# Hospital Contracting Practices

by

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March 27, 2003

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**For Discussion Purposes Only**

# Health Care Markets Are Changing

- Not so long ago…
  - Rapidly escalating health care costs
  - Moral hazard and unnecessary care issues
  - Employers, employees, consumers and governments insisted on new approaches to health care cost containment
  - IN: Managed care, HMOs and federal DRGs
  - OUT: Cost-based reimbursement, UCRs and most regulatory solutions to high costs

# Health Care Markets Are Changing
(continued)

- Not so long ago…
  - Hospitals were forced to become more efficient
    - ⇨Fewer admissions; falling lengths of stay
    - ⇨Surgery and ancillary services moved to the outpatient setting
    - ⇨A variety of cost containment strategies were adopted to manage the supply chain

# Health Care Markets Are Changing
(continued)

- Not so long ago…
  - Hospitals found themselves with many empty beds and the resulting excess capacity created bargaining strength for managed care
    - ⇨Selective contracting and steering kept hospital prices down by trading “discounts for volume”
  - Hospitals slowly made structural changes
    - ⇨Mergers, closures, bed reductions, systems formed, consolidations, buying MD practices, and service mix changes

# Health Care Markets Are Changing
**(continued)**

- Antitrust authorities' issues in recent years
  - Frustrated with court decisions when challenging hospital mergers; insurers can take care of themselves
  - Settlements with physician IPAs re: boycotts
  - The "high point" for blunting possible effects of payer concentration: the Aetna-Prudential deal (1999)
    - ⇨HMO-POS-only product market (fully-funded only)
    - ⇨Concern about possible monopoly and *monopsony* power
  - At the same time…a hot economy encouraged demand for freer access; the "backlash" began

# The Managed Care "Backlash"

- The managed care "backlash" has now shifted the bargaining strength to hospitals
  - More choice means broader networks, fewer gatekeepers, less risk sharing
  - MCOs have more difficulty steering
  - Fewer opportunities for selective contracting
  - Fewer discounts for volume
  - MCOs not "managing care" as tightly
  - Capacity has fallen in many areas

# Hospital Responses

- What have hospitals done with this new-found bargaining strength?
  - Many hospitals are catching up…
    - ⇨higher reimbursements
    - ⇨less risk bearing
    - ⇨different contract terms

# Insurer Responses

- What have insurers done in the face of new bargaining strength by hospitals?
  - Paid higher reimbursements to providers
  - Raised premiums; no longer “buying share”
  - Still, insurers are not defenseless, if they keep existing or develop new negotiating tools…
    - ⇨Playing physicians off against the hospital, especially on relatively high margin business such as outpatient surgery and imaging

# Insurer Responses
**(continued)**

- Maintaining risk sharing with physicians, where possible
- Punishing with a loss of business elsewhere
  - Service line or geographic “carve outs”
- “Tiering” to preserve steering and ability to shop for discounts
  - Setting up restrictive network options
  - Greater reliance on co-insurance to steer
- The “nuclear deterrence” option…disruption for everyone, including physicians explaining to their patients why they are no longer covered

# Antitrust Authorities' Response

- What are the antitrust authorities doing in the face of this shift?
  - More focus on providers
    - ⇨Hospital merger retrospectives (not insurers?)
    - ⇨Physician consent decrees
    - ⇨Considering new approaches to providers co-operating to control costs and provide better health care (e.g., MedSouth in Denver)
  - Holding these hearings to learn what is changing and what the likely competitive effects might be

# Health Care Markets: Competitive Implications

- When, if ever, does shifting bargaining strength become new-found market power?
- …and how might such market power be used?
- If health plans are to "shop" effectively on behalf of employers, can hospitals somehow block the health plans' attempts to create new tools to steer patients to lower-cost alternatives (assuming that is what end-users want)?
- The ultimate pricing discipline on providers…
  - Employers, in support of insurers (narrow networks, quality)
  - Expansion by existing rivals and new entry

# The Contracting Practices at Issue

- Selective and Exclusive Contracting
- System-Wide Contracting (a.k.a. “Full-Line Forcing”)

# The Selective Contracting Issue

- Selective contracting has been effective in keeping provider prices down
  - Payer-driven…shopping by bids is efficient
  - Threat of significant lost business
  - Requires alternative providers with marginal capacity
  - Requires ability to steer patients to the selected provider
  - Exclusive contracts…most direct form of assuring that the expected volume materializes

# The Selective Contracting Issue
(continued)

- Usually pro-competitive results…not an antitrust problem
- Still, lawsuits by excluded providers are sometimes filed
- Typical Claim:  Anticompetitive foreclosure designed to monopolize the hospital market
  - The underlying economic logic of the claim is usually quite strained

# Typical Plaintiff's Foreclosure Allegations May Include:

- Conspiracy with the big insurer
- Predatory pricing to lure the insurer into the conspiracy (against its own interests)
- Coercive tying of "exclusive" to some product line that is already allegedly monopolized and, thus, not offered by the rival hospital
- Sufficient foreclosure to drive out efficient rival
- Barriers to entry (and re-entry)

# When Might This Be A Problem?

- Rarely…almost always buyer-driven; no coercion; usually, net savings to the insurer
- The mechanism of foreclosure must make economic sense relative to the facts (whether by tying, predation, or conspiracy between buyer and seller)
- Foreclosure must be sufficient to drive out efficient providers and prevent entry of competing buyers to support the allegedly foreclosed hospital
- Substantial barriers to entry…or no recoupment is possible

# The “Full-Line Forcing” Issue

A hospital system will sign a contract with a buyer **only if** the contract covers:

- Virtually “all” the services that the system and its related entities offer, ***and***
- Virtually “all” the geographic locations that the buyer could purchase services from the hospital system.
- Usually, no exclusivity required…but inclusion is required.
- “Tiering” may be blocked; “carve outs” also

# When Might This Strategy Make Economic Sense?

- Fundamentally, a tying theory (two products)
  - Tying product…hospital or physician services at the "must-have" location
  - Tied or "forced" product…services at the location that the insurer would not contract for, if not "forced"
  - Must have substantial market power in the tying market
  - *But*…can it be leveraged to another market?
  - Evidence of coercion?
  - Legitimate business justifications?

# When Might This Strategy Make Economic Sense? (continued)

- The hospital system's logic
  - Transaction cost efficiencies…real, but small?
  - Want to stay a player at every location
    - ⇨Fixed costs can be spread, if capacity exists
    - ⇨Possibly, strong incremental profits over the whole system
  - Perhaps…want to avoid threat of punishment by "geographic carve out"
  - If no "tiering" is allowed by contract, may be preventing an insurer's attempt to steer patients to lower-cost alternatives

# When Might This Strategy Make Economic Sense? (continued)

- The “one monopoly power” theory
  - Why not just set a monopoly price in the monopoly market?
  - A predatory strategy to change the market structure? (Requires a significant barrier to entry)
  - When is it possible to leverage monopoly power to another market?

# Economic Issues to Be Evaluated: The Analytical Steps

1. When would this strategic behavior be possible or make economic sense?
2. Does the hospital system have substantial market power in any of the relevant markets?
3. Is that market power sufficient to force insurers to purchase services they do not want?
4. Have the insurers exhausted all of their alternatives and countervailing strategies?

# Economic Issues to Be Evaluated
(continued)

5. Has the system caused prices in the “forced” markets to rise to supracompetitive levels?

6. Does the system have a reasonable business justification for the practice?

7. Has the system lowered prices in the alleged monopoly markets, such that the bundled price is competitive? That is, are the system’s cost savings passed on as lower total prices?

8. Does the contracting practice create significant barriers to entry or cause exit, say, through effective predatory strategies?

# When Might This Be A Problem?

- The firm has substantial market power in one or more relevant markets used to impose the "forcing" and other conditions (e.g., no tiering, no carve outs)
- Not payer-driven…the contracts preclude payers from purchasing the mix of services they would otherwise prefer to purchase, a la carte, (including "one" monopoly price)
- The contracts have caused the current market prices for the package to be driven to supra-competitive levels (including the "tied" market), ***and***
- No offsetting efficiencies or reasonable business justifications

# Hospital Contracting Practices

***END OF PRESENTATION***

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