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MAKING HEALTH MARKETS WORK BETTER THROUGH TARGETED DOSES OF COMPETITION, REGULATION, AND COLLABORATION

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I. INTRODUCTION

Some thoughtful commentators have argued that many health services, including insurance, are so unique and vital to the health of so many that they should not be bought and sold in markets like other goods and services.¹ Their judgment is that markets inevitably lead to some—and possibly a considerable—degree of rationing by income, at least in the context of the United States' health system until 2014, when the Patient Protection and Affordable Care Act ("ACA") is scheduled to be more fully implemented.² Rationing by income is judged to be inherently unjust, since life itself, as well as profound differences in the quality of life, are at stake so often. Those who reason this way would largely or completely replace market allocation mechanisms with expert allocation mechanisms.³ They would turn health professionals into employees of the federal government, and "ensure" that all (Americans) get the care they "need" through systems

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1. Bruce C. Vladeck, *Perspective: Market Realities Meet Balanced Government: Another Look At Columbia/HCA*, HEALTH AFF., Mar./Apr. 1998, at 37, 39; *PNHP Mission Statement*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM, <http://www.pnhp.org/about/pnhp-mission-statement> (last visited Oct. 7, 2011); NAT'L BUREAU OF ECON. RESEARCH, *INDIVIDUAL AND SOCIAL RESPONSIBILITY: CHILD CARE, EDUCATION, MEDICAL CARE, AND LONG-TERM CARE IN AMERICA* 126 (Victor R. Fuchs ed., 1996).

2. *Single-Payer FAQ*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM, <http://www.pnhp.org/facts/single-payer-faq> (last visited Oct. 7, 2011); see Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1003-399V-3, 124 Stat. 119, 139, 150, 151, 159, 162, 998 (2010) (to be codified at 42 U.S.C. §§ 300gg-94-1395x). The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. The two preceding laws will be hereinafter cited together as "ACA."

3. *PNHP Mission Statement*, *supra* note 1; *Single-Payer FAQ*, *supra* note 2.

of professionally driven logic, control, and governmental supply, financed largely if not exclusively by taxes on the general population.⁴

Others argue that the allocation of taxpayer-funded resources by experts would inevitably lead to health care rationing by politics, which they view not only as inherently unjust, but also un-American and unconstitutional, and which at the end of the day is the same thing in their eyes.⁵ They cannot imagine a worse outcome than divorcing the allocation of health resources from the marketplace, for they believe consumers have the inalienable right to buy what they want with their own money—whether others want to tax it away or make them spend it differently [or not].⁶ They also believe that if you cannot afford to buy what you want or need with your own money, you have no right to expect those with more means to help you, except through voluntary and preferably local charity.⁷

As we have (painfully) observed, now twice in twenty years, the epic battles over health reform in the United States, based as they are on fundamentally different views of the role of government in a democratic republic, have led to partisan polarization, apocalyptic rhetoric, and genuine fear.⁸ I write this article not to praise fear, but to bury it, by describing how to amend health market rules in such a way as to preserve key freedoms and personal choice while improving the distributive justice, economic efficiency, and ultimately sustainability of universal access to vital health services. It turns out that health reform and true economic efficiency can be complementary. It also turns out that the ACA provides some, but by no means all, of the tools to improve market performance in a host of circumstances. The purpose of this article is to identify these circumstances and match them with specific tools. Although this article cannot reconcile those who oppose any collective role in making sure all Americans have

4. PNHP *Mission Statement*, *supra* note 1; *Single-Payer FAQ*, *supra* note 2; *About CNA*, CAL. NURSES ASS'N, <http://www.nationalnursesunited.org/affiliates/entry/cna-about> (last visited Oct. 7, 2011).

5. Ilya Shapiro, *The Individual Mandate: An Unconstitutional Expansion of Federal Power (A Reply to Kermit Roosevelt)*, ENCYCLOPEDIA BRITANNICA BLOG (Sept. 26, 2011), <http://www.britannica.com/blogs/2011/09/individual-mandate-unconstitutional-expansion-federal-power-reply-kermit-roosevelt/>; Michael F. Cannon, *How Can I Ration Your Medical Care?*, TOWNHALL MAG., Sept. 2009, at 50, 51-54.

6. Cannon, *supra* note 5, at 52, 54; Michael F. Cannon, *A "Right" to Health Care?*, NAT'L REV. ONLINE (June 29, 2007, 6:00 AM) [hereinafter Cannon, *A "Right" to Health Care?*], <http://www.nationalreview.com/articles/221410/right-health-care/michael-f-cannon>.

7. Cannon, *A "Right" to Health Care?*, *supra* note 6; Leonard Peikoff, *Health Care Is Not a Right*, Address at a Town Hall Meeting on the Clinton Health Plan 1, 2 (Dec. 11, 1993), available at [http://afcm.org/Health-Care-Is-Not-A-Right_\(c\)-Leonard-Peikoff.pdf](http://afcm.org/Health-Care-Is-Not-A-Right_(c)-Leonard-Peikoff.pdf).

8. *Health Care Reform*, NYTIMES.COM, http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/health_care_reform/index.html (last updated Nov. 15, 2011).

access to care, I can perhaps show that actual market performance—in terms of prices closer to cost and cost growth closer to our limited ability to pay—could be substantially improved from wise and more widespread applications of market-savvy policy tools.

I will try to answer four questions: (1) What do we want health markets to do? (2) What are the major barriers to achieving optimal performance? (3) Under what conditions can each policy approach (*laissez-faire*, collaboration, regulation) improve current market outcomes? (4) What additional tools, beyond those in the ACA, are desperately needed to get us closer to the promised land?

II. MARKET DESIDERATA

The fundamental criterion of economically efficient market performance (competitive equilibrium) is for consumers to be willing to pay what they have to pay to cover the marginal social cost of producing what the consumer wants. Under conditions that are assumed to prevail in competitive markets, this maximizes the value of society's resource allocation. Technically, economists want price (P) to be driven down to the efficient unit cost level (C^*), where cost includes a competitive return on the minimally necessary capital investment. This is not the same thing as "maximizing the number of competitors," or creating a "business friendly" environment, though that rhetoric is popular and those structural conditions may improve market performance if barriers to entry have been high for some time. But if price is neither near nor moving rapidly toward the unit cost of efficient providers, something is seriously wrong with market performance, regardless of how happy sellers might be.⁹

Another signal of allocative efficiency is whether the quantity (q) of services is optimal (q^*). This is defined as the quantity where efficient marginal cost equals price, where price reflects what a fully informed consumer would pay and an efficient provider would require to cover the costs of the last unit, i.e., where marginal value equals efficient marginal cost. In the health care context, q^* is all the services needed to ensure efficacious care for a particular condition and no more.

Quality (Q) of each unit or of the set of units delivered is typically ignored in textbook economics, since it is assumed that producers of the q^* will naturally supply consumers with the optimal quality (Q^*) that they are, being fully informed about the marginal value of true quality, willing to pay for. Thus, quality should be supplied to balance value and cost, just like quantity. Quality is more complicated than it seems, for part of good quality

9. See Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence Is Waning*, HEALTH AFF., Mar./Apr. 2004, at 8, 12.

is the correct set of quantities, the q , but quality goes beyond that to include patient experience. It is not just what is done to or with a patient, but how it is done, that defines quality health care in the 21st century.

Finally, in the real world, many people prefer some degree of equity in access to health markets, which could be expressed as all (Americans) will get minimally necessary q^* and Q^* to preserve their capacity to work and live a normal life. Support for universal equity is clearly not unanimous, but it is real and powerful enough to be highly relevant to practical and policy discussions of health market performance.

III. HEALTH MARKET REALITIES

None of these desired outcomes are met in most health markets today. Given the margins and cost growth performances that have been observed for many years, I infer that market prices are often far above unit costs ($P > C$).¹⁰ Technically, this is both because providers are not efficient ($C > C^*$)¹¹ and because local market power enables many to charge private payers (and sometimes government payers) more than C .¹² Provider market power is amplified when insurers, starting with the largest one for most hospitals and physicians—the Medicare program—are compelled by politics, tradition, or in the absence of credible information on differential provider quality, feel compelled to provide access to practically any willing provider.¹³ Rather than negotiate the more than 10,000 medical service prices with approximately 700,000 doctors and 6,000 hospitals, they set

10. In the understated elegance of Joe Newhouse's historical explanation of provider prices in the U.S. health care system: "Thus, the standard market mechanisms for eliminating rents—or prices above average cost—were weak in the market for medical services, and did not operate at all in the limiting case of insurance that reimbursed patients in full at the margin." JOSEPH P. NEWHOUSE, *PRICING THE PRICELESS: A HEALTH CARE CONUNDRUM* 11 (2002).

11. MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY, SECTION 3B: PHYSICIAN SERVICES 114 (2004); *The Overuse, Underuse, and Misuse of Health Care: Hearing Before the S. Comm. on Finance, 110th Cong.* 6 (2008) [hereinafter *Misuse of Health Care*] (statement of Peter R. Orszag, Director, Congressional Budget Office).

12. Paul B. Ginsburg, *Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?*, HEALTH AFF., w3-472, w3-474, w3-477-78 (Oct. 8, 2003) <http://content.healthaffairs.org/content/early/2003/10/08/hlthaff.w3.472.full.pdf>; James C. Robinson, *Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology*, AM. J. MANAGED CARE, e241, e247 (June 2011), <http://www.ajmc.com/media/pdf/86aee848e56115f8d8d43711599ce6ef.pdf>.

13. Robert A. Berenson & Jane Horvath, *Confronting The Barriers To Chronic Care Management In Medicine*, HEALTH AFF., w3-37, w3-42 (Jan. 22, 2003) <http://www.healthaffairs.org/RWJ/Berenson.pdf>; MEDPAC, *supra* note 11, at 109.

administered price schedules that ensure most are willing to participate.¹⁴ This, by definition, means that most prices exceed the reservation price or unit cost for most providers. At the same time, endemic process inefficiencies, Medicaid underpayment, and uncompensated care for the under- and uninsured, especially for hospitals, keep overall margins low. This complex set of facts, which also includes prices a bit higher than costs, costs higher than need be, as well as small and variable margins on large cash flows, defines the conundrum of incentive realignment in U.S. health care.

Finally, there is quite a bit of evidence that $q > q^*$ for many patients and conditions.¹⁵ Again, technically this is because the incentives for overuse are strong: providers make more money from doing more,¹⁶ consumers/patients often face low or zero marginal cost from more and more expensive services,¹⁷ and fear of malpractice claims¹⁸ and anxiety about possible maladies leads to far more testing and procedures than necessary.¹⁹

While we have some of the best clinicians and hospitals in the world—and indeed perform very well vis-a-vis the rest of the world in complex domains (heart attacks, some surgeries),²⁰—our providers also have highly variable skill and knowledge and do a far worse job than many other countries' systems in consistently delivering high quality primary and chronic care management.²¹ This is where most of the money is actually spent and most of the health care system's value-added to population health actually

14. MEDPAC, *supra* note 11, at 109; *Misuse of Health Care*, *supra* note 11, at 7; BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK: PHYSICIANS AND SURGEONS 3 (2010-2011 ed. 2006), available at <http://www.bls.gov/oco/pdf/ocos074.pdf>; Overview, CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx> (last updated Sept. 30, 2011); KAISER FAMILY FOUND., *Total Hospitals, 2009*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=382&cat=8> (last visited Oct. 8, 2011); *Data Compendium: 2010 Edition*, CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.cms.gov/DataCompendium/14_2010_Data_Compendium.asp#TopOfPage (last updated Oct. 27, 2011).

15. *Misuse of Health Care*, *supra* note 11, at 2, 7.

16. *Id.*

17. *Id.* at 7.

18. Tara F. Bishop et al., *Physicians' Views on Defensive Medicine: A National Survey*, 170 ARCHIVES INTERNAL MED. 1081, 1081 (2010).

19. Gerard F. Anderson et al., *Health Spending In The United States And The Rest Of The Industrialized World*, 24 HEALTH AFF. 903, 910 (2005).

20. See ORG. FOR ECON. CO-OPERATION & DEV., *HEALTH AT A GLANCE 2009*, at 123, 125, 129 (2009) [hereinafter OECD]; Peter S. Hussey et al., *How Does The Quality Of Care Compare In Five Countries?*, HEALTH AFF., May/June 2004, at 89, 92.

21. See OECD, *supra* note 20, at 117, 119, 121.

occurs.²² This means our average quality is far below what it should be ($Q < Q^*$) far too often.²³ In addition, our lack of equitable access to care exacerbates average quality gaps.²⁴

More fundamental reasons for suboptimal health market performance include the reality that health care is a complex multi-product industry where inherent uncertainty is great. This is the case because humans are not all alike, and accurate diagnosis can require very subtle powers of discernment. This process is not like buying apples or tomatoes that you can hold and evaluate before purchase. Inherent uncertainty and the contingent nature of illness means that even after purchase, many consumers will never know how effective the health insurance or health services they purchased actually were.

Furthermore, asymmetric information about health and health care services between buyers and sellers means that patients will always depend on providers for technical advice and more or less have to trust that providers are at all times duty bound to act and advise in the patient's best interest.²⁵ This reality, plus third party payment²⁶—itself a requirement in the modern world of potentially catastrophic expenses that can bankrupt all but the richest citizens—means that providers are constantly tempted to err on the side of more versus fewer services in pursuit of the patient's "best interest," especially given lingering (if sometimes quantitatively exaggerated)²⁷ malpractice concerns. And as long as fee-for-service payment remains the norm, some providers will be sorely tempted to provide more services than needed, as any other seller in conditions of asymmetric information would be.²⁸ Some providers do resist this temptation. But there is growing evidence that the self-deniers are on the verge of being outnumbered in American medicine today,²⁹ even if the primary motivation

22. *U.S. Health Care Costs*, KAISEREDU.ORG (March 2010), <http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx#content6>.

23. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T HEALTH & HUMAN SERVS., 2010 NATIONAL HEALTHCARE QUALITY REPORT 2 (2011).

24. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED. (IOM), *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 53 (2001).

25. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 *AM. ECON. REV.* 941, 949-50 (1963); see Peter J. Hammer et al., *Kenneth Arrow and the Changing Economics of Health Care: "Why Arrow? Why Now?"*, 26 *J. HEALTH POL. POL'Y & L.* 835, 836, 841 (2001).

26. Arrow, *supra* note 25, at 962.

27. See Anderson et al., *supra* note 19, at 910, 912.

28. See *id.* at 910.

29. See Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care*, 138 *ANNALS INTERNAL MED.* 273, 276 (2003); Atul Gawande, *The Cost Conundrum*, *THE NEW YORKER*, June 1, 2009, at 36, 40, 42.

is less venal than defensive, and even deeply symbiotic with declining professional morale in an era of unmet expectations of autonomy and prestige.³⁰

In other words, asymmetric information and third-party payment leads to too many services and too much spending. In addition, local market power leads to prices being higher than efficient unit cost, both from pricing power and from the absence of incentives and market dynamics that require providers to reduce cost to the minimum. Indeed, of all the fundamental problems in health markets, the absence of strong self-correcting mechanisms is the most troubling. Entry and accurate quality information are theoretically (and often empirically) sufficient to improve most markets' performance over time, but health markets and relationships with sympathetic but self-interested, providers are so complex that credible information that less care can often be better care is not readily or widely accepted. Instead, market "entry" of providers, or higher supply in more desirable locations (where income and life style opportunities are higher) has been shown time and time again to lead to supply-induced demand for certain kinds of preference-sensitive care.³¹ All these forces together lead to per capita health care cost growth which exceeds economy-wide productivity growth (and thus real income growth potential) by 2-3% per annum.³² Over time this is the main threat to middle class access to coverage and care (the uninsured now exceed 50 million and continue to grow)³³ as well as the main structural imbalance in public budgets at the federal, state, and local levels.³⁴ We cannot and should not be satisfied with health market performance in the status quo.

IV. POLICY TOOLS

There are three types of tools available to policy makers to affect market performance: (1) competition-promotion, (2) regulation or structured competition, and (3) collaboration-facilitation. The key question is not whether health markets actually satisfy the conditions of perfect competition. Few markets actually do, up close. The relevant question is, can policy

30. Hoangmai H. Pham et al., *Financial Pressures Spur Physician Entrepreneurialism*, HEALTH AFF., Mar./ Apr. 2004 at 70, 79-80.

31. Fisher, *supra* note 29, at 286.

32. VICTOR R. FUCHS, STANFORD INST. FOR ECON. POLICY RESEARCH, POLICY BRIEF: THE FUTURE OF MANAGED CARE 2 (2000); see CONG. BUDGET OFFICE, CBO'S 2011 LONG-TERM BUDGET OUTLOOK 35, 42 (2011) [hereinafter CBO LONG-TERM BUDGET OUTLOOK].

33. CBO LONG-TERM BUDGET OUTLOOK, *supra* note 32, at 36.

34. *Id.* at 35, 43; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-496SP, STATE AND LOCAL GOVERNMENTS' FISCAL OUTLOOK 3 (Apr. 2011).

changes actually improve health market performance over the current status quo? I answer this question for each set of tools in turn.

A. *Competition-promotion*

The concept of “first, do no harm,” at least as old as the Hippocratic Oath, should also be applied to policies governing health markets because many of the deviations from optimal performance are the fault of policy, law, and regulation, which often is the result of pursuing non-market goals with health policy tools that happened to be convenient. The simplest competition-promoting policy to consider then is *laissez-faire*,³⁵ which in the health care context entails reductions in regulation or legislative barriers to market freedom and competitive performance.

There are at least three types of cases where more *laissez-faire* should be tried:

When quality regulations are redundant and increase cost. One example stems from lack of coordination of payers performing quality audits on hospitals. A given hospital may be inspected on site by teams from Medicare, Medicaid, the U.S. Department of Defense, private insurers, the Joint Commission, as well as state, county and city governments, all looking for the very same quality and safety performance metrics.³⁶ But each visit takes substantial documentation and senior-plus-mid-management time.³⁷ Coordination among quality regulators could save time, money, and improve quality by allowing senior management to devote more time to improving it rather than so much redundant time proving compliance with regulations.

When the law itself is the barrier to efficiency. The classic cases here are scope of practice restrictions that are not evidence-based. The recent Institute of Medicine (“IOM”) report on nursing compiled, yet again, the overwhelming evidence that nurse practitioners are perfectly capable of delivering very high percentages of the primary care needs of the general population, but many state legislatures, under pressure from local medical societies, refuse to grant scope of practice privileges commensurate with

35. *Laissez-faire*, literally “let do” in French, more generally is used by economists to mean free from policy intervention. BLACK’S LAW DICTIONARY 954 (9th ed. 2009). It is important to note, if only in passing, that no market activity is possible without a governmental authority defining and enforcing property rights and contracts, so the idea of “markets without government altogether” is a myth, however enduring and alluring it may be in some ideological camps.

36. See BARRY R. FURROW ET AL., HEALTH LAW 159-94 (6th ed. 2008) (overviewing the different private and public entities that inspect hospitals).

37. See *Eligibility for Hospital and Critical Access Hospital Accreditation*, THE JOINT COMMISSION (Jan. 11, 2008), http://www.jointcommission.org/eligibility_hospital_cah_accreditation/.

their training and experience and the best available clinical evidence.³⁸ This is also true for many other health professions, like psychologists, optometrists, nurse anesthetists, nurse midwives, pharmacists, etc.³⁹

Another example of far-from-perfect current law is patent law for pharmaceuticals. Patents are unquestionably necessary to spur innovation, especially in markets where the innovation is knowledge, and therefore easily transferable once known.⁴⁰ Without government-granted patent/monopoly protection, there would be far less innovation than we observe today. At the same time, granting a patent conveys monopoly power on the patent holder, so this raises prices and costs to others, necessitating a balance of competing interests, or a tradeoff.⁴¹ This is the main reason that in the United States, patent life is limited. In 1995, patent life for all products was increased from seventeen to twenty years,⁴² but in PhRMA's case, this is misleading, since the patent clock starts ticking when the intellectual properties of the new compound are filed, not when the drug is approved by the FDA for sale.⁴³ The drug testing and then the formal FDA approval process, while necessary to assure efficacy and safety, can take eight to twelve years,⁴⁴ which shortens the effective patent life to twelve to eight years. The shortened monopoly period to effectively recoup the costs of research and development and reward the investment and risk surely leads to higher brand name drug prices than might otherwise be the case. In 1984, the Hatch-Waxman legislation attempted to balance the

38. INST. OF MED. (IOM), *THE FUTURE OF NURSING: FOCUS ON SCOPE OF PRACTICE 2* (2010), available at <http://www.iom.edu/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Nursing%20Scope%20of%20Practice%202010%20Brief.pdf>.

39. See REBECCA LEBUHN & DAVID A. SWANKIN, CITIZEN ADVOCACY CTR., *REFORMING SCOPES OF PRACTICE 3, 4, 15* (2010), available at <https://www.ncsbn.org/ReformingScopesofPractice-WhitePaper.pdf>.

40. Richard C. Levin et al., *Appropriating the Returns from Industrial Research and Development*, in *BROOKINGS PAPERS ON ECONOMIC ACTIVITY* NO. 3, at 783, 787-88 (1987), available at <http://www.jstor.org/pss/2534454>.

41. JEAN O. LANJOUW, ECON. GROWTH CTR., YALE UNIV., CTR. DISCUSSION PAPER NO. 775, *THE INTRODUCTION OF PHARMACEUTICAL PRODUCT PATENTS IN INDIA: "HEARTLESS EXPLOITATION OF THE POOR AND SUFFERING"?* 4 (1997), available at http://www.econ.yale.edu/growth_pdf/cdp775.pdf.

42. It had been set at seventeen years since Thomas Jefferson was president. See 35 U.S.C. § 154 (1994); 35 U.S.C. § 154 (2000) (demonstrating the change in U.S. patent life from seventeen to twenty years).

43. See MERRILL MATHEWS JR., INST. FOR POLICY INNOVATION, *FROM INCEPTION TO INGESTION: THE COST OF CREATING NEW DRUGS* (Sept. 9, 2002), available at [http://ipi.org/ipi/IPIPublications.nsf/0/4a4dae090d22a1d886256c38005da8d9/\\$FILE/II-CostofnewDrugs-3.pdf](http://ipi.org/ipi/IPIPublications.nsf/0/4a4dae090d22a1d886256c38005da8d9/$FILE/II-CostofnewDrugs-3.pdf).

44. CAL. BIOMEDICAL RESEARCH ASS'N, *FACT SHEET: NEW DRUG DEVELOPMENT PROCESS*, available at <http://ca-biomed.org/pdf/media-kit/fact-sheets/CBRADrugDevelop.pdf> (last visited Nov. 20, 2011).

competing objectives of encouraging new and more effective drugs with price competition from generics once patent protection expires, by allowing speedy approval of generics at the FDA while granting up to an additional five years of exclusivity—monopoly—to patent holders, once their patent had expired.⁴⁵ Economic analysis suggests that this effectively extended the average effective life of drug patents by two to three years.⁴⁶

Furthermore, to extend the time of high profits accruing in the post-approval patent protection period, name brand manufacturers have regularly filed nuisance lawsuits strategically near the time of patent expiration to challenge generic manufacturers' products because the suit alone freezes FDA approval of generics for thirty months.⁴⁷ In retaliation, generic manufacturers have countersued.⁴⁸ Clearly, all this litigious effort could have been diverted to developing new drugs rather than fighting over the monopoly profits of old ones. The ACA contribution to current drug monopoly law extended the Hatch-Waxman post-patent exclusivity period from five to twelve years for biologics,⁴⁹ the most important class of new drugs in the twenty-first century, but promises to end the peri-expiration lawsuit games in as yet unspecified ways.⁵⁰ This provision was the result of complicated political bargaining that, like the original Hatch-Waxman compromise, did not benefit from state-of-the-art unbiased economic analysis.⁵¹

Optimal patent life is a relatively new area of research that is by no means settled into agreed upon and easily measurable formulae, but one

45. Drug Price Competition and Patent Term Restoration Act, Pub. L. No. 98-417, 98 Stat. 1538, 1589, 1590 (1984).

46. Henry G. Grabowski & John M. Vernon, *Effective Patent Life in Pharmaceuticals*, 19 INT'L J. TECH. MGMT. 98, 109 (2000).

47. *Greater Access to Generic Drugs: New FDA Initiatives to Improve the Drug Review Process and Reduce Legal Loopholes*, U.S. FOOD & DRUG ADMIN. (Jan. 2011), <http://www.fda.gov/drugs/resourcesforyou/consumers/ucm143545.htm>; see CONG. BUDGET OFFICE, HOW INCREASED COMPETITION FROM GENERIC DRUGS HAS AFFECTED PRICES AND RETURNS IN THE PHARMACEUTICAL INDUSTRY 41 (1998), available at <http://www.cbo.gov/ftpdocs/6xx/doc655/pharm.pdf>.

48. See generally FED. TRADE COMM'N, GENERIC DRUG ENTRY PRIOR TO PATENT EXPIRATION: AN FTC STUDY 44 n.13 (July 2002) available at <http://www.ftc.gov/os/2002/07/genericdrugstudy.pdf> (outlining generic and brand name drug manufacturer patent suits).

49. ACA § 7002(a) (amending PHSA § 351, 42 U.S.C. § 262).

50. ACA § 7002(c)(1) (amending 35 U.S.C. § 271(e)).

51. See Paul Blumenthal, *The Legacy of Billy Tauzin: The White House-PhRMA Deal*, SUNLIGHT FOUND. (Feb. 12, 2010, 12:51 PM), <http://sunlightfoundation.com/blog/2010/02/12/the-legacy-of-billy-tauzin-the-white-house-phrma-deal/>; Emily K. Strunk, *Debate Over Exclusivity in Biologics Provision of PPACA Heats Up*, HEALTH REFORM RES. CTR., AKIN GUMP STRAUSS HAUER & FELD LLP, <http://aghealthreform.com/2011/02/14/debate-over-exclusivity-in-biologics-provision-of-ppaca-heats-up/> (last visited Oct. 4 2011).

overarching conclusion seems clear: effective patent length should be set based on technological and financial realities of individual markets, not “one length fits all” as under current law. The post-ACA exclusivity period lengthens effective patent life for biologic pharmaceuticals back to and even beyond the twenty years of current U.S. patent law for all products except pharmaceuticals.⁵² It is hard to believe that this time frame appropriately balances our competing priorities of encouraging innovation and universal access to affordable high quality care. Analytic re-examination of the rules for new and competing pharmaceutical approval and exclusivity would seem to be a public policy priority of the highest order.

The third area where retreating from existing legal restrictions on market competition could improve market performance might be generally described as when emotion or nostalgia creates a protected class of providers. Due to political pressure from rural members of Congress and a general sense that rural America needs and deserves federal help to sustain its unique way of life,⁵³ Medicare has designated roughly 1300 rural hospitals as Critical Access Hospitals (“CAHs”),⁵⁴ over 430 hospitals as sole community providers (“SCPs”)⁵⁵ and 140 as Medicare dependent hospitals (“MDHs”).⁵⁶ Any of these designations entitles the hospital to some form of cost-based reimbursement rather than prospective payment levels pegged to average degrees of efficiency across the hospital industry.⁵⁷ These hospitals all have fewer than 100 beds (most fewer than twenty-five) and about 20% of them are more than thirty-five miles from alternative sources of emergency care.⁵⁸ Since only about 20% of the US population still lives in rural areas, and some of them seek acute care in urban areas, these hospitals account for only 15% of Medicare’s total inpatient spending.⁵⁹

52. ACA § 7002(g) (amending PHSA § 351, 42 U.S.C. § 262).

53. See Council of Econ. Advisers, *Strengthening the Rural Economy—The Current State of Rural America*, THE WHITE HOUSE, <http://www.whitehouse.gov/administration/eop/cea/factsheets-reports/strengthening-the-rural-economy/the-current-state-of-rural-america> (last visited Oct. 13, 2011).

54. *Critical Access Hospitals Payment Systems*, MEDPAC.GOV, http://www.medpac.gov/documents/MedPAC_Payment_Basics_09_CAH.pdf (last updated Oct. 2009).

55. *Sole Community Hospitals*, TRICARE MGMT., <http://www.tricare.mil/hospitalclassification/> (last visited Nov. 20, 2011).

56. G. MARK HOLMES ET AL., N.C. RURAL HEALTH RES. & POL’Y ANALYSIS CTR., FINAL REP. NO. 98, A COMPARISON OF RURAL HOSPITALS WITH SPECIAL MEDICARE PAYMENT PROVISIONS TO URBAN AND RURAL HOSPITALS PAID UNDER PROSPECTIVE PAYMENT 10 (2010); see also 42 C.F.R. § 412.108 (2010).

57. *Critical Access Hospitals Payment Systems Payment Basics*, *supra* note 54.

58. *Id.*; see also 42 C.F.R. §§ 412.92, .108 (2010).

59. *Census 2000 Population Statistics: U.S. Population Living in Urban vs. Rural Areas*, FED. HIGHWAY ADMIN., http://www.fhwa.dot.gov/planning/census_issues/metropolitan_planning/cps2k.cfm (last visited October 17, 2011); *A Data Book: Healthcare Spending and the*

So why worry about such a small percentage of spending if it is basically serving another purpose as well, namely propping up rural economies and their desirability as places to live? The short answer is because saving 10% or 20% off of the 15% of Medicare's total inpatient spending would represent a large dollar amount of savings. In addition, some rural hospitals are doing fine without the special payment rules, and for the others, excess Medicare payments alone do not guarantee financial stability or even survival for the smallest rural hospitals which are also threatened by uneven management of care processes and cash flow, low volumes of services, low payment from Medicaid and private providers, and uncompensated care.⁶⁰ Quality of care in small, low volume hospitals is also a recurring concern.⁶¹ The better health policy would be to wean rural hospitals off cost-based Medicare reimbursement, which will force the ones which need help to form partnerships and referral arrangements with other hospitals and management teams who can help them transition to a service mix and business model that is sustainable, if possible. Then a separate set of subsidy decisions should be made about ensuring an adequate degree of access to acute care for rural Americans.⁶² These are complex and ultimately social and political judgments, but the burden of keeping inefficient rural hospitals afloat should not fall to the Medicare program, or even to the overall health care system per se.

Another competition-promotion policy to consider is antitrust. The very purpose of the antitrust laws, if not the intent of every set of antitrust enforcers, is to protect and enhance consumer welfare from anti-competitive actions of individual sellers or groups of sellers acting in concert, which would lead to higher prices or lower quality than would occur under unrestrained competitive pressures.⁶³ Thus, the sin in antitrust is generally some kind of restraint of trade or action which suppresses competition. In practice in complex health markets, however, there has been relatively little success in applying antitrust remedies wisely, as a recent review of case law and scholarship shows:

Case law has constrained enforcers' ability to control concentration and has given overly permissive signals to providers who are contemplating further

Medicare Program, MEDPAC.GOV, 80 (June 2010), <http://www.medpac.gov/documents/jun10databookentirereport.pdf>.

60. HOLMES, *supra* note 56, at 4, 20.

61. See AM. HOSP. ASSOC., *THE OPPORTUNITIES AND CHALLENGES FOR RURAL HOSPITALS IN AN ERA OF HEALTH REFORM* 3, 7 (2010), available at www.aha.org/research/reports/tw/11apr-tw-rural.pdf.

62. Having grown up in a town of 2,000 in a county of 10,000 in the Mississippi Delta, I am highly sympathetic, personally.

63. See Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, HEALTH AFF., Mar./Apr. 2002, at 185, 192.

consolidation. Moreover, doctrine has developed erratically, failing to find a coherent approach to analyzing the complex nature of health care markets, and conveying the impression that decisions are more driven by outcomes than by sound analysis of precedent and economic policy.⁶⁴

There is nothing wrong with antitrust theory, but the truth is that basic research into the empirical implications of imperfectly competitive and multi-product health markets is sorely needed. This would give enforcers and jurists the analytic support they need for judgments about the relative likelihood of pro- or anti-competitive outcomes from joint ventures and mergers that are rampant now, in some ways driven by the incentive realignment strategies embedded in and emerging from the regulations pursuant to the ACA. When antitrust law scholar Thomas Greaney writes: "What antitrust needs most, however, is sound economic and policy research,"⁶⁵ then we must infer that antitrust policy cannot carry a heavy burden in correcting widespread market imbalances in the next few years. Even if we had first-rate analysis to rely on, the truth is that in many cases the underlying source of local market power for some hospitals—and sometimes for single specialty or large multi-specialty physician groups—cannot be remedied effectively with traditional antitrust tools such as stopping a merger or a divestiture order. This is because the hospital (or physician group) is likely to either be a de facto monopoly (natural or not) or have an outsized quality reputation, a form of product differentiation that is impossible or difficult to calibrate and divest.

Antitrust policy, however, can be useful for very targeted, fact-driven purposes. For example, the U.S. Department of Justice and the Michigan Attorney General recently filed a civil antitrust action against Blue Cross Blue Shield of Michigan ("BCBSM") alleging that some of its "Most Favored Nation" clauses in hospital contracts raise prices of consumers, by forcing hospitals to charge up to 40% more to other insurers than BCBSM pays them.⁶⁶ Similarly, antitrust enforcement could be used to stop the anti-competitive practice of device manufacturers who prevent hospitals from disclosing transaction prices to physicians.⁶⁷ This has the effect of reducing

64. *Id.* at 193.

65. *Id.* at 194.

66. Complaint of United States of America and State of Michigan at 3, *United States and Michigan v. Blue Cross Blue Shield of Mich.*, No. 2:10-cv-14155-DPH-MKM (E.D. Mich. 2010) available at <http://www.justice.gov/atr/cases/f263200/263235.pdf>; see also Jeffrey May, *Health Insurer Sued Over Most Favored Nation Clauses*, WOLTERS KLUWER LAW & BUS. (Oct. 19, 2010), <http://antitrustconnect.com/2010/10/19/health-insurer-sued-over-most-favored-nation-clauses/>.

67. Mark V. Pauly & Lawton R. Burns, *Price Transparency For Medical Devices*, 27 HEALTH AFF. 1544, 1551-52 (2008).

hospital bargaining power with device manufacturers, and clearly raises costs and reduces ultimate consumer welfare.⁶⁸

What are the most important other market imbalances, and what are other possible competition-promoting remedies? The two cases mentioned as candidates for targeted antitrust enforcement suggest the class of imbalances, basically, whenever margins are large, whenever P is far above C^* . Insurers with dominant market shares, especially in the individual and small group market, can earn very hefty margins, or, in more technical terms, experience a low medical loss ratio ("MLR") (percent of premium dollars spent on covered medical services). The smaller the MLR, the more likely profits or margins are large relative to premium revenue collected. A recent survey reported that 27% of small group insurers and 46% of non-group insurers have MLRs lower than required in 2011 by the ACA.⁶⁹ The difficulty is that competitive entry is not easy to engender in insurance markets, given the inherent advantages incumbent firms have in contracting with local providers. This is especially true if they have achieved large market share and therefore bargaining power vis-a-vis hospitals (witness the MFN example from BCBSM)⁷⁰ and the simultaneous ability to pay physicians high enough fees to discourage potential competitors from entry, which benefits physicians and insurers but harms consumers and others in local markets. This is exactly why so many analysts supported a carefully structured public option health plan to jumpstart local insurance market competition where there is little today.⁷¹

B. *Structured Competition, Countervailing Buying Power and Targeted Regulation as Remedies*

It is important to note, if only in passing, that no market activity is possible without a governmental authority defining and enforcing property

68. *Id.* at 1545, 1552.

69. HEALTHSCAPE ADVISORS, LLC, MINIMUM MLR BENCHMARKING—HOW DOES YOUR PLAN STACK UP?, available at http://gallery.mailchimp.com/351e723f2128c004676ac2dcf/files/HSA_MLR_Benchmarking_Quick_Sheet.2.pdf (last visited Nov. 20, 2011); see also Sara Hansard, *2010 Data Show Small Group, Individual Health Plans Would Have to Make Rebates*, Health Ins. Rep. (BNA) (May 4, 2011), available at <http://www.healthscapeadvisors.com/articles/BNAMLRArticle.pdf>.

70. May, *supra* note 66.

71. *Competition in the Healthcare Marketplace: Hearing Before the Subcomm. on Consumer Prot., Product Safety, and Ins. of the Comm. on Commerce, Science, and Transp.*, 111th Cong. 85-99 (2009) (statement by Richard A. Feinstein, Director, Bureau of Competition, Federal Trade Commission, Len M. Nichols, Director, Health Policy Program, New America Foundation, David Balto, Senior Fellow, Center for American Progress Action Fund, Mark Riley, National Treasurer, National Community Pharmacists Association, and Grace-Marie Turner, President, Galen Institute).

rights and contracts. Thus, the idea of markets without government altogether is a myth, however enduring and alluring it may be in some ideological camps. Policy is about setting market rules so that the self-interest of market players furthers the social interest of agreed upon policy goals, as defined by politics. Structured competition then is not about market manipulation, but about setting the rules of competition to move market performance closer to the competitive ideal, $P = C^*$. Remember, sellers prefer $P > C$.

Alain Enthoven first articulated the idea of “managed competition.”⁷² He was among the first market analysts and advocates to recognize that voluntary insurance markets as then (and currently) structured in the U.S. were never going to be able to deliver affordable coverage for all Americans.⁷³ Assuming that affordable private insurance coverage for all is indeed the policy goal we share,⁷⁴ insurance market rules will have to be changed so that aggressive underwriting and risk selection is no longer profitable. This does not require putting insurers out of business or turning them into regulated utilities (though the MLR regulation provisions in the ACA come unnecessarily close to this result),⁷⁵ but it does require changing the rules so that their business models will have to change to remain profitable. Guaranteed issue,⁷⁶ modified or full community rating,⁷⁷ the end of pre-existing condition restrictions,⁷⁸ an individual requirement to purchase insurance plus subsidies for the low-income and risk adjustment to

72. Alain C. Enthoven, *History and Principles of Managed Competition*, HEALTH AFF., Jan. 1993 (Supp.), at 24, 29.

73. See *id.* at 42 (“A system of universal coverage will not work if everybody is covered, but only those who voluntarily choose to do so pay for it. Such a system would be destroyed by free riders.”).

74. This is the core issue, along with the metaphorical issue of competing theories of the proper role for government, animating the political struggles over the passage and implementation of the ACA.

75. See PHSa § 2718(a), added by ACA § 10101 (to be codified at 42 U.S.C. § 300gg-18) (which requires insurers to submit a report including the percentage of total premium revenue, after accounting for collection or receipts for risk adjustment, risk corridors, and payments of reinsurance); see also Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection Affordable Care Act, 75 Fed. Reg. 74,864, 74,879, 74,886 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158).

76. See PHSa § 2702, added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-1) (ensuring guaranteed availability of coverage); see also PHSa § 2703, added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-2) (ensuring guaranteed renewability of coverage).

77. See PHSa § 2701, added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg) (ensuring modified community rating).

78. See PHSa § 2704(a), added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg) (prohibiting insurers from excluded applicants based on preexisting conditions).

standardize the risk pools across insurers⁷⁹ will largely accomplish the policy goal. These new rules will channel or structure insurance market competition to focus more on price and quality and less on socially undesirable risk selection. If implemented wisely and with appropriate subtlety, the ACA, which includes all of these conditions, should come close to accomplishing this.

Other elements of structured competition in the ACA include “administrative simplification.” Today, hospitals spend about 20% of revenue and physicians’ offices spend 30% of revenue on the administrative expense of getting paid,⁸⁰ i.e., complying with the myriad claim forms and rules that insurers enforce idiosyncratically to compete on paying the fewest fraudulent claims. Fraud has to be checked, of course, but the ACA uses federal regulation to set in motion a process of adopting standard claims adjudication algorithms, so that clinicians and hospitals can spend more resources on patient care.⁸¹ Competition over claims adjudication algorithms, assuming the standard method is reasonably good at weeding out fraudulent claims, is highly unproductive for the health care system as a whole—even if it may be profitable for individual insurers, which is exactly why they have always done it. A structured competition approach will require all insurers to use the same algorithm, as the ACA does in 2016, and thereby will help focus competition into more socially productive avenues.⁸²

New market competition rules, administrative simplification, and medical loss ratio transparency⁸³ will all usher in new insurer business models that will focus on competing by helping all enrollees find value in the health care system rather than by competing to exclude the largest share of sick enrollees or denying the largest share of claims filed. Thus, insurers will have to focus on avoiding full body scans, medical arms races, and

79. See ACA § 1501 (to be codified at 42 U.S.C. § 18091) (The ACA enacted individual mandate provision requiring most Americans to have health insurance coverage.); see also ACA § 1401 (to be codified at I.R.C. § 36) (covering subsidies for low-income individuals.); see also ACA § 1343 (to be codified as 42 U.S.C. § 18063) (covering risk adjustment.).

80. See HEALTHCARE ADMIN. SIMPLIFICATION COAL. (HASC), BRINGING BETTER VALUE: RECOMMENDATIONS TO ADDRESS THE COSTS AND CAUSES OF ADMINISTRATIVE COMPLEXITY IN THE NATION’S HEALTHCARE SYSTEM 7 (2009), available at <http://www.ahima.org/downloads/pdfs/advocacy/HASCRpt20090717.pdf> (stating administrative costs account for an average of 35% of healthcare spending, including 27% of spending at physician offices and 21% at hospitals.).

81. ACA § 1104 (to be codified at 42 U.S.C. § 1320d-2).

82. *Id.*

83. I would argue all that was necessary for good market results was for medical loss ratio transparency, not the specific regulatory levels of MLR required by the ACA. However, it is the law as it now stands and so while it is overkill, the same result I focus on here will likely occur.

other volume-enhancing strategies of the past. Insurers will also find it in their interest to pro-actively move away from unaccountable fee-for-service provider payment systems—and indeed, they already are.⁸⁴ Thus structured competition in insurance markets will likely lead to more effective countervailing buying power in health service markets.

But will private insurers have enough clout to counter provider market power at the local level? They, and many commentators, fear not.⁸⁵ This is why I and others think Medicare has to play a catalytic and collaborative role in exercising countervailing market power. Only Medicare has sufficient market share to make it worthwhile for providers to change their business models from health service maximization to health promotion and coordinating care.⁸⁶ Insurers can help immensely by continuing value-based design research, for value-based cost-sharing can align consumer/patient interests with payer and provider interests in an efficient and high-quality health care system.⁸⁷

Still, no one really thinks that even all of this will be enough to shift our health care cost growth trajectories to a sustainable slope soon enough to avoid much more fiscal and economic stress of the sort our national politicians have been arguing about lately. In short, we have to pay China back for all the borrowing we have done,⁸⁸ and that will require a cohesive

84. See, e.g., Michael E. Chernew et al., *Private Payer Innovation in Massachusetts: The 'Alternative Quality Contract'*, 30 HEALTH AFF. 51, 51-52, 61 (2011) (discussing Blue Cross Blue Shield of Massachusetts's move from fee-for-service payment to an "Alternate Quality Contract," which is modified global payment system); see also John E. Kralewski et al., *The Effects of Medical Group Practice and Physician Payment Methods on Costs of Care*, 35 HEALTH SERVICES RES. 591, 608 (2000) (demonstrating how capitation payments are associated with lower costs to patients).

85. See Robert A. Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 700-05 (2010) (discussing providers' increasing market power to negotiate higher payment rates from private insurers in California); PAUL B. GINSBURG, CTR. FOR STUDYING HEALTH SYSTEM CHANGE, RESEARCH BRIEF No. 16, *WIDE VARIATION IN HOSPITAL AND PHYSICIAN PAYMENT RATES EVIDENCE OF PROVIDER MARKET POWER*, at 1, 1-2 (Nov. 2010).

86. Richard Kronick, *Understanding the Medicare Financing Problem*, in MAKING MEDICARE SUSTAINABLE 7, 17-18 (Len M. Nichols & Robert A. Berenson, eds. 2009).

87. See A. Mark Fendrick & Michael E. Chernew, *Value-based Insurance Design: Aligning Incentives to Bridge the Divide Between Quality Improvement and Cost Containment*, 12 AM. J. MANAGED CARE (SPECIAL ISSUE) SP5, SP5 (2006) (stating value-based design insurance allows a focus on value of services, not cost or quality alone); see also Michael Chernew & A. Mark Fendrick, *Value and Increased Cost Sharing in the American Health Care System*, 43 HEALTH SERVICES RES. 451, 452 (2008) (noting that an ideal system would target copayments not based on the value of services, but patient groups who receive the value of services).

88. See *Major Foreign Portfolio Holdings of U.S. Securities*, U.S. DEP'T OF THE TREASURY, <http://www.treasury.gov/resource-center/data-chart-center/tic/Documents/mfh.txt> (last updated Nov. 16, 2011) (showing China is the top holder of American treasury securities).

and aggressive strategy of all of the above plus collaboration where necessary and feasible.

C. *Collaboration*

When is collaboration preferred to competition, even by economists? When no one knows the best way or technique, when there are large social payoffs from figuring it out quickly, and when the gains from collaboration are likely to greatly outweigh the net gains from competition. Clearly, despite the incentive realignments created by the ACA and the related innovations spawned by the ACA in the private sector, no one really knows how to write down the math of the transition and the new business models for every stakeholder in the health care system today. The scale of the necessary investments dwarfs the resources of most individual organizations.

Investments are necessary in: (1) contracting expertise and templates for all actors in the health care system, from physician practices large and small to hospitals of all kinds; (2) measuring development for much larger units of services (many fewer than 8,000 CPT codes) and for the quality of those bundled services, (3) creating transparent databases that can support incentive realignment and efficient contracting, like all payer claims databases, health information exchanges of interoperable clinical data, and the specific elements of the medical loss ratio; (4) supporting consumer engagement strategies, including: wellness programs that motivate, value based insurance designs, and decision support systems that channel patient self-interest in an efficient and sustainable health care system to align with payer and provider interest; and (5) developing antitrust safe harbors that are also checks on excess market power so that optimal joint venture and accountability/reward sharing arrangements are worked out and spread.

Collaboration and sharing come most naturally among entities that do not compete locally. Since medicine is a profession with standards that are expected of all practitioners, standards that are constantly rising, the clinical medical literature is based on the premise that knowledge that advances patient outcomes and safety is a public good and should be shared so all clinicians and patients may benefit from it, not just the patients of the doctor that discovered the new modality. The rewards that go with recognition for the discovery are presumed to be sufficient to preclude the need to hide the knowledge and be the only practitioner who performs the technique. The collaborative investments outlined above may confer temporary competitive advantage to some stakeholders if they were successful alone, but our national sense of urgency to rein in health care cost growth is sufficiently great, and the likelihood of anyone squaring any of those circles quickly on their own is so low, that collaboration among public and private stakeholders is paramount at the present moment. In many ways, this is the

effort that the Center for Medicare and Medicaid Innovation within CMS is trying to lead, but it is only going to succeed if a critical mass of private sector entities—hospitals, physicians, and health plans—embrace and engage in the collaborations and experiments needed.

V. CONCLUSION

This article has outlined a set of positive roles for government policy to play in transforming the U.S. health care system. It identifies clear cases in which, compared to the pre-ACA status quo, *laissez-faire*, regulation and collaboration are likely to substantially improve the performance of health service and insurance markets. The ACA itself provides many tools that will clearly be helpful in creating a sustainable health system that serves almost all Americans better than they are served today. At the same time, the complexities of incentive realignment are so great and our need for cost growth reduction so profound, that collaboration among public and private decision makers will be necessary as well, since the incentives that must be realigned must work for all payers, clinicians, and patients. With the proper spirit of collaboration and investments, our health care system could serve all Americans and become sustainable within ten years. This would satisfy both a moral and an economic imperative. My contention in this article is that a wiser application of a broad set of economic policy tools can help us accomplish this common purpose. The urgency of our task is such that we should, to the extent possible, dispense with political distractions and intensify this quest to the highest possible extent.

