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DESIGNATED SERVICE PROVIDERS: ENHANCING COMPETITION OR RAISING BARRIERS

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With the drive to reduce spiraling costs of medical care, funders are increasingly engaging in selective contracting agreements with designated service provider networks. International experience suggests that this has several disparate effects on competition. In some instances it is argued that selective contracting increases competition between provider networks and drives down prices for funders and ultimately consumers. Others argue that such arrangements have negative impacts on the market by leading to foreclosure of non-contracted businesses and potentially raising prices to the uninsured.

This paper seeks firstly to outline relevant theory related to selective contracting and its impact on competition. Secondly, to look at the implications on healthcare markets, and finally to draw lessons for South Africa.

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1. Introduction

In South Africa and many countries internationally, there is increasing concern over the rising costs of healthcare. For funders (including medical schemes and health insurance companies) the challenge of managing cost is increasingly being addressed by careful cost minimization through various forms of contractual arrangements with key healthcare providers. These range from full vertical integration between insurers and providers (such as the Kaiser Permanent system in the United States) to looser systems of vertical restraints such as restricting treatment to a network of service providers with whom fixed prices have been negotiated. In the South African context, the use of a designated service provider is becoming more commonplace (particularly for prescribed minimum benefits) as medical schemes negotiate contracts with healthcare providers to provide services at lower set rates. In exchange, the medical scheme guarantees these providers minimum volumes through exclusive contracting. If patients wish to use alternate providers outside of the network they generally have to pay a co-payment, which could be equal to the difference in costs or a percentage of the fee (as a penalty to incentivise utilization of providers within the network).

The introduction of these vertical arrangements has been met with varying responses. From a consumer perspective a primary concern that has been raised is that restrictions on service providers compromise a patients choice of healthcare provider and thereby has a negative impact on freedom of choice and consumer wellbeing. For example, an industry survey by Old Mutual Actuarial Consultants in 2010[1] found that 60% of medical scheme members surveyed had a negative attitude to Designated Service Provider arrangements, for the following reasons: 31% wanted “freedom of choice”, 13% wanted “to see own doctor” and 9% found it “inconvenient”.

From a provider perspective the core argument raised relates to the potential foreclosing effects of such contracts on non-contracted horizontal competitors.

As the cost of medical treatment continues to rise, the range and frequency of vertical restraints between insurers and providers is likely to increase in South Africa in the future. This paper reviews some of the likely implications of this. It is structured as follows:

- First, we outline the key test related to the general assessment of vertical restraints in a competition context.
- Secondly, we describe certain features of healthcare markets, which differentiate it from other markets and have a bearing on the assessment of competition.
- Thirdly, we relate some of the positive and negative impacts of selective distribution in the healthcare industry and how it has been assessed in terms of the literature.
- Fourthly, we draw out key issues for consideration for South African authorities going forward.

2. Vertical restraints in competition

The impact of vertical restraints on competition is a topic that has been fraught with debate over the past few decades in both the industrial organization literature as well as legal case precedent. This is primarily due to the contradictory impacts of these restraints on competition. With an exception of resale price maintenance (which has to a large extent

[1] 2010 OMAC Healthcare Survey, OMAC Actuaries and Consultants, http://www.bhfglobal.com/files/bhf/OMACHealthcareSurvey.pdf

been seen as anti-competitive[2]) most vertical restraints are subject to rule of reason laws due to the fact that they can have both pro-competitive and anticompetitive effects. In this paper we primarily focus on the vertical restraint most commonly used in DSP arrangements, which is exclusive dealing or selective contracting.

Exclusive contracts are generally acknowledged to have several efficiency enhancing effects. Firstly, they can lower transaction costs by reducing the need for multiple negotiations and by reducing other transaction specific costs (such as administrative costs or transport costs). Secondly they can provide security of supply. Thirdly they can provide for the internalization of spillovers in industries where free-riding can lead to inefficient levels of investment (for example, the free-riding of investments in advertising in industries in which advertising or in-store demonstrations are important). Fourthly, they can promote investment by reducing the risk of investing in relationship specific investments (for example, by providing assurance of meeting minimum scale).

However, exclusive contracts have also been argued to be anticompetitive in certain instances. The primary concern is that exclusive contracts increase the risk of input or customer foreclosure and increase barriers to entry. This is because exclusivity that prevents a new or existing competitor from getting sufficient customers (or inputs) to reach a minimum viable scale can have a foreclosing effect. This is particularly relevant in instances in which multiple parties with exclusive agreements have a cumulative effect. In addition, it is argued that exclusive contracting can also soften competition by reducing interbrand competition. Exclusive contracts can also facilitate collusion in instances in which they contain restrictive clauses (such as most-favoured-nation clauses).

The likelihood that vertical restraints could potentially have anticompetitive effects was challenged by the Chicago School of economists (Bork, 1978, Posner 1976) who contended that exclusive dealing should not be prohibited by competition authorities as its impact on competition is pro-competitive or neutral. The key arguments made in support were (1) that since one cannot induce buyers to buy something that hurts their interests, exclusive dealing arrangements will only exist in instances in which there are efficiencies, (2) that exclusive dealing does not necessarily reduce supply to rivals if they still have access to other suppliers and (3) that there is a single monopoly profit that cannot be leveraged to other parts of the value chain (Bork, 1978). It was thus argued that competition authorities should have little or no intervention in vertical restraints.

This line of thought was challenged by various economists who noted that there exist several market features and externalities, which lend credence to the idea of foreclosure through vertical restraints in particular circumstances. For example, Aghion and Bolton (1987) show that if an incumbent and buyer agree on a contract that is partially exclusive, which enables the buyer and seller to extract some of the rent that would have accrued to a new entrant it could lead to anticompetitive foreclosure (an example of partial exclusivity, would be a contract from which a buyer can be released by payment of a penalty). Rasmusen et al (1991) and Segal and Whinston (2000) model instances in which there are many small buyers who believe that they cannot affect the market. If a new entrant needs to secure a few buyers to reach a minimum efficient scale, and each buyer signs with the incumbent believing that they act alone (assuming co-ordination between buyers is not possible) exclusive contracts could also have a foreclosing effect.

At present, vertical restraints such as exclusive dealing are seen to be benign and procompetitive in most cases. However, it is acknowledged that under particular circumstances such restraints could be problematic. As such, there is no per se prohibition

[2] Minimum resale price maintenance is per se prohibited under S5(2) the Competition Act 89 of 1998 of South Africa.

of vertical restraints (with an exception of retail price maintenance in general) and they are assessed on a rule of reason basis with a focus on the effects on competition.

A typical assessment of whether an exclusive contract is problematic therefore generally includes the following steps:

1. *Assessment of market power:* Vertical restraints are generally only problematic when there is market power in either the upstream or downstream market. International guidelines generally follow this approach with the EC providing a safe harbor for vertical restraints between companies with a market share below 30%.[3] The OFT does not specify a market share threshold but will only consider vertical restraints in instances in which one of the parties has market power.[4]
2. *Competitive harm:* The next step necessary is for the Competition Authorities or complainant to show that the exclusivity of the contract is harming competition. This should include a full competition assessment of the market and the nature of the contract. For example, the EC Guidelines on Article 81 discuss assessing the nature of the contract, market power, market position of buyers, parties to the competition and competitors, entry barriers, maturity of the market, level of trade, nature of the product and other factors. Other factors include the cumulative effects of multiple agreements on the market, whether the agreements are agreed or imposed, the regulatory environment etc. [5] In addition, it is necessary to show that the harm extends to consumers rather than to competitors.
3. *Efficiencies:* The defendant would have to produce sufficient evidence that the exclusive contract produces sufficient efficiencies that consumers actually benefit
4. *Weighing up:* The court or adjudicator would then need to weigh up the benefit of the efficiencies provided against the likely harm to competition taking into account the market.

3. Application to healthcare markets

As vertical restraints are generally assessed on a rule-of-reason basis it is necessary to carefully consider any competition assessment within the context of the market structure. In healthcare markets this means a consideration of the peculiarities of healthcare markets. These include the following:

1. *The nature and importance of the product:* Healthcare is a good with intrinsic value and importance to an individual. There is a highly inelastic demand for many healthcare services.
2. *Third party payment systems:* As in many markets in which there are high levels of uncertainty combined with individual risk, healthcare is characterised by its link to insurance and the prevalence of third party payment systems. However, the existence of third party payers adds an additional layer of complexity to the competition analysis of healthcare by separating the beneficiary of treatment from the payer. This has the effect of distorting behavior patterns as it reduces the price-sensitivity of insured patients, and therefore increases incentives for overconsumption of healthcare (moral hazard). In addition, there is a difference in incentives for the payer whose objective is to minimize costs and the patient whose objective is to maximize value without a consideration of costs.
3. *The timing of the purchase decision:* Health insurance is an option demand system due to the intertemporal component of the transaction. In healthcare markets a

[3] Guidelines on Vertical Restraints, EC Notice, SEC(2010) 411 Brussels
[4] Vertical restraints, OFT, 2004 EC Guidelines on Article 81
[5] Guidelines on Vertical Restraints, EC Notice, SEC(2010) 411 Brussels

customer chooses his insurer in an earlier period. His choice set includes various factors based on the information available and needs in that period. Sickness is usually unexpected both in onset and type. As such, at the time of the initial decision to purchase health insurance, a customer does not know what treatment he will eventually need. When the customer does need to access healthcare services in a later period he is then faced with a restriction in access to the provider that has been contracted. Though a customer may have a strong preference for one provider over another, at this point in time switching is not possible as he is locked into a contract with his insurer and therefore there is no real intrabrand competition after the fact. Competition across provider therefore occurs at medical scheme level and competition between plans occurs when the patient makes his initial choice. At that point he may not be sufficiently aware of implications of the DSPs in the agreement (given he does not know what he will need). Furthermore, they may be unclear or may be subject to change. In addition, customer understanding of DSPs may be limited

4. *The existence of a pool of uninsured customers subject to market dynamics:* Along with the pool of insured customers there often exists a separate pool of uninsured customers who are subject to the market dynamics but who may not be beneficiaries of the exclusive contracts negotiated with third party payers. This also has a bearing on market dynamics.

Thus various factors related to the nature of the market are relevant for an enquiry into vertical restraints. Any application of the test to the healthcare market has to therefore take cognaissance of those facts. For example, various features within healthcare market can impact on an assessment of market power. Firstly, the inelastic nature of the product can increase the market power of the provider. Secondly, the fact that the decision to purchase (made by the medical scheme) is separate from the decision to utilise (made by the patient), combined with limited substitution options can heighten the market power of both the insurer and the provider. Bearing this in mind we now turn to an overview of the pros and cons of exclusive contracts within a healthcare environment and the findings of both empirical and theoretical literature.

3.1 Benefits of DSP arrangements in healthcare

The Chicago School posited that exclusive arrangements would not exist unless there were efficiency benefits that made them attractive to customers. The core benefit of DSP arrangements are reductions in costs, which should lead to reductions in consumer prices. These could, in part, result from the reduction in transaction costs as the insurer does not have to have systems (such as billing and payment systems) set up with all possible providers, but just needs to focus on those within the network. However, the most commonly cited argument is that it is largely the result of lower negotiated prices.

DSP agreements generally provide insurers with the ability to purchase healthcare at a lower cost than on a free market. Unlike the standard exclusive dealing example in which a classic anticompetitive outcome of exclusive dealing is higher prices, it can be argued, that at least at the start of the competitive interaction, DSP agreements lead to lower industry prices. These prices can stem from two sources. Firstly, when selective contracting increases volumes allowing providers to reduce costs and secondly, where a credible threat of exclusion from the network provides the insurer with bargaining power allowing them to negotiate lower prices (Town and Vistnes 2001).

From a theoretical perspective Gal Or (1997, 1999) models vertical restraints within a healthcare framework and shows that where there is an exclusionary equilibrium in which all hospitals and insurers are paired, lower prices are achieved by insurers and passed on to patients improving patient welfare.

While we have not studied price effects in a South African context, empirical evidence from the US suggests that these savings could be large. For example, Douven et al (2010) cites US studies that show that prices attained by managed care organisations (who traditionally are focused on DSP type arrangements) are generally 10-20% less than insurers. Cutler (2000) found HMOs had a 30-40% lower expenditure in the treatment of heart disease than traditional insurers, primarily due to lower unit prices rather than different treatment patterns. Ho (2005) cites Miller and Luft (1997) who showed that HMOs spent approximately 10% less than indemnity insurance. Vita (2001) exploits the existence of variation in laws regarding selective contracting across US states to examine whether laws that require insurers to contract with any provider that meets their requirements (termed Any Willing Provider legislation "AWP") or requires them to reimburse any provider even if outside the network, (termed Freedom of Choice legislation "FOC") have an impact on prices. Using panel data he found that per capita expenditure was higher in states which had passed AWP or FOC legislation.

As such, indications are that insurers benefit from cost reductions related to DSPs. If these benefits are passed through to patients, this would be indicative of an increase in consumer surplus due to lower prices.

3.2 Concerns related to the existence of DSPs

There are three key concerns that emerge from the literature on DSPs. Firstly, that DSPs can lead to anticompetitive foreclosure of competitors. Secondly, that DSP agreements reduce consumer welfare, and thirdly, that in markets in which there is an uninsured population, DSP agreements have an externality on the uninsured.

(i) Foreclosure

The most common concern related to vertical restraints in general, is the concern that they could potentially serve to foreclose competitors. This is the central concern with selective contracting of DSPs. As discussed in the section on vertical restraints, the likely harm from foreclosure is screened on the basis of market power. However, in healthcare markets an assessment of market power has to be nuanced due to the existence of distortions such as price insensitivity of final customers and the potential for cumulative effects of multiple agreements. While off-network competitors often allege that DSP arrangements foreclose markets to them there is some debate as to whether the circumstances under which this is feasible actually exist.

Theoretical outcomes have been mixed. Gaynor and Ma (1996) examine the potential anticompetitive effects of exclusive dealing between insurance companies and healthcare providers. Using a model of two upstream providers and two insurance companies with differentiated preferences they show that neither hospital nor insurance companies would have positive profits in equilibrium and that exclusive dealing is therefore not profitable or likely. However, they show that consumer welfare is reduced by the restriction on choice of providers. The finding does not accord with observations in the market which shows that these contracts do exist. The conclusion is however, supported to some extent by Halbersma and Katona (2011) who find that neither party has an individual incentive for exclusivity. However, they find that they have a joint incentive for vertical restraints where side payments are possible.

Many other studies dispute this result. Gal-Or (1997) studies a bargaining equilibrium of two insurers and two hospitals differentiated along Hotelling lines. She shows that selective contracting can occur in equilibrium and that for some parameters (where hospital differentiation is smaller than insurer differentiation) anticompetitive exclusion is profitable. Her 1999 paper extends this conclusion to multiple hospitals and insurers located along Salop circles.

Douven et al (2010) use a more advanced bargaining model (a Fontenay and Gans model) to show that either hospitals or insurers can find exclusion profitable by foreclosing a competitor. As such, while the overall literature is mixed, there is a theoretical basis for the assumption that anti-competitive exclusion can be profitable in this situation.

(ii) Reduction in consumer utility

Due to the option demand nature of health insurance, patients who contract with insurers with DSPs or exclusivity contracts lose utility as they can no longer contract with their first best provider. At the time of engaging in the contract, the specifics of their disease or illness is not available so they are unable to select a plan on the basis of their actual needs. As such there is a loss in consumer choice. Gaynor and Ma (1996) show that selective contracting reduces consumer welfare on this basis even in the absence of foreclosure.

In addition, Ho (2005) uses a 3-step model to measure the change in consumer welfare as a result of a restriction in provider choice. She predicts a substantial increase in consumer welfare as a result of increased choice. However, she does this at fixed prices and notes that it needs to be weighed up against price reductions that the restricted choice creates.

(iii) Externality on the uninsured:

Another area in which designated service providers can impact on the market as a whole is by increasing the prices to the uninsured. This can be seen in the following example. Assume two upstream providers (say hospitals A and B) and two groups of customers (insured and non-insured). Assume the insurer contracts exclusively with hospital A. In addition, they continue to serve a few uninsured customers. Hospital B now can only see uninsured but still have the same cost base. They would either have to raise prices in order to meet costs or alternately find some means of attracting non-insured customers from hospital A. As such, they could reduce prices to attract other customers, or raise prices to their existing base. The choice is likely to depend on the differentiation between the hospitals and the level of substitutability. However, it is clear that under some circumstances there may be an externality on the uninsured resulting in higher prices.

Bijlsma et al (2010) studies the externality of selective contracting on non-insured customers. He shows that exclusive contracting can raise the costs of self-insurance if the excluded provider has market power. However, his model suggests that selective contracting is not detrimental to consumer welfare if there is no market power.

4. Lessons for South Africa

As DSP arrangements proliferate it is likely that the Competition Authorities will be increasingly faced with requests to examine the impact of such vertical restraints on competition. As such, going forward it would be useful to develop a set of basic guidelines for vertical restraints to guide the market. Some considerations:

Should South Africa have a safe harbor?

The range of benign arrangements existing in the market suggests that some method of filtering those that warrant further investigation is necessary. Since theory suggests the effects are most likely to be found in instances in which there is dominance in either the downstream or upstream market it may be useful to develop some form of “safe harbor” rule for filtering out vertical restraints. However, the existence of a safe harbor may prevent companies harmed by cumulative effects from seeking assistance.

Importance of merger control

Market power is a key consideration to the assessment of vertical restraints. As shown above, anticompetitive foreclosure and externalities on the non-insured are likely to occur in instances in which one of the parties have market power. The experience of authorities in the US suggests that complaints often arise in very narrow geographic markets and sometimes result in exclusion of upstream insurers. As such, merger control becomes very important in ensuring that competition at local level does not become concentrated in a manner that creates an opportunity for exclusivity contracts which have impacts on upstream insurers, or alternatively, impacts on patients who are inconvenienced by having to travel greater distances to access a provider on their network.

Barriers to the formation of networks

DSP arrangements become most effective in instances in which there is strong competition between providers for the contract or market. Many provider markets in South Africa have a few large participants and a competitive fringe of independent practitioners or providers. In order to maximize the efficiency of the bidding process we need to consider ways in which to incentivise independent providers to form networks to compete for contracts to ensure that the independent providers are not lost from the market, and in order to create a more rigorous bidding environment (though this may have its own challenges logistically and may also facilitate collusion on some level).

5. Conclusion

Designated Service Provider arrangements can be pro-competitive or anti-competitive based on the particulars of the case at hand. The key benefit arising from DSP arrangements is lower prices. However, this could potentially come at the expense of anti-competitive exclusion of competitors, which would weaken competition in the market in the long run. In addition, a reduction in choice leads to a loss of consumer utility. DSP arrangements can also have an externality on the uninsured in the market. As DSP arrangements increase in South Africa it is likely that complaints of foreclosure from excluded competitors will rise. Competition Authorities will need to assess them on a case-by-case basis taking into account the specific distortions in healthcare markets when considering market power. To avoid having to unnecessarily scrutinize a wide range of constraints, it may be useful to consider the development of a safe harbor for vertical restraints in order to minimize uncertainty relating to contracts that are likely to be benign. In addition, merger control that avoids dominance in narrow markets is also important.

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