



Coordination versus Competition in Health Care Reform

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Many current proposals to increase the value of care delivered in the U.S. health care system focus on improved coordination — and with good reason. Badly coordinated care, duplicated efforts,

bungled handoffs, and failures to follow up result in too much care for some patients, too little care for others, and the wrong care for many. A host of current reform efforts aim to reduce these inefficiencies in both public and private markets. These efforts range from penalizing hospitals with higher-than-expected readmission rates, to rewarding primary care providers when patients receive higher-value care, to providing incentives for the adoption of electronic health records. Accountable care organizations (ACOs) and bundled payments are designed to create monetary incentives for coordinated care. The hope is that coordination will improve value by ensuring that

the right care is provided in the right place at the right time.

These laudable efforts, however, may unintentionally be at odds with another strategy for improving value: promoting competition in health care markets. In general, less competition means higher prices; one well-publicized symptom of the lack of competition in U.S. health care is providers' ability to charge different prices for the same service.¹ Competition may drive higher quality, particularly when prices are constrained.² The benefits of competition in private markets may even spill over to higher quality in Medicare, for which the Centers for Medicare and Medicaid Services (CMS) sets

prices.² A number of policy interventions, such as quality-reporting and price-transparency initiatives, are based on the idea that better information can promote competition and lead to greater value, and these initiatives have the potential to be very effective when patients have a choice of providers.

Efforts to promote integrated, coordinated care, however, can generate incentives for provider consolidation that may reduce competition — witness, for instance, the antitrust concerns surrounding the implementation of the ACO initiative.³ Consolidation may take the form of vertical integration, such as a hospital's acquisition of physician groups, which has ambiguous consequences for competition, or of horizontal integration, such as the merging of two hospitals, which nearly always reduces competition.² Consolidation is most

| Key Current Policies and Their Potential Effects on Health Care Coordination and the Competitive Environment.* | | | |
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| Policy | Description | Implications for Coordination | Implications for Competition |
| Accountable care organizations | Integrated provider groups participating in the Medicare Shared Savings Program created by the Affordable Care Act | Promote coordination | Create incentives for potentially anticompetitive horizontal and vertical integration |
| Bundled payments | Episode-based payments to groups of providers (e.g., CMS Bundled Payments for Care Improvement Initiative; http://innovation.cms.gov/initiatives/bundled-payments) | Promote coordination | May be anticompetitive in private markets but not in public programs with administered prices |
| Quality reporting | Publicly accessible information on provider quality (e.g., the Hospital Compare website run by CMS; www.medicare.gov/hospitalcompare) | Neutral | Promotes competition (if people use it) |
| Price transparency | Publicly accessible information on prices (e.g., New Hampshire's HealthCost website; www.nhhealthcost.org) | Neutral | Promotes competition (although has potential to limit "discounts") |
| Pay for performance (for hospitals, physicians, and nursing homes) | Reimbursement policies that explicitly reward quality (e.g., Medicare's Hospital Value-Based Purchasing Program) | May improve coordination if it includes explicit incentives for doing so (e.g., reducing readmissions) | May augment the effect of quality reporting |
| Electronic health records | The American Recovery and Reinvestment Act (2009) included subsidies to provide incentives for the meaningful use of electronic records by medical care providers. | Potentially positive if interoperability achieved | Potentially anticompetitive if lack of interoperability causes patients to be locked in to a provider or provider network |
| High-deductible and consumer-directed health plans | Promotion of plans with greater consumer cost sharing to mitigate low-value use | Neutral | Promote competition (up to a point) |

* CMS denotes Centers for Medicare and Medicaid Services.

likely to raise prices when providers of similar, rather than complementary, services merge — which is why hospital mergers are closely monitored by the Federal Trade Commission (FTC).

There are subtler forms of anticompetitive behavior as well. Bundled payments, a darling of procoordination delivery-system reformers, can spark antitrust concerns, as they have done most famously in the case of computer software. The problem arises because bundling offers providers who have market power in one product domain (such as tertiary hospital care) an opportunity to dampen competition in other product domains (such as primary care) by requiring insurers to con-

tract with them for both products in order to receive discounts.⁴

There is thus often — though not always — a trade-off between coordination and competition. Well-integrated provider networks may promote coordinated care that improves the allocation of health care resources, but they are likely to undermine competitive pressures to keep prices down while maintaining high quality. Coordinated systems may thus deliver the right care to the right patient at the right time, but at the wrong price. Competitive markets may do a better job of keeping prices low, but with the well-documented drawbacks of fragmentation. Some policies, such as the use of electronic

health records, can in theory promote both competition and coordination, but only if they are implemented well — an interoperable health information technology (IT) environment, for example, should promote both, but health IT without interoperability may simply lock patients in to their current providers or provider networks by making it difficult or costly to move their records, reducing competition. The opportunities for a win-win are limited.

The current suite of policies for addressing the ills of the health care system does not embody a unified approach to the roles of coordination and competition (see table). In part, this lack

of coherence reflects the fact that our insurance “system” is really several different systems, including moderately competitive private insurance markets for the nonelderly, nondisabled population and a single government payer, Medicare, for the elderly and disabled that largely pays providers set prices on a fee-for-service basis. These two payers currently pursue different approaches to reform. The most recent round of Medicare reform initiatives focuses on coordination, with ACOs as the prime example. In fact, the FTC has signaled that it will weigh the benefits of integration in improving quality against the potential harms of reduced competition.⁵ For the privately insured sector, the current focus is on enhancing competition through price transparency and “skin in the game” for consumers.

But the same doctors and hospitals must deal with both of these insurance systems, and the bottom line is a mixed message to providers. Moreover, the two sets of policies may undercut each other. For example, increased coordination that benefits Medicare beneficiaries may undercut private-sector efforts to reduce prices. An added complication is the fact that any policy must be evaluated relative to current practice in its own sector. For example, the promotion of ACOs has the potential to undercut competition by driving consolidation, but it might improve payment efficiency if it allows CMS to switch from fee for service to capitated provider payments (although it would still come at the cost of reducing competition that might have driven innovation and lower prices).

So what should policymakers do? We offer three broad prescriptions that may help strike the right balance between coordination and competition. First, we can look for the win-win opportunities to enhance both competition and coordination. As noted, health IT may be an example of such an opportunity if it is implemented well. There may also be win-draw opportunities in which either coordination or competition may be enhanced without harming the other. For example, the contracting processes that CMS uses for Medicare Advantage plans, Medicare Part D, and durable medical equipment have some competitive aspects but do not fully leverage the forces of competition to promote quality without sacrificing coordination. These processes could be improved.

Second, the courts and regulatory agencies that are tasked with enforcing antitrust law could focus explicitly on this trade-off when they examine health care and health insurance markets. After decades of relatively unsuccessful attempts to prevent hospital mergers, the FTC has recently had a string of successes in that arena. Similar vigilance is needed in other areas, particularly in the new realm of ACOs. As we gain insight into the reasons for the price dispersion in health care markets that transparency initiatives are bringing to light, we should explore whether this dispersion results not just from variation in quality and efficiency but potentially from anti-competitive behavior.

Third, policymakers could systematically look across silos to consider the effects that an initiative in one sector will have on

consumers in another — and on providers overall. To do so, they must have a clear understanding of the trade-offs at hand and the interaction of multiple policies and regulations aimed at improving quality and value. Coordination may foster delivery of the right quantity of care to each patient, while competition may help keep the prices for that care as low as possible. It is not obvious a priori what point on the competition–coordination spectrum provides the highest value in terms of quality of care and health benefit per dollar of spending. But total spending depends on both quantity and price. We need to evaluate the net effect of the suite of new public and private insurance-market policies on both price and quantity as we consider which policies might restore federal health care spending to a fiscally sustainable path.

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