Healthcare Contracting

DOJ/FTC Healthcare Competition Workshop

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Assumptions

- Costs/Margins vary
  - AMC versus community hospital
  - Brain surgery versus broken leg
  - Service versus imaging
- Why? Political constraints? Historical accident? Market size and fixed entry costs?
- Situation gives insurer incentive to purchase cheaper items from one provider – which is a form of a narrow network

Market power

Suppose a provider has market power

- Could bargain for higher price from insurer
- Could bargain for certain contract
  - Anti-tiering/anti-steering
  - Bundling (all-or-nothing contracting)
  - Carve-outs
  - Gag clause
  - Exclusive dealing (United Regional Wichita Falls)
- Hard to do (?) if high deductible health plan

Harm?

- What would be possible theories of harm from anti-tiering / anti-steering / bundling provisions?
  - Foreclosure: prevent growth of, or economies of scale in, competing hospital or provider
  - Monopolization: prevent entry of competing imaging firm or provider
  - Higher prices: competing provider knows it cannot grow so chooses a high price

Efficiencies?

- What would be possible efficiencies from these contracts?
  - Cross-subsidization is necessary…
  - Provider does not know true profitability of each service; needs to sell whole bundle in order to be sure costs are covered
  - Provider needs referrals from one service to another
  - Provider needs scale in order to keep average costs down
  - Unrestricted network is more choice for consumers
  - Consumers will be confused by plans with restrictions

Effect of wide networks

- Observed in pharma: Part D
- Protected classes (antiretrovirals, antidepressants, antipsychotics,
- anticonvulsants, immunosuppressants, and antineoplastics) and "pharmacy key drug types"
  - Can show price effects (Duggan and Scott Morton, 2010 AER)
  - Competition stimulated in other classes, prices fall
  - No price change in protected classes and PKDT
- Recent attempt to reduce the number of protected classes in Part D
- Recent attempt to allow any willing provider to participate in Part D pharmacy networks

New research

Mark Shepard, Harvard PhD student on the market this year

- A high-cost hospital with market power that forbids tiering may result in insurer omitting the hospital entirely from its narrow network plan. Consumers then choose between high and low cost plans
- Consumers who like high-cost care sign up for high-cost plan and use lots of expensive care. Plan costs rise.
- The next period, more consumers switch to low cost plan…repeat.
- Death spiral for high-cost plan => high-cost hospital has no business

Tiering permits the low-cost plan to include the high-cost hospital on an expensive tier. To avoid the scenario above, high-cost hospital may want tiering

- Consumers value extra choice
- In equilibrium, less adverse selection, high-cost hospital can be in all plans