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Health care industry needs to rethink current market model

By: Mathew Kaiserman – May 14, 2013

Economists will tell you markets work, but … . The "but" is a number of basic assumptions, including good price signals from buyers to sellers.

When market participants interact, we expect downward pressure on prices (consumers demand lower prices while suppliers enter to offer lower prices), yet the health care market has proven to be anything but normal.

The existence of an intermediary insurance market may offer a few explanations, as many problems can potentially be explained by design flaws within our insurance structure that affect natural market forces.

The U.S. spends more on health as a percentage of GDP than any other OECD (Organization for Economic Cooperation and Development) country at roughly 17.6 percent, with an OECD average of 9.5 percent. Some might argue this is due to the quality of U.S. health care. This has been widely debated among experts from the Cato Institute, the Commonwealth Fund and the McKinsey Global Institute, among others.

In the end, quality is a mixed bag, with the U.S. leading in some areas and lagging behind in others.

In 2007, Congressional Research Services reported the U.S. ranked third highest for medical-error deaths among developed countries.

Clearly, these high costs get passed right on to consumers, right? Out-of-pocket payments, as a percentage of total U.S. health expenditures, have actually declined nearly every year since the Centers for Medicare and Medicaid began keeping track in 1960 (from 47.7 percent in 1960 to 11.55 percent in 2010), with insurance covering an increasing majority of the tab.

Eventually these costs get passed back to consumers or employers in higher premiums; however, there is a significant delay between the health care consumer's decision and its impact on their pocketbook.

Consumers seldom shop for medical care. Instead, they (or their employers) shop for insurance with a focus on deductibles and co-pays instead of end prices - as evidenced by consistent decreases in out-of-pocket expenditures. The consumer then shops for health care, often with little regard to price and more concern for comfort and convenience, so suppliers don't receive the normal demand signal that says, "Lower prices or we go elsewhere."

Historically, insurance companies had natural incentives to negotiate lower prices on behalf of buyers. Cost advantages could be passed on to consumers, allowing insurance companies to offer lower rates, increasing enrollment and decreasing overall risk.

A wide body of evidence (chronicled well in J. White's "Markets and Medical Care: The United States, 1993-2005") suggests, however, that insurance companies lost bargaining power as the health care industry consolidated and realized consumers were more loyal to local providers than they were to health plans.

The evidence seems to be corroborated by the modest net profit margins of health insurers (3.6 percent as reported by Yahoo! Finance), while the health industry - more specifically those who supply health care providers, such as drug manufacturers - earn upward of 16.8 percent.

No one should be surprised that product prices increase in any industry where consumers are shielded from the immediate personal wealth implications of their purchasing decisions.

Our co-pay and deductible system in the U.S. health insurance industry is premised on the belief that insurance companies can adequately bargain on the consumer's behalf and restrict consumer choices.

The system is failing. If we are concerned about rising health care costs and want to maintain a market-based health care industry, we need to rethink the old model of fixed deductibles and co-pays, taking into account their impact on market forces.