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Getting The Product Right: How Competition Policy Can Improve Health Care Markets

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ABSTRACT **As hospital, physician, and health insurance markets consolidate and change in response to health care reform, some commentators have called for vigorous enforcement of the federal antitrust laws to prevent the acquisition and exercise of market power. In health care, however, stricter antitrust enforcement will benefit consumers only if it accounts for the competitive distortions caused by the sector's long history of government regulation. This article directs policy makers to a neglected dimension of health care competition that has been altered by regulation: the product. Competition may have failed to significantly lower costs, increase access, or improve quality in health care because we have been buying and selling the wrong things. Competition policy makers—meaning both antitrust enforcers and regulators—should force the health care industry to define and market products that can be assembled and warranted to consumers while keeping emerging sectors such as mHealth free from overregulation, wasteful subsidy, and appropriation by established insurer and provider interests.**

As the implementation of the Affordable Care Act (ACA) continues, hospitals, physicians, health insurers, and others are reorganizing their operations and revising their business models. These activities include hospital mergers, consolidations of physicians' practices, hospitals' acquisitions of physicians' practices, and joint negotiations by providers with payers through collective intermediaries such as accountable care organizations (ACOs).

The effects of this market restructuring are not yet known. The potential payoff is greater efficiency through integration and consolidation.[1] The risk is growing market power that can be used to raise prices and otherwise harm consumers.[2,3] The stakes are substantial: The United States wastes approximately $1 trillion each year because its health care system is inefficient: Money is not spent on things that people value most, and those things are not produced at the lowest possible cost.[4]

According to economic theory, unfettered competition should lower prices, expand output, improve quality, ensure consumer choice, and promote innovation. Federal laws such as the Sherman Antitrust Act of 1890 and the Clayton Antitrust Act of 1914 therefore prohibit a variety of anticompetitive activities, including agreements that unreasonably restrain trade, monopolization, and mergers that might substantially lessen competition in a given market. The standards and enforcement practices of two federal agencies—the US Department of Justice and the Federal Trade Commission—strongly influence how the federal courts interpret the Sherman and Clayton Acts. Private parties can also file lawsuits seeking relief under the antitrust laws.

Regulation And Competition

Health care markets are less than competitive mainly because their long history of regulation and subsidy has distorted prices, quality, and innovation. Professional licensing laws, for example, parcel out specified functions among privileged groups, which discourages others from developing and marketing cheaper, more accessible alternatives.[5] Similarly, incentives and disincentives from public subsidies cause suppliers to behave differently in the private marketplace than they otherwise would. Because of the demographics of inpatient care, Medicare's rules are the principal determinant of how hospital care is organized and delivered.

In short, government policies, not free enterprise, make the principal revenue-seeking actors in the US health care system look and act the way they do.[6] When the competitive environment falls so far short of the ideal, antitrust enforcement alone is unlikely to substantially benefit consumers.[7] There is little to be gained from promoting market dynamics that are at best only weakly competitive.

NEGLECTING THE PRODUCT Even more limiting to effective antitrust oversight is the fact that government policies have distorted the products that the $3 trillion health care system buys and sells. Because of regulations and subsidies, what pass for products in health care are often professional process steps that have uncertain value to patients. Instead, they serve the economic interests of physicians, hospitals, and other suppliers within an established administrative framework of health insurance. Very little effort has been devoted to understanding this fundamental problem.

This article argues that competition policy makers—meaning both antitrust enforcers and regulators—should focus more attention on whether the goods and services being supplied are in fact valuable to consumers. This simple but overlooked approach could serve as a critical supplement to relying on market concentration, bargaining power, or even quoted prices or asserted quality as evidence of effective competition.

COMPETITIVE PRODUCTS A competitive product is an assembled unit that has both intuitive and measurable value to the buyer. Incentivizing the health care system to trade in competitive products should be a top priority for both antitrust enforcers and health care regulators. Policy makers and providers have begun to think this way in some areas (for example, adopting bundled pricing for surgery), but they have yet to recognize its potential to improve overall competition in health care.

Many competitive products can be designed to meet both clinical need and consumer demand. Several such products exist today, including simple diagnostics and definitive treatments for minor problems. When a very common symptom such as sore throat has a less frequent but more dangerous cause, such as a streptococcal infection, a strep test is a competitive product. A combination of diagnosis and treatment for sore throat at a single price would also be a competitive product.

Competitive products are being developed for more complex care, such as all-inclusive treatment for particular cardiac conditions, orthopedic problems, or cancers. Another example is monthly maintenance therapy for a chronic disease such as diabetes. A specialized cancer care center, for example, can assemble into a single product a full diagnostic workup of an identified malignancy, culminating in a structured presentation of therapeutic options to the patient. Each possible therapeutic modality for that cancer can also be "productized" at a single price for a full course of treatment.

Thinking in terms of competitive products can improve quality and safety as well as lowering price. Both boosting clinical performance and more accurately communicating residual risks (for example, through informed consent) become more tractable problems when competitive products are available.

With respect to quality, competitive products often can be warranted for their ability to perform as promised. For example, many providers of in vitro fertilization offer substantial refunds if a live birth does not occur. As this example suggests, quality warranties are likely to differ between products covered by insurance (where cash rebates mean less) and products paid for by the patient.

With respect to safety, avoiding physical harm during treatment is important to consumers regardless of what their insurance covers. Bundled cancer care, for example, might include treatment of potential side effects. More generally, a product mind-set could help providers evaluate and reduce the aggregate risk associated with achieving a defined medical objective.

SOURCES OF HEALTH CARE PRODUCTS Most health care products today are defined by physicians, whose ordering decisions account for roughly two-thirds of health care expenditures—including referrals to specialists, diagnostic tests, hospitalization, medication, and other treatments. Professional norms tend to equate products with workflow and inputs.

Under traditional fee-for-service payment, health care providers first devise a process step and then create a way to bill for it. The result is that medical goods and services tend to be de-

fined by historical compilations that are often supplemented but seldom pruned or reorganized and that were seldom developed with specific clinical outcomes in mind.

Hospital charge masters (proprietary master lists of prices), for example, attach plausible but arbitrary prices to long lists of processes and supplies as the basis for billing patients or insurance companies. For physician services, the codebook known as *Current Procedural Terminology* is a collective professional endeavor that is developed and owned by the American Medical Association, which makes it unlikely to be useful in increasing competition.

Such approaches to product definition discourage both cost-efficiency and innovation. In most industries, sellers assemble inputs into products and manage their supply chains. Health care providers mainly collect the information they need in order to get paid. Therefore, they tend to understand the revenue (that is, the reimbursement) associated with each process step much better than the overall costs of achieving a desirable outcome.

Health insurance is another familiar form of health care product. For a few types of insurance—typically those offered through prepaid group practices such as Kaiser Permanente—*coverage* means comprehensive care for medical needs that arise during the year for which premiums are paid. And a few large employers and managed care organizations are experimenting with value-based insurance design, which covers on more favorable terms those interventions that are more likely to be of value to particular patients.[8]

However, most health insurers rely on the professional conventions described above to construct covered benefits and negotiate per service prices with providers. This reinforces existing habits that equate products with process steps. It even compounds the problem by blunting the financial incentive that patients might have to question those habits.

As a result, managed care organizations continue to bargain with providers over components of diagnosis or treatment—such as a night in the hospital, the receipt of a laboratory test, and a consultation by a specialist—that are production inputs, not products. Under these circumstances, insurers tend to focus on avoiding risk and reducing claims, not on streamlining and improving care.

A critical defect in product design is that patients generally require close coordination between professional skills and physical resources, but regulation often keeps physicians economically partitioned from hospitals and other structured practice environments. Contributing factors include requirements for medical staff self-governance, prohibitions on the corporate employment of physicians, insurance payment practices that divide professional fees from facility fees, and fraud and abuse and tax-exemption laws that restrict contractual integration.

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Most physicians, therefore, still work mainly in solo or single-specialty practices and order additional care processes for patients from other sources, instead of assembling competitive products within integrated patient care organizations. For example, the production of inpatient services in hospitals is subject to multiple chains of command, with a large number of well-intentioned professionals doing what they are trained to do and hoping that the final product—patient care—will assemble itself without explicit planning or coordination.

Managed Care Products And Hospital Mergers

The recent history of hospital mergers and acquisitions shows how challenging it is to distinguish between meaningful competition and what often passes for it in health care. Review of proposed mergers and acquisitions by the antitrust agencies is an important activity because antitrust law is often powerless to correct problems once a market has become uncompetitive.[9,10]

BASELINE CHARACTERISTICS OF HOSPITAL MARKETS Antitrust enforcers typically assume that markets not dominated by one or two firms are reasonably competitive and that current business practices in those markets are economically desirable. In reaching those conclusions, the courts and enforcement agencies rely on landmarks such as the apparent size and scope of markets, the number of existing and potential sellers, the power and distribution of buyers, and prevailing prices and quality. However, these landmarks are frequently obscured for hospitals

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by long histories of government subsidy, restriction, and legally sanctioned professional privilege.

In most industries, entrepreneurs invest capital with the expectation of satisfying demand and making a profit. Those investments determine the characteristics and baseline number of competitors—among which reductions attract the attention of antitrust enforcers. Most hospitals, however, were not established as commercial enterprises but were "socially constructed." In other words, they originated from other motives and resources, including community philanthropy, federal funds made available by the Hill-Burton Act,[11] Medicare capital cost repayments, and tax-exempt bond proceeds—all of which were liberally supplemented by third-party fee-for-service payments for care ordered by physicians. The result has been a large number of desirable public resources that lack the market discipline necessary to keep production costs within the limits that ordinary consumer demand could sustain.

Consequently, it is debatable whether the antitrust agencies' enforcement actions with respect to hospital mergers and acquisitions shine light where it does the most good, or do a limited amount of good where the light happens to shine brightest. Nearly all legal challenges have been brought in small communities that historically supported three or four hospitals.[12] The government can prove its case more easily in those settings. However, there is little evidence that smaller communities are a major source of inefficiency in health care or that larger communities systematically outperform them.

The choice between mechanically enforcing antitrust law and anticipating regulatory change that might improve competition in spite of consolidation was central to the decision in a recent case brought by the Federal Trade Commission and the State of Idaho against a Boise hospital. A federal judge ordered the hospital to divest itself of a physician group that it had acquired because the acquisition increased the hospital's bargaining leverage with health insurers and allowed the hospital to use more lucrative billing codes for physician services.[13]

Simultaneously, however, the judge praised the hospital for preparing to compete in a post-ACA environment in which payment will be based on patient outcomes: "In a world that was not governed by the Clayton Act, the best result might be to approve the Acquisition and... see if the predicted price increases actually occurred.... But the Clayton Act...does not give the Court discretion to...conduct a health care experiment."[12(p76–77)] Indeed, keeping physicians economically independent of hospitals is not a desirable policy over the long term, and Medicare can be expected to revise its rules regarding relative payment for hospital-based and nonhospital outpatient services as the competitive landscape evolves.

THE MANAGED CARE EFFECT Antitrust analysis defines a *product market* as part of assessing anticompetitive risk. Importantly, however, it fails to consider the possibility that the services that providers and insurers currently deliver are not the services that a truly competitive market would generate in response to consumer demand. The Idaho case also illustrates the potential importance to competition policy of properly characterizing the product.

For nearly twenty years, bargaining between providers and managed care organizations has been billed as the main event in health care competition, with antitrust enforcers serving as referees. The stated goal of enforcement has been to deter transactions that might increase providers' bargaining leverage vis-à-vis insurers, because that tends to push premiums up.

In conducting their investigations, the agencies apply a model of "two-stage competition" in hospital markets: First, hospitals bargain for inclusion in insurers' networks at agreed-on prices; and second, insured patients choose among multiple network facilities for specific services. As described above, however, insurer-provider bargaining typically rehearses the conventional litany of professional processes or inputs, and it seldom results in package deals for assembled, warranted products. Unsurprisingly, few health policy experts have considered these negotiations to constitute a major improvement to the health care system.

Historically, the two-stage construct is a compromise that emerged from the regulatory backlash against managed care in the late 1990s. Instead of competing in a health care system composed of Kaiser-like entities that offered members comprehensive care on a prepaid basis

but restricted their choice of providers to those within the organized system, insurers retreated to products that featured broad physician and hospital networks with negotiated prices for fragmented and unmanaged services.

This approach seemed less threatening to existing stakeholders and relationships and therefore was more politically palatable. As a policy outcome, however, it was less effective at reducing costs and did not demonstrably protect quality. One commentator summarized the emergence of insurer-provider bargaining as the centerpiece of managed care by asking: "Is that all there is?"[14]

Managed care was supposed to imbue a disorganized, cost-insensitive system with coordinated clinical and financial discipline. Instead, it yielded little more than contractual discounting of conventional fees for faux products, an "achievement" that was itself possible only because of the excess hospital capacity that generous public subsidies for construction and operation had created during previous decades.

Policy Makers' Next Steps To Improve Competition

Regulators and antitrust agencies must work in tandem to improve competition in health care. They can start by incentivizing the development of competitive products.

Integrating regulatory change with antitrust enforcement can induce existing providers, suppliers, and payment intermediaries such as health insurers to assemble more products and to compete in delivering them. It can also foster the growth of a commercial space upstream of conventional health care providers in which people living their everyday lives—not patients separated from those lives—purchase new forms of health improvement and basic care unhampered by the barriers that currently distort competition involving hospital, physicians, and insurers.

BUNDLED PAYMENT AND MEASUREMENT Payment policy and transparency, the two most popular types of delivery system reform, are also the best candidates for regulatory-antitrust collaboration to foster the development of competitive products. However, current efforts to phase out fee-for-service reimbursement, institute performance-based payment, and share information about outcomes tend to mix competitive concepts with more general issues of quality, professionalism, and insurance risk bearing. Medicare administrators and federal antitrust authorities should launch a combined effort to shift payment toward assembled products that can be warranted for a desired effect, and to help the public compare providers based on accurate information about the price, quality, and safety of those products.

BARRIERS TO COMPETITIVE ENTRY Competition policy makers should reduce or remove regulatory barriers to market entry for new health care facilities (for example, certificate of need requirements) and health care professionals (such as unnecessarily restrictive licensing laws). If entry is easy, market power cannot be exercised even in concentrated markets without attracting new suppliers and returning prices to competitive levels.

Market entry also promotes innovation, which further reduces the risk of consumer harm from concentration. New competitors are more likely to create products with intuitive appeal and measurable benefits. Over time, this process could create a virtuous circle that continues to redefine health care products and invites even greater diversity in sources of supply and methods of production.

ACCOUNTABLE CARE ORGANIZATIONS Shared-savings models for Medicare ACOs reward physician-hospital partnerships that meet quality benchmarks at reduced cost. The antitrust agencies, fraud regulators, and the Internal Revenue Service issued coordinated policy statements in 2011 that set a useful precedent for policy collaboration but failed to present a clear vision of what competition involving Medicare ACOs might achieve.[15,16]

ACOs cannot just be "good guys" that bear insurance risk, like the stillborn provider-sponsored organizations that politicians supported as physician-led alternatives to commercial health maintenance organizations in the 1990s. Instead, competition policy makers should incentivize ACOs to design and deliver assembled products. For example, they should base payments to ACOs on the measured value of such products as well as on aggregate savings to Medicare.

ENTRENCHED PROVIDERS AND INSURERS Because large providers and large insurers share an interest in maintaining the status quo, scrutinizing arrangements that perpetuate false products and deter competitive entry is becoming an important area for competition policy.[17] It is tempting to think of insurers as motivated purchasers of medical care. However, they are imperfect agents for policyholders and for the private employers that sponsor health coverage.[18] Failure to understand the products they are buying may partially explain the otherwise puzzling fact that these consumers have not demanded better performance from their insurance.

Competition policy makers must learn to distinguish contractual arrangements that create

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useful products for patients from those that shelter both providers and insurers from competitive threats.[19] Packaged treatments for episodes of care will usually improve competition. However, large "bundles" of per service fees not tied to the treatment of any particular illness that major health insurers and large hospitals often negotiate may render markets less contestable by preventing other competitors from offering more limited, but lower-price or higher-quality, alternatives.[20] Similarly, large insurers may use "most-favored customer" clauses in their provider contracts to discourage physicians or hospitals from accepting lower fees from smaller competitors or potential entrants than they receive from the large insurer. These clauses may also inhibit product innovation.[21]

PHYSICIAN EXCLUSIVITY As is the case with bundling, having physicians contract exclusively with a single managed care network or ACO may either improve the product or erect a barrier to competition. The Department of Justice and Federal Trade Commission favor nonexclusive contracting, particularly for physician specialists, on the theory that exclusive contracting deters entry by new insurers that hope to form their own networks and aggregates physicians into groups that might gain market power to the detriment of consumers.

If physicians are simply fungible inputs to insurance networks, nonexclusivity may be preferable because it tends to prevent the formation of bottlenecks in supply. If the strength of physicians' commitment to an integrated organization drives performance, however, exclusive relationships may be more conducive to meeting standards for quality and reliability and may enable those organizations to develop more competitive products.

CLINICAL INTEGRATION Since the 1990s the antitrust agencies have permitted independent physicians who participate in provider networks and are "clinically integrated" to jointly negotiate fees with insurers without that negotiation being automatically condemned as unlawful price-fixing. The agencies have accepted many forms of clinical integration, including shared information systems, common treatment protocols, and uniform processes for reviewing the quality of care.

Like price, however, quality should be attached to products that are useful to patients, not to technical details that contribute only marginally to successful outcomes.[22] Therefore, the agencies should narrow the "clinical integration" exception and require providers to demonstrate that they have both reengineered care to create meaningful products and measured the outcomes associated with those products.

UPSTREAM PRODUCTS An affordable health care system depends on both cost-effective treatment and good underlying health. Innovations in portable medical technologies, decision-support systems, and communication platforms are expanding the possibilities for do-it-yourself care. Networked technologies also create opportunities for private entrepreneurship involving health promotion. These are competitive products, similar to the online reference sources and home improvement retailers that enable people to build simple projects themselves instead of hiring professionals.

It is important that incumbent providers, payers, and suppliers not use their existing advantages to foreclose competition in this upstream space. For example, mobile medical applications ("mHealth") are a rapidly growing commercial sector. Having competition policy protect mHealth from both private anticompetitive conduct and unnecessary regulation is smart preventive law. In keeping with this approach, the Food and Drug Administration recently launched a national effort to build entrepreneurial interest in mHealth and issued a guidance document that frees from burdensome regulation new inventions that do not present significant risks of patient harm.[23]

Conclusion

Stricter enforcement of antitrust law has become a popular remedy for high health care costs. Without careful planning, however, targeting "consolidation" will be as incoherent a policy tool for improving health system performance as attacking "waste, fraud, and abuse" was a generation ago.

The greatest obstacle to effective competition

in health care is failure to understand the product. A product is more than a series of process steps that can be billed for. Instead of perpetuating stylized negotiations between private insurers and providers that seldom make assembled, warranted products available to consumers, competition policy makers should force the health care industry to define and market such products, while protecting emerging sectors such as mHealth from appropriation by established insurer and provider interests. Because government regulation and payment policies heavily influence competition in health care, the antitrust agencies should work closely with federal and state regulators to accomplish these goals. ■

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