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## VIEWPOINT

# Paradigm Lost: Provider Concentration And The Failure Of Market Theory

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**ABSTRACT** In classic market theory, increased concentration among providers leads to higher prices for consumers. In the world of contemporary health policy, many stakeholders echo the classic market theory, blaming high health care prices on the increased concentration of providers, such as occurs when hospitals merge or are acquired by other hospitals. Thus, the consolidation of providers has become a convenient target for policy makers who want to be viewed as actively pursuing solutions to the growth in health care spending. Yet many of the factors fueling increased provider concentration are widely believed to be desirable, or practically unavoidable. Meanwhile, health care prices are increasing at historically low levels. Thus, there appears to be a contradiction between efforts to contain health care prices and the fact that aggressive policies aimed at reducing provider concentration might be ineffective and could even have the unintended effect of stunting positive developments. In a group of *Health Affairs* articles, William Sage and Paul Ginsburg and Gregory Pawlson respond to this conundrum by proposing a range of policy alternatives that, in this author's opinion, are either impractical or counterproductive because they have their roots in classical economic models of an industry with pervasive market failure. More effective and practical responses may be less theoretically elegant but more realistic and more reasonable.

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**T**he belated rediscovery of provider prices as a significant contributor to the high costs of US health care (although the data were there in the literature all along),<sup>1,2</sup> coupled with the presumed role of provider concentration in producing some of the upward pressure on prices,<sup>3</sup> has created a serious conundrum for those who seek to apply conventional economic reasoning to matters of health policy. The conundrum arises from the conflict between the presumed per se undesirability of increased concentration and the fact that many of the causes of that increase may themselves be highly desirable—or at least practically unavoidable.

The dilemma posed for policy makers and analysts arises from the assumption that increased concentration is intrinsically a bad thing, even though many good things seem to be happening as provider concentration progresses. On the one hand, the number of independent health care providers appears to be decreasing as a result of hospital mergers and acquisitions, the agglomeration of physicians into larger and larger group practices, and the alignment of physician practices with hospitals. The relationship between increased provider concentration and increased prices has long been conventional wisdom (even if recent data and analyses have called that wisdom at least partially into question).<sup>4,5</sup>

Ergo, such increases in concentration should be opposed.

On the other hand, at least some of the factors driving increased concentration are widely believed to improve care and population health, or at least to encourage greater efficiency in the delivery of health care services. These factors include growing clinical integration across previously atomized providers; the dramatic reduction in use of inpatient services, which decreases the number of full-service hospitals needed in any given market; the mandatory adoption of expensive information technologies; and the growing experimentation with payment schemes in which providers bear at least some degree of financial risk.

All of the poster children of the Affordable Care Act, the presumed exemplars of how to achieve the Triple Aim in health care<sup>6</sup>—Mayo Clinic, Gundersen Lutheran Health System, Intermountain Healthcare, Geisinger Health System, and Kaiser Permanente—have dominant reputations and market positions in their home markets (concentration), and the latter two are insurers as well as providers. Moreover, in this era of greater provider concentration, hospital prices are growing at historically low levels.<sup>7</sup>

Efforts to resolve this conundrum—that is, concentration is assumed to be bad, but its causes may be good; besides, it may not be having the assumed bad economic impact—include a group of *Health Affairs* articles (including this one) by William Sage<sup>8</sup> and by Paul Ginsburg and Gregory Pawlson,<sup>9</sup> three especially thoughtful and deservedly respected commentators. But their very different sets of policy recommendations are ultimately unsatisfying and unrealistic.

In seeking to combat one particular manifestation of market failure in health care—in this case, the growing concentration of providers in a decreasing number of economic units or organizations—the authors fail to address some of the more powerful sources of such failure. Like traditional astronomers in the age of Copernicus, they propose ever-more-elaborate mechanisms to reconcile contemporary observational data with a fundamentally obsolete conceptual model.<sup>10</sup>

### Sage: ‘Getting The Product Right’

Sage’s prescriptions are more radical than those of Ginsburg and Pawlson. Sage proposes restructuring health care markets by “getting the product right,” by which he means replacing current units of payment—which are excessively granular and connected to the services that consumers desire in only the most partial and indirect ways—with “assembled products that can be

warranted for a desired effect,”<sup>8(p??)</sup> such as the packaged cardiac surgery program at Geisinger, and that have demonstrable value to patients, in pursuit of a system that produces “things that people value most,” and “at the lowest possible cost.”<sup>8(p??)</sup>

What any of this has to do with what most people seek to obtain from the health care system escapes me. I understand—and, indeed, I have long worked to promote—the bundling of disaggregated services into clinically coherent units for purposes of fee-for-service payment. However, any physician who prescribed such a predetermined bundle of services for a patient with an upper respiratory infection, lower back pain, or depression (or all three) without a thorough history and understanding of the patient’s life circumstances could be justly accused of malpractice. In many cases, a bundle can’t responsibly be defined until at least some disaggregated services are provided, if only to aid the provider in making a diagnosis.

In fairness, Sage is trying to address the very real and very significant costs of the inefficiency that permeates the US health care system. Recognizing that the power to influence prices that comes with increased market power theoretically reduces the incentives for efficiency, Sage proposes to reduce that power by redefining what health care payers buy. This, in turn, would presumably give consumers greater ability to make informed, price-sensitive decisions about which health services they wished to consume.

It would not be unfair to describe this as health care’s equivalent of the ZipCar strategy, which is based on the belief that some consumers are more interested in having occasional transportation than in owning a car. Some health care consumers seek only to receive the least expensive treatments for ailments that they already know they have. However, many are willing to pay a premium to have a doctor whose knowledge, professionalism, and relationship with the consumer permits her to figure out what is, in fact, needed.

At the same time, encouraging producers to redefine their products in ways that might be more appealing to targeted consumers could well increase the kind of product differentiation by reputation that is a major source of the generic market failure in health care. Antitrust analysis is generally complicated in markets with differentiated products. Sage’s proposal would either exacerbate that problem or require the creation of a new authoritative regulatory structure to determine exactly how new products should be defined.

# The basic flaw in both Sage's analysis and that of Ginsburg and Pawlson is the myth of the sovereign individual consumer.

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## Ginsburg And Pawlson: Let Consumers Decide What To Buy

Ginsburg and Pawlson's policy prescriptions are more conventional and more eclectic.<sup>9</sup> Some of them might be quite practical, if mutually contradictory—which further illuminates the thanklessness of trying to salvage an inappropriate conceptual model by reasserting its assumptions.

The authors' theory seems to be that if increased provider consolidation limits the ability of insurers to exert downward pressure on prices, then the solution to high prices is transferring an increasing share of the purchasing function to individual consumers through higher out-of-pocket liabilities and the development of tiered networks, which offer different prices to consumers with ostensibly different preferences. However, this prescription only exacerbates the underlying problem. No matter how much information—the magical potion in many market-based approaches to health policy—atomized consumers may have, it is almost certainly less than that of even the most indolent insurance company.

If sellers have too much market power, in other words, a policy that supports a shift in the buying function from insurers with some market power to consumers with effectively none is not likely to succeed in imposing discipline on producers from the demand side. Such a policy is also dangerous, since tiered pricing is known to lead to adverse health behaviors, which may well cause premature morbidity and mortality.<sup>11</sup> Furthermore, increased out-of-pocket liabilities have a disparate impact on lower-income people, especially lower-income people of color.

Ginsburg and Pawlson also appear to be in favor of narrowing provider networks as a way of reducing providers' leverage in negotiations with payers and thereby holding prices down. They note that in the 1990s such policies engen-

dered significant consumer resistance because of the restrictions they imposed on access to providers. However, they seem not to mind the fact that such resistance may be minimized in the future by the growing inability of many households to afford the kind of health care they prefer. Such an approach not only fails to counteract the growing economic inequality in this country but also appears to legitimate it.

Ginsburg and Pawlson's approval of efforts to subsidize the development of stronger and more competitive physician organizations actually makes a great deal of sense to me. However, it seems to directly contradict some of Ginsburg's earlier prescriptions. The authors are, in effect, supporting a response to the market power of hospitals by encouraging increased market power among physicians, who are sometimes their competitors and at other times their partners.

One could imagine a number of scenarios in which—at least in a world with more-reasonable payment policies—competition between hospitals and organized physician groups would have a dampening effect on the prices for certain services that they competed to provide, such as some outpatient surgeries and diagnostic procedures. Historically, of course, the effect of this competition has not been to reduce overall expenditures: Instead, it has led to substantial increases in the volume of such services provided in many markets.<sup>12</sup>

Furthermore, one could also envision at least hypothetical scenarios in which hospitals in concentrated markets would team up with large and influential physician groups to maximize both overall prices and the precision of targeted price discrimination strategies, in which “must have” services for well-insured populations were priced at particularly profitable levels.

## The Myth Of The Sovereign Consumer

As a general principle, in politics and football as well as economics, seeking to control the behavior of an entity with excessive power by weakening competitive entities is not a very good strategy, no matter how much information those competitors have. In the context of US history, the principal response to excessive economic power has been governmental antitrust policy. In light of the conundrum defined above, however, both of these articles acknowledge that at least in some markets, a return to formal government-imposed rate setting for hospital prices may be necessary. I have more to say about that below, but a few more general observations must come first.

The basic flaw in both Sage's analysis<sup>8</sup> and that

of Ginsburg and Pawlson,<sup>9</sup> which perfectly reflects the underlying bias in neoclassical economics, is the myth of the sovereign individual consumer.<sup>13</sup> One effect of changes in health financing in the past two decades is unavoidably clear, if too often overlooked or minimized in importance by the health policy community: The average individual with health insurance is considerably worse off now than twenty years ago. Out-of-pocket payments are much higher, for both premiums and copayments;<sup>14</sup> cash on the barrelhead is increasingly required for services that used to be provided first and billed for afterward;<sup>15</sup> and the numbers of avaricious debt collectors and medically related bankruptcies continue to soar.<sup>16</sup>

At the same time, consumers are regularly inundated with self-serving or downright erroneous information from health insurers, providers, and entrepreneurs alike about health care services and their use that carries the implicit message that any illness or financial difficulty is essentially the fault of the consumer.

It is ironic that the increased unaffordability of routine health care is exactly the problem that historically led to the creation of health insurance programs in both the public and private sectors. Those who are quick to applaud the expected demise of employer-sponsored coverage in the United States overlook the extent to which large employers, eager at least to not offend their employees, historically used their purchasing power with insurers to protect those employees (as well as to maintain an enormous *de facto* cross-subsidization of the less healthy employees and family members by the healthier ones).

Of course, government insurance programs wield this purchasing power more directly, more openly, and—when it comes to the effect on provider prices and the minimization of out-of-pocket liabilities for individual households—far more effectively.<sup>17</sup> In other words, Medicare and Medicaid, and their beneficiaries, are much less at risk of increased prices resulting from provider concentration than are most private insurers or privately insured people.

Those who are uneasy about further increasing the government's role in minimizing price growth in health care might do well to compare today's high-deductible plans to the historical experience of Blue Cross plans with private-sector monopoly control (which hardly ever paid hospitals more than their actual costs) and first-dollar coverage.

As a proud former rate setter in both state and federal governments, I confess to an absence of alarm at these authors' recognition that if none

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of their nostrums work, rate regulation may become increasingly unavoidable. But I am skeptical of the political likelihood of a return to rate setting; nor am I entirely convinced of its desirability. The exercise of government power is one way to constrain sellers in concentrated markets, but not the only one.

It is conceivable, for instance, that one explanation of the relatively low rate of hospital price increases in recent years is that private insurers, in response to some of the first- and second-order pressures generated by the Affordable Care Act, are actually negotiating aggressively with hospitals, instead of just passing on increases to their customers or enrollees, as was standard practice in the past. It's even more likely that most hospitals, facing cuts in the share of their revenue that comes from Medicare and Medicaid, are dramatically reducing their costs, which permits them to raise prices more slowly even while maintaining margins. For certain outpatient services, hospitals are certainly facing increasing competition from physicians and other providers.

Neither Copernicus nor Kepler—nor even Newton—fully understood the implications of their destruction of ancient astronomical models. Similarly, it's hard to know how and when the policy community will fully catch up to the changes occurring all around it. But Sage provides an important clue when he suggests that hospitals “were ‘socially constructed.’”<sup>18(p??)</sup>

Instead of continuing to try to impose axiomatic and solipsistic theories on a reality to which they increasingly fail to apply, we need to figure out what kind of health care system we really want and how much we are prepared to pay for it. Then we need to invent or reconfigure the social institutions that we will have to have to get that system. ■

Bruce Vladeck's employer, Nexera, Inc., is a wholly owned subsidiary of the Greater New York Hospital Association. [Published online May 19, 2014.]

## NOTES

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