Competition issues in the healthcare sector

FTC talk

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Why healthcare?

Renewed focus due to recent reform of law

Massive fraction of GDP

Not efficient, as any consumer can attest
- poor management?
- inherently unproductive?

Alternatively, not enough competition

Biosimilars

Biologics have 15% market share of pharma spending; growing at 12% per annum.

What is a biosimilar?

Impact of conventional generic; biosimilar will be different

Nonetheless, first instance of competition and must expect strategic behavior

Well-known examples from Waxman-Hatch Act

Biosimilar entry cost

FDA entry regulations: how much testing?
IP barriers
Process manufacturing barriers

Contract manufacturers

- Will have low entry costs, information that is competitive advantage, given subtleties of process
- Restrictions on contract manufacturers will matter for realized entry

Nature of competition

Firms that innovate (produce brands) in the small molecule area planning to/already do make biosimilars.
=> Unlike current market structure, will see multimarket contact, perhaps softer competition?

Promotion to providers or consumers may be used to emphasize differences among biosimilars/brand.
=> Regulations on promotion of biosimilars will affect price competition

Competition among insurers

Concentrated market?

- Data terrible; don't know true market structure
- First order problem with simple solution: government needs to collect data across country

Competition among insurers is critical policy issue

- Healthcare is 17% of GDP
- Significant fraction flows through private insurance industry (private, Part D, Part C)
- If paying markup due to market power on health insurance, large dollar loss to consumers

Impact of health reform on insurance competition

Electronic Medical Record and switching costs: Viard (phones), Dafny (employer health ins)

Standardization:

- standard format to describe product
- standard levels of coverage: bronze, silver, etc
- “poor quality” plan now illegal

Research suggests transparency and standards result in lower prices.

- search costs fall; value of reputation falls.

Exchanges and entry

Exchanges lower entry costs for insurers

- large pool of consumers
- mandate to buy increases market size
- standard format
- low distribution costs

=> More entry?

However, must meet standards concerning network quality and breadth. The more strict is the “large network” standard, the harder for insurers to break in with low cost products.

Multi-state option available to policy-makers to increase number of entrants

Exchanges and rural areas

How to create competition in rural areas?

Special permission to be innovative in forming acceptable network?

- mobile healthcare vans
- nurse practitioners
- telemedicine

Incumbent will have an interest in blocking entrant's ability to use novel delivery forms

Flagship hospital

Flagship hospital in geographic area; high quality => market power.
If inelastic demand => high prices

- Cannot divest parts of hospital due to economies of scope
- Can create cross-price elasticity of demand with local hospital using protocols
  - Like PBMs do with formulary
  - Works for subset of services: pregnancy, not liver transplant . However, ordinary services have large market share.
- Regulate prices

Contracting

Why haven't we seen demand for the narrow network as a response to large price increases?

- MFN: price protection relative to other insurers
- Anti-steering: insurer may not create product that steers patients away from certain providers
- Guaranteed inclusion: guarantee the participation of certain providers in limited network product if provider meets certain criteria
- Product Participation Parity: provider must participate in insurer's broad/narrow product if agrees to participate in competitor's broad/narrow product.

Web of contracts…

Massachusetts insurance markets

Recent changes in law in Massachusetts (Oct 1, 2010)

- ❑ Prevents hospital system from requiring all or nothing contract with all hospitals. Must allow insurer to contract selectively across hospitals.
- ❑ Prevents hospital/insurer from requiring plans be negotiated in bundle. Must allow separate contracts by plan (narrow v broad).
- ❑ Prevents contract terms from referencing prices of competitors or networks of competitors

⇒May lead to innovative network design and lower prices

⇒May lead to entry

Off-label marketing

Current regulations not working
Drugs approved for particular indication
- Physicians may use for any purpose
- Firms may not directly promote off-label use
- Firms earn profits w/no liability when off-label

Detailing representatives
- Steep financial incentive scheme
- May answer questions, give out literature on off-label uses

=> Lots of off-label use followed by litigation

Good reasons for off-label use

- Physicians know something about science and run experiments
- Pediatric, obstetric uses very common
- Uses where no other options: cancer
- Innovator has evidence of new use but patent runs out now or in a short time

- In general, problem of incentivizing collection of valuable information about drug if no property rights going forward. (e.g. carrots)
- Without large randomized trial, physicians not confident about efficacy or dosing.

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Innovator's incentives

Innovator runs lots of small clinical trials looking for new uses. Good idea
Some show significant results.

What is mechanism by which these are turned into journal articles for distribution?

Medical journals require registration of clinical trials
- Any non-profit, searchable registry

Substantial transaction cost for individual physician to learn there were 50 trials of drug Y for condition X.

Optimal regulation

Innovator has free speech rights.

Regulatory standard is “not false or misleading.”

Any one article on off-label use likely contains true data presented correctly.

But, arguably physician is not working on correct statistical problem