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Perspective

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FUNDAMENTALS OF U.S. HEALTH POLICY

The Role of Market Forces in U.S. Health Care

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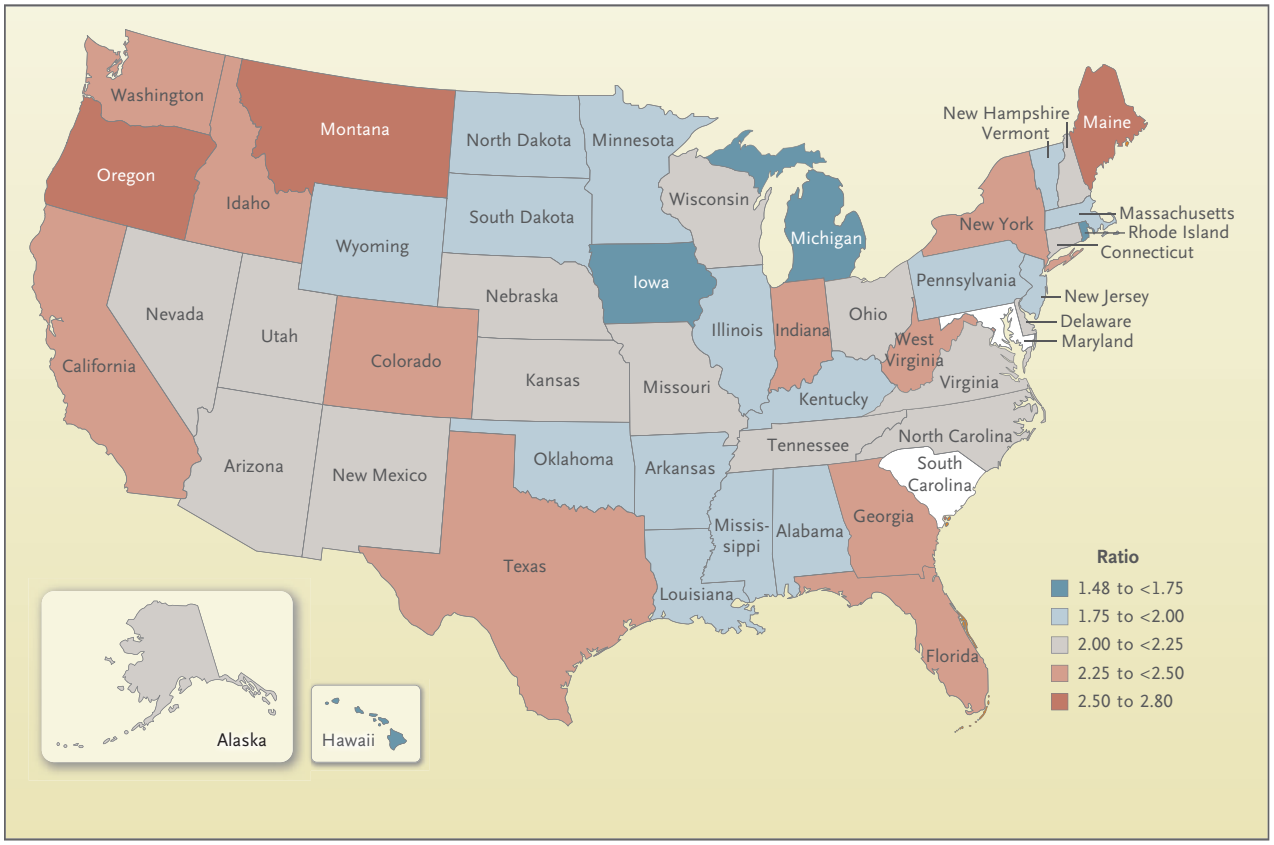
Prior to the explosion of Covid-19, which has sent shockwaves through the U.S. health care system, controlling the growth of health care spending was a central health policy issue. Once Covid-19 is largely behind us, health policy will return to this goal with perhaps even more urgency, because the fiscal pressures on public and private payers, which were substantial before the pandemic, will be even greater.

The key to success moving forward, as we recover from the Covid-19 shock, will be to create a more efficient delivery system. We will have to reduce the amount of low-value care delivered and address excessive prices that burden payers and distort incentives. The important question is how to do that.

A prominent aspect of the pre-Covid policy debate involved the role that markets should play in meeting these inevitable challenges. Markets are the foundation of our economy. When functioning well, they convey between buyers and sellers enormous amounts of information about production costs and consumer demand. They promote efficient production and cost-reducing innovation.

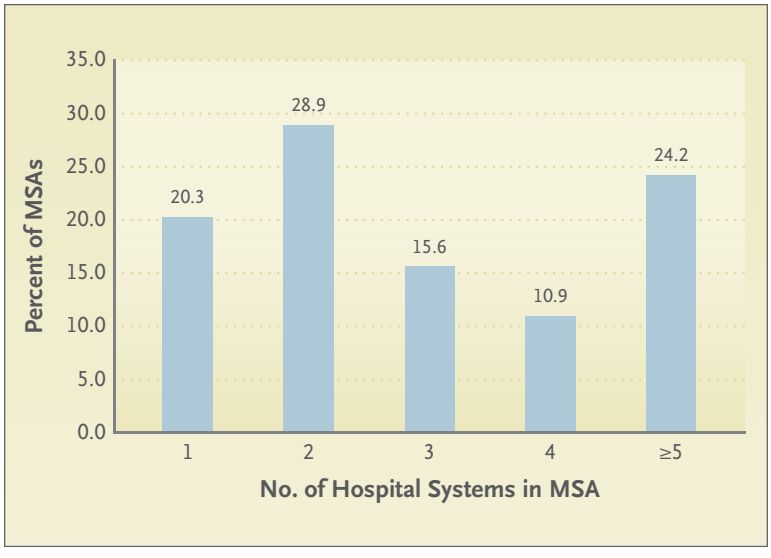
No market functions perfectly, however, and health care markets are more imperfect than most. One indication of the failure of competition is the wide variation in prices for care across markets (see map).[1] Competition in health care fails for several fundamental reasons. First, patients often lack the information needed to assess both their care needs and the quality of their care. Second, illness and health care needs are inherently difficult to predict, exposing people to financial risks that they must insure against. This risk gives rise to an insurance system that shields patients from the price of care, dampening their incentive to use care judiciously and to seek care from providers offering high-quality care at affordable prices. The information problem, amplified by insurance, reduces the ability and incentives for patients to seek low-price, high-quality providers and impedes well-functioning markets. This problem has been magnified lately by consolidation of health care providers. Rural markets are, not surprisingly, a problem, but even many urban market are very consolidated (see graph).

The need for insurance, which pools risk, creates another problem. Specifically, premiums reflect the mix of beneficiaries in the risk pool. Though it may seem optimal for individuals to be able to purchase the insurance plan they most desire, the set of plans and the associated premiums will change as people select their plans. Apart from equity concerns, this dynamic creates inefficiency because diseases often have lifelong spending implications whereas insurance policies typically have a term of only a year. It is thus impossible, with existing institutions, to insure against the life-



Ratio of Inpatient Commercial to Medicare Prices.

Data are the author's measures based on data from 2018 IBM MarketScan Commercial Claims and Encounters Database and Medicare Provider Utilization and Payment Data. Methods are described in Chernew et al.[1] Maryland is omitted because of its global payment model, and South Carolina is excluded because of a data-use agreement.



Distribution of Metropolitan Statistical Areas (MSAs) by the Number of Hospital Systems.

Data are the author's tabulations from 2017 Torch Insight data, adjusted for common system ownership.

time risk associated with illness without public policies to promote risk pooling. Other markets face similar challenges, but the magnitude of these problems is greater in health care. A separate concern is that competing insurers, which can hold down premiums, fragment the payment system. This can allow consolidated providers to charge more and, because providers must accommodate different insurer systems, may add to administrative costs. On balance, all these concerns suggest that an unregulated health care market is unlikely to lead to desired outcomes.

The weaknesses associated with market-based health care systems are severe, but that does not mean

the market should be abandoned. Markets have proven successful in many ways — for example, they have been effective at encouraging innovative care delivery and financing approaches, such as telemedicine, and new payment models, such as accountable care organizations and episode-based payment. Markets have promoted efficient reallocation of resources (e.g., from inpatient to outpatient care or from nursing home to community-based care) in ways that publicly run systems may not. Furthermore, there is evidence that private plans in Medicare (Medicare Advantage plans) can obtain better care at lower cost than the traditional fee-for-service Medicare program can. However, these positive results in Medicare may not generalize to commercial markets, because Medicare Advantage plans have institutional advantages, such as the ability of patients to get care from nonnetwork providers at Medicare prices, that allow them to pay, roughly, Medicare prices rather than commercial prices.

Moreover, when they were forced to compete for enrollees on the marketplaces created by the Affordable Care Act (ACA), without employer involvement in plan designs, insurers rapidly adopted narrow-network designs that promote lower prices for care. It is not clear whether this experience would generalize to higher-income consumers, but at least in this setting, competition has shown that it can generate plan behavior that restrains premiums. If higher-income beneficiaries wanted broader networks with higher premiums, plans with those characteristics would presumably become available on an exchange.

Efforts to improve markets for health care services have often aimed to increase the price sensitivity of patients when they're choosing to use care or selecting a provider. Such efforts include initiatives to provide patients with better information about health care prices and quality or to design benefit packages that encourage cost-conscious decision making. Unfortunately, existing strategies for improving price transparency have had very little success, primarily because patients rarely use the transparency tools that are available, decisions are complex, and patients fear disrupting their relationships with their physicians.[2]

Benefit designs that provide incentives for desired behaviors have had a larger effect, but have still generally failed to significantly ameliorate market failures. Specifically, blunt cost-sharing approaches, such as high-deductible plans, have failed to encourage price shopping, and though they have reduced utilization, these reductions have affected higher- and lower-value care similarly.

Value-based insurance design has increased the use of high-value services but has rarely addressed the use of low-value services. Reference-pricing plans have changed behavior and lowered spending but have been limited to selected services such as imaging and orthopedic procedures. Tiered and narrow-network plans have also shown some success but have exacerbated problems such as surprise billing.

The slow diffusion of these competition-promoting plans probably reflects employers' hesitance to impose the financial risk on workers that higher cost sharing entails, as well as hesitance to disrupt existing provider relationships. Without widespread diffusion, the amplifying effect that these plans would create by lowering market prices, as opposed to just steering patients, will not occur. The core problem is that for markets to work, patients must face the economic consequences of their choices, but labor-market concerns dampen employers' enthusiasm for adopting plans that impose such consequences.[3]

Efforts to increase price sensitivity in the choice of health plans often focus on supporting insurance exchanges, which remove the labor-market barriers to efficient plan construction, and removing policies, such as the tax deductibility of insurance, that shield decision makers from the full price of a health plan. Such efforts could promote diffusion of plan designs that encourage efficient use of care and reduce costs.

Yet exchanges are not without drawbacks. Risk adjustment remains a challenge, and there is considerable evidence that beneficiaries make poor plan choices.[4] People who choose plans with less generous coverage or narrow networks may not fully appreciate the risk they're accepting and may avoid needed, high-value care. Similarly, elimination of the favorable tax treatment of health insurance would surely induce more price sensitivity in people choosing health plans but could weaken the stability of the risk pool and lead to even less generous plans, which, though requiring lower premiums, would impose greater risk, create greater disparities, and possibly lead to worse health care choices.

As a result, any action to support plan competition and encourage adoption of strong patient incentives by plans would probably need to be accompanied by safeguards that maintain market stability, minimize the consequences of poor plan or care choices, and — because efficiency does not imply equity (and may, in fact, exacerbate inequality) —

address inevitable disparity concerns.

The problems with health care markets are significant, but in evaluating their merits, we need to compare them with other systems, such as government-run models. Government management of the health care system has its own set of inherent weaknesses. For example, fiscal and industry pressures can cause government payment rates to be too low and poorly allocated across services and geographic markets. Some health care sectors, such as long-term care hospitals, are overpaid. Examples such as the sustainable-growth-rate system, the Merit-based Incentive Payment System, and the Medicare Stars program in Medicare Advantage all illustrate challenges with efficient government-program design. Perhaps most important, in practice the outcomes from government-managed health care depend crucially on how well the government functions.

An audio interview with Dr. Chernew is available at NEJM.org

Fortunately, we do not have to choose between unimpeded markets and complete government control. In fact, many of the "single-payer" health care systems around the world have some market components, and many are actually expanding the role of markets. The more important question is how government and markets can complement one another. Essentially, we do not need to abandon markets — we can make them better. Specifically, relatively incremental actions, such as continued support for ACA marketplaces, continued efforts to increase the effectiveness of transparency initiatives, pro-competitive reforms to reduce the deleterious consequences of provider consolidation,[5] and regulations to prevent the most severe market failures, such as limits on surprise billing or more aggressive caps on excessive prices in the commercial market, seem like first-order ways to improve market functioning with a relatively light touch. If we fail to improve market functioning, stronger government involvement will most likely be needed.

Disclosure forms provided by the author are available at NEJM.org.

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1. Chernew ME, Hicks AL, Shah SA. Wide state-level variation in commercial health care prices suggests uneven impact of price regulation. Health Aff (Millwood) 2020;39:791-9.
2. Mehrotra A, Chernew ME, Sinaiko AD. Promise and reality of price transparency. N Engl J Med 2018;378:1348-54.
3. Sinaiko AD, Alidina S, Mehrotra A. Why aren't more employers implementing reference-based pricing benefit design? Am J Manag Care 2019;25:85-8.
4. Sinaiko AD, Hirth RA. Consumers, health insurance and dominated choices. J Health Econ 2011;30:450-7.
5. Gaynor M, Mostashari F, Ginsburg PB. Making health care markets work: competition policy for health care. Washington, DC: Brookings Institution, April 2017.

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Beyond a Moment — Reckoning with Our History and Embracing Antiracism in Medicine

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Medicine has reached a new consciousness of the depth and devastation of racism in the United States. Amid a national-turned-global reckoning on racism in the spring of 2020, medical institutions and associations have declared en masse that structural racism and police violence are critical public health issues. But to go beyond declarations and move forward with fighting racism in medicine, we must understand the racial biases in our responses to past and present public health issues and plot an ethically and structurally different path to a new future.

Although the American Public Health Association and individual advocates have identified police violence and racism as public health issues for decades, medicine as a whole is painfully late in its awakening. The morbidity, mortality, and racial disparities associated with police violence are long-standing. The health and health care disparities that plague the United States are ubiquitous and well studied. Structural racism has been described and identified as a root cause of health inequities.[1] To cite but one example: the history of medicine and public health in the United States reveals a pattern of medicalizing the suffering of White communities while ignoring or criminalizing the similar suffering of minority communities, especially Black communities. This dichotomy is particularly stark with regard to issues at the intersection of health, politics, and law. That our collective awareness comes only in the wake of a global protest movement for racial justice highlights the pervasiveness of our collective biases and willful ignorance.

Two modern-era instances of this phenomenon illustrate the way in which it perpetuates racism,