

Theory of harm 3: Bargaining

Introduction

1. Theory of harm 3 (ToH 3) seeks to test whether private hospital operators have market power in the negotiations with insurers on the prices charged for insured patients. Hospital operators' market power in these negotiations may derive, in whole or in part, from the hospital operators having hospitals with local market power. This may allow hospital operators to secure higher prices for insured patients across their group of hospitals. The more hospitals with local market power a hospital operator has and the more important these are to the insurer, the stronger may be the hospital operator's negotiating position vis a vis the insurer.
2. In our market questionnaire we requested documentation and correspondence relating to negotiations between hospital operators and insurers. We were provided with a large body of material covering recent negotiations, including analysis, strategy papers, internal email correspondence and external correspondence between the parties. As part of our assessment of ToH 3, we have conducted a detailed review of this material to better understand the drivers of these negotiations and the key factors that influence their outcome. In this appendix we summarize the evidence provided by both hospital operators and insurers relating to how they negotiate and their respective positions in these negotiations. We also set out our analysis comparing the price charged by different hospital operators to different insurers.
3. This appendix is split into three parts.
4. Part 1 considers the respective bargaining power of hospital operators and insurers in negotiations over their principle contract. In the case of smaller insurers, this is often a loose annual agreement that is focused on the price of particular services. In the case of the larger insurers, this is usually a more detailed multi-year contract (often referred to as a Hospital Agreement Plan (HAP)) that, along with prices, sets a number of detailed conditions. Part 1 covers the following issues:
 - (a) Managing network composition—insurer difficulties. This section summarizes the evidence we reviewed on how insurers try to increase their bargaining power in negotiations by threatening to remove a hospital or hospital operator from their network. In particular, the evidence we reviewed shows that insurers may face difficulties in using this threat when the insurer considers that its policy holders will need to access a number of hospitals owned by the hospital operator whether or not it has an agreement in place.
 - (b) How insurers have used network recognition in negotiations. This section summarizes our review of the evidence concerning cases where insurers appear to have used their principal negotiating strength, removing or threatening to remove a hospital from their network, to extract improved terms.
 - (c) How changing contracting arrangements may improve the bargaining position of insurers. This section considers then evidence on situations where an insurer has constructed its network using a competitive tender.
 - (d) Other factors that may impact the bargaining position of insurers. This section summarizes the evidence we have reviewed on how the negotiating position of

insurers could be affected by: (i) attempts by an insurer to partially delist a hospital; (ii) the use of co-insurance by insurers to signal high-priced hospitals to policyholders; (iii) encouraging the growth of alternative hospitals in an area; (iv) sponsoring new entry; and (v) vertical integration by insurers.

- (e) The size and financial strength of the parties is likely to impact negotiating outcomes. This section considers the evidence on whether a large insurer is likely to have more negotiating power than a small insurer and the role that the financial strength of the insurer or the hospital operator may play in a negotiation.
5. Part 2 considers how insurers have sought to improve their negotiating position by asserting more control over the choice of the facility that patients use. If the insurer can assert control over where a patient is treated, it will increase the credibility of any proposition to reward lower-cost hospitals with more patients and withdraw patients from high-cost facilities. In attempting to assert more control over the 'patient journey', the types of policies we have seen insurers introduce include:
- (a) actively guiding policyholders at the point of claim to a lower-cost hospital;
- (b) introducing new (usually lower-cost) 'restricted' policies with a correspondingly smaller network of hospitals; and
- (c) identifying specific services where there may be more providers or more scope for competition, contracting for these separately and requiring customers to use a restricted list of providers for these services.
6. Part 3 sets out our analysis in relation to comparing the price charged by different hospital operators to different insurers as a result of these negotiations: were we to find that certain hospital operators had more market power than other hospital operators, we would expect, other things being equal, these hospital operators to charge higher prices.

Bargaining framework and hospital negotiations

7. Contracts between a hospital operator and an insurer are typically the product of bilateral negotiations where an agreement is reached over the price and the other terms on which the parties will trade with each other.
8. Although insurers fund medical treatments, they are not a 'buyer' of hospital services in a conventional sense. The hospital service is provided to the policyholder and the decisions about who provides treatment or where that treatment takes place is usually made by a medical professional. However, given the contracting relationship, it makes sense to think of the insurer as a buyer of hospital services. Characterized as such, the hospital is the upstream seller and the medical insurer is the downstream purchaser, effectively buying hospital treatments for its policyholders in bulk.

Bargaining framework

9. The outcome of a bilateral negotiation, such as the one between a hospital operator and an insurer, depends on the parties' respective bargaining power. This will in turn depend in large part on the respective value of each party's outside option. That is the value of their next best alternative should they fail to reach an agreement. For example, an insurer's outside option could be to send its patients to a hospital owned by a different hospital operator. Alternatively, a hospital operator's outside option might be to work with a different insurer or to pursue more NHS work.

10. The parties' outside options effectively place a ceiling on how much a buyer will be willing to pay to a supplier and a floor on how much a supplier will be willing to accept from a buyer. Clearly no party will enter into an agreement that is worse than that it could achieve elsewhere. The less valuable the outside option and the worse the consequences of not reaching a deal, the more likely a party will be willing to make concessions to complete a deal. In the context of hospital negotiations, if an insurer is reliant on a particular hospital or a particular hospital operator, its outside options will be weak and it is less likely to have a strong hand in negotiations.

Bargaining by hospital operators and insurers

11. The fact that insurers are funders of healthcare, rather than conventional buyers, has implications for how negotiations are framed. Unless a buyer can credibly threaten to switch a substantial portion of its purchasing to a rival, its bargaining position going into a negotiation is likely to be weak. For an insurer, this means that it must be able to exert some meaningful control over where (and by whom) its patients are treated.
12. Hospital networks are the principal mechanism used by insurers to control access to their policyholders. When a customer signs up with an insurer, associated with the policy there is a network of hospitals the policy holder is allowed to use. When a hospital is included on an insurer's network, this means that the insurer has committed to pay for a treatment when a policyholder chooses to be treated at that hospital operator's hospital.
13. In return for the right to treat policyholders, the hospital operator fixes the level of its prices and the terms of service (eg quality standards) for a defined period of time. The prospect of having access to this group of potential patients provides the hospital operator with an incentive to price competitively in order to be included in the insurer's network. In other words, it is the ability to exclude a given hospital or hospital group from their network that give the insurers their main lever in negotiations. Whether or not this threat is credible largely determines the strength of an insurer's negotiating position.
14. During negotiations, hospital operators seek the broadest possible recognition and assurances that they will have access to as many patients as possible, with the insurers seeking to trade this for the lowest possible price. The more patients that the insurer can credibly deliver, or withhold, the stronger its bargaining power is likely to be.

Initial remarks

15. It is difficult to draw firm conclusions or make generalizations about the relative negotiating strength of insurers and hospital operators as a group. In each negotiation, this is likely to depend on the identity of the hospital operator and the insurer involved. However, considering the bilateral negotiations over the main contract in isolation, based on our review of documents provided by parties, it does seem that insurers are often in a relatively weak position. Their main negotiating lever in these bilateral contract negotiations, delisting a hospital or hospital operator, is often of limited credibility given that taking such a step can cause the insurer serious harm. This is because, where the hospital operator owns hospitals that face limited competition in certain local areas, the insurer is going to need to continue to allow its policyholders to use these facilities whether or not an agreement has been reached on price. The evidence seems to indicate that the more hospitals with local market power a hospital operator has and the more important these are to the insurer, the stronger is the hospital operator's negotiating position vis a vis the insurer.

16. While we found examples of contract disputes involving all hospital operators, the evidence we reviewed shows that some large hospital operators are often the most assertive, willing to challenge insurers, and most likely to emerge with the outcome they wanted from a negotiation.
17. However, there do seem to be two scenarios where insurers may find themselves in a stronger negotiating position and able to secure favourable outcomes:
 - (a) where a hospital operator requires the insurer to recognize a facility that was not previously included on its hospital network: there are a number of examples where insurers have secured discounts at specific sites in return for adding a new hospital to their networks;¹ and
 - (b) where an insurer has managed to use a tender exercise to generate competitive tension between hospital operators wanting to be part of its network (this is also discussed in Part 2).
18. As noted above, it is important to take into account the identity of the parties to the negotiation when considering where negotiating power is likely to rest. In particular, it seems that the size of the insurer is likely to be important. It would seem that the bargaining position of Bupa (and to a lesser extent AXA PPP) is significantly stronger than that of smaller insurers. Even if the hospital operator knows that Bupa cannot delist its hospitals in locations where competition is limited, the consequences of having some of its other hospitals delisted by Bupa (or AXA PPP) and potentially losing a significant proportion of their revenue, even for a short period of time, could be severe. This can be seen in the recent dispute between BMI and Bupa, where Bupa delisted 37 BMI hospitals and appears to have secured a favourable outcome as a result. BUPA argues that the outcome of the negotiation should not be interpreted as evidence that Bupa now has countervailing buyer. Amongst other points, Bupa says that BMI's decision to agree terms without a lengthy 'out of contract' period was, in part, because BMI was facing acute debt refinancing challenges. Bupa also says that it cannot rely on these factors always being present to encourage BMI (or other operators) to offer better value for money.
19. As discussed in Part 2 of this appendix, many insurers are increasingly seeking to enhance their negotiating position by asserting more control over where patients are treated. In some cases this is done by actively guiding policyholders at the point of claim to a lower-cost hospital (for example, via an open referral). However, the most common approach adopted by insurers is to identify where they can remove services from bilaterally negotiated contracts and contract for these separately (often via competitive tender). In some cases this is done by introducing lower-cost policies accompanied by a restricted choice of hospitals. In other cases this is achieved by identifying specific services that can be removed from the main contract and subjected to a separate tender exercise. The aim of these approaches is to subject a proportion of the insurer's spend to more competition. As such, these approaches have often been met with significant resistance by hospital operators.

¹ In relation to discounts offered in return for recognizing new facilities we would encourage submissions from parties as to whether these discounts are sustained or whether this is a short-term benefit that is withdrawn in future rounds of negotiation.

Part 1: The bargaining position of hospital operators and insurers during their principal contract negotiations

A: Managing network composition—insurer difficulties

20. The principle mechanism insurers use as a bargaining tool in negotiations is the shape and size of their network. The impact on both the insurer and the hospital operator of a threat to add or remove a hospital from an insurer's network if price or contract terms cannot be agreed is likely to be the key factor that determines the outcome of a negotiation. If the cost to the insurer is too large to make the threat credible, the insurer is likely to find itself in a weak negotiating position. This section covers evidence we have reviewed regarding the two key difficulties identified by insurers when faced with the decision of whether or not to remove a hospital or a hospital operator from their core hospital network:
- (a) the cost to the insurer itself of removing a hospital from its network can be significant; and
 - (b) removing a hospital from a network can harm the insurer's business and cause it to lose policyholders.
21. The more hospitals a hospital operator owns that face limited local competition, the more significant both these risks are likely to be for an insurer. This is likely to make any threat to delist by the insurer less credible.

The cost to an insurer of removing a hospital from its network

22. Insurers argue that they face significant costs if they fail to reach an agreement with a hospital operator on prices or other contract terms. This stems from the fact that, even if the insurer removes a particular hospital from its networks, many patients may continue to use it, particularly if there are few alternatives in the local area. If the hospital operator then increases prices at these hospitals when out of contract, this can prove very costly for the insurer. The more dependent the insurer is on a particular hospital operator, ie the more hospitals the hospital operator has which face limited competition in their local areas and the more important these are to the insurer, the higher these costs can be expected to be. The documents we reviewed suggested that this was often a pressing concern for insurers and the threat of a significant price rise (which can be in excess of 30 per cent) was a common approach utilized by hospital operators in negotiations when responding to a threat of delisting. In assessing whether it is viable to delist a hospital or hospital operator, the insurer must take into account that delisting a particular hospital or hospitals may weaken its negotiating position with other hospital operators.
23. After reviewing the evidence, we identified that in certain circumstances the following factors may increase the cost to an insurer of removing a hospital or a hospital operator from its network:
- (a) insurers may face a significant increase in the level of prices if out of contract with a hospital operator;
 - (b) insurers may face a delay before they can amend their network to reflect the fact that they have removed a hospital or a hospital operator—increasing their exposure to out-of-contract charges;
 - (c) removing a hospital from an insurer's network may not be viable if the alternative hospitals available are more expensive;

- (d) removing a particular hospital operator may transfer pricing power to other hospital operators in parallel negotiations; and
- (e) planning for a delisting is itself time-consuming and costly.

Removing a hospital from its network can cause an insurer to lose policyholders

24. As well as the immediate costs associated with removing a hospital or a hospital operator from an insurer's network, reducing the options available to customers may lead to a loss of policyholders. The risk that a network change may cause policyholders to switch to a different insurer may be increased by the actions of hospital operators.
- *Assessing the risk of losing policyholders*
25. While insurers appear to be concerned about the potential loss of patients that could result from a delisting, this is difficult to estimate accurately and we identified much less analysis devoted to this task compared with evaluating any increase in short-term treatment costs. Where it is assessed, the focus tends to be around how corporate clients are likely to react.
- *Hospital operators can actively increase the likelihood of switching by policyholders*
26. Several insurers noted in their response that the adverse reaction of policyholders to a dispute between an insurer and a hospital operator was likely to be magnified if the hospital group actively sought either to make customers aware of the dispute or impact the customer directly to put pressure on the insurer.
- *A public dispute with a hospital operator may damage an insurer's reputation*
27. A major out-of-contract situation between a large hospital group and an insurer is likely to be reported in the press. Insurers suggested that this could cause damage to their reputation and relationships with customers. In particular, Bupa cited the example of its dispute with BMI during late 2011 and early 2012, which was very public and covered extensively in regional and national press. The reputational harm, it argued, fell disproportionately on itself as the insurer.
28. As evidence, Bupa cited the fact that it experienced a significant spike in complaints and the loss of a number of corporate customers to other PMI providers over this period. While we accept there is likely to be some truth to this view, we also found examples of insurers planning how they engaged very carefully and using the media to put pressure on hospital operators during contract negotiations. We are also aware that some insurers have confidentiality clauses in agreements which limit the ability of hospital operators to speak publicly about negotiations.

B: How insurers have used network recognition in negotiations

29. While insurers highlight the fact that failing to reach an agreement with hospital operators is likely to be very difficult, given that removing a hospital operator is potentially both costly and damaging to their business, hospital operators state that it is something that gives the insurer bargaining power. They point to the fact that insurers do not recognize all hospitals and have shown that delisting even the largest hospital group is a real and credible risk (citing the negotiations between Bupa and BMI). We

have identified some examples where insurers either have delisted certain hospitals or have actively explored the proposition. The most public example is that of Bupa delisting several BMI hospitals in January 2012. Some of Nuffield Health's hospitals have consistently not been included in AXA PPP's main acute hospital network. We also identified some internal deliberations where certain insurers expressed the view that, if they opted to, they could realistically delist some hospitals from other operators albeit at potentially significant direct or indirect cost in some cases. However, these examples appear to be relatively rare.

30. On the other hand, AXA PPP's response to the CC's issues statement certainly suggested that it regarded itself in a position to negotiate with most hospital operators, although HCA's status in London results in commercial constraints: 'the negotiating power (outside of London) is to some extent balanced by our continued efforts to manage costs and the PH providers' objective to achieve recognition for as many of their non-solus hospitals as possible.'

C: Changing contracting arrangements may improve the bargaining position of insurers

31. Insurers considered that their bargaining power was weak in the context of a bilateral negotiation. However, there are instances where insurers have sought to use alternative contracting arrangements that could potentially improve their bargaining position.

Regional tendering

32. Having reviewed the evidence provided we identified two examples where insurers have constructed part of their core network by way of a tendering exercise:
 - (a) the development of AXA PPP's regional network in the late 1990s (as well as a small number of regions where it has retendered since); and
 - (b) PruHealth's reconfiguration of its hospital networks (both its core network and a restricted network product).

Local pricing

33. In its market questionnaire response, one insurer noted that uniform pricing across hospitals of the same hospital operator masked local price signals and could distort competition in local markets. This insurer chose not to focus its efforts on trying to negotiate differentiated pricing based on the location of different facilities. In its experience, the large hospital operators focus on negotiating prices at a national level and any deviation from this – such as lower prices in specific localities or for particular services – would only be considered by the hospital operators if they were offset by price increases elsewhere. The insurer reported that the net effect is usually revenue neutral.
34. While it may increase transparency, we are not convinced that insisting on differential pricing across different hospitals will necessarily improve an insurer's bargaining position.

D: Other factors that may impact the bargaining position of hospital operators or insurers

35. In various submissions a number of possibilities were raised as to other factors that might influence negotiating outcomes or steps insurers or hospital operators could take to improve their negotiating position. In reviewing the material provided we considered the extent to which the following aspects could influence the negotiating position of insurers or hospital operators:
- (a) the need of hospital operators to get new facilities recognized;
 - (b) attempts by an insurer to partially delist a hospital;
 - (c) the use of co-insurance by insurers to signal high-priced hospitals to policy-holders;
 - (d) encouraging the growth of alternative hospitals in an area;
 - (e) sponsoring new entry; and
 - (f) vertical integration by an insurer.

The recognition of new facilities

36. While the evidence we have reviewed suggests that removing hospitals from an existing network can be challenging for an insurer, the threat not to recognize a new hospital appeared to be more credible. At the point where a hospital operator is seeking recognition of a new facility, we identified a number of examples where the insurer was able to extract pricing concessions.
37. However, we also identified examples suggesting that, where a hospital operator takes over a facility that is already widely used, not granting the new operator network recognition may be more challenging.
38. While an insurer's negotiating position appears to be strongest before a facility is recognized, some hospitals have secured automatic recognition of new facilities via clauses in their contract secured as part of their main negotiation.
39. However, we also found that the insurer itself might seek to give assurance that any new facilities would be recognized if it was keen to promote the growth of a less costly operator.

Attempts by an insurer to partially delist a hospital

40. One insurer noted that during a negotiation it was minded to delist a specific hospital for all treatments other than those the hospital specialized in. While it noted that this was less extreme than a full delisting, and might make the threat more credible in a negotiation, it flagged two challenges which it considered limited the effectiveness of this as an option: first, the specialism it would continue to recognize was likely to be the one it regarded as a 'must have' service and so there was a risk that it would face a significant price increase; and secondly, it could be difficult to communicate to customers that they could be treated for some specialisms at their local hospital but not others.

Co-payment

41. Another option potentially open to an insurer that is concerned about the cost of a particular provider is to have some form of co-payment in customers' policies. This could potentially be used as a way to signal that a particular facility is high cost without preventing a customer from attending it. We identified some examples where this was been applied but it does not appear to be a widely used practice.

Encourage the growth of alternative hospitals

42. An insurer could potentially work with a hospital operator to encourage a group of consultants that were splitting their practice to concentrate their time with a particular hospital. This is an option that one insurer explored in its negotiations with a particular hospital operator, where it considered collaborating with the hospital operator in question by identifying relevant consultants and helping consultants move their practice. However, it found that there were practical and legal difficulties with the implementation of this proposal.

Sponsorship

43. One option open to a buyer to improve its negotiating position is actively to support or sponsor entry. One insurer noted that it had considered making loans to, investments in, and/or partnering with smaller competitors in local areas, particularly PPU's. This would aim to aid their expansion and development as credible alternatives to the larger hospital operators. However, it had not undertaken this type of investment. We have not found any examples of an insurer sponsoring entry elsewhere.

Vertical integration by insurers

44. A potential option open to a buyer in a weak negotiating position is to vertically integrate and thus supply the service in-house. In the case of hospital services, the only vertically integrated provider is Bupa, which owns the Cromwell Hospital in London. We did not identify any evidence to suggest that this materially affected the extent of Bupa's negotiating power with hospital operators in London.

E: The size and financial strength of an insurer or hospital operator is likely to impact negotiating outcomes

45. We also considered the impact that the size of an insurer, as well as the financial strength of the parties, could have on a negotiation. Following our review of the evidence, we identified three relevant issues:
 - (a) the additional strength that a large insurer is likely to have in a negotiation;
 - (b) the importance of the financial strength of the insurer or the hospital operator in a negotiation; and
 - (c) the position of small insurers in negotiations with hospital operators.

Position of large insurers

46. It is clear from the evidence we reviewed that the discounts that hospital operators are prepared to give a particular insurer in large part depend on the volume of business that an insurer can provide to that hospital operator.

47. Likewise, the impact on a hospital operator of a threat by an insurer to withdraw its business is likely to be more severe if that insurer makes up a significant proportion of the hospital operator's business.
48. We have identified evidence from recent negotiations that suggested that Bupa, in particular, is aware that its purchases represent a significant proportion, although declining, of some hospital operators' overall revenue, and considered this an important bargaining chip it could use in negotiations.
49. Furthermore, a large insurer such as Bupa (or AXA PPP) may not need to delist all of a hospital operator's hospitals to affect its revenues materially. Simply delisting those facilities that it does not regard as 'must have' may seriously harm the viability of these facilities. For example, in its dispute with BMI in early 2012, Bupa did not remove all BMI hospitals from its network. Its final decision was to delist 37 BMI hospitals from its network. We are also aware that decisions such as to sell certain hospitals can turn on whether those hospitals are likely to receive network recognition from large insurers.
50. The effect of an insurer withdrawing its business from a hospital operator can be more pronounced if consultants decide to move the remainder of their patients to a different hospital (so called 'consultant drag effect'). This was regarded as more likely where the insurer reflects a large proportion of the consultants' business.

Financial strength of the parties

51. Although the size of the insurer may mean that a large proportion of the hospital operator's revenue is potentially at risk, the strength of each party's negotiating position may also depend on their respective ability to hold out in the event of a stand-off during negotiations. Given the interdependencies between hospital operators and insurers in this market, it is likely that, in many cases, a protracted dispute or out of contract situations are not in the long-term interest of either the hospital operator or the insurer. In which case, the ability of either party to withstand a short-term dispute may prove decisive. We have identified examples where the financial strength or weakness of the parties appeared to play an important role in determining the outcome of the negotiation.

Position of a small insurer

52. The threat of delisting a hospital from its network is likely to be a weaker threat if coming from a smaller insurer, as the smaller insurer represents a smaller proportion of the hospital operator's overall revenue.
53. However, if size is important and the difference in the price paid to hospital operators by small and large insurers is large, then this is likely to affect the competitiveness of small insurers. The fact that the largest insurers are able to secure relatively large discounts gives hospital operators an incentive to provide additional discount to small insurers where insurers are competing for a significant contract. We have seen some examples where small insurers have been able to secure specific discounts to help them compete for major corporate accounts against Bupa and AXA PPP.

Part 2: Steps insurers have taken to improve their bargaining position—restricted networks, open referral and service-line tenders

54. It is clear from documents and submissions that most insurers feel that they rarely secure favourable terms through traditional bilateral contract negotiations with

hospital operators. In their view this predominantly stems from the fact that their main bargaining tool, removing a hospital or a hospital operator from their core network, is a weak threat given that it also carries significant risk for the insurer. This in turn reflects the fact that insurers have traditionally recognized most hospitals in the UK and policies have traditionally placed few restrictions on where a patient can be treated, leaving this to the discretion of the patient and their consultant. In an attempt to rebalance their negotiating power, many insurers have been clearly trying to assert more control over the choice of facility that patients use. If the insurer can increase control over where a patient is treated, it will increase the credibility of any proposition to reward lower-cost hospitals with more patients and withdraw patients from high-cost facilities.

55. In attempting to assert more control over the 'patient journey', the types of policies recently introduced by insurers include:
- (a) actively guiding policyholders at the point of claim to a lower-cost hospital. Commonly this can be done by requiring the policyholder to get an open referral from their GP and assisting them in finding a consultant, but it may also involve steering patients that do not have an open referral at the point of authorization;
 - (b) introducing new (usually lower cost) 'restricted' policies with a correspondingly smaller network of hospitals. These may also include a requirement for open referrals. Insurers often opt to select the hospitals included on this network by way of a competitive tender; and
 - (c) identifying specific services where there may be more providers or more scope for competition, contracting for these separately and requiring customers to use a restricted list of providers for these services. Again contracting will typically be by way of a competitive tender.

Hospital strategy—resist or seek to benefit from insurer's directional policies

Directional policies have become a flashpoint in main contract negotiations

56. Hospital operators often object when insurers seek to actively direct policyholders to cheaper facilities, in particular where insurers do so by trying to remove either policyholders (point (b) above) or services (point (c) above) from the main agreement and contracting for them separately. Hospital operators typically argue that the pricing within their agreement was predicated on a certain volume of patients and insurers should not be able to introduce new policies designed to reduce this volume.
57. Since 2005, when Bupa launched its MRI network, the ability of the insurer to procure services independently of the main contract has often been a flashpoint in the main contract negotiations. Insurers express frustration that attempts to direct patients towards less costly providers can jeopardize their existing agreement, with hospitals often taking an aggressive stance, or seeking to negotiate terms in their main contract to ensure that directional activity, that is against their interest, is prohibited or remains 'revenue neutral'.

The approach taken by hospital operators has varied

58. As insurers have developed more directional policies, the response of different hospital operators has been noticeably different. In reviewing the documents provided we have seen a number of disputes between hospital operators and insurers as a result of insurers' decisions to try direct patients away from the hospital

operator. In some cases hospital operators have argued that any loss in revenue should be compensated by adjustments to prices elsewhere in their contracts. We are also aware that some hospital operators have sought contractual protections that limit the scope for the insurer to pursue these types of policy.

59. We are also aware of other instances where hospital operators have sought to benefit from attempts by insurers to direct patients to their preferred provider by offering discounts in return for being the insurers' provider of choice. However, those hospital operators have often expressed disappointment at the extent to which insurers have proved able to guide patients to their hospitals in practice.

Restricted networks and open referral

60. An increasing number of insurers have in recent years sought to introduce new policies, accompanied by a restricted network of hospitals. These have had varying degrees of success in securing lower prices from hospital operators and have been met by varying degrees of resistance. We notice that some hospital operators have been willing to support these initiatives, but usually want to be confident that they will benefit from additional revenue and not simply treat the same patients at a lower price. For this reason discounts for participation in the restricted network are often structured as a rebate or volume discount payable only once a certain revenue threshold is passed. For example, when Bupa sought to tender a network that required hospital operators to submit a new price for treating all patients signing up to the policy, without any assurance that existing policy holders would be stopped from 'trading down', two hospital operators refused to offer further discounts to participate in the network at launch citing concerns that it would not be commercially justifiable to further reduce their tariffs agreed under their existing contracts. Without either of these two hospital operators even a 'restricted' network is unlikely to have sufficient national coverage to have broad appeal.
61. Requiring patients to get an 'open' rather than named referral from their GP is a way for insurers to ensure that they have more control of a patient's treatment path and is an approach which has been explored by several insurers. If insurers are able to prioritize referrals to consultants that work at lower cost hospitals, over time we would expect this would improve their bargaining position. However, these policies are relatively new and to date we have seen relatively little impact on wider contract negotiations.

Service-line tenders

62. One of the most common ways insurers have sought to reduce treatment costs is to identify specific services or treatments that it can tender for separately. It will then require any policyholder that needs to have one of these treatments to go to a network provider. These tend to be relatively standardized procedures or services where there might be more potential providers than the full service hospitals. In practice this will likely limit the scope for this approach, in that there are only certain procedures that may be suitable. Two areas that have most commonly been subject to service-line tenders are imaging (MRI, CT scans, etc) and ophthalmology (especially cataract services). We identified many cases where the introduction of service-line networks was met with considerable resistance from hospital operators. However, it appears that this has become a relatively common way to contract for these services and an effective way to subject aspects of an insurer's purchases to competitive pressure.

Part 3: Prices charged by hospital operators to insurers

Overview

63. As part of our assessment of ToH 3 we compared the prices charged by various hospital operators with different insurers.
64. The prices charged by different hospital operators may provide a useful insight into the degree of any market power. Our analysis of internal documents suggests that some hospital operators are more likely to have more market power in negotiations with insurers than other hospital operators and we would expect, other things being equal, these hospital operators to charge higher prices. Likewise, some insurers appear to be in a stronger position when negotiating with hospital operators than other insurers and we would expect these insurers to pay a lower price, other things being equal.
65. However, comparing prices charged by different hospital operators to each insurer is not simple. Each insurer has a price list which can run to thousands of different treatments.
66. Furthermore, pricing patterns can vary across hospitals and insurers. During negotiations, discussions typically focus on how the price of the overall portfolio of a hospital's services will change, with relatively little focus on the price of individual treatments. While a particular hospital may have a lower price for one treatment this may be offset by a higher price for a different treatment. This means that comparing the price of too small a number of procedures may lead to distorted results as the hospital operator may have higher or lower charges elsewhere.

Methodology

67. The comparison of prices involved two strands of analysis:
 - (a) a simple comparison of the average revenue per admission earned by hospital operators from each insurer, without controlling for the mix of treatments;² and
 - (b) further analysis compared a basket of treatments that are purchased by a given insurer from all hospital operators.³ This is a like-with-like comparison based on a common set of treatments. Analysis of the common basket of procedures included:
 - (i) average prices of individual treatments in the basket;
 - (ii) hospital revenue per patient admission based on the basket of treatments; and
 - (iii) a weighted price index based on the basket of procedures.
68. The two different pieces of analysis were based on two separate data sets, both covering 2011:

² This analysis compared average revenue per admission for BMI, HCA, Nuffield Health, Ramsay, Spire, Aspen from Aviva, Bupa, Simply Health, WPA and PruHealth.

³ This analysis included BMI, HCA, Nuffield Health, Ramsay, Spire and Aviva, Bupa, Simply Health, WPA and PruHealth.

- (a) Aggregate data provided by hospital operators covering the volume of patients they treated and the revenue they earned from different insurers. This data was only used for calculating the average revenue per admission.
- (b) Disaggregated transaction data at invoice level, with information on patient visit date, discharge date, episode setting (inpatient, day case and outpatient), surgical procedure (CCSD code), invoiced charged for one patient visit, and itemized charge for each service provided by Healthcode, a clearing house between private hospitals and medical insurers. This data was used for calculating the average revenue per admission and the price index of the common basket of treatments.

Comparison of average price per admission

- 69. The average revenue per admission offers a simple and potentially informative price measure that can be compared across pairs of hospital operator and insurer. In particular, it is not limited to surgical procedures, as CCSD codes are, and it covers all areas of expenditure associated with inpatient and day-case admissions.
- 70. However, care needs to be taken in interpreting a simple average per admission, as it does not account for the different mix of treatments that a hospital operator may perform. For example, a hospital that treats a smaller number of high acuity patients, where the charge per patient is likely to be higher, will appear comparatively more expensive when compared with a hospital operator that treats a large volume of low acuity patients at a lower price. However, in practice the two hospital operators could have identical prices for the same procedures.
- 71. As hospitals in central London seem more likely to perform high acuity treatments while hospitals outside London appear more likely to perform similar treatments, we also compared average revenue per admission only for hospital operators that did not have a significant central London presence.

Comparison of a common basket of procedures—price index

- 72. As explained above, a difficulty in comparing the average price per admission charged by different hospital operators is the fact that insurers need to purchase many different procedures, each of which is likely to have a different price. The overall cost to the insurer will depend on how many policy holders are treated for each procedure.
- 73. The invoice data allowed us to compare the price charged by each hospital operator to each insurer for each different procedure. Using this data we were able to make a like for like comparison across hospital operators. We compared the average price that would be charged by two hospital operators were they to treat exactly the same number of patients for the same procedures. We note that this is also the approach that several insurers have taken in comparing the price charged by different hospital operators. We also note that this is one way to compare baskets of prices.
- 74. In order to make a like for like comparison, we first needed to identify a basket of procedures that were purchased by a given insurer from all hospital operators under analysis. The price of these procedures for that insurer could therefore be compared across hospital operators.
- 75. Once we had identified a basket of procedures that were common across an insurer and all hospital operators, we calculated the hypothetical expenditure the insurer

would face were it to purchase all the procedures in the basket from one hospital operator. The higher the prices charged by the hospital operator, the higher the hypothetical expenditure the insurer has to incur.

76. The steps we took to calculate our price index were as follows:
- (a) identify the procedures that have been purchased by a given insurer from all major hospital operators. The basket comprised all procedures where each of the major hospital operators had treated at least five of the insurer's patients in 2011;
 - (b) for each procedure calculate the average price charged by each hospital operator to the insurer;
 - (c) calculate the hypothetical expenditure associated with each procedure in the basket in case the insurer were to purchase all its national volume of this procedure from one hospital operator at the average price charged by that hospital operator to the insurer;
 - (d) sum together the hypothetical expenditures associated with each procedure to obtain the total hypothetical expenditure the insurer would have to incur in order to purchase the basket of procedures from that particular hospital operator; and
 - (e) index the hypothetical expenditure at one hospital operator's price relative to the insurer's actual expenditure on the basket of treatments at the different prices with different hospital operators.
77. A difference in the price charged by different hospital operators could be explained by market power but could also reflect other differences, for example in underlying costs. A variation in costs is likely to be present, for example, when comparing hospitals in central London with hospitals outside London. For this reason we have constructed a separate price index for non-London hospitals and central London hospitals.

Data limitations

78. To ensure that our price comparison between hospital operators is consistent, we tried to capture all charges associated with an episode of treatment—ie all charges from when the patient is admitted in a hospital for a procedure until when the patient is discharged. However, we are aware of the following issues:
- (a) we were told that some hospitals bundle pre- or post-operative treatments/tests in the same invoice while others may invoice separately at a later date;
 - (b) we have no information on the condition of the patient (severity, co-morbidities, illness) which may affect the level of the charge; and
 - (c) we are aware that there may be some errors in the data where hospital operators have billed an insurer more than once for the same procedure.
79. In the invoice data, 21 per cent of episodes included more than one CCSD code (ie the patient has had more than one surgical procedure performed). As it is not possible to disaggregate which part of the charge is associated with each CCSD code, we excluded these episodes from our analysis.
80. As we are only able to include procedures in the basket that an insurer had purchased from all the hospital operators, this reduced the number of procedures

that could be compared. We are considering the extent to which our baskets are representative. The table below sets out the number of procedures in each insurer's basket.

Number of procedures in each insurer's basket

<i>Insurer</i>	<i>Number of procedures in basket</i>	<i>% of overall expenditure basket accounts for</i>	<i>% of expenditure with any CCSD code basket accounts for</i>	<i>% of expenditure with only one CCSD code basket accounts for</i>
Aviva	[X]	[X]	[X]	[X]
AXA PPP	[X]	[X]	[X]	[X]
Bupa	[X]	[X]	[X]	[X]
Pruhealth	[X] [X]	[X]	[X]	[X]
Simplyhealth	[X]	[X]	[X]	[X]
WPA	[X]	[X]	[X]	[X]

Source: CC analysis.

Note: Third column: 'overall expenditure' refers to an insurer's expenditure on all admissions, including no surgical procedure, a single surgical procedure (ie, one CCSD code) or multiple surgical procedures (ie, multiple CCSD codes). Fourth column: 'expenditure with any CCSD code' refers to an insurer's expenditure on admissions related to a single surgical procedure (ie, one CCSD code) or multiple surgical procedures (ie, multiple CCSD codes). Fifth column: 'expenditure with only one CCSD code' refers to an insurer's expenditure on admissions related to a single surgical procedure (ie, one CCSD code).