentives to deliver high-quality, cost-effective care.

About HCAI and OHCA

HCAI, formerly the Office of Statewide Health Planning and Development, was created in 1978 to provide the state with an enhanced understanding of the structure and function of its healthcare delivery systems. Since that time, HCAI's role has expanded to include delivery of services that promote equitable access to health care for all Californians.

HCAI is a leader in collecting data and disseminating information about California's healthcare infrastructure, promoting an equitably distributed healthcare workforce, and publishing valuable information about healthcare outcomes. HCAI also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's nonprofit healthcare facilities. HCAI works to improve affordability of health care costs including through spending targets and affordable generic drugs. These programmatic functions are advised by several boards and commissions.

HCAI serves as the building department for hospitals and skilled nursing facilities in California. Its primary goal is to promote patient safety by ensuring that each facility remains functional during a natural disaster.

HCAI collects, analyzes, and disseminates information about hospitals, skilled nursing facilities, clinics, and home health agencies, licensed within California. Examples of facility information include financial reports and claims data, service utilization data, and quality of care information.

Another HCAI program addressing healthcare costs is its Hospital Bill Complaint Program, which enforces the Hospital Fair Pricing Act. Under the Act, hospitals are required to have both discount payment and charity care policies to provide financial assistance to qualified patients. HCAI's Hospital Bill Complaint Program helps patients who have been wrongly denied financial assistance.

To promote a diverse and culturally competent workforce, HCAI analyzes California's healthcare infrastructure and workforce needs. HCAI provides direct grant funding to medical schools, nursing programs, and other healthcare training institutions. HCAI also offers scholarships and loan repayments to students and health professionals who agree to provide patient care in medically underserved areas. Scholarship and loan repayments are offered for allied health, nursing, behavioral health, physicians, dental, and other medical professions.

The California Health Facility Construction Loan Insurance Program (Cal-Mortgage Program) offers loan insurance to nonprofit and public health facilities to develop and expand healthcare services throughout California.

HCAI is also responsible for pharmaceutical policy and programs that aim to improve equitable access and affordability of medications in California by developing strategic partnerships and innovation policy solutions in the pharmaceutical sector. Strategic partnership activities include administering the CalRx program, which empowers the State of California to develop, produce,

and distribute generic drugs and sell them at low cost. This program has launched initiatives to both produce its own insulin and to leverage the State of California's purchasing power to buy naloxone at a reduced cost. Future work on the pharmaceutical sector will include data analysis, research, and policy recommendations.

Additionally, built on the principle that every Californian should have access to their health information, HCAI's Data Exchange Framework (DxF) is a statewide initiative aimed at improving the secure, real-time exchange of data among health and social services entities throughout California – giving providers a clear understanding of a patient's full health history and the information needed to provide timely, safe, and effective whole-person care while maintaining data privacy and security.

The Office of the Patient Advocate program rates health care organizations using health care performance measures based on the quality of medical care and patient experience. This program publishes other quality information, including consumer health care complaints.

OHCA Background

In enacting the California Health Care Quality and Affordability Act (Health and Safety Code, section 127500, *et seq.* (Act)), the Legislature recognized the health care affordability crisis for Californians struggling with continued and rapid growth in health care costs. The Act established OHCA as a core program within HCAI. OHCA has three primary responsibilities: (1) slow health care spending growth, (2) promote high-value health system performance, and (3) assess market consolidation that may impact market competition and consumer affordability. OHCA accomplishes these goals by collecting, analyzing, and publicly reporting data on total health care spending. OHCA also enforces spending targets that are established by the Health Care Affordability Board. While slowing spending growth, OHCA promotes high value health system performance by measuring quality, equity, adoption of alternative payment models, and by promoting investment in primary care, behavioral health, and workforce stability. Lastly, OHCA reviews and assesses market consolidation, market power, and other market failures through cost and market impact reviews (CMIRs) of mergers, acquisitions, or corporate affiliations.

1. Introduction

In 2022 the Legislature passed, and Governor Newsom signed the California Health Care Quality and Affordability Act (Act) to address the high cost of health care. The Act established OHCA and the Health Care Affordability Board to implement strategies to control health care costs and improve the value of California's health care system. OHCA was established in the Department of Health Access and Information (HCAI).

On August 28, 2024, OHCA hosted the Health Care Affordability Board meeting in Monterey, California to learn more about the high health care costs from the many Monterey residents who had previously traveled to Board meetings in Sacramento to express their concerns. At this meeting, OHCA staff and leaders from Covered California and CalPERS presented data demonstrating that hospitals in Monterey are high-cost outliers. The presentations highlighted data in response to several possible explanations for high costs – risk mix, higher quality, more charity care and bad debt, or payer mix. As detailed in this report, none of those directly explain the higher costs. OHCA staff also presented tools in the statute to address high costs, including sector targets and conducting investigative studies.

Under its enabling statute, OHCA shall "monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity." The Director of HCAI, who oversees OHCA, is authorized to make investigations concerning "(a) All matters relating to the business activities and subjects under the jurisdiction of the department; . . . and (c)[s]uch other matters as may be provided by law."[5] Elizabeth Landsberg, the Director of HCAI, announced at the October 14, 2024 Health Care Affordability Board meeting an investigative study of hospital market competition in Monterey County. OHCA engaged health care economic experts, Arnold Analytics to assist OHCA in the investigative study and produce this report. This report is the culmination of that study.

The goal of this report is to further investigate the central question: to what extent are Monterey's hospital prices higher than those in other parts of California and what might explain the difference?[6] To do so, this report proceeds in six parts. Section 2 provides a background of the Monterey health care market, detailing the key providers, payers, and patient demographics. Section 3 presents a detailed data analysis that quantifies how Monterey prices compare to other hospital markets in California. Next, Section 4 explains the consequences of high prices. Section 5 systematically evaluates several potential explanations for these high prices—including high operating costs, superior quality of care, subsidization of public programs, lack of competition—and uses data analysis and interview findings to assess their validity. Having identified the primary drivers, Section 6 describes spending targets and two applicable policy options. Finally, Section 7 concludes with findings.

[5] Cal. Health & Saf. Code, §127507, subd. (a) and Cal. Gov. Code, § 11180

[6] Monterey and Monterey County are used interchangeably throughout this report.

This report focuses on three general acute care ("GAC") hospitals in Monterey County—Community Hospital of the Monterey Peninsula ("CHOMP"), Natividad Medical Center ("Natividad"), and Salinas Valley Health Medical Center ("SVHMC") (collectively "three hospitals"). These three hospitals constitute the hospital market in Monterey County.[7] As described below, these hospitals also have extensive non-hospital operations, including ownership of physician practices or medical groups. The potential for robust competition in the county lies among these three hospitals.

Among commercially insured patients, prices at Monterey County's hospitals significantly exceed state and regional benchmarks. New commercial price analyses conducted for this report show Monterey inpatient admission prices for the 10 most common admissions to be 31% above the Bay Area average and Monterey outpatient visit prices for 23 common procedures to be 47% above the Bay Area average. Additional new price analyses using individual and small group market facility inpatient and outpatient claims from Covered California confirm that Monterey inpatient admission prices are the highest in the state, even adjusting for county wage variation and patient demographics such as age, gender, race/ethnicity, and Diagnosis-Related Groups (DRGs). These new analyses are consistent with previously reported prices from national hospital price studies that reported Monterey hospitals to be high priced.[8]

These high prices contribute to significant profits. From 2018 to 2023, the operating margins for CHOMP and Salinas Valley were always between 10% and 22%, consistently higher than the statewide average for hospitals of 0% to 4%.[9] The financial burden of high prices is so severe that, as indicated during interviews, local unions have actively encouraged their members to travel out of the county for procedures like childbirth or joint replacements to avoid the crushing costs.

To understand the root cause of these high prices, this report systematically evaluates several potential explanations. High prices to commercial insurers could, for example, be explained by higher-than-average operating costs, superior quality of care, or the need to subsidize a disproportionate share of underfunded public insurance programs (often referred to as "cost-shifting"). This investigation, however, finds that none of these factors adequately explain commercial pricing in Monterey County. While hospital administrator wages are notably high,

[7] Mee Memorial Hospital is a fourth (much smaller) GAC hospital in Monterey County but is near the southern border of the county as opposed to the northern border like the other three. The forthcoming analysis reveals it has little to no competitive impact on the other three GAC hospitals in the county. The analysis also reveals GAC hospitals outside of Monterey County have little competitive impact on the three hospitals.

[8] See e.g., Whaley, C., Kerber, R., Wang, D., Kofner, A., Briscombe, B. (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. *RAND Corporation*. https://doi.org/10.7249/RRA1144-2-v2 which reports overall commercial prices at CHOMP to be 466% of what Medicare would pay for the same services, with Natividad at 420% and Salinas Valley at 340%. These figures are notably higher than the Bay Area average of 320% and the statewide average of 287%. The disparity is even more pronounced for inpatient facility prices, where CHOMP's prices reach 572% of Medicare rates, compared to the Bay Area average of 311%.

[9] California Department of Health Care Access and Information. (n.d.) *Hospital Financials*. https://hcai.ca.gov/data/cost-transparency/hospital-financials/

overall labor costs are not high enough to account for the extreme price levels, especially when compared to other hospitals in the Bay Area that face similar labor costs.

Furthermore, higher prices are not necessarily associated with higher quality of care. Federal data shows that Monterey hospitals generally receive quality ratings that are similar to, not better than, their peers across the state. Finally, the notion that the subsidization of public patients causes high prices (or cost-shifting) is generally rejected by economists. This report discusses scenarios where cost-shifting could potentially occur, but the explanation cannot explain CHOMP's high relative prices in the state as its public payer share was 63% in 2022, right at the statewide public payer share of 62%.[10] Natividad and to a lesser extent SVHMC have more of a case given their public payer shares in 2022 were 78% and 70%, respectively, but again there are only a handful of ways that cost-shifting could potentially be possible and the bulk of the evidence is that hospitals are generally not in a position to cost-shift.[11] This study's analysis shows a lack of correlation between a hospital's share of public-payer patients and its commercial prices in California.

With these alternative explanations ruled out, the evidence points overwhelmingly to a market structure defined by a profound lack of competition. Insights from interviews with health plans and other stakeholders corroborate this conclusion. A consistent theme emerged: health plans describe the three major hospitals as "must-haves" in their networks due to geographic isolation. This gives the hospitals immense leverage in negotiations with payers. Health plan executives indicated that they have little ability to push back on price increases from must-have hospitals. Terminating a contract with any of the major hospitals is not a commercially viable option because many families and employers would consider such a network unacceptable. This market power is amplified by significant physician consolidation—particularly the alignment of the county's largest medical groups with CHOMP and SVHMC through Montage Health—and tight referral patterns that lead back to the high-priced hospitals. This dynamic is compounded by the prevalence of "percent of billed charges" contracts, a contracting method which is less common in competitive markets, where prices increase as soon as chargemaster rates increase. The convergence of these factors—geographic dominance, physician alignment, and unfavorable contract terms—has created a market environment where high prices can be sustained, placing a significant financial burden on the families and employers of Monterey County.

2. Background on Monterey County

Monterey County has a population of 436,251. Mostly rural, its largest cities are Salinas and Monterey. Most of the population lives in northern coastal areas and in the Salinas Valley, with the rest of the county very sparsely populated. Its economy is based on tourism, retirement living and agriculture. The first two are concentrated in the coastal areas, while much of the agriculture is located in the Salinas Valley. Property prices are high in the coastal areas and

[10] Slide 92 at California Department of Health Care Access and Information. (2024, August 28). *Health Care Affordability Board Meeting* [PowerPoint slides]. https://hcai.ca.gov/wp-content/uploads/2024/09/August-2024-OHCA-Board-Meeting-Presentation-1.pdf

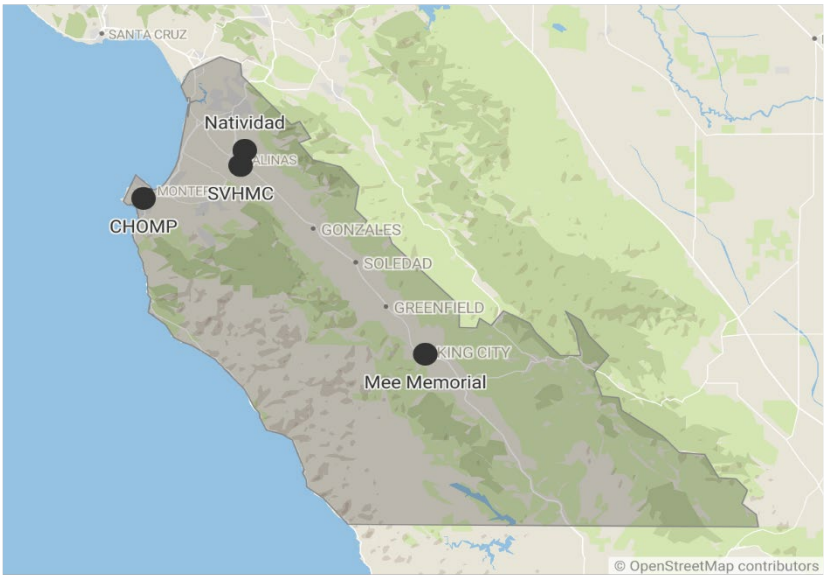
[11] Ibid. at slides 93 and 94.

earnings are low in agriculture, resulting in large income and wealth differences in the county. In 2020, high-income areas had median household income above $95,000, much higher than the California statewide median of $60,000. In central and eastern Salinas, 46 percent of individuals live below the poverty line. In 2020, 27 percent of county residents were White and 60 percent Hispanic.[12]

There are three large general acute care hospitals in Monterey County: CHOMP, SVHMC, and Natividad. CHOMP is part of Montage Health, which also owns the Montage Medical Group, an orthopedic practice, urgent care centers and ASPIRE Health, an insurer that offers a Medicare Advantage plan. Salinas Valley Health ("SVH") comprises a 243 bed SVHMC and Salinas Valley Health Clinics, including both primary care and specialty care. CHOMP is a private nonprofit hospital. SVHMC is a district hospital and Natividad is a county hospital. Natividad serves as the safety net hospital in the county, with Medi-Cal accounting for over 60 percent of patients. As a county hospital, Natividad is able to directly employ physicians. Mee Memorial Hospital is much smaller (72 beds) and over 45 miles from the others and does not act as a competitive constraint to the three focus hospitals.

Distance and mountainous terrain make travel between the Monterey peninsula and other parts of the county time consuming (see Figure 1). As a result, according to interviews conducted for this study, many residents of the county consider only one or two of the hospitals as accessible to them. This effectively segments the market for medical care in the county. Insurers perceive that they must include all three of the large hospitals in their networks.

Figure 1. Map of Monterey County hospitals



[12] United States Census Bureau. (2024). *Data Profiles*. ttps://data.census.gov/profile?q=United+States&g=010XX00US

Notes: The darkened region demarcates Monterey County. The focus of this report is the three hospitals in the northern part of Monterey County.

Many interviewees mentioned that physicians are generally in short supply, noting the very high cost of housing and lack of employment opportunities for spouses of physicians. In contrast with other areas, where hospitals compete with private equity and insurers to acquire medical practices, interviewees characterized the situation as independent practices asking to be acquired by hospital systems due to difficulties in recruiting physicians to replace those retiring or remaining economically viable in general.

The insurance market in Monterey County is limited. Interviewees explained that major national insurers are not seeking contracts with local employers, limiting their activities to serving local employees of firms headquartered outside of Monterey County. Blue Cross of California (Anthem Blue Cross) and Blue Shield of California provide most of the commercial coverage. Monterey stands out among California markets for having a small managed care presence. Few individuals are enrolled in HMOs. Until recently, Kaiser Permanente had no presence in the county. Medicare Advantage penetration in the county is only 15 percent, in contrast with 52 percent penetration statewide. Interviewees stated that Monterey County strikes them as resembling more rural counties elsewhere in the state, with limited competition between providers, absence of managed care, and with the “Blues” (Blue Cross of California and Blue Shield of California) accounting for most commercial market share.

a. HCAI presentation

HCAI staff presented “Case Study: Hospitals in Monterey County and State Options to Address High Costs” at the August 2024 Affordability Board meeting.[13] The presentation looked at the patient demographics and payer mix of the three Monterey hospitals and compared them to statewide averages. The presentation did the same comparison for hospital financial metrics as well as hospital wage metrics. Hospital wage metrics were additionally compared to Bay Area averages.

Key findings from the presentation were as follows:

Patient demographics and payer mix

- *Race and Ethnicity:* CHOMP's patients are predominantly White (55%), while SVHMC and Natividad primarily serve Hispanic patients (76% and 84%, respectively).
- *Age:* CHOMP serves an older population, with 34% of patients aged 65 or older. In contrast, Natividad and SVHMC serve younger populations, with a larger percentage of their patients being under 18 than CHOMP’s.
- *Payer Type:* Medicare is the largest payer for CHOMP (34%). For SVHMC and Natividad, the primary payer is Medi-Cal, at 51% and 68%, respectively.

[13] California Department of Health Care Access and Information. (2024, August 28). *Health Care Affordability Board Meeting* [PowerPoint slides]. https://hcai.ca.gov/wp-content/uploads/2024/09/August-2024-OHCA-Board-Meeting-Presentation-1.pdf

- *Patient Setting:* SVHMC and Natividad have a larger share of emergency department visits compared to the statewide average, while CHOMP's are slightly lower.

Hospital Financial Metrics

- *Net Patient Revenue (NPR):* From 2016 to 2022, the NPR per adjusted discharge for CHOMP and SVHMC was consistently higher than the statewide average. In 2022, CHOMP's NPR per adjusted discharge was $35,000, Natividad's was $32,000, and SVHMC's was $29,000, compared to the statewide average of $27,000
- *Operating Margin:* Between 2018 and 2022, CHOMP and SVHMC had operating margins that were significantly higher than the statewide average. For instance, in 2020, SVHMC's operating margin peaked at 22.20% when the statewide average was 0.89%.

Hospital Wage Metrics

- *Registered Nurses (RNs):* In 2021, the average hourly wage for RNs at all three Monterey County hospitals was above the statewide average of $65 but below the Bay Area average of $83. CHOMP paid the highest at $81 per hour.
- *Nursing Administrators:* The hourly wage for nursing administrators at all three hospitals exceeded the statewide average ($75) in 2021. CHOMP and SVHMC also paid more than the Bay Area average ($96). CHOMP paid $107 per hour.
- *Hospital Administrators:* CHOMP and SVHMC paid their hospital administrators above the statewide ($108) and Bay Area averages ($116). In 2021, CHOMP paid hospital administrators an average of $183 per hour.

3. Prices and Quality

This study was in large part motivated by reports of high hospital prices in Monterey County. During interviews, numerous health plan executives indicated that Monterey hospitals are high priced, with one stating that CHOMP was the most expensive hospital they'd seen in California during their career "bar none". This section summarizes the findings from prior price studies before proceeding to new price analyses that were conducted specifically for this report. The section concludes with a discussion of hospital quality in Monterey and how to interpret the price findings in light of the quality evidence.

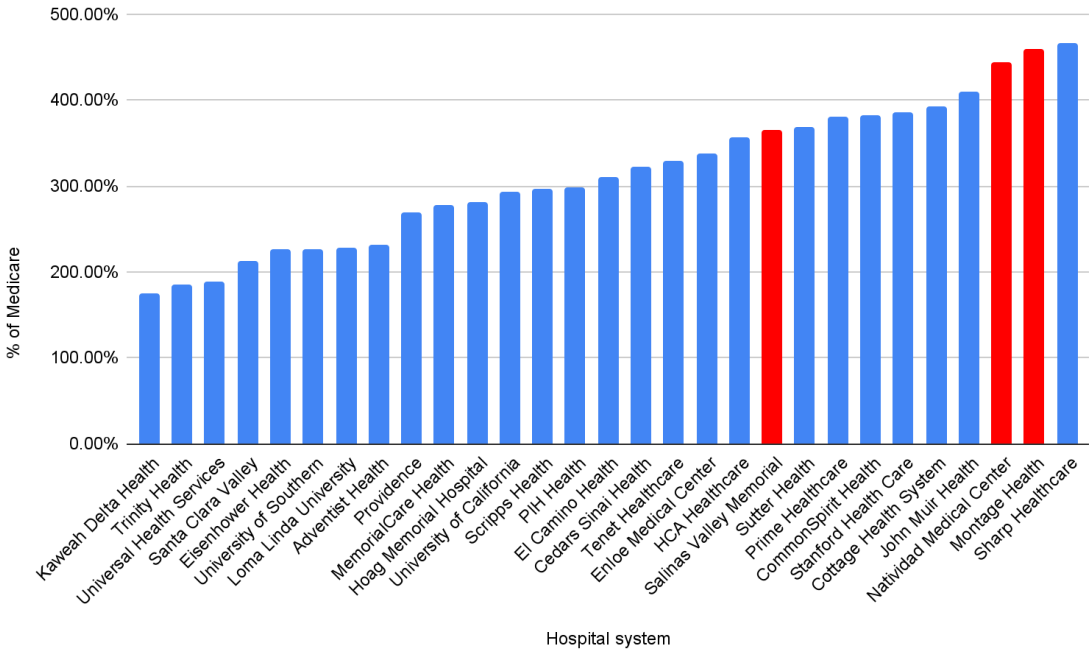
a. Prices

i. Prior analysis

Two national studies published prior to this report revealed Monterey County hospitals as unusually high-priced. First, in a series of studies, researchers from the RAND Corporation collected a national database of commercial claims data. The most recent RAND hospital price study listed Montage Health as the second most expensive hospital system in California in 2022

in terms of commercial hospital prices, followed by Natividad as the third most expensive and Salinas Valley as the tenth (Figure 2).[14]

Figure 2. Commercial Hospital Price (Inpatient + Outpatient, Facility + Professional) for California Hospital Systems, 2022



Source: Whaley, C., Kerber, R., Wang, D., Kofner, A., Briscombe, B. (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. *RAND Corporation*. https://doi.org/10.7249/RRA1144-2-v2

Prices in the RAND study were calculated as a percentage of what Medicare would have paid for the same services. Importantly, Medicare payments are adjusted for geographic variation in wages (i.e., hospitals in higher wage areas receive higher Medicare payments), which means prices quoted as a percentage of Medicare are labor-cost adjusted and thus enable a more appropriate comparison of prices across regions with differing costs of living. Medicare rates are constructed to represent an approximate "break-even" payment rate for efficient hospitals.[15]

It is well known that prices for hospital services paid by commercial plans are much higher than what Medicare or Medi-Cal pay for the same services. The RAND study confirms this to be true by showing that nationally in 2022 inpatient hospital facility services averaged 254% of Medicare prices, outpatient hospital facility services averaged 279% of Medicare, and all associated professional services (inpatient plus outpatient) averaged 184% of Medicare. The

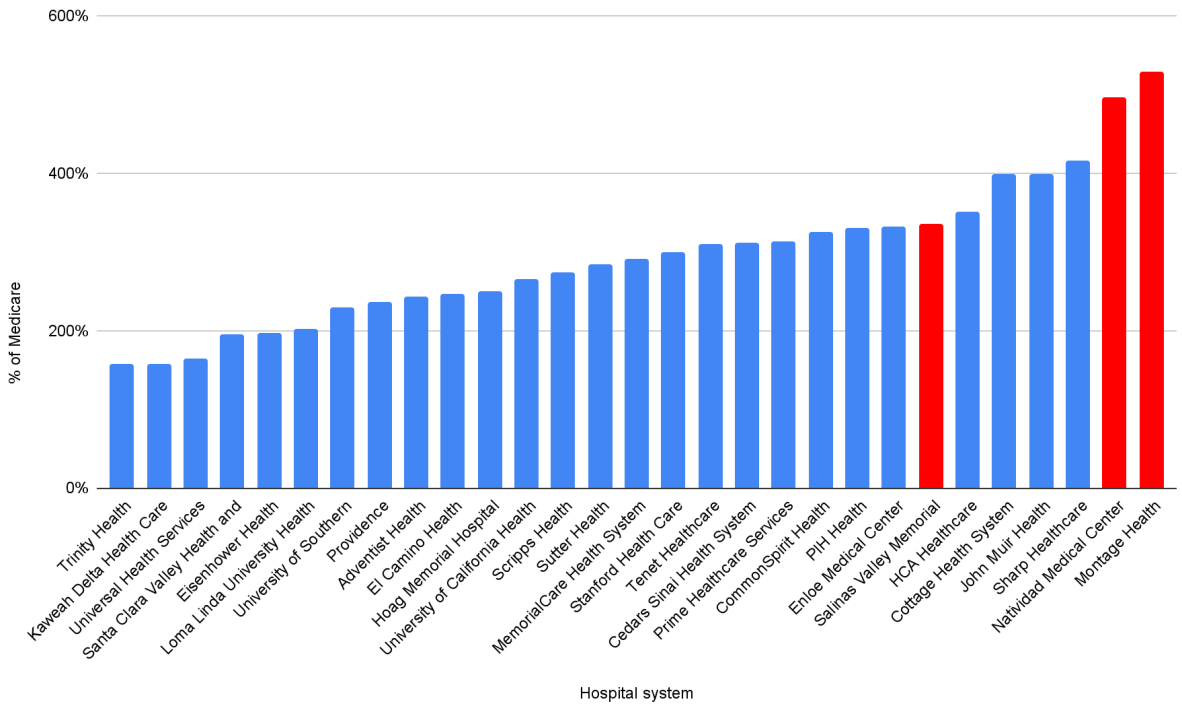
[14] Whaley, C., Kerber, R., Wang, D., Kofner, A., Briscombe, B. (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. *RAND Corporation*. https://doi.org/10.7249/RRA1144-2-v2

[15] Medicare Payment Advisory Commission. (2023). *Chapter 3: Hospital inpatient and outpatient services*. https://www.medpac.gov/wp-content/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC_v2.pdf

reported results for California were above the national averages across all three categories (280% inpatient, 344% outpatient, 196% professional), which landed California as the sixth most expensive state in the U.S. Being among the most expensive hospitals in California often means being among the most expensive nationally.

In terms of inpatient prices specifically, the Monterey hospital systems were the most expensive (Montage), second most expensive (Natividad), and seventh most expensive (SVH) in California according to the most recent RAND study (Figure 3).

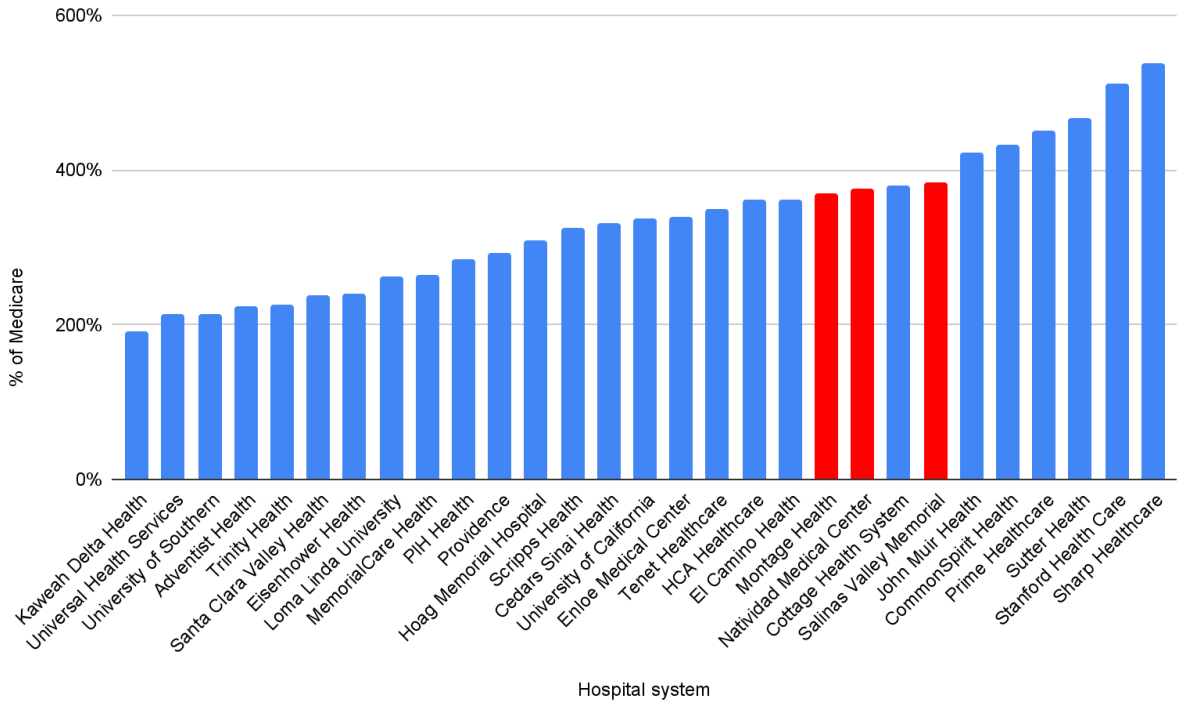
Figure 3. Commercial hospital inpatient prices for California hospital systems, 2022



Source: Whaley, C., Kerber, R., Wang, D., Kofner, A., Briscombe, B. (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. *RAND Corporation*. https://doi.org/10.7249/RRA1144-2-v2

Monterey hospital outpatient prices were above average among California hospital systems, but they did not reach the heights their inpatient prices did among systems. The RAND study estimated Montage, Natividad, and SVH to have the seventh, eighth, and ninth highest outpatient prices among hospital systems in California with them all falling just below 400% of Medicare (Figure 4).

Figure 4. Commercial hospital outpatient prices for California hospital systems, 2022

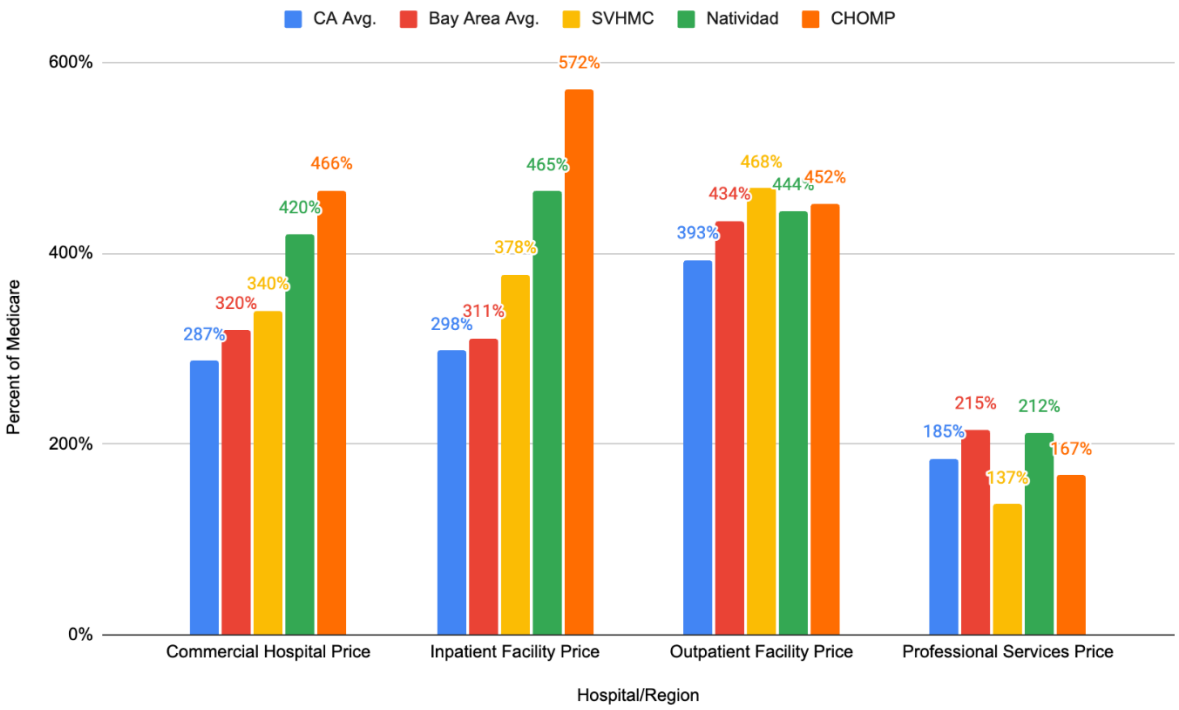


Source: Whaley, C., Kerber, R., Wang, D., Kofner, A., Briscombe, B. (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. *RAND Corporation*. https://doi.org/10.7249/RRA1144-2-v2

Figure 5 shows how the three Monterey hospitals compare to Bay Area and California averages for overall, inpatient facility, outpatient facility, and professional services prices. The Bay Area average is above the California average for each of the four price types so this report will compare the Monterey hospitals to the Bay Area averages in what follows.

In terms of overall prices, CHOMP (466% of Medicare) and Natividad (420% of Medicare) were far above the Bay Area average of 320% while SVHMC was above (340% of Medicare), but in the vicinity of the Bay Area average. The gap between the Bay Area average and the three Monterey hospitals becomes even more dramatic for inpatient facility prices where CHOMP (572% of Medicare), Natividad (465% of Medicare), and SVHMC (378% of Medicare) were all considerably above the Bay Area average of 311% of Medicare. In terms of outpatient prices, the Monterey hospitals were slightly above the Bay Area average of 434% while for professional services prices at the Monterey hospitals were below the Bay Area average of 215% of Medicare with SVHMC (137% of Medicare) and CHOMP (167% of Medicare) being considerably lower.

Figure 5. Hospital price comparison to state and Bay Area averages

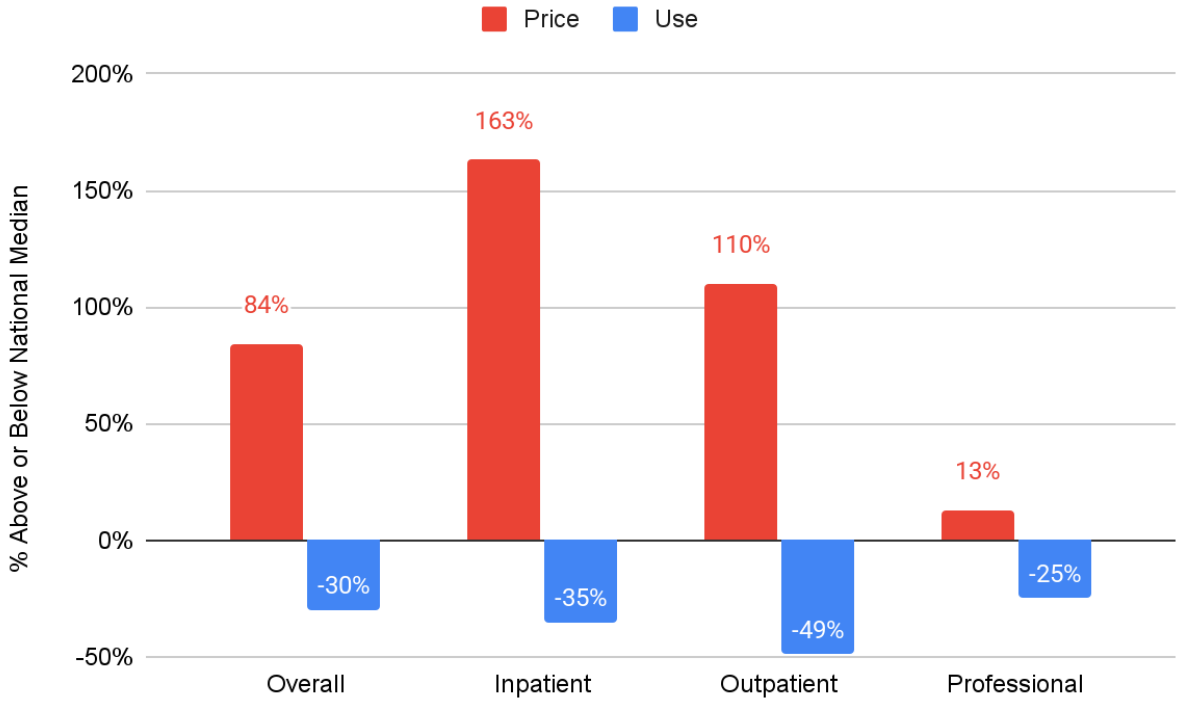


Source: Slides 119-122 from California Department of Health Care Access and Information. (2024, August 28). *Health Care Affordability Board Meeting* [PowerPoint slides]. https://hcai.ca.gov/wp-content/uploads/2024/09/August-2024-OHCA-Board-Meeting-Presentation-1.pdf
Notes: Bay Area is defined here as the counties of Alameda, Contra Costa, Napa, San Francisco, San Jose, San Mateo, Santa Cruz, and Santa Rosa, which differs a bit from the CDPH definition (see page 3) of Bay Area that used in the rest of the report.

The results of the second national hospital price study conducted by researchers at the Health Care Cost Institute (HCCI) prior to this report are consistent with the RAND study. The HCCI study used claims data from three large national insurers–Blue Cross Blue Shield, Aetna, and Humana. The HCCI data includes claims from over 50 million enrollees per year accounting for over a third of all enrollees in employer-sponsored insurance in the U.S.

The HCCI study analyzed metro areas instead of counties and found that the Salinas, CA metro area (which contains Monterey County) had hospital prices 84% above the national median hospital price (Figure 6). The breakdown by price type was similar to what the RAND study found–very high inpatient prices (163% above the national median), high outpatient prices (110% above the national median), and relatively much lower professional prices (13% above the national median). The HCCI study also looked at utilization and found that hospital utilization is below the national median in Monterey. Overall utilization (or “use”) was 30% below the national median while inpatient, outpatient, and professional utilization were 35% below, 49% below, and 25% below, respectively. Showing price and use side-by-side makes it clear that high commercial spending per enrollee in Monterey is driven by price, not utilization.

Figure 6. Salinas metro area compared to national median price and use, 2021



Source: Health Care Cost Institute. (2023). *Healthy Marketplace Index*. https://healthcostinstitute.org/hcci-originals/hmi-interactive#HMI-Price-and-Use

1. Impact of Monterey hospital prices on premiums

Higher prices are ultimately paid by consumers in the form of higher health insurance premiums. Both Covered California and the California Public Employees' Retirement System (CalPERS) presented at the August 2024 Health Care Affordability Board meeting about the premium challenges their plan offerings in Monterey have had.[16]

Covered California's Region 9, which includes Monterey, Santa Cruz, and San Benito counties, has seen consistently higher premium increases than other parts of the state. From 2014 to 2025, the average annual increase in the region was 10.9% while the statewide average was 7.6%.[17] In 2024, the gross premium for an individual in Monterey ($884) was significantly higher than the statewide average ($655).[18] Despite the high premiums, Covered California reported the risk pool in Region 9 to be healthier than the state average. The average risk score for the

[16] Slides 49-83 California Department of Health Care Access and Information. (2024, August 28). *Health Care Affordability Board Meeting* [PowerPoint slides]. https://hcai.ca.gov/wp-content/uploads/2024/09/August-2024-OHCA-Board-Meeting-Presentation-1.pdf
[17] Ibid., 55.
[18] Ibid., 59.

region has been 15% lower than the state's since 2018, indicating that the health status of the population is not the primary driver of high premiums.[19]

Currently, Anthem, Blue Shield, and Kaiser Permanente offer plans in Region 9. Valley Health Plan exited Region 9 in 2025 due to high costs and provider access issues, while Blue Shield of California, despite considering withdrawal, decided to continue operating in Monterey through 2026.

According to Covered California, carriers such as Blue Shield of California, Valley Health Plan, and Kaiser Permanente report encountering difficulties negotiating with hospitals like CHOMP and SVHMC, which prefer billed charges-based contracts where prices increase as soon as chargemaster rates increase. Billed charges are a contracting method less common in competitive markets. Kaiser has no contract with any hospital in Monterey County and is thus limited to serving 14 of 37 Monterey County zip codes.[20]

CalPERS sets a uniform statewide premium for state members. For public agency members (e.g., schools, counties), it sets premiums based on three regions. CalPERS noted that 2024 premiums in its northern region 1 were $185 per month higher than premiums in its southern region 3. CalPERS attributed this difference to lower prices in Southern California and the Central Valley across all service categories (inpatient, outpatient, professional). They also made the point that high prices are associated with a lack of competition and that higher prices are not associated with better quality. With respect to Monterey, the CalPERS presentation showed that Monterey was worst in terms of value (measured as total allowed per Global Relative Value Unit (GRVU)) with respect to hospital outpatient prices, second worst (behind Yuba County) with respect to hospital inpatient prices, and better than the statewide average when it came to professional prices. This pattern is consistent with the pattern above of hospital inpatient and outpatient prices being the problem, not professional prices.

ii. New analyses

Arnold Analytics conducted several new price analyses for this study using commercial claims data from CalPERS and Covered California.[21] The purpose of doing these additional analyses was to both add to the price findings of the national studies summarized above and integrate what was learned from interviews with payers, labor unions, and the three Monterey hospitals alongside the data to add context to Arnold Analytics' quantitative findings.

In both the CalPERS and Covered California analyses, allowed amounts were wage adjusted. Medicare uses what is referred to as the Medicare wage index to determine how much a hospital is reimbursed for the services it provides to Medicare beneficiaries. The underlying principle is that it costs more to employ health care professionals in some parts of the country than in others. The wage index is intended to account for these variations, ensuring that

[19] Ibid., 60.

[20] Covered California (2025). *2026 Products by Zip Code* [Data set]. Covered California. https://hbex.coveredca.com/data-research/

[21] Arnold Analytics conducted the CalPERS analysis and analysts at Covered California conducted the Covered California analysis based on guidance from Arnold Analytics.

providers in high-wage areas are not unfairly penalized and that those in low-wage areas are not overcompensated.

Monterey is a high-wage area, so it is important to adjust for this fact when comparing its prices to other parts of the state. Without this adjustment Monterey could look high-priced simply because its labor costs are higher and these higher labor costs get translated into higher prices.

Figure 7 presents a map of the “Alternative Medicare Wage Index” for each county in California. The Alternative Medicare Wage Index has a number of benefits over the current Medicare wage index. Most notably, the current index exclusively uses wage data from hospitals. This narrow focus fails to capture the broader labor market dynamics in a given area. Critics argue that the wages paid by other health care employers, and even employers in other industries competing for the same labor pool, provide a more accurate picture of local labor costs. The current system also means hospitals affect their own reimbursement through their wage decisions.[22]

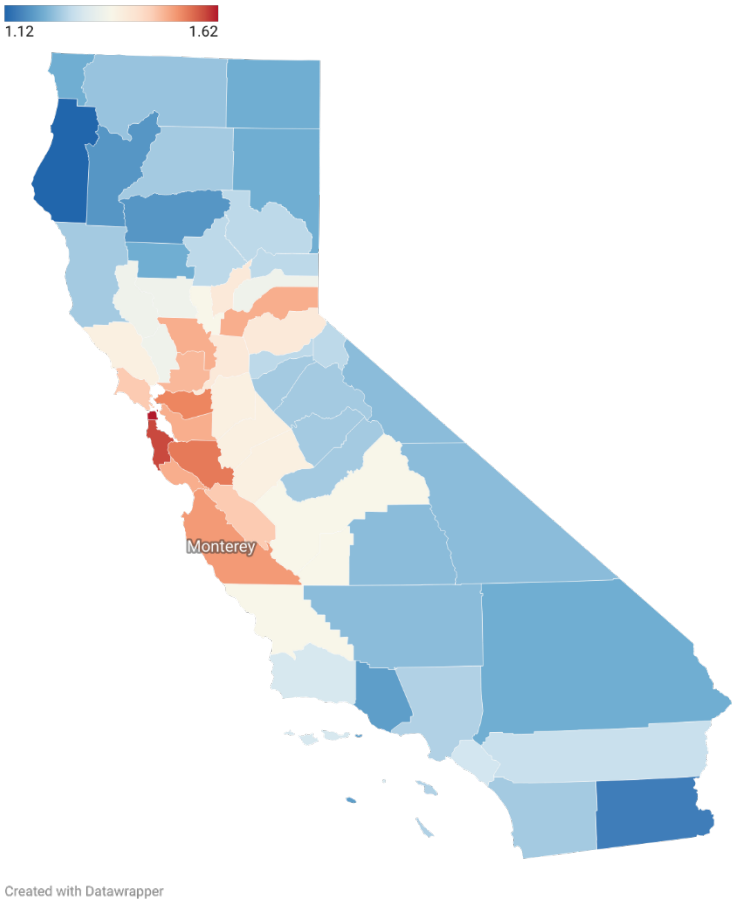
Counties with higher indices get their prices adjusted downward by more in the calculation to account for the fact that they have higher costs. The index is constructed so that the average wage nationally equals 1. Use of the wage index to account for variations in counties allows for apples to apples comparison of prices across the state. For example, San Francisco County has the highest index at 1.62. So, dividing its raw prices by its index will bring its raw prices down further than a county whose raw prices are divided by an index of 1.2.

Figure 7 shows that the lowest index in California is 1.12 (Humboldt County), indicating that wages are above the national average in all counties in California. San Francisco County has the highest wage index at 1.62, meaning that wages are 62% above the national average. Monterey has a wage index of 1.52, which is 5th highest in California, behind San Francisco County (1.62), San Mateo County (1.59), Santa Clara County (1.55), and Contra Costa County (1.54).[23]

[22] This presentation from MedPAC highlights the issues with the current wage index Binkowski, A., Stensland, J., Cline, C., & Maeda, J. (2023, March 2). *Reforming Medicare’s wage index systems* [PowerPoint slides]. MedPAC. https://www.medpac.gov/wp-content/uploads/2022/07/Wage-index-March-2023-SEC.pdf

[23] Monterey falls to 9th under the current wage index at 1.80 behind Santa Benito (1.90), Santa Clara (1.90), Santa Cruz (1.87), San Francisco (1.84), San Mateo (1.84), Marin (1.83), Alameda (1.82), and Contra Costa (1.82).

Figure 7. Alternative Medicare wage index by county



Source: MedPAC. (2023). *Chapter 9 online-only appendix: Reforming Medicare's wage index systems–Comparing current (2022) CMS wage indexes with illustrative alternative wage indexes (June 2023 report)* [Data set]. MedPAC. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch9_MedPAC_Report_Online_Only_Appendix_Comparing_Wage_Indexes_SEC.pdf
Notes: An index of 1 corresponds to wages at the national average.

1. CalPERS

OHCA received 2013-2023 inpatient facility, outpatient facility, and professional claims from CalPERS covering all their members located throughout California.[24] Presented next are several prices for each type of claim (inpatient, outpatient, professional). For inpatient prices, the reported price is the price associated with an admission, that is, the sum of total allowed amounts of all inpatient facility claims accumulated during the hospital stay.

Table 1 presents wage-adjusted inpatient admission prices for the ten most common Diagnosis-Related Groups (DRGs) in the CalPERS data. The prices shown are an average across 2013-

[24] Arnold Analytics excluded skilled nursing facility claims, claims from enrollees in CalPERS' supplement to Medicare plan in the forthcoming analysis. They also dropped prices in the top and bottom 1% in each year to avoid the influence of outliers.

2023. DRGs are a cornerstone of inpatient hospital reimbursement in the United States, particularly for Medicare. They are a classification system that groups patients with similar clinical conditions and expected resource consumption into distinct categories. This system forms the basis of Medicare's Inpatient Prospective Payment System (IPPS), a method where hospitals are paid a predetermined, fixed amount for each patient's stay based on their assigned DRG, regardless of the actual costs incurred.

A number of the most common DRGs in the CalPERS data are related to childbirth. Table 1 presents the average wage-adjusted price in Monterey for each DRG, the average wage-adjusted price in the Bay Area, and the percent that Monterey is above the Bay Area average (sorted from highest to lowest). Monterey is the most expensive county among the 36 counties included in the analysis for 4 of the top 10 most common DRGs and the second most expensive for 3.[25] Monterey is above the Bay Area average for 9 of the 10 DRGs ranging from 18% above to 168% above.

Table 1. Wage-adjusted inpatient admissions prices for the 10 most common DRGs

	Monterey wage-adjusted price	**Bay Area wage-adjusted price**	**% above Bay Area (sorted highest to lowest)**
885 - PSYCHOSES	$22,031	$8,208	168%
897 - ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHABILITATION THERAPY WITHOUT MCC	$13,311	$8,449	58%
807 - VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITHOUT CC/MCC	$14,862	$10,399	43%
806 - VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH CC	$16,287	$12,069	35%
871 - SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	$53,487	$40,579	32%
788 - CESAREAN SECTION WITHOUT STERILIZATION WITHOUT CC/MCC	$22,890	$17,696	29%
392 - ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITHOUT MCC	$20,577	$15,927	29%
787 - CESAREAN SECTION WITHOUT STERILIZATION WITH CC	$28,794	$22,765	26%
872 - SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	$26,248	$22,247	18%
470 - MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	$23,362	$25,415	-8%
AVERAGE	**$24,185**	**$18,375**	**32%**

Source: Authors' analysis of 2013-2023 inpatient facility claims from CalPERS.

[25] The 22 excluded counties are those with populations with less than 100,000.

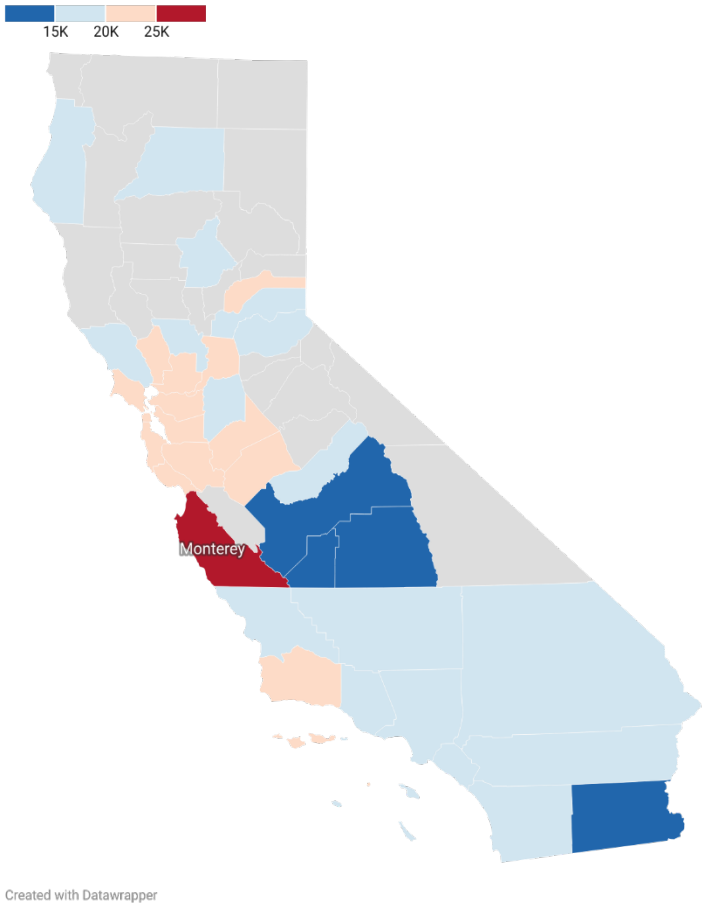
Notes: Only claims from CalPERS' "basic plan" enrollees are included (i.e., claims from Medicare supplement plan enrollees are excluded). Inpatient claims are aggregated to the "stay" (i.e., admission) level.

Figure 8 presents regression-adjusted inpatient admission prices for the counties in California with populations over 100,000. The prices shown are adjusted for patient age and sex as well as the admission's DRG. Admissions related to the top 200 most common DRGs are included in the regression. The prices in the figure control for differences in patient characteristics (age and sex) and severity (as captured by the DRG) that could lead to some counties having higher prices than others based on having more complicated cases.[26]

The prices shown in Figure 8 are now not only adjusted for potential wages differences across counties, but also patient severity differences. It is clear from the figure that Monterey stands out in terms of inpatient admission prices even after controlling for a host of reasons prices could justifiably be higher. It is notable that the Bay Area is generally high-priced even after adjusting for the fact that wages are higher in the Bay Area. This suggests something other than costs are behind the high prices, something discussed in more detail later in the report.

[26] Specifically, Arnold Analytics regressed the wage-adjusted price of an admission on age, sex, DRG, and county and year fixed effects. What they plot in Figure 9 is the estimated fixed effect for each county after they add back the sample mean price. This is similar to the approach in Cooper, Z., Craig, S., Gaynor, M., & Van Reenan, J. (2019). The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *Quarterly Journal of Economics*, 134(1), 51-107. https://doi.org/10.1093/qje/qjy020

Figure 8. Regression-adjusted CalPERS inpatient admission prices, 2013-2023



Source: Authors' analysis of 2013-2023 inpatient facility claims from CalPERS.
Notes: Only claims from CalPERS' "basic plan" enrollees are included (i.e., claims from Medicare supplement plan enrollees are excluded). Grayed out counties have populations of less than 100,000 and were excluded from the analysis due to small sample sizes.

Table 2 and Figure 9 repeat the analyses in Table 1 and Figure 8, but for outpatient prices. Given the vast number of outpatient claims in the dataset, the analysis was limited to the 23 most common outpatient CPT codes described in Whaley et al. (2025).[27] Table 2 shows Monterey's prices across the 23 services sorted from Monterey's highest percentage above the Bay Area average to lowest. Monterey was above the Bay Area average for 19 services, ranging from 5% above to 206% above. Across all 23 services, Monterey prices were on average 47% above the Bay Area average. Monterey had the fourth highest regression-adjusted outpatient prices among the 36 counties with populations greater than 100,000 included in the analysis (Figure 9).

[27]. Whaley, C., Radhakrishnan, N., Richards, M., Simon, K., & Chartock, B. (2025). Understanding health care price variation: evidence from Transparency-in-Coverage data. *Health Affairs Scholar*, 3(2) 1-8. https://doi.org/10.1093/haschl/qxaf011

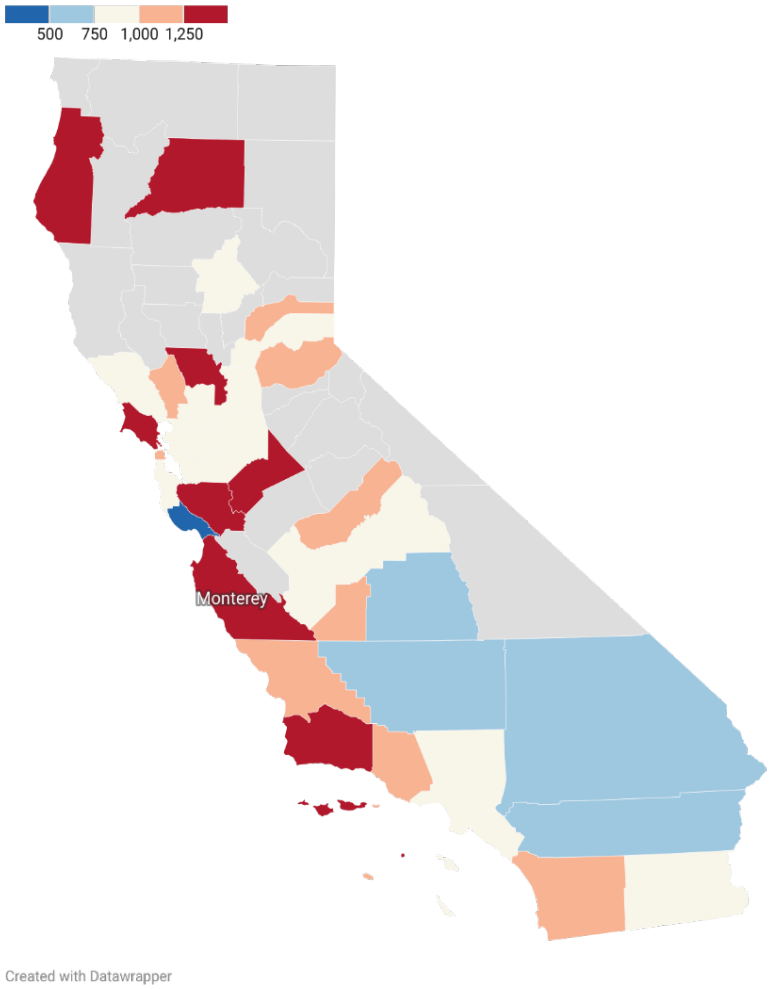
Table 2. Wage-adjusted outpatient visit prices for 23 common CPT codes

	Monterey wage-adjusted price	Bay Area wage-adjusted price	% above the Bay Area (lowest to highest)
71260 - Computed tomography (CT), thorax; with contrast.	$3,430	$1,121	206%
73502 - Radiologic examination, hip, unilateral; complete, minimum 2 views.	$611	$270	127%
74177 - Computed tomography (CT), abdomen and pelvis; with contrast.	$4,563	$2,157	112%
76700 - Ultrasound, abdomen, complete.	$1,138	$558	104%
76856 - Ultrasound, pelvic (nonobstetric), complete.	$1,276	$641	99%
71046 - Radiologic examination, chest; 2 views.	$440	$250	76%
45385 - Colonoscopy with removal of polyp(s) by snare technique.	$4,300	$2,566	68%
45378 - Colonoscopy, diagnostic.	$3,398	$2,154	58%
76830 - Ultrasound, transvaginal.	$846	$535	58%
76536 - Ultrasound, soft tissues of head and neck.	$554	$372	49%
93005 - Electrocardiogram (ECG); tracing only, without interpretation.	$754	$528	43%
45380 - Colonoscopy with biopsy, single or multiple.	$3,590	$2,578	39%
73030 - Radiologic examination, shoulder; complete, minimum 2 views.	$391	$284	37%
72100 - Radiologic examination, spine, lumbosacral; 2 or 3 views.	$471	$352	34%
73630 - Radiologic examination, foot; complete, minimum 3 views.	$381	$293	30%
43239 - Esophagogastroduodenoscopy (EGD) with biopsy, single or multiple.	$4,109	$3,181	29%
71250 - Computed tomography (CT), thorax; without contrast.	$1,149	$916	25%
86850 - Antibody screen, RBC, each serum technique.	$453	$416	9%
76642 - Ultrasound, breast, unilateral, complete.	$495	$470	5%
88305 - Level IV - Surgical pathology, gross and microscopic examination.	$506	$601	-16%
93017 - Cardiovascular stress test; tracing only, without interpretation.	$864	$1,133	-24%
77080 - Dual-energy X-ray absorptiometry (DXA), bone density study.	$259	$393	-34%

	Monterey wage-adjusted price	Bay Area wage-adjusted price	% above the Bay Area (lowest to highest)
93306 - Transthoracic echocardiogram (TTE), complete.	$1,559	$2,487	-37%
Average	**$1,545**	**$1,055**	**47%**

Source: Authors' analysis of 2013-2023 outpatient facility claims from CalPERS.
Notes: Only claims from CalPERS' "basic plan" enrollees are included (i.e., claims from Medicare supplement plan enrollees are excluded). Outpatient claims are aggregated to the visit level.

Figure 9. Regression-adjusted CalPERS outpatient visit prices, 2013-2023

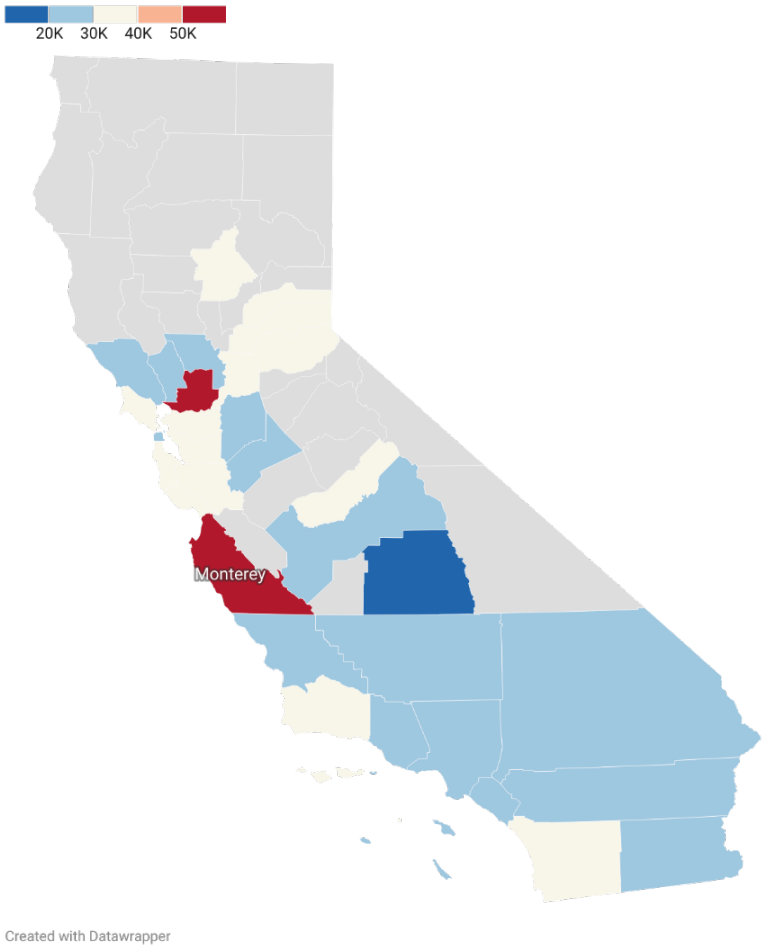


Source: Authors' analysis of 2013-2023 outpatient facility claims from CalPERS.
Notes: Only claims from CalPERS' "basic plan" enrollees are included (i.e., claims from Medicare supplement plan enrollees are excluded). Grayed out counties have populations of less than 100,000 and were excluded from the analysis due to small sample sizes.

2. Covered California

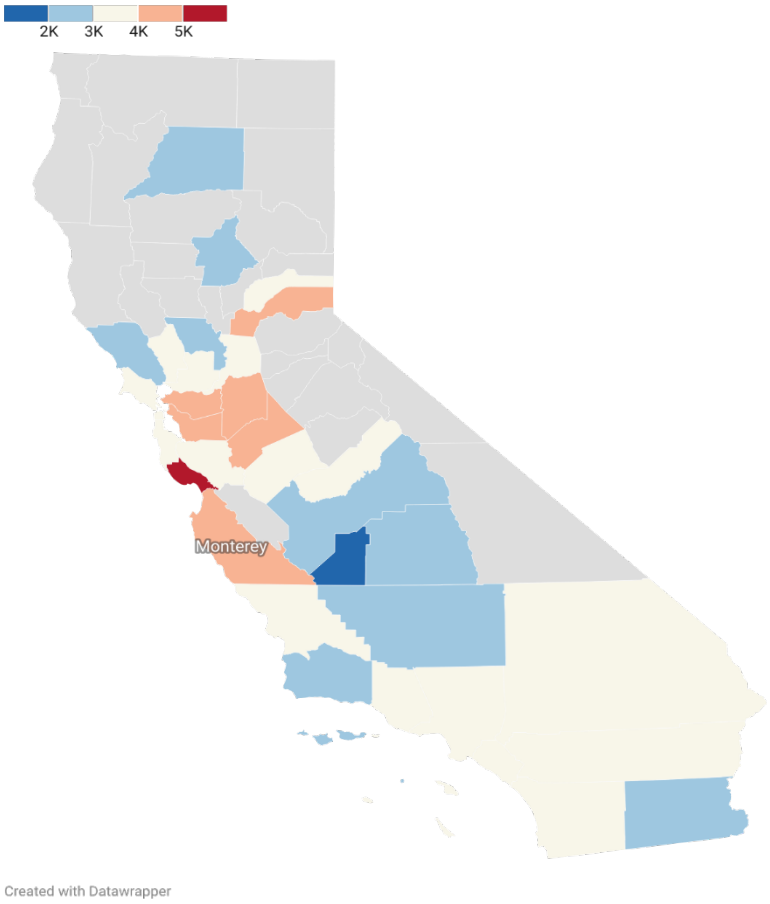
Figures 10 and 11 replicate the analyses in Figures 8 and 9 using individual and small group facility claims data (including data from both on-exchange and off-exchange plans) from Covered California from 2018 to 2024. The analysis controlled for patient age, sex, and race/ethnicity, as well as DRG (for inpatient admission prices) and revenue code (for outpatient visit prices). The results are consistent with findings using CalPERS data–Monterey has high inpatient and outpatient prices. The Covered California inpatient analysis included 32 of the 36 counties in the CalPERS analysis. For inpatient prices, Monterey had the highest prices among the 32 counties. For outpatient prices, the Covered California analysis included 34 of the 36 counties in the CalPERS analysis. Monterey had the 4th highest outpatient prices among the 34 counties.

Figure 10. Regression-adjusted Covered California inpatient admission prices, 2018-2024



Source: Analysis of 2018-2024 inpatient facility claims from Covered California.
Notes: Analysis conducted by analysts at Covered California. Analysis includes claims from on-exchange and off-exchange individual and small group plans. Hospitals with low claim volumes (less than 10 individual patients, less than 10 inpatient claims, or less than 30 outpatient claims) or a high concentration (over 90%) of claims with a single health insurance issuer are excluded from this analysis. Grayed out counties have populations of less than 100,000 and were excluded from the analysis due to small sample sizes.

Figure 11. Regression-adjusted Covered California outpatient visit prices, 2018-2024



Source: Analysis of 2018-2024 outpatient facility claims from Covered California.
Notes: Analysis conducted by analysts at Covered California. Analysis includes claims from on-exchange and off-exchange individual and small group plans. Hospitals with low claim volumes (less than 10 individual patients, less than 10 inpatient claims, or less than 30 outpatient claims) or a high concentration (over 90%) of claims with a single health insurance issuer are excluded from this analysis. Grayed out counties have populations of less than 100,000 and were excluded from the analysis due to small sample sizes.

b. Quality

The research literature indicates little to no correlation between hospital price and quality.[28] Furthermore, some studies suggest that in competitive markets, higher prices might be associated with better outcomes, whereas this relationship is absent in concentrated markets, implying that higher prices may reflect market power rather than superior quality in such

[28] See e.g., Hussey, P., Wertheimer, S., & Mehrotra, A. (2013). The association between health care quality and cost: a systematic review. *Annals of Internal Medicine, 158*(1), 27-34. https://doi.org/10.7326/0003-4819-158-1-201301010-00006 and Jamalabadi, S., Winter, V., & Schreyögg, J. (2020). A Systematic Review of the Association Between Hospital Cost/price and the Quality of Care. *Applied Health Economics and Health Policy, 18*(5):625-39. https://doi.org/10.1007/s40258-020-00577-6

scenarios.[29] Therefore, the prevailing consensus in the research is that a higher price tag is not a reliable indicator of better hospital care.

Despite the research consensus, there is still the possibility that on a case-by-case basis hospitals with higher prices do have higher quality. This section uses data from Hospital Compare to assess whether that is true of the Monterey-area hospitals. Hospital Compare is a public repository of hospital quality data provided by the Centers for Medicare & Medicaid Services ("CMS"). It aggregates extensive data across numerous domains of hospital performance, providing a standardized dataset for analysis and evaluation.

Hospital Compare contains several distinct categories of metrics. Process of care measures assess hospital adherence to evidence-based clinical protocols, such as the percentage of patients receiving appropriate antibiotics before surgery. Outcome of care measures provide risk-adjusted data on patient results, including 30-day mortality and readmission rates for conditions like acute myocardial infarction and heart failure, as well as rates of hospital-acquired infections and other complications. Finally, the dataset includes patient-reported experience data from the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") survey, a standardized instrument that captures patient perspectives on critical aspects of their care, including communication with clinicians, pain management, and the cleanliness of the hospital environment. Tables 3 and 4 below provide the most recent quality measures from Hospital Compare for the three Monterey hospitals. The tables also compare the measures to California and/or national averages.

The first measure in Table 3 is the overall star rating–a composite score created by CMS to summarize a wide range of quality measures into a single rating of one to five stars. The star rating is calculated annually using a multi-step methodology that aggregates dozens of individual quality measures. These measures are first organized into five distinct groups, each assessing a different dimension of hospital care. The five groups and their respective weights in the final calculation are:

- Mortality (22%): Measures death rates for patients with specific conditions like heart attack, heart failure, and pneumonia.
- Safety of Care (22%): Tracks the rate of various hospital-acquired infections and other serious complications.
- Readmission (22%): Calculates the rate of patients who are readmitted to the hospital within 30 days of discharge for conditions such as hip/knee replacement and chronic obstructive pulmonary disease (COPD).
- Patient Experience (22%): Based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, this group includes patient-reported data on topics like communication with doctors and nurses, and the cleanliness and quietness of the hospital.

[29] Cooper, Z., Doyle, J., Jr., Graves, J., & Gruber, J. (2022). Do Higher-Priced Hospitals Deliver Higher-Quality Care? *National Bureau of Economic Research*. https://www.nber.org/system/files/working_papers/w29809/w29809.pdf

- Timely and Effective Care (12%): Encompasses a variety of process measures, such as the percentage of patients receiving appropriate preventative care or timely treatment for sepsis.

Table 3 shows that based on overall star rating CHOMP and Natividad are average quality (3 stars) while SVHMC is above average with 4 stars.

The next measure in the table is “Patient survey rating.” The "Patient survey rating" is a star rating system developed by CMS that exclusively reflects patient perspectives on their hospital care using HCAHPS survey. The HCAHPS survey is designed to capture a patient's objective experience by aggregating reports from recently discharged patients across several key domains of care. The survey focuses on the quality of communication, asking patients to report on their interactions with both nurses and doctors, as well as the clarity of explanations about new medicines. It also measures the responsiveness of hospital staff to patient needs and the effectiveness of pain management. Furthermore, the survey assesses the physical hospital environment by asking about the cleanliness and quietness of the patient's surroundings. Finally, it evaluates the quality of the discharge information provided to patients to ensure they are adequately prepared for their transition home.

Table 3 shows that based on patient star rating all three Monterey-area hospitals are of average quality (3 stars). The rest of the table shows various more narrow measures of quality. On some measures the Monterey hospitals appear better than California and national averages (e.g., colonoscopy follow-up) and on others they appear worse (e.g., sepsis care). Overall, the takeaway from Table 3 is that quality is not obviously better at the Monterey hospitals in a way that could partially explain significantly higher prices.

Table 3. Quality – Overall, Patient Survey, and Timely & Effective Care

	CHOMP	SVHMC	Natividad	CA Avg.	National Avg.
Overall star rating (1-5, 5=best)	3	4	3	3	3
Patient survey rating (1-5, 5=best)	3	3	3	3	3
Timely & effective care					
Sepsis care					
Percentage of patients who received appropriate care for severe sepsis and/or septic shock (**higher** percentages are better)	50%	63%	57%	68%	63%
Colonoscopy follow-up					
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy (**higher** percentages are better)	100%	100%	98%	91%	92%

	CHOMP	SVHMC	Natividad	CA Avg.	National Avg.
Emergency department care					
Percentage of patients who left the emergency department before being seen (**lower** percentages are better)	1%	2%	1%	2%	2%
Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival (**higher** percentages are better)	75%	62%	27%	72%	70%
Emergency department volume	High*	Very High	High		
Average (median) time patients spent in the emergency department before leaving from the visit (a **lower** number of minutes is better)	177	166	137	192 (High) 207 (Very High)	214 (High) 194 (Very High)
Healthcare personnel vaccination					
Percentage of healthcare workers given influenza vaccination (**higher** percentages are better)	75%	85%	57%	73%	80%
Safe use of opioids					
Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge. (**lower** percentage is better)	24%	12%	14%	14%	15%
Use of medical imaging					
Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments (like physical therapy) first (**lower** percentages are better)	30.0%	NA	NA	37.1%	35.5%
Percentage of outpatient CT scans of the abdomen that were “combination” (double) scans (**lower** percentages are better)	6.0%	3.3%	2.2%	5.7%	5.9%
Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery (**lower** percentages are better)	3.6%	3.2%	4.4%	4.1%	3.7%

	CHOMP	SVHMC	Natividad	CA Avg.	National Avg.
Percentage of patients who had an advanced breast screening on the same day or within 45 days of their initial mammogram or digital breast tomosynthesis (DBT) study (percentages **between 5% and 12%** are best)	26.8%	6.9%	5.2%	9.0%	9.0%

Source: Medicare. (2025). *Hospital Comparison Tool* [Data Set]. Centers for Medicare and Medicaid Services. https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital

Notes: NA=not available. *High=40-59k patients annually, Very High=60k+ patients annually

Table 4 adds more to the quality picture by presenting measures of quality related to complications and death. Here grayed out cells indicate the hospital is statistically no different from the national average on the measure. Green cells indicate the hospital was statistically better than the national average on the measure. Red cells indicate the hospital was statistically worse than the national average on the measure. The three hospitals appear to perform better when it comes to Clostridium difficile (C.diff.) intestinal infections and the hospital-wide and heart failure death rates are better at CHOMP while the pneumonia death rate is better at SVHMC. CHOMP performs worse than the national average when it comes to serious complications. But otherwise, there is a lot of gray in Table 4, leading again to conclude that quality is not obviously better at the Monterey-area hospitals in a way that could partially explain significantly higher prices.

Table 4. Quality – Complications and Deaths

	CHOMP	SVHMC	Natividad
Complications			
Rate of complications for hip/knee replacement patients		NA	NA
Serious complications	Worse		
Deaths among patients with serious treatable complications after surgery			
Infections			
Central line-associated bloodstream infections (CLABSI) in ICUs and select wards			
Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards			
Surgical site infections (SSI) from colon surgery			
Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections			

	CHOMP	SVHMC	Natividad
Clostridium difficile (C.diff.) intestinal infections	Better	Better	Better
Death rates			
Death rate for patients (hospital-wide)	Better		
Death rate for COPD patients			
Death rate for heart attack patients			
Death rate for heart failure patients	Better		
Death rate for pneumonia patients		Better	
Death rate for stroke patients			
Death rate for CABG surgery patients			
Unplanned hospital visits			
Rate of readmission after discharge from hospital (hospital-wide)			
Rate of readmission for chronic obstructive pulmonary disease (COPD) patients			
Rate of readmission for heart attack patients			NA
Rate of readmission for heart failure patients			
Rate of readmission for pneumonia patients			

Source: Medicare. (2025). *Hospital Comparison Tool* [Data Set]. Centers for Medicare and Medicaid Services. https://www.medicare.gov/care-compare/?redirect=true&providerType=Hospital

Notes: NA=not available. Green cells indicate the hospital was statistically better than the national average on the measure. Red cells indicate the hospital was statistically worse than the national average on the measure. Gray cells indicate the hospital was statistically no different than the national average on the measure.

4. Consequences of High Prices

High prices for health care services have a wide range of negative impacts throughout the State of California. High prices for services mean that premiums for private health insurance will be higher, making it more difficult for many to afford coverage. As a result, more people will be uninsured. The economics literature shows that when premiums for employer-sponsored health insurance increase, much of the burden falls on employees (discussed below). Most visible is the higher dollar amounts that employees must contribute to premiums. Less visible is the extent to which increased premiums for health insurance lead to smaller wage and salary increases for employees in firms continuing to provide coverage.

Economists explain how employers attempt to develop a compensation package consisting of wages, health insurance and other fringe benefits, such as pensions, that they perceive as most attractive to employees. As health insurance becomes more expensive, some employers make

health insurance less comprehensive to limit the increased cost, reduce increases in wages and salaries or reduce pension contributions. Research suggests that a substantial portion of increased health insurance premiums is funded by reduced wage increases.[30] A recent Health Affairs Forefront Blog by Daniel Arnold pointed out how this acts as a highly regressive tax, placing particularly large burdens on low-wage employees.[31] This inequity affects job security, as rising health insurance premiums lead more employers to outsource work by low-wage employees, for example, janitorial services or food services, to companies offering less comprehensive health insurance or no insurance at all.

The relationship between premiums and wages came up frequently in interviews with leaders of labor unions representing employees in Monterey County. Those interviewed expressed serious concerns about the impact of high health insurance premiums, which they attributed to high prices for hospital services, on the welfare of their members. They pointed to wage increases being small or nonexistent as a result of health insurance premium increases. According to one respondent: “High and rising health care costs mean the union members are not going to get salary increases or more in pensions.” They described how health plans run by unions tried to respond to rising insurance premiums, including increasing cost sharing to enrollees, narrowing enrollee choice of provider, and suggesting and supporting individual members or dependents to get care outside of the county in order to keep costs down. This includes traveling 40 miles to Gilroy for hip and knee replacements, 80 miles to Stanford Medicine for some highly specialized services, and to a variety of hospitals outside the county for maternity care.

Higher premiums for health insurance strain government budgets on both the spending side and the revenue side. Since employer and most employee contributions to employer-sponsored health insurance are excluded from employees’ taxable income, revenues at both the federal and state level are reduced. For fiscal year 2026, the federal loss of revenue from the exclusion is projected to be $309.4 billion.[32] Effects on California revenue are believed to also be substantial, but published estimates are not available. Higher premiums will also raise governments’ spending for employee health benefits.

The higher health insurance premiums are, the greater the number of lower-income persons who will be unable to afford insurance.[33] To the degree that some employers drop coverage in response to higher premiums, more low-wage workers with incomes below Medi-Cal thresholds

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[30] See, for example, Baicker, K., & Chandra, A. (2006). The Labor Market Effects of Rising Health Insurance Premiums. *Journal of Labor Economics, 24*(3), 609-634. https://doi.org/10.1086/505049 ,Sommers, B. D. (2005). Who really pays for health insurance? The incidence of employer-provided health insurance with sticky nominal wages. International Journal of Health Care Finance and Economics, 5(1), 89-118. https://doi.org/10.1007/s10754-005-6603-5 . A recent study focused on higher health costs driven by hospital mergers is Arnold, D., & Whaley, C. (2020). Who Pays for Health Care Costs?: The Effects of Health Care Prices on Wages. *RAND Corporation*. https://doi.org/10.7249/WRA621-2

[31] Arnold, D. (2025, August 8*). Beyond The Bill: The Hidden Economic Toll Of High Commercial Provider Prices*. Health Affairs. https://www.healthaffairs.org/content/forefront/beyond-bill-hidden-economic-toll-high-commercial-provider-prices

[32] U.S Department of the Treasury. (2024, November 27). *Tax Expenditures Fiscal Year 2026*. https://home.treasury.gov/system/files/131/Tax-Expenditures-FY2026.pdf

[33] Brot-Golderberg, Z., Cooper, Z., Craig, S. V., Klarnet, L.R., Lurie, I., & Miller, C.L. (2024). Who Pays for Rising Health Care Prices? Evidence from Hospital Mergers*. National Bureau of Economic Research*. https://doi.org/10.3386/w32613

will enroll, expanding enrollment in the program. This increases fiscal pressure on the state's budget and on the federal budget because of matching federal funds provided to states. The federal government also offers premium tax credits or subsidies to those obtaining insurance through Covered California and similar health insurance exchanges in other states. Overall, at both the federal and state level, higher health care prices will "crowd out" spending on other public priorities and either lead to tax increases or preclude tax reductions. Since states must balance their budgets each year, effects at the state level could be even stronger than at the federal level.

5. Understanding High Prices

This section goes through possible explanations for the high prices observed. It starts by looking at costs. If the operating costs (e.g., labor) at Monterey hospitals are exceedingly high then this may partially explain the high costs. After operating costs, another factor to consider is if there is a lack of competition in Monterey. There has been a substantial amount of research on health care consolidation (and hospitals in particular) that has shown that consolidation (i.e., less competition) has led to higher prices.[34] After assessing the state of competition, this section addresses the idea that hospitals raise commercial prices in response to increased patient volume from public payers or reductions in rates from public payers. Finally, this section discusses inadequate margins for professional services, which came up frequently in interviews with the hospitals.

a. Costs

i. HCAI hospital annual financial data

High prices might be explained by higher operating costs. For instance, if Monterey hospitals had to pay health professionals significantly more to convince them to work in Monterey, this could explain a portion of the higher prices. But the data do not support this. The costs per service for Monterey hospitals are not unusually high by Bay Area standards. As already seen from the Alternative Medicare Wage Index (Figure 8), the labor costs in Monterey are not higher than other Bay Area counties. Figure 12 shows operating expenses per case-mix adjusted discharge among Bay Area hospitals in 2023 using HCAI's hospital annual financial data. Case-mix adjusted discharges are calculated by multiplying inpatient discharges by an outpatient factor and a hospital's case-mix index.[35] The outpatient factor adjusts for the fact that hospitals with a lot of outpatient volume are likely to have higher costs while the case-mix index adjusts for the fact that hospitals with more complex patients are likely to have higher costs.

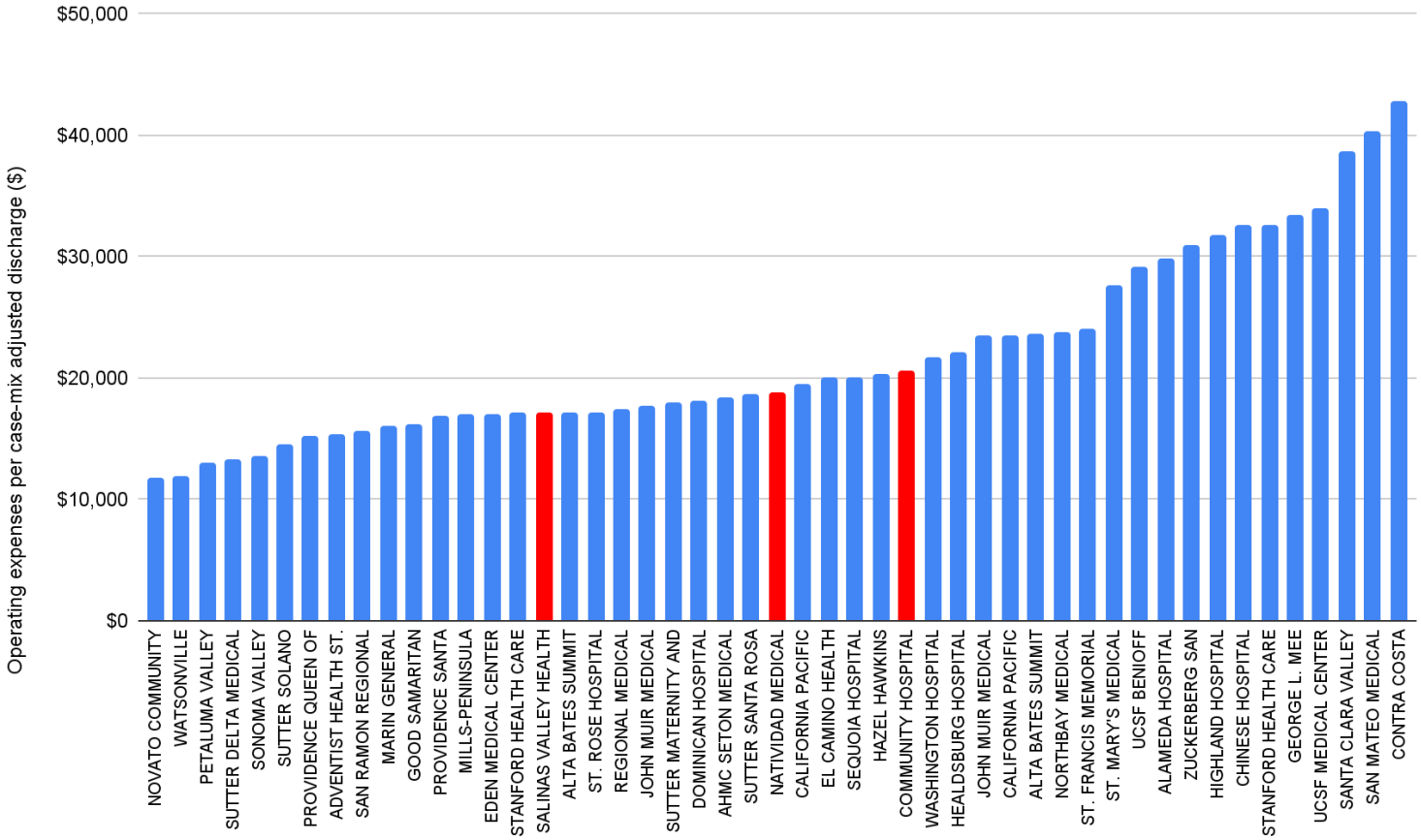
Figure 12 shows CHOMP and Natividad fall near the median ($18,818) among Bay Area hospitals at around $20,000 in operating expenses per case-mix adjusted discharge while

[34] Levinson, Z., Godwin, J., Hulver, S., & Neuman, T. (2024, April 19). *Ten Things to Know About Consolidation in Health Care Provider Markets*. Kaiser Family Foundation. https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

[35] Note that this is a different approach than HCAI takes when calculating its inpatient NPR per case-mix adjusted measure which does not account for outpatient volume. Not accounting for outpatient volume leads to a similar conclusion that Monterey hospitals are near the middle of the distribution.

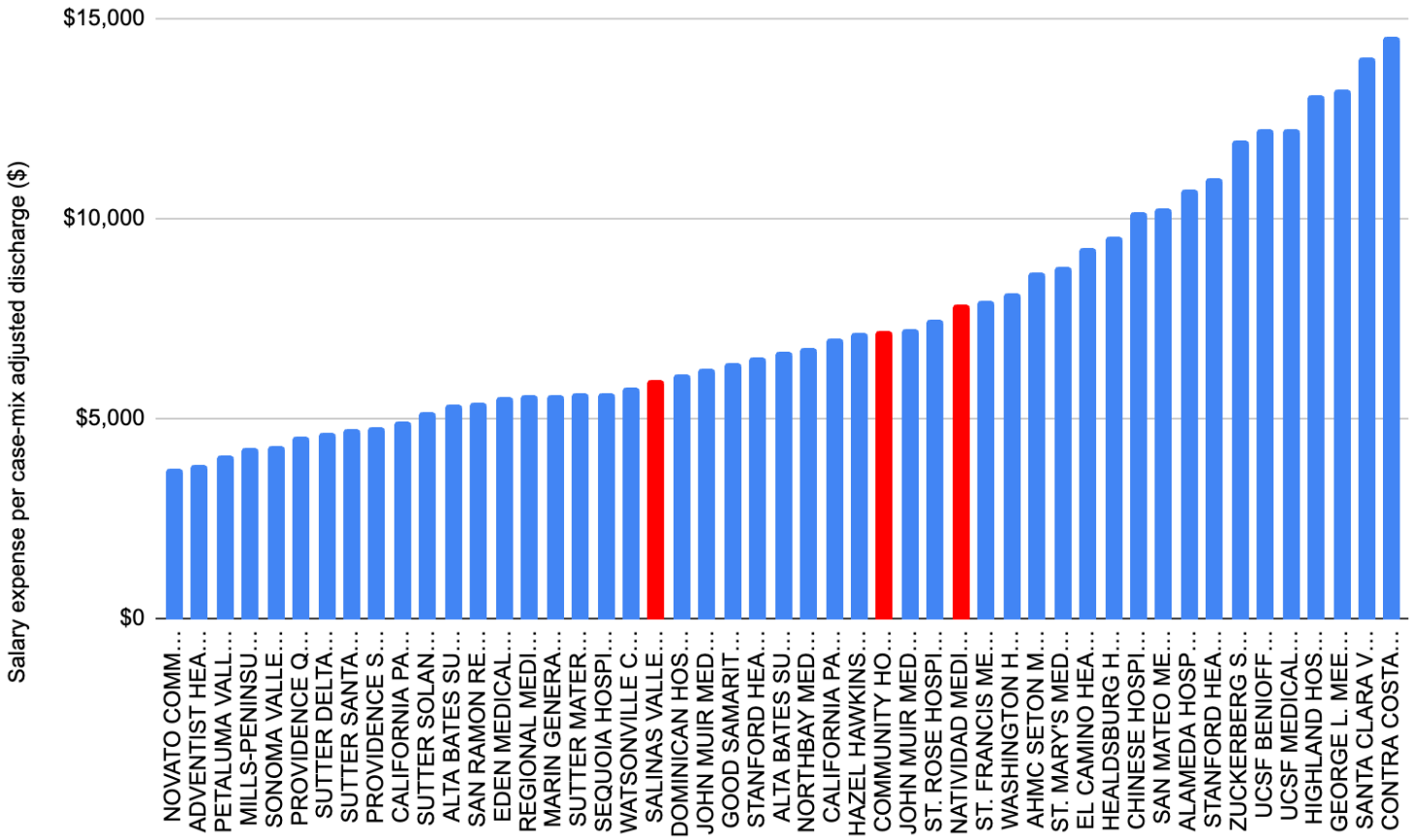
SVHMC is closer to the bottom end of the distribution at about $15,000. Figure 12 makes it clear that high input costs are not driving the high prices in Monterey. To further make this point, Figure 13 shows salary expense per case-mix adjusted discharge. Again, CHOMP and Natividad are right around the median among Bay Area hospitals while SVHMC is a bit below.

Figure 12. Operating expenses per case-mix adjusted discharge for Bay Area hospitals, 2023



Source: Authors' analysis of 2023 HCAI hospital annual financial data

Figure 13. Salary expense per case-mix adjusted discharge for Bay Area hospitals, 2023

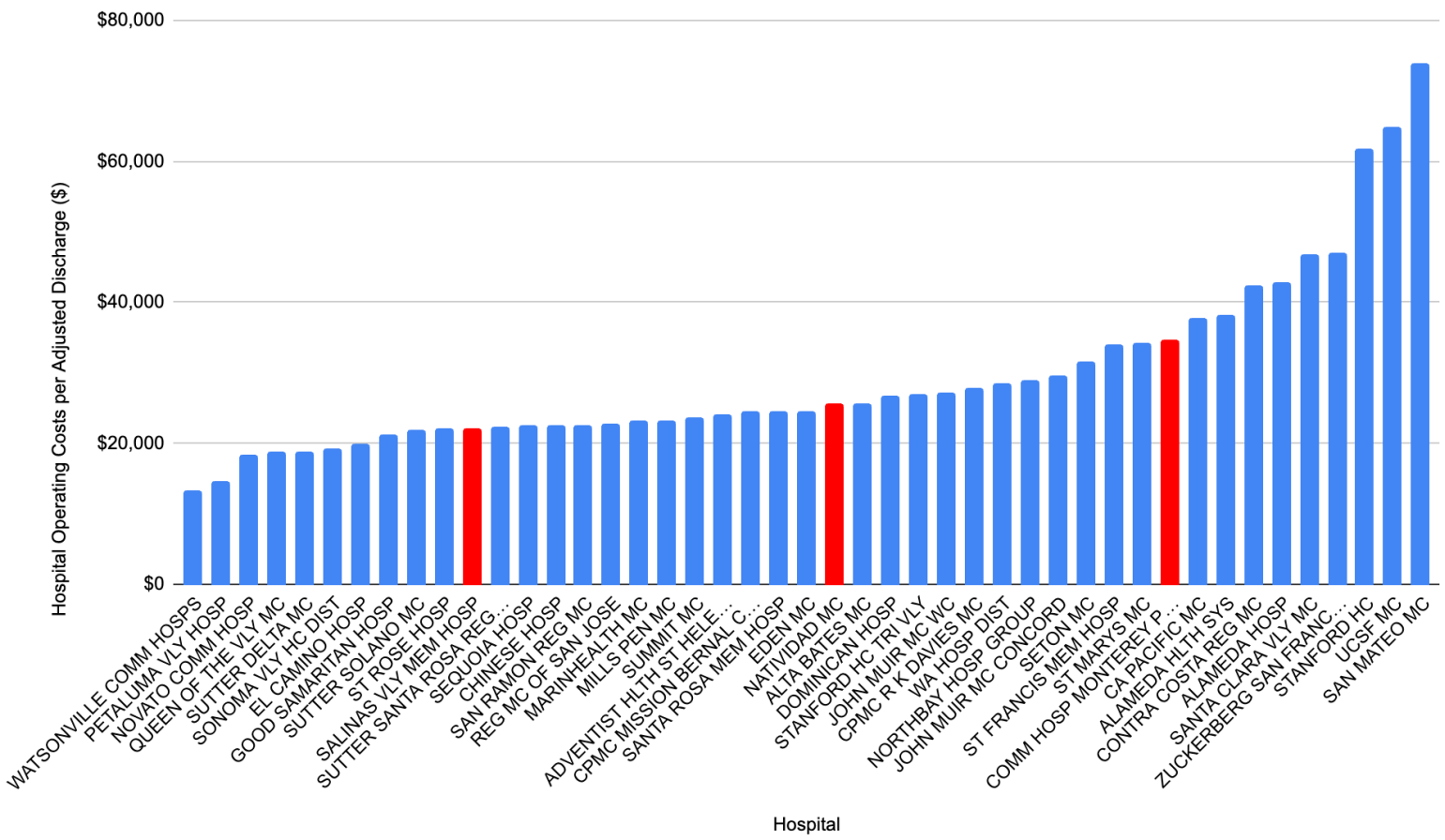


Source: Authors' analysis of 2023 HCAI hospital annual financial data

ii. Medicare cost report analysis

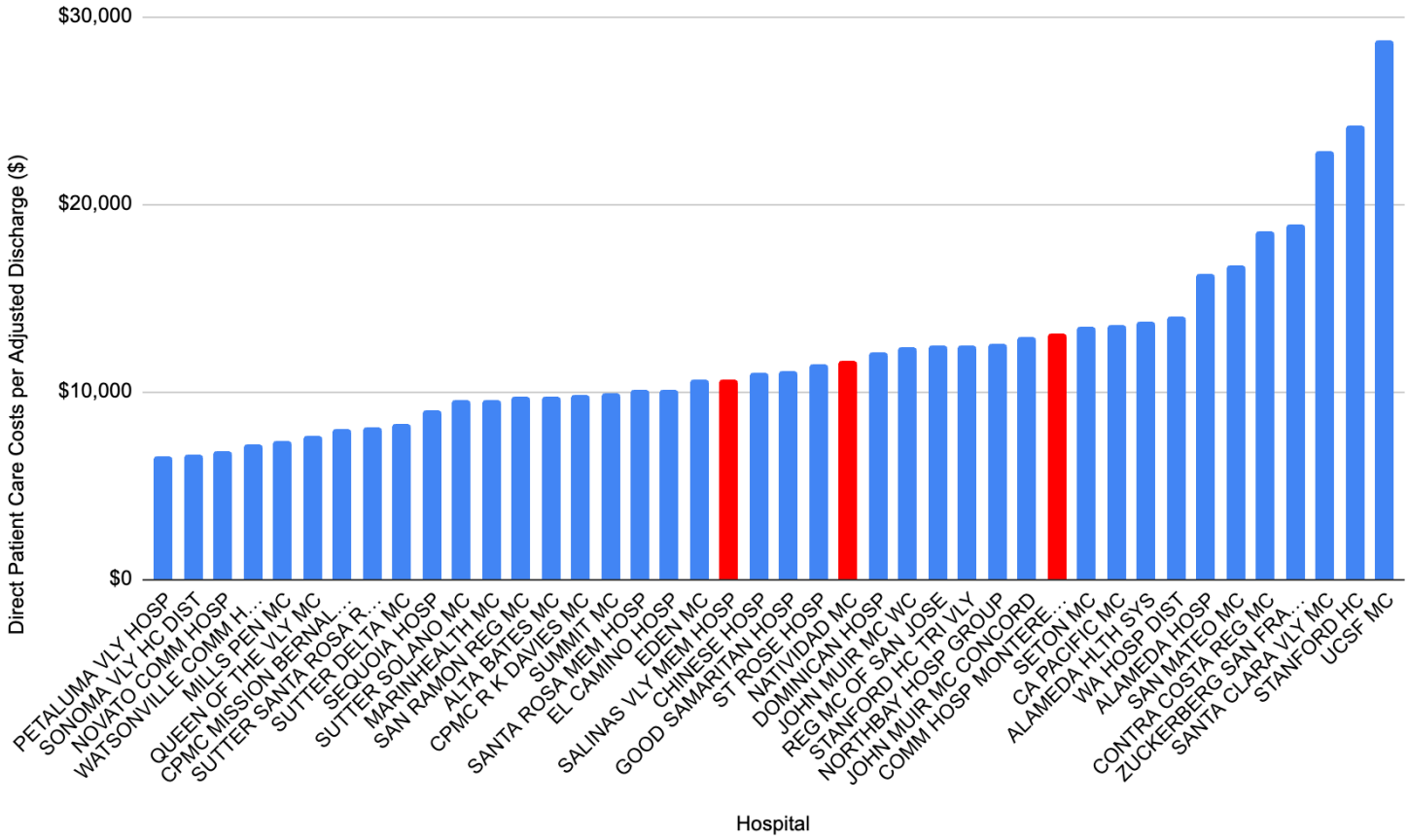
Figures 14 and 15 analyze two more measures of costs—hospital operating costs per adjusted discharge and direct patient care costs per adjusted discharge—using data from the Medicare Cost Reports as collected by NASHP. Adjusted discharges in Figures 14 and 15 account for outpatient volume, but do not include a case-mix adjustment as it is not always available in the Medicare Cost Reports. Still, the story is largely the same for these additional cost measures– the Monterey hospitals are not outliers in terms of costs when compared to other Bay Area hospitals.

Figure 14. Hospital operating costs per adjusted discharge for Bay Area hospitals, 2023



Source: Authors' analysis of NASHP data https://tool.nashp.org/

Figure 15. Direct patient care costs per adjusted discharge for Bay Area hospitals, 2023



Source: Authors' analysis of NASHP data https://tool.nashp.org/

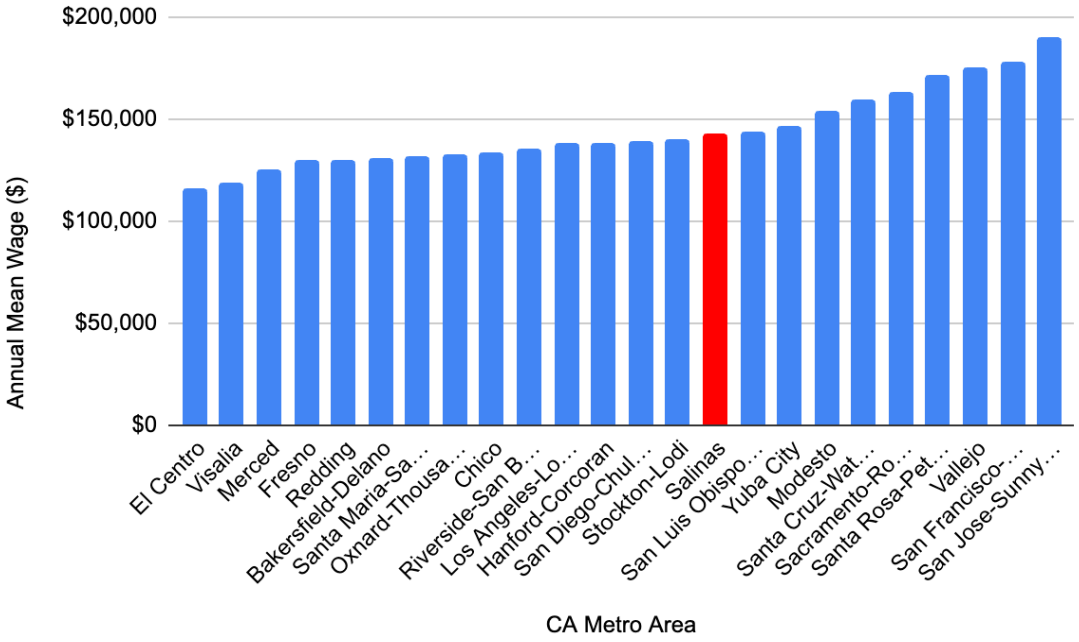
iii. Wages of health care workers

This subsection uses data from the Bureau of Labor Statistics (BLS) to dive deeper into wages and produce additional insights beyond what is available from the Alternative Medicare Wage Index. BLS data for health care workers in May 2024 show that wages for health care workers employed by hospitals in Salinas are somewhat high, but not exceptional when compared to other regions, particularly high cost of living areas in California (Figure 16). For example, Registered Nurses (RNs) earn $143,410 in annual gross income on average - more than in Santa Barbara or Los Angeles but well below San Francisco and San Jose. Licensed Practical and Vocational Nurses ($79,580) and Nursing Assistants ($48,370) follow the same pattern. Healthcare support workers and surgical technologists in Salinas also earn less than counterparts in the Bay Area. Among the 25 metro areas in California reported by the BLS, Monterey County ranks 7th for nursing assistants, 8th for Licensed Practical and Vocational Nurses, 10th for RNs, 12th for Healthcare Support Occupations, 13th for both Medical and Health Services Managers and Surgical Technologists. In short, Monterey County has wages above the state averages for most health care workers and the wages paid in Salinas are typically competitive with areas in Southern California that have a higher cost of living but are

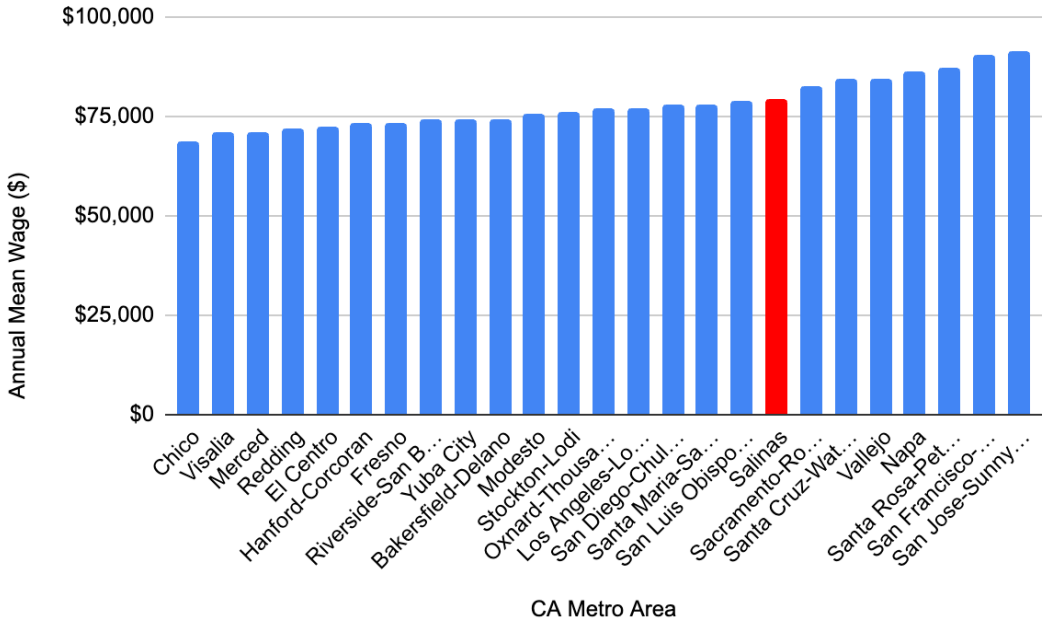
typically lower than Bay Area levels. As such, the need to pay high wages to attract and retain staff is unlikely to be a primary driver of outlier hospital prices in Monterey.

Figure 16. Annual Mean Wages for Health Care Workers, January 2024

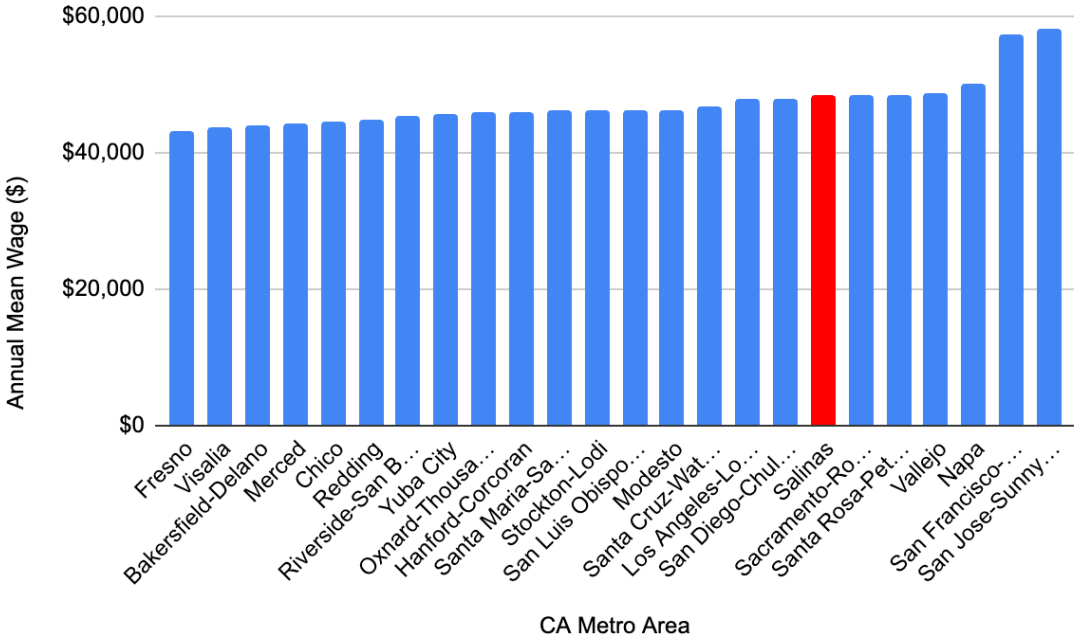
(A) Registered Nurses



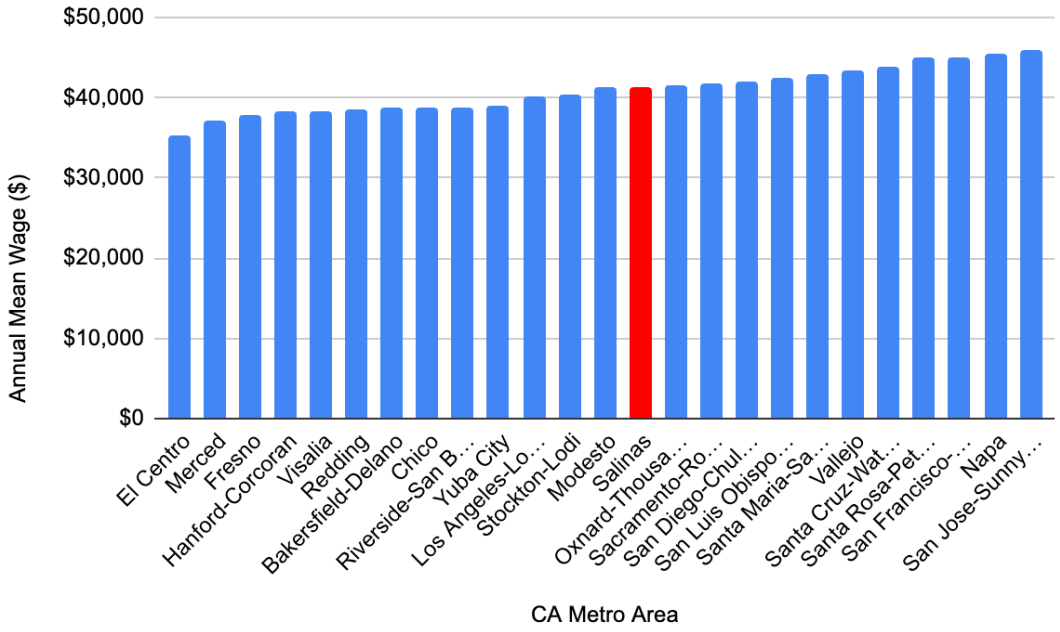
(B) Licensed and Practical Vocational Nurses



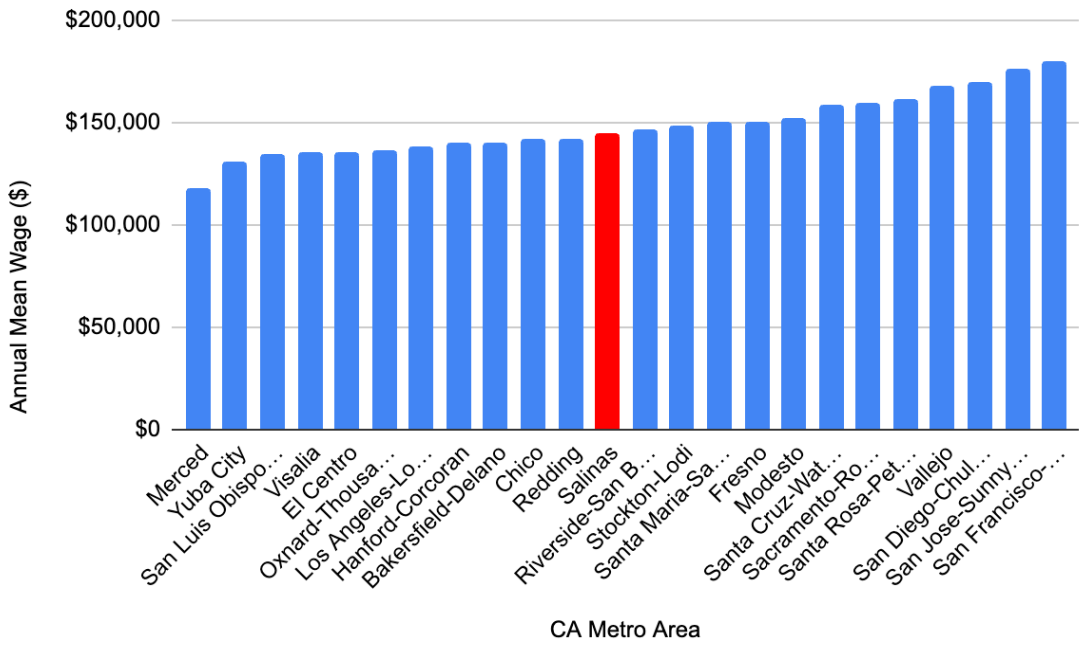
(C) Nursing Assistants



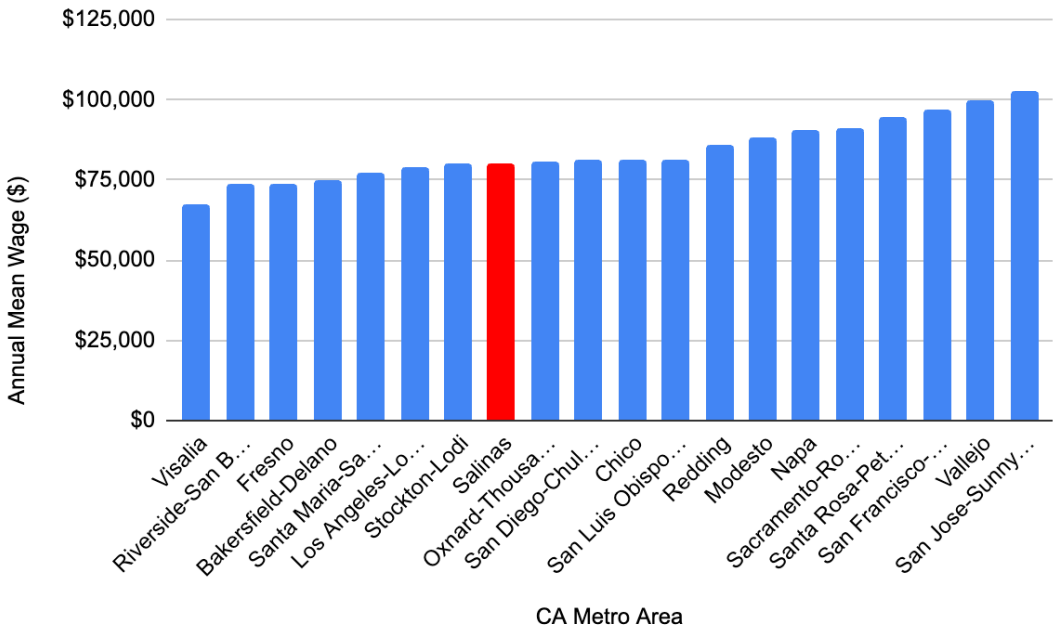
(D) Healthcare Support Occupations



(E) Medical and Health Services Managers



(F) Surgical Technologists



Source: United States Bureau of Labor Statistics. (2024). *Occupational Employment and Wage Statistics* [Data set]. https://data.bls.gov/oes/#/home

November 13, 2025

b. Lack of competition among systems

High prices can also be explained by a lack of competition. In markets with effective competition, patients benefit in several ways. In a competitive hospital market, providers would compete on several dimensions, such as by offering lower prices to attract patients and insurers and working to improve quality.[36] However, in highly concentrated hospital markets, the opposite often occurs. With fewer alternatives, hospitals have greater leverage in negotiations with health plans and insurers, leading to higher prices for health care services.[37] The lack of hospital market competition reduces motivation to limit costs and increase quality. These high prices are ultimately passed on to consumers and others paying for health insurance through higher premiums, deductibles, and out-of-pocket expenses.

Health care markets, and by extension hospital markets, have several characteristics that impede robust competition:

- *Information Asymmetry.* Patients (consumers) typically lack the specialized medical knowledge to make fully informed decisions about their treatment options, the quality of providers, and the value of different services. This information gap gives significant power to hospitals and physicians.
- *Barriers to Entry.* Establishing a new hospital is capital-intensive and requires compliance with various regulatory requirements. This can limit competition by making it difficult for new, potentially more efficient or higher-quality hospitals to enter the market. Additionally, financing a new hospital's construction is costly, with costs commonly exceeding $100 million.[38]
- *Price Insensitivity and Lack of Transparency.* The prevalence of health insurance means that patients often do not pay the full price of their care, making them less sensitive to prices when choosing providers and making decisions about treatment. Furthermore, hospital pricing is complex and opaque, making it nearly impossible for consumers to compare prices for shoppable services beforehand.
- *Externalities.* The services provided by a hospital have impacts beyond those on the patients they treat, often called spillover effects on the broader community. For example, a hospital's emergency preparedness or its provision of unprofitable but essential services like a burn unit benefits the entire community, not just the patients who use those services. A private market may under-provide these services because the hospital cannot capture the full social benefit in its revenue.

[36] Gaynor, M., Ho, K., & Town, R.J. (2015). The Industrial Organization of Health-Care Markets. *Journal of Economic Literature, 53*(2), 235-238. https://doi.org/10.1257/jel.53.2.235

[37] Ho, K., & Lee, R. S. (2017). Insurer Competition in Health Care Markets. *Econometrica, 82*(2), 379-417. https://doi.org/10.3982/ECTA13570

[38] FreshBooks. (2024, July 2). *How Much Does It Cost to Build a Hospital: Construction Cost.* https://www.freshbooks.com/hub/estimates/how-much-does-it-cost-to-build-a-hospital

- *Consolidation and Market Power.* The trend of hospital mergers and acquisitions has led to highly concentrated markets.[39] Dominant hospital systems can exercise significant market power, leading to higher prices and potentially lower quality without the competitive pressure to improve.

This subsection begins with what interviews revealed about the leverage the Monterey hospitals have. It proceeds to data analysis that supports what was learned in interviews. The data analysis begins with a calculation of market shares by zip code. Then this section proceeds with a discussion of a model of patient choice that attempts to predict where patients would go if their preferred hospitals were not available. Patient choice models produce two outputs–diversion ratios and willingness-to-pay (WTP) estimates–that are frequently used in antitrust analysis to determine the extent to which hospitals are direct competitors.

i. Insurer interviews

As part of this study, OHCA interviewed several California health plans and insurers to hear their perspectives about the Monterey Hospitals. Interviews suggest that the insurers believe the primary reason for the high prices in Monterey County is limited and ineffective competition among the hospitals. As mentioned above, interviews with insurers found that all three hospitals are must-haves for commercial plans. A hospital is considered a must-have when its inclusion in an insurer's provider network is essentially non-negotiable because consumers (or their employers) will not view the plan as adequate without it or when state or federal network adequacy standards require it be included in a network because there are not alternative sites of care in a region. In particular, network adequacy standards obligate insurers to maintain reasonable geographic access and timely access (e.g., the network must have a hospital with sufficient capacity within 30 minutes or 15 miles of each covered person's residence or workplace) in order to sell plans.[40] Network adequacy requirements can effectively turn certain hospitals into must-have providers when they are the only facility in a region offering required services. A hospital can also hold must-have status when it holds unique market power as the only provider of specialized services (e.g., trauma center, neonatal ICU, transplant program) in the region, employs or affiliates with a significant share of primary care and specialty referrals, or when it has such a strong brand reputation or loyalty that patients are unwilling to switch to alternatives. Because must-have status gives the hospital strong leverage in negotiations, insurers often must accept higher reimbursement rates.

CHOMP serves residents of Monterey, Carmel, and the surrounding affluent communities. Data from HCAI show that for zip codes 93940 and 93955, CHOMP's inpatient market share can be as high as 79% to 84%;[41] the geography of the Monterey Peninsula makes it virtually impossible

[39] Fulton, B. D. (2017). Health Care Market Concentration Trends in the United States: Evidence and Policy Responses. *Health Affairs, 36*(9), 1530-1538. https://doi.org/10.1377/hlthaff.2017.0556

[40] Gu, A. Y., Ellson, M., & Gudiksen, K.L. (2021, December 16). *Network Adequacy Standards in California: How They Work and Why They Matter*. California Health Care Foundation. https://www.chcf.org/resource/network-adequacy-standards-ca-how-they-work-why-they-matter/

[41] California Department of Health Care Access and Information. (2024). *2022-2023 Patient Origin/Market Share (Pivot Profile)* [Data set]. CalHHS. https://data.chhs.ca.gov/dataset/patient-origin-market-share-pivot-profile-inpatient-emergency-department-and-ambulatory-surgery

for an insurer to offer a competitive network in that area without including CHOMP. Natividad provides specialized services as the region's safety-net hospital with Monterey County's only Level II Trauma Center. SVHMC serves a broader geographic area than CHOMP and a more diverse patient population. In interviews, many insurers identified both SVHMC and Natividad as critical to meeting network adequacy standards for zip codes in Salinas. An executive from one insurer specifically said that "network adequacy is the biggest regulatory hurdle to having leverage with hospitals" and mentioned considering dropping CHOMP or SVHMC, but then explained that if it dropped those hospitals, it would then need to withdraw coverage in the Monterey Bay or Salinas zip codes respectively. Another insurance executive said that members would not drive between hospitals saying "in that area, dropping any of the three hospitals would be very hard. In that area, 20 miles may as well be half a world away - it's a commercial viability problem." Yet another insurance executive explained that although Monterey County represents a small share of their covered lives in California, many of their employer clients have a few employees who live there. To maintain statewide coverage for those clients, the insurer felt it had to offer plans in those zip codes—and therefore accepted the hospital rates as offered.

In short, each of Monterey County's three hospitals occupies a unique and indispensable position in the local healthcare landscape and the health plans and insurers feel they have little to no negotiating leverage. Rather than competing with each other, each of the hospitals has must-have status, allowing them to command higher prices, contributing directly to the area's elevated health care prices. While there are hospitals elsewhere in California that have must-have status, often due to unique offerings of highly specialized services, what is so unusual about Monterey County is that all three of its major hospitals have that status.

ii. Physician alignment with health systems

Across the U.S., physicians are increasingly choosing to join large medical groups or become employees of hospitals and health systems. Data from the American Medical Association (AMA) shows that the percentage of physicians in private practice fell from 60.1% in 2012 to 46.7% in 2022.[42] Conversely, the number of physicians employed directly by hospitals or in medical groups at least partially owned by a hospital increased significantly over the same period. In California, in 2023, 30% of physicians practiced in private practice, while 23% practiced primarily in a hospital (i.e., in inpatient, outpatient and emergency department settings).[43] This trend is largely driven by a desire to reduce administrative burdens to focus more on patient care. Joining a large medical group also provides physicians with financial stability, capital, and bargaining power.

This trend is apparent in Monterey County, where a significant portion of the physician workforce is either directly employed by or closely affiliated with one of the large hospital-owned medical groups. For example, in April 2025, Monterey Spine and Joint joined Montage Health,

[42] Kane, C. K. (2023). *Policy Research Perspectives: Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022*. American Medical Association. https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf

[43] Coffman, J., Fix, M., & Lee, P.R. (2025, July 9). *California Physicians Almanac — 2025 Edition*. California Health Care Foundation. https://www.chcf.org/resource/california-physicians-almanac/

with 13 of its 14 physicians now employed under the name Montage Orthopedics and Sports Medicine.[44] While some independent physician practices exist in the area, all large medical groups are owned by a health system. Additionally, with the exception of a few, highly specialized medical groups, interviews found that the few physicians in private practice typically had admitting privileges at only one hospital. While the health systems said that they did not restrict physicians from admitting at other facilities, the relatively large travel time between hospitals and the need to take calls at multiple hospitals meant that even independent physicians often admitted their patients to only one of the three hospitals. The interviews suggested that physicians may be driving consolidation and integration with health systems because they are seeking stable salaries and more predictable call schedules compared to independent private practice. Nonetheless, the literature indicates that this consolidation poses a risk of increased healthcare costs.

Nationally, a growing body of literature shows that when health systems acquire medical groups, prices for the same services tend to increase significantly without measurable improvements in the quality of care or patient outcomes.[45] Instead, the higher costs are due to the increased market power of the health system when negotiating with commercial insurers. For example, researchers at Brown University found that primary care physicians affiliated with hospitals charged 10.7% higher prices for the same office visits compared to their independent counterparts.[46] Another study found that after an acquisition by a hospital system, physician prices increased by 14%, with a high degree of variability based on specialty (e.g., prices for primary care physicians increased by 15.1% while prices for cardiologists increased by approximately 33.5%).[47] Another study, published in Health Affairs, found that vertical integration leads to statistically and economically significant increases in hospital prices and spending.[48] This phenomenon is often driven by a change in billing practices, such as the use of higher-cost hospital outpatient department fees for services that were previously billed as lower-cost office visits.

Vertical integration between hospitals and medical groups does more than raise prices. When hospitals acquire or tightly affiliate with medical groups, they not only gain greater control over referrals but also create a formidable barrier to entry for potential competitors[49]. The challenge

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[44] *Monterey Spine & Joint joins Montage Health's family of services*. (2025, April 9). Montage Health. https://www.montagehealth.org/the-beat/monterey-spine-and-joint-joins-montage-health/#:~:text=MSJ%20is%20now%20called%20Montage,care%20to%20the%20local%20community

[45] Satiani, B., Way, D. P., Hoyt, D. B., & Ellison, C. E. (2025). Systematic Review of Integration Strategies Across the US Healthcare System: Assessment of Price, Cost, and Quality of Care. *Journal of the American College of Surgeons, 240*(5), 758-773. https://doi.org/10.1097/xcs.0000000000001229

[46] Singh, Y., Radhakrishnan, N., Adler, L., & Whaley, C. (2025). Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications. *JAMA Health Forum, 6*(1). https://doi.org/10.1001/jamahealthforum.2024.4935

[47] Capps, C., Dranove, D., & Ody, C. (2018). The effect of hospital acquisitions of physician practices on prices and spending. *Journal of Health Economics, 59*, 139-152. https://doi.org/10.1016/j.jhealeco.2018.04.001

[48] Baker, L. C., Bundorf, M. K., & Kessler, D. P. (2014). Vertical integration: hospital ownership of physician practices is associated with higher prices and spending. *Health Affairs, 33*(5), 756-763. https://doi.org/10.1377/hlthaff.2013.1279

[49] Harris, A., Philbin, S., Post, B., Jordan, N., Beestrum, M., Epstein, R., & McHugh, M. (2025). Cost, Quality, and Utilization After Hospital-Physician and Hospital-Post Acute Care Vertical Integration: A Systematic Review. *Medical Care Research and Review, 82*(1), 3-42. https://doi.org/10.1177/10775587241247682, Whaley, C., & Zhao, X.

for new entrants is that they must compete simultaneously on multiple fronts. A stand-alone medical group or independent clinic can no longer rely on a steady stream of referrals from community physicians, because many of those physicians are now contractually or financially tied to the incumbent health system. Likewise, an aspiring hospital entrant faces the uphill task of building not just inpatient capacity but also an outpatient referral network that can steer patients into the hospital. In essence, successful entry now requires establishing a presence at multiple levels of the delivery system at once, and that significantly increases both the cost and the risk of market entry.

These dynamics extend even to non-hospital competitors like ambulatory surgery centers (ASCs) or specialty clinics. In less consolidated markets, ASCs can thrive by partnering with independent physicians who refer patients for outpatient procedures. But in a market like Monterey, where medical groups are absorbed into hospital systems, those referral streams dry up. Physicians employed by a hospital system are rarely free to refer patients outside the system, and even when they technically can, there are often strong financial or contractual disincentives to do so. As a result, a new ASC in Monterey would likely struggle to attract enough volume to remain financially viable, regardless of whether its prices are competitive or its quality is high.

As a result, while physician professional fees in Monterey County are currently similar to statewide averages, they could rise significantly as physicians gain market power through affiliations with health systems.

iii. Market shares by zip code

There is very little travel in or out of the county for health care services in Monterey. In 2022-2023, 87% of the discharges of Monterey County residents were at hospitals in Monterey County. Santa Clara and Santa Cruz were the next most visited counties with 7% and 2% of discharges, respectively.[50] The Monterey hospitals also provided very little care to out-of-towners–only 6% of discharges at Monterey County hospitals were of non-Monterey County residents. This dearth of movement in or out of the county makes it clear that any source of competition would occur within the county borders.

Table 5 shows the market share of inpatient discharges for each hospital that accounted for greater than 1% of the inpatient discharges of Monterey residents. CHOMP accounted for 34% of discharges, SVHMC accounted for 28%, and Natividad accounted for 23%. After these three, Stanford (including its Children's hospital) was next with 6% followed by UCSF with 1%. Aside from high acuity cases that sometimes go to Stanford, Monterey residents hardly ever travel outside the county for care.

(2024). The Effects of Physician Vertical Integration on Referral Patterns, Patient Welfare, and Market Dynamics. *Journal of Public Economics, 238*, 105175. https://doi.org/10.1016/j.jpubeco.2024.105175, and Post, B., Buchmueller, T., & Ryan, A.M. (2017). Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality. *Medical Care Research and Review, 75(4)*, 399-433. https://doi.org/10.1177/1077558717727834

[50] Authors' analysis of HCAI 2022-2023 Patient Origin/Market Share (Pivot Profile).

Table 5. Total inpatient discharges of Monterey County residents, 2022-2023

Hospital	# of IP discharges	Market share
COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA	14,642	34%
SALINAS VALLEY HEALTH MEDICAL CENTER	12,023	28%
NATIVIDAD MEDICAL CENTER	9,903	23%
STANFORD HEALTH CARE	1,240	3%
LUCILE PACKARD CHILDREN'S HOSPITAL STANFORD	1,088	3%
UCSF MEDICAL CENTER	551	1%
WATSONVILLE COMMUNITY HOSPITAL	436	1%
GEORGE L. MEE MEMORIAL HOSPITAL	390	1%
DOMINICAN HOSPITAL	238	1%
Total discharges of patients residing in Monterey County	**42,685**	**100%**

Source: HCAI 2022-2023 Patient Origin/Market Share (Pivot Profile)
Notes: Hospitals with less than 1% market share not shown.

Table 6 paints the same picture in terms of emergency department (ED) encounters. The three Monterey hospitals account for 86% of ED encounters with SVHMC (32%) and Natividad (29%) leading in terms of market share.

Table 6. Total ED encounters of Monterey County residents, 2022-2023

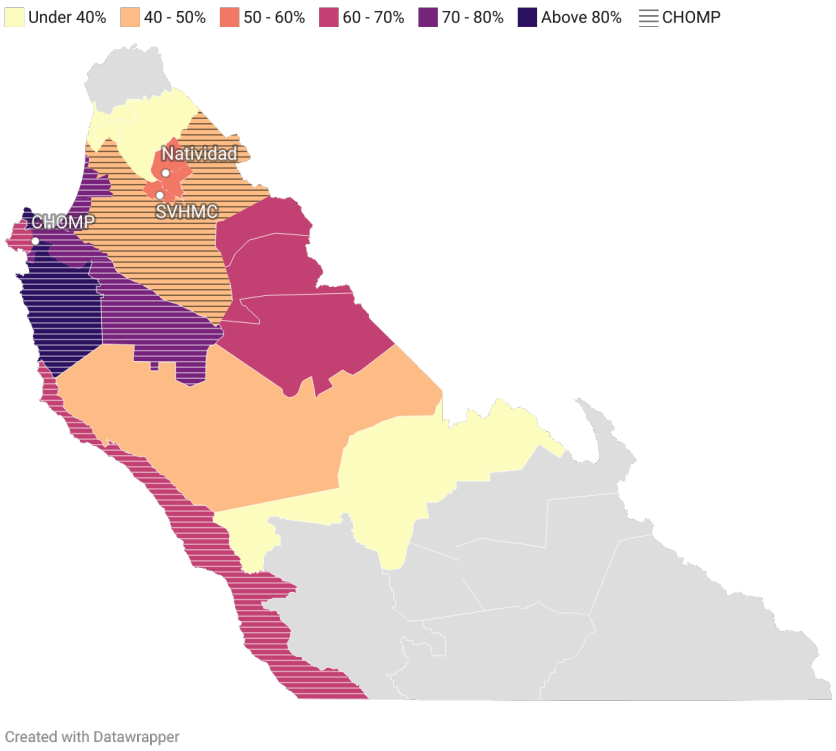
Hospital	# of ED encounters	Market share
SALINAS VALLEY HEALTH MEDICAL CENTER	121,595	32%
NATIVIDAD MEDICAL CENTER	108,904	29%
COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA	96,359	25%
GEORGE L. MEE MEMORIAL HOSPITAL	30,721	8%
WATSONVILLE COMMUNITY HOSPITAL	5,217	1%
Total ED encounters of Monterey County residents	**380,030**	**100%**

Source: HCAI 2022-2023 Patient Origin/Market Share (Pivot Profile)
Notes: Hospitals with less than 1% market share not shown.

The previously mentioned issue of Monterey residents having to travel and navigate mountainous terrain when they seek care is reflected starkly in zip code market shares. Figure 17 shows the commercial market share of the market leader in each zip code. CHOMP is the market leader in the colored zip codes that are hatched. SVHMC is the market leader in the

colored zip codes that are not hatched. Natividad is not the commercial market share leader in any Monterey zip code, which is partially a reflection of the fact that it does much less commercial business than CHOMP and SVHMC. None of the three Monterey hospitals are the market leader in the gray zip codes.[51] The takeaway from Figure 17 is that the Monterey hospitals dominate their local markets with zip code shares often above 50% and sometimes above 80%.

Figure 17. Market leader's commercial market share by Monterey zip code



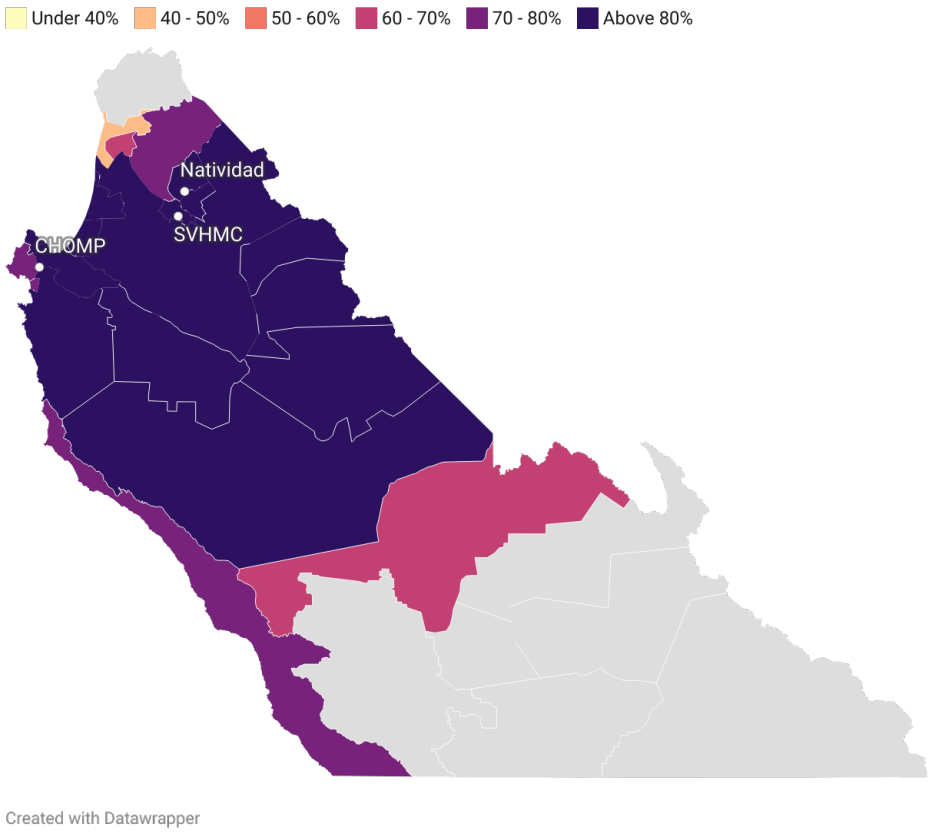
Source: HCAI 2022-2023 Patient Discharge Data
Notes: The figure shows the highest commercial market share within each zip code in Monterey County. CHOMP is the market leader in the hatched colored areas. SVHMC is the market leader in the colored areas that are not hatched. The market leader in the grayed zip codes is not one of the three hospitals that are the focus of this report. The colored zip codes account for 83% of the discharges in Monterey County. The gray zip code at the top of the county accounts for 15% of discharges while gray zip codes at the bottom of the county account for 2% of discharges.

Figure 18 shows the combined market share of the three Monterey hospitals in the zip codes that were colored in the previous figure. In the vast majority of zip codes, the three hospitals combine for over 80% of the market, showing that hardly any inpatient care for Monterey

[51] The gray zip code at the top of the county accounts for 15% of discharges in the county while the gray zip codes at the bottom collectively account for only 2% of county discharges.

residents is being delivered outside the county. The levels of market share shown in Figures 17 and 18 are a strong indicator of market power.

Figure 18. Combined commercial market share of CHOMP, SVHMC, and Natividad by Monterey zip code



Source: HCAI 2022-2023 Patient Discharge Data
Notes: The colored zip codes account for 83% of the discharges in Monterey County. The gray zip code at the top of the county accounts for 15% of discharges while gray zip codes at the bottom of the county account for 2% of discharges.

iv. Hospital choice model

In markets with significant differentiation among providers—based on factors like geography, size, patient mix, teaching status, and range of services—traditional measures of market concentration like market shares may not provide a full explanation of high commercial prices. For this reason, a more direct assessment of market power and competitive dynamics is often necessary. This involves using economic tools that are agnostic with respect to formal market definition but provide insight into the intensity of competition between hospitals.

Two common measures used to evaluate hospital competition are diversion ratios and willingness to pay (WTP) estimates. To produce these measures, economists first estimate a patient choice model that identifies patients' preferred ranking of hospitals. These models estimate how a patient's choice depends on factors such as hospital characteristics (e.g., size

and teaching status), the patient's zip code (which determines travel time), the patient's medical condition, and their age and sex. Based on these characteristics, the model can predict a patient's first-choice hospital as well as their second choice if their preferred hospital were unavailable. This predictive foundation allows for a quantitative assessment of competitive interactions.

The model used here follows the one described in Raval et al. (2017).[52] The process is guided by two key elements: a pre-determined order of variables ranked from most to least important in predicting patient choice based on prior research, and a minimum group size (e.g., 25 patients) to ensure more precise estimates.

The variable hierarchy used is:

1. Patient location
    a. Zip code
2. Admission type
    a. Major diagnostic category
    b. Emergency admission indicator
    c. DRG type (medical vs. surgical)
    d. DRG weight quartile
    e. DRG
3. Patient demographics
    a. Age group (<19, 20-44, 45-59, 60+)
    b. Sex
    c. Race/Ethnicity

As described further below, performing detailed sorting of patient segments enables more accurate predictions about how people behave. For example, instead of just assuming patients will go to the next closest hospital if their hospital closes, this approach can reveal that a specific group—like older patients with heart conditions—would actually prefer to travel farther to a hospital with a better cardiac unit. By creating these highly customized segments, researchers can replace broad assumptions with data-driven insights, allowing them to more accurately predict how a major change, like a hospital merger, will truly affect a community.

- The iterative process begins with the most specific attempt at grouping, where the model tries to match patients across all nine characteristics listed above, from their location down to their demographics. The model then reviews these initial groups, and any that meet or exceed the minimum size requirement, such as 25 admissions, are considered complete.
- For all patients who remain in groups that are too small, the model starts to relax the criteria. It removes the least important characteristic from the pre-determined hierarchy

[52] Raval, D., Rosenbaum, T., & Tenn, S. A. (2017). A semiparametric discrete choice model: An application to hospital mergers. *Economic Inquiry, 55*(4),1919-1944. https://doi.org/10.1111/ecin.12454

("Race/Ethnicity" is removed first) and then re-groups the remaining patients based on the remaining eight characteristics.[53]
- This procedure repeats, progressively dropping the next least important variable and regrouping until every patient has been allocated to a group that satisfies the minimum size requirement. The end result is a collection of highly customized patient segments.

A diversion ratio is a percentage that shows what would happen if a specific product or service were no longer available. It answers the question: "If Hospital A were dropped from your insurance network, what percentage of its patients would divert their business to Hospital B?" This metric is meant to provide a clear, data-driven measure of how closely two businesses compete. A high diversion ratio indicates that two companies are strong substitutes in the eyes of consumers and are therefore direct, head-to-head competitors. For example, if Doctor Office A closes and 40% of its patients divert to Doctor Office B down the street, the diversion ratio is 40%, revealing a potentially significant competitive relationship between them.

Economists often calculate diversion ratios from the hospital choices of commercial patients (as opposed to Medicare and Medi-Cal patients) because commercial patients are, from a financial perspective, the most sought after by hospitals due to their higher reimbursement rates. This is the approach taken in what follows.

Table 7 shows the commercial diversion ratios among CHOMP, Salinas Valley, and Natividad. The ratios suggest that if CHOMP were not available, its patients would be more likely to flow to SVHMC (32%) than Natividad (14%). After Natividad, the model predicts CHOMP patients would go to Stanford (9%) and UCSF (5%).

Given their proximity, it is no surprise that the model predicts 59% of Natividad's patients would go to SVHMC while a much smaller, but still significant 21% would go to CHOMP. What is perhaps a surprise is that the model predicts SVHMC's patients would go about equally to CHOMP (32%) and Natividad (30%). There must be characteristics of SVHMC patients that make the services of CHOMP attractive enough that they are willing to forgo the shorter drive to Natividad.

Table 7. Diversion ratios

	To CHOMP	To SVHMC	To Natividad	To Stanford	To UCSF
From CHOMP	NA	32%	14%	9%	5%
From SVHMC	32%	NA	30%	12%	3%
From Natividad	21%	59%	NA	7%	3%

Source: Authors' analysis of 2022-2023 HCAI patient discharge data (PDD).

[53] Arnold Analytics experimented with altering the order of removal of the characteristics toward the bottom of the hierarchy and the results were similar.

It is important to note that diversion ratios are a measure of *consumer behavior*, not hospital conduct. High ratios only say that, from the patient's perspective, two hospitals are close substitutes. They reveal the underlying structure of the market and answer the question: "If forced to choose, where would patients go?" While symmetric high ratios can show that two hospitals are each other's biggest competitive threat, they do not guarantee that the two hospitals are intensely competing. For instance, there is a classic antitrust concern, known as tacit collusion or coordinated effects, that is a form of market failure that happens precisely because the hospitals are such close substitutes. The reason the two hospitals can maintain high prices without a formal agreement is that they both understand that (1) they are mutual threats (each knows that a huge portion of the other's patients would switch over if it lowered prices) and (2) the risk of a price war between them could be devastating on both of their bottom lines.

Table 8 shows willingness to pay (WTP) estimates calculated from commercial patients residing in Monterey County. Economists calculate WTP to assess hospital market power. WTP attempts to measure the incremental attractiveness of a hospital to individuals in an area and, in turn, the importance of the hospital to health plans trying to market their products to individuals.[54] The units for WTP estimates are in something economists call "utils." The way to interpret WTPs is not based on their actual values, but on how much higher they are relative to those of other hospitals.

Based on the WTPs in the middle column of Table 8, CHOMP and SVHMC have a lot of market power as their WTPs are about 4x higher than Natividad,[55] the next highest WTP in the table, and over 10x higher than Stanford and UCSF. Stanford and UCSF have market power in their respective local markets, but not in Monterey County according to WTP. The last column in Table 8 weights admissions using DRG weights to recognize that hospitals that do more complex care (higher DRG weights) could be more important to health plans trying to construct a viable network. This weighting unsurprisingly shrinks the gap between CHOMP/SVHMC and Stanford/UCSF given the amount of complex care the latter are capable of, but the gap is still immense, indicating that CHOMP/SVHMC have a lot of market power either way you choose to calculate WTP.

[54] WTP in the context of hospital competition was introduced by Town, R., & Vistnes, G. (2001). Hospital competition in HMO networks. *RAND Journal of Economics, 20*(5), 733-753. https://doi.org/10.1016/s0167-6296(01)00096-0 . More formally, WTP estimates are produced by estimating a patient choice model that probabilistically identifies a patients' first and second choice hospitals and then estimates how much worse off patients would be if they were forced to switch to their second-choice. That difference, summed across all patients, determines the incremental value of a hospital to a health plan, and thus determines the hospital's WTP.

[55] Part of the reason Natividad shows up lower in this table is that it does not do nearly the commercial volume that CHOMP and SVHMC do. Looking at the implied WTPs among Medicaid patients would make Natividad look stronger.

Table 8. Willingness to pay estimates

	WTP	WTP weighted
CHOMP	11,374	15,195
SVHMC	9,162	11,722
Natividad	2,397	3,963
Stanford	1,094	2,218
UCSF	571	1,332

Source: Authors' analysis of 2022-2023 HCAI patient discharge data (PDD).
Notes: WTP=willingness to pay. Based on commercial discharges of Monterey County residents. The weighted version assigns each admission its DRG weight (instead of 1) to recognize that hospitals that do more complex care (higher DRG weights) could be more important to plans trying to construct a viable network.

c. Cost-shifting

The term "cost-shifting" is used to describe a hospital's reaction to payment rates from public programs like Medicare and Medicaid not keeping pace with the cost of delivering care.[56] The theory is that the hospital will compensate for the lower rates paid by Medicare and Medicaid by negotiating higher payment rates from the commercial health plans and insurers it contracts with. This reactive price increase to shift the cost burden to commercial payers is distinct from the common practice of price discrimination, which is simply the act of charging different payers different prices for the same service. For hospital rates, much of the difference between rates negotiated with commercial insurers and rates set by the Medicare and Medicaid[57] programs likely reflects price discrimination (i.e., commercial plans are charged a higher rate because they will pay more than government payers).

The idea of cost-shifting is widely promoted by many hospital executives, but economists have long been skeptical. Economists' fundamental challenge to the idea is a simple but powerful question: If a hospital truly had the ability to get higher rates from private payers, why would it have waited for insufficient increases or even a reduction in rates from public payers to do so? A rational, revenue-maximizing hospital would presumably already be charging the highest price the market would bear.

The broad consensus within the economics literature is that cost-shifting by hospitals is not a prevalent or significant market phenomenon.[58] For the majority of hospitals, the conditions for

[56] The ideas discussed in this section draw extensively from Ginsburg, P. B. (2023). *Government And Commercial Insurer Payment Rates To Hospitals: A Commentary On Priselac*. Health Affairs Forefront. https://www.healthaffairs.org/content/forefront/government-and-commercial-insurer-payment-rates-hospitals-commentary-priselac

[57] With most Medicaid patients enrolled in managed care plans that receive capitation payments, there likely is some negotiation of hospital rates between hospitals and Medicaid carriers.

[58] Frakt, A. B. (2011). How much do hospitals cost shift? A review of the evidence. *The Milbank Quarterly, 89*(1), 90-130. https://doi.org/10.1111/j.1468-0009.2011.00621.x

cost-shifting do not exist. Most operate in metropolitan or suburban areas with other viable hospitals nearby. This competition creates a market where insurers have significant negotiating power. If one hospital demands a steep price increase, an insurer can often threaten to remove it from its network, knowing its members can go to another quality hospital down the road. In this competitive environment, a hospital has very little leverage to simply raise its commercial rates in response to changes in government rates.

In fact, research suggests the opposite of cost-shifting often happens. When faced with payment rate cuts from Medicare, many hospitals are forced to become more efficient and reduce their costs to protect their operating margins. Some studies have even found that a reduction in Medicare payments was associated with a corresponding reduction in prices charged to private insurers, as hospitals lowered their rates to attract a higher volume of privately insured patients to make up for the revenue gap.[59] This suggests that for the average hospital, public payments impose a discipline that leads to cost control rather than cost-shifting.

Despite its general rarity, cost-shifting can occur when specific market conditions lead to a hospital having extraordinary leverage with health plans. This can manifest as a hospital being the sole provider in a geographic area, making it an essential part of any insurer's network. It can also result from a hospital having achieved “must-have” status through a stellar reputation for unique, high-quality specialized services, such as a top-tier cancer institute or transplant center. In either case, the hospital is insulated from normal competitive pressures, and insurers have no choice but to meet its price demands to offer in-network access for their enrollees.

It is possible that some of the nonprofit hospitals with must-have status along with strong orientation towards their community or social missions may not have historically maximized their revenue from private insurers, leaving them with the ability to raise rates if their financial viability is threatened by reduced public payer rates. In this case, a high proportion of patients funded by public payers (or uninsured) could lead to higher prices negotiated with private insurers.

If cost-shifting is indeed happening in Monterey County, it could partially explain Natividad and SVHMC having relatively high prices in relation to other hospitals in California. Natividad and, to a lesser extent, SVHMC have a higher percentage of patients funded by public payers than the statewide average. In 2022, the statewide average payer mix was 62% public payer (Medicare + Medi-Cal). SVHMC’s public payer share was 70% and Natividad’s was 78% in that year. This level of public payer share could potentially explain some of the high prices at these two hospitals if they were able to cost-shift. CHOMP’s public payer share was 63% in 2022—right in line with the statewide average—so an unfavorable payer mix does not serve as an explanation for its relatively high prices.

In sum, the evidence is generally against cost-shifting being a real phenomenon. It is theoretically possible in the context of must-have hospitals, but there is no published literature that has identified cost-shifting by must-have hospitals, making it difficult to comment on how

[59] White, C. (2013). Contrary to cost-shift theory, lower Medicare hospital payment rates for inpatient care lead to lower private payment rates. *Health Affairs, 32*(5), 935-943. https://doi.org/10.1377/hlthaff.2012.0332

likely it is that the Monterey hospitals are successfully cost-shifting. But the ability to cost shift does not necessarily justify the higher prices.

d. Inadequate system margins for professional services

In interviews with OHCA and public comments submitted to the Health Care Affordability Board, Health systems in Monterey point out that they have low or negative margins for professional services in Monterey County. Financial statements from SVH show consistently low margins for their medical group, and tax filings indicate that Montage Medical Group has operated at a loss for 13 consecutive years, with the sole exception of 2020.[60] At the same time, analysis of commercial claims data shows that professional service prices in Monterey are generally in line with other regions, in stark contrast to the Monterey hospitals' facility prices (inpatient and outpatient), which stand out as among the highest in the state.

Given hospitals' demonstrated leverage in negotiating extremely high facility rates, it is unclear why affiliated medical groups continue to report sustained financial losses. One Monterey County hospital executive explained that clinics were much smaller in the past, but the financial burden grew over time as the clinics grew. Perhaps there is a strategy behind continuing to keep the rates for clinics low in contrast to rates for hospital facilities being very high. Clinics could be a "loss leader" in the sense that they generate referrals for highly profitable hospital stays or outpatient procedures. For example, physicians in hospital-owned clinics have been shown to shift patients from ambulatory surgery centers to hospital outpatient departments, which have higher prices.[61] Low professional fees could serve as a barrier to entry, making it difficult for a physician group to enter the market since it would have to earn a profit on professional services rather than favoring hospital facilities for referrals. Operating losses on clinics could provide some justification for a portion of the very high prices for inpatient and outpatient facility services, but do not explain the bulk of it. As noted above, professional fees in Monterey are about average for California while hospital facility prices are extremely high.

6. Policy Options

The evidence in this report suggests that the primary driver of high hospital prices in Monterey County is a lack of effective competition. CHOMP, SVHMC, and Natividad each hold a must-have status, meaning that health insurers cannot realistically offer a viable network without including them. This dynamic severely limits insurers' bargaining leverage, since excluding any one of the hospitals would result in a network that fails to meet patient demand or regulatory requirements. Compounding this issue is the extensive vertical integration between hospitals and medical groups, which not only increases referral capture but also reduces the likelihood that patients could be steered to lower-cost settings, even if owned by one of the hospitals (e.g.

[60] Montage Health is required to file form 990 which can be found at https://projects.propublica.org/nonprofits/organizations/942789696 . SVH and Natividad's financial statements are available at their respective websites (https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/ and https://www.natividad.com/board-of-trustees-meetings/).

[61] Richards, M. R., Seward, J., & Whaley, C. (2021). Treatment consolidation after vertical integration: Evidence from outpatient procedure markets. *Journal of Health Economics, 81*. https://doi.org/10.1016/j.jhealeco.2021.102569 and Whaley, C., & Zhao, X. (2024). The effects of physician vertical integration on referral patterns, patient welfare, and market dynamics. *Journal of Public Economics, 238*. https://doi.org/10.1016/j.jpubeco.2024.105175

surgicenters). Together, these factors create a highly consolidated and insulated market structure where regulatory action, such as loosening state network adequacy standards or antitrust enforcement, or traditional market-based policy solutions, such as encouraging new hospital construction, are unlikely to succeed in constraining prices.

Kaiser Permanente's entry into Monterey County in 2025 could introduce some competitive pressure, particularly in outpatient services, especially primary care. Early in 2025, Kaiser opened a medical office in Salinas that provides primary care, OB-GYN, pediatrics, and lab and radiology services. For hospital-based care, however, Kaiser members must rely on Watsonville Community Hospital, located in Santa Cruz County, limiting its attractiveness to many in Monterey County. Kaiser's integrated model has been shown in some markets to constrain hospital prices in some markets,[62] and Kaiser's entry into Monterey County might intensify competition locally as a new entrant. In other markets, however, general acute care hospitals may not view Kaiser as a direct rival. For example, in litigation over Sutter Health, courts treated Kaiser hospitals as excluded from the relevant market because commercial payers typically cannot substitute Kaiser providers for non-Kaiser hospitals.[63]

Spending Targets

To improve customer affordability, California (and other states) have set an annual target for overall health care spending growth (often tied to economic indicators, like growth in state gross domestic product or in wages).[64] In April 2024, the California Health Care Affordability Board set a statewide spending target for growth in per capita spending, starting at 3.5% in 2025 and gradually decreasing to 3% by 2029 for health care entities that include health plans, hospitals and large medical groups. In April 2025, the Board also approved a lower spending target for hospitals identified as having disproportionately high prices, including CHOMP and SVHMC, starting at 1.8% in 2026 and lowering to 1.6% in 2029.

Enforcement of spending targets is, by necessity, retroactive, meaning that OHCA will measure and report on which health care entities exceeded the spending target after the performance year ends. This process involves OHCA collecting and analyzing spending measures of per capita growth in total medical expenses or total health care expenditures for health care entities and determining whether the target was met for a given performance year.[65] If a health care entity exceeds the target, OHCA's progressive enforcement process includes providing technical assistance, public testimony, performance improvement plans, and financial penalties. However, there can be a significant time delay between the performance year and the time at

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[62] Ho, K., & Lee, R. S. (2017). Insurer Competition in Health Care Markets. *Econometrica, 85*(2), 379-417. https://robinlee.sites.fas.harvard.edu/papers/InsurerComp.pdf

[63] Cal. v. Sutter Health Sys., 84 F. Supp. 2d 1057, 1075 (N.D. Cal. 2000) and Sidibe v. Sutter Health, 103 F.4th 675 (9th Cir. 2024).

[64] Gudiksen, K.L., & Murray, R.B. (2022). Options for states to constrain pricing power of health care providers. Frontiers Health Services, 2. https://doi.org/10.3389/frhs.2022.1020920 and Koller, C. (2025). Moving From Aspiration to Evidence to Action. *Health Affairs Forefront.* https:/doi.org/10.1377/forefront.20250613.722568/full/

[65] Total medical expenses (TME) measures all payments from payers to providers for reimbursement of the cost of health care, including medical claims, pharmacy claims, and non-claims payments. Total health care expenditures (THCE) includes total medical expense plus administrative costs and profits of health insurers and health plans.

which any performance improvement plans or penalties are imposed. This lag helps ensure data accuracy, but also translates to a longer time horizon for prices to be impacted.

Spending targets are a long-term framework for health care entities to manage cost growth. To meet spending targets health care entities must strategically manage cost growth in prices, volume, or both; meaning they are compelled to improve affordability of health care. However, spending targets are not a price cap or price reduction—they do not require cutting prices. For that reason, and because a health care entity's existing payment levels are part of the baseline from which their spending can grow, spending targets incorporate existing price disparities among health care entities that can allow higher-priced hospitals to remain more expensive than their lower-priced peers. To address these disparities in the hospital sector, the Board set lower targets for high-cost hospitals that was informed in part by OHCA's recommendation stating: "under the status quo, the high-cost facilities would continue to grow no more than the statewide spending target but are doing so from a higher baseline level. Further limiting the rate of growth for these hospitals would bring the costs incurred by consumers for these hospitals more in line with the broader hospital sector, thereby reducing historical inequities between high-cost facilities and more efficient facilities."[66]

Two other policy options studied by various experts for lowering hospital prices include: 1) capping the prices paid by commercial insurers to a percentage of what Medicare would pay for the same services, and 2) hospital global budgets. Each of these options would have tradeoffs if applied to the hospitals in Monterey.

Medicare-based Price Caps

Some health policy experts have suggested capping the rates that hospitals can charge to commercial plans.[67] Theoretically, these price caps could be tied to prices that Medicare pays for similar services (e.g. 250% of Medicare rates), to current market prices (e.g. five times the 20th percentile of price in the relevant market), or to any rate-setting methodology set by the state.[68] Because all three hospitals in the Monterey market have high commercial prices, with two of the hospitals identified by the Affordability Board as high-cost hospitals in its April 2025 board action, the most reasonable approach in this market is likely to be restricting hospitals to charging commercial insurers no more than a set percentage of Medicare's reimbursement rates. To avoid significant shocks to the health care delivery system, regulators might choose to first implement price caps that approximate current payment levels and ratchet them down over time. For example, regulators could calculate the average of current prices charged by each of those hospitals as a percentage of Medicare for both inpatient and outpatient services. Analysis

[66] https://hcai.ca.gov/wp-content/uploads/2025/06/OHCA-Recommendations-to-Board-Proposed-Hospital-Sector-and-Target-Corrected-1.pdf Office of Health Care Affordability. (2025). *Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Hospital Sector Target Values*. California Department of Health Care Access and Information. https://hcai.ca.gov/wp-content/uploads/2025/06/OHCA-Recommendations-to-Board-Proposed-Hospital-Sector-and-Target-Corrected-1.pdf

[67] Congressional Budget Office. (2022). *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services*. https://www.cbo.gov/publication/58541

[68] Chernew, M. E., Dafny, L. S., & Pany, M. (2020). *A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market*. Brookings. https://www.brookings.edu/wp-content/uploads/2020/03/CDP_PP_WEB.pdf

of data from self-insured employers in the RAND study suggests that current prices in Monterey County hover around 450% Medicare rates for hospital care, but a more robust analysis of California's Health Care Payments Data (HPD) may allow regulators to set initial rates that more accurately reflect current payment levels. Regulators could then adjust that cap downward over a period of five to ten years to require prices in Monterey County to converge over time towards prices paid in similar locations in California.

The advantage of this price-setting mechanism is straightforward: once the cap is established, the hospitals may not bill commercial insurers or self-funded plans more than that cap. Compliance can be verified by comparing billed commercial prices against Medicare fee schedules. This model can generate immediate savings, since it directly lowers high commercial rates in markets where hospitals have outsized leverage. Other advantages of this approach are that it is transparent and anchors prices to an established federal benchmark and demands more in price reduction from those hospitals with the highest prices.

However, Medicare-based price caps face opposition from providers and if the caps are initially set too low, the shock to the hospital delivery system may threaten access or quality and regulators should consider maintaining hospital financial stability in addition to cost-savings. In addition, this method is complicated to implement; policymakers should not assume that adopting Medicare reimbursement rates is significantly easier than state rate-setting systems of the 1970s and 1980s.

Medicare uses diagnosis-related groups (DRGs) to pay for in-patient hospital stays. DRGs are a case-mix system that classifies patients and weighs the reimbursement rates based on clinical diagnoses, comorbidities or the presence of complications among other things.[69] Each DRG weight represents the average resources required to care for cases in that particular DRG. Many commercial payers and Medi-Cal, especially Medi-Cal Managed Care plans, do not use DRGs as the payment unit and may use alternative payment methods that include capitated rates, case rates, bundled payments, episode-based payments etc. Determining compliance with a policy that sets maximum billed charges as a percentage of what Medicare would have charged may be quite administratively complex.

Furthermore, this method adopts Medicare rates, which were designed for a primarily older and disabled population and may not fully reflect the costs of caring for commercially insured patients. For example, Medicare rates reflect the costs of providing care to the Medicare-eligible population (primarily adults over 65 and people with disabilities) and may overstate the cost of providing pediatric and maternity care to commercially insured patients, since the few children and pregnant women covered by Medicare are typically high-risk patients who qualified for Medicare due to disability. Finally, while price caps are intended to be price ceilings, they can become default payment rates, especially for hospitals with market power, as hospitals might perceive a financial incentive to raise rates up to the cap even if they had previously charged

[69] Centers for Medicare and Medicaid. (2025). *MS-DRG Classifications and Software* (Version 42.1). CMS. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software

less. This concern may be particularly important for Natividad, which has historically had lower payment rates than CHOMP and SVHMC.

Hospital Global Budgets

A third, well-studied method of price restrictions is the use of global budgets. Under this approach, state regulators establish a fixed annual revenue allotment for each hospital that can be adjusted for factors such as changes in population, demographics, and quality performance.[70] Hospital global budgets can be fixed, meaning a hospital is guaranteed a fixed amount of annual revenue regardless of its patient volume. Alternatively, hospital global budgets can be variable, meaning the budget would cover a hospital's fixed costs and adjust up or down with changes in variable costs associated with volume changes. Once state regulators set each hospital's budget, the hospital is paid prospectively, and the state monitors compliance by reconciling actual spending against the budget at the end of each year and adjusting future allotments accordingly.[71] Similar to Medicare-based price caps, initial global budgets could be set for the three hospitals in Monterey County at a level that is similar to current levels and tightened slowly over time.

When states implement global budgets, they generally want to apply those restrictions to all hospitals in a region so that no single hospital has an incentive to shift patients to hospitals not covered by a global budget. Maryland addressed this concern by first applying global budgets to rural hospitals, where there was only one facility in each area, in 2010 and then expanded global budgets to all acute care hospitals in the state in 2014. The situation in Monterey County, where all three hospitals appear to have minimal competition, presents a unique opportunity for the state to apply global budgets as a price control mechanism.

The main benefits of global budgets are that they give hospitals stable funding, directly limit revenue growth, and encourage investment in strategies that improve health such as reducing preventable admissions, primary and preventive care, and coordinated care. There are strong incentives for efficiency, with hospitals retaining savings if they keep spending below budget. Maryland's experience suggests they can slow hospital spending growth while improving certain quality metrics, such as reduced readmissions.[72] In addition, unlike Medicare-based price caps, state regulators set an overall budget, but hospital administrators retain flexibility to make decisions about staffing, service lines, and care delivery strategies.

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[70] Global Health Payment, LCC. (2018). *Toward Hospital Global Budgeting: State Considerations*. State Health and Value Strategies. https://www.shvs.org/wp-content/uploads/2018/05/SHVS_-Global-Hospital-Budgets_FINAL.pdf and \ Berenson, R., & Murray, R.B. (2022). How Price Regulation Is Needed to Advance Market Competition. *Health Affairs, 41*(1), 26-34. https://doi.org/10.1377/hlthaff.2021.01235.

[71] Murray, R. B., & Gudiksen, K. L. (2024). *Rate Regulatory Handbook: A Guide for State Implementation of Cost Constraint Models*. The Source on Healthcare Price and Competition. https://sourceonhealthcare.org/provider-rate-regulation/#regulatoryhandbook

[72] Murray, R. B., & Gudiksen, K. L. (2025). *U.S. State-Based Hospital Rate Setting: What Worked, What Didn't, and What We Need to Do Now*. The Source on Healthcare Price and Competition. https://sourceonhealthcare.org/profile/u-s-state-based-hospital-rate-setting-what-worked-what-didnt-and-what-we-need-to-do-now/

Conversely, global budgets likely require a waiver from CMS to implement them in an all-payer context and can risk under-provision of services including increased waiting times for elective procedures if budgets are set too tightly. They also represent a major shift from fee-for-service payment, which is likely a long-term positive result, but could cause distortions in the market unless state regulators are careful to avoid financial incentives for hospitals to reduce the amount of care provided or attempt to shift care out of the hospital to unregulated non-hospital providers. If the state considers implementing global budgets for hospitals in Monterey County, they should be implemented for all three hospitals, with financial incentives considered to prevent the hospitals from shifting care that is currently provided at the hospital to non-hospital facilities.

Overall, the lack of meaningful competition in Monterey County points to the need to continue the conversation to bring hospital prices closer in line with other parts of California. Each of the three policy tools described, spending targets, Medicare-based price caps, and global budgets, offers a different balance of strengths and limitations. For example, the Health Care Affordability Board has already set spending targets for hospitals statewide and lower targets for CHOMP and SVHMC, but the retrospective nature of the spending targets and their delayed enforcement may limit their immediate impact. Medicare-based price caps are more straightforward to monitor and can generate faster savings, but they do not give state policymakers much flexibility to make adjustments when the Medicare fee structure does not reflect the relative costs of providing certain services to the commercially insured population. Global budgets, by contrast, represent a more fundamental shift in payment away from fee-for-service to more value-based arrangements. Global budgets can stabilize hospital finances, incentivize efficiency, and give hospital leaders flexibility in managing costs, though they also require significant regulatory infrastructure and oversight to prevent unintended consequences. With all of these approaches, policymakers will need to weigh ease of implementation and near-term enforcement against the potential for longer-term structural reform that provides hospitals with both stability and incentives to deliver high-quality, cost-effective care.

7. Conclusion

The data and interviews presented in this report converge on a clear finding: Monterey County's exceptionally high hospital prices are driven not by operating costs, quality, or patient mix, but by structural market conditions that severely limit competition. Commercial price data show that hospital charges in Monterey far exceed both statewide and Bay Area benchmarks, with inpatient prices at CHOMP reaching nearly six times Medicare rates. These price levels are not justified by higher labor costs, since wages for most staff are comparable to those in neighboring regions; nor are they explained by superior quality of care, as federal quality ratings place Monterey hospitals in the middle of the pack. Low or negative margins on clinics and higher percentages of Medicare and Med-Cal patients (only in SVHMC and Natividad) likely explain a portion of these hospital price differences but leave substantial amounts unexplained.

Taken as a whole, the evidence paints a picture of a health care market that is functionally insulated from the forces of competition. In other parts of the state, payers can use selective contracting or patient steering to discipline high-priced providers, but those tools break down in

Monterey because all three hospitals are perceived as must-haves. While must-have hospitals exist all over the state of California and the country, what is relatively unique about Monterey County is that CHOMP, SVHMC, and Natividad each hold a must-have status. Hospital–physician integration, geographic dominance, and contracting practices channel patients to higher-priced hospitals, sustaining unusually high hospital prices in the county. This reality explains why prices have climbed to extreme levels without corresponding improvements in quality or community benefit spending and why the burden has fallen heavily on local families, employers, and unions, some of whom reported sending patients outside the county for care.

Ultimately, the combination of quantitative data and qualitative insights from interviews makes the conclusion inescapable: the defining feature of Monterey County's hospital market is a lack of effective competition. The market structure enables hospitals to sustain prices that are among the highest in the state while maintaining strong operating margins; highlighting the limits of relying on market-based solutions in a setting where competitive checks on hospital behavior have all but disappeared.