

**MEMORANDUM -  
FIPO's INITIAL SUBMISSION TO THE COMPETITION COMMISSION**

**1. Executive Summary**

1.1 FIPO welcomes the opportunity to submit the views of its members to the Competition Commission (the "CC") in the course of a detailed investigation. In this memorandum, references to paragraph numbers are references to the OFT Report.

1.2 In summary, FIPO has deep concerns about the OFT's approach in the Report. The OFT acknowledges that it has not carried out an in-depth analysis of the complex features of this sector, and perhaps it could not have done, during a first phase investigation. Nevertheless, the OFT apparently feels that it can indicate a way forward in which, by imposing remedies on consultants (and on PH providers), the market will be impacted in ways that are not understood at all.

1.3 In the Report the OFT:

- Largely ignores the main purpose of the provision of healthcare, namely that properly qualified medical personnel should treat patients.
- Does not properly distinguish amongst the various actors (e.g. the patient who seeks treatment and the purchaser of a medical insurance policy, often the employer of the patient; the medical advisors and the private medical insurance ("PMI") providers who may also wish to provide advice) and therefore is not clear about the incentives and drivers (including the commercial drivers) of the different players.
- Fails to provide a critical analysis of the consequences on competition and patient choice when the majority of patients in the private healthcare ("PH") sector are PMI funded and the two main PMI providers insure 65% of them (see point 3.5 below).
- In particular, fails to consider purchasing patterns for PMI products and to analyse the terms of PMI policies and the impact of the trend towards increasing limitations on choice imposed on patients and GPs.
- As a consequence, gives the impression that PMI providers are almost guardians of the patient's interests and does not analyse the consequences of breaking the pathway in the patient's journey between the patient, the GP and the consultant. Rather, the OFT seems at times to welcome it.
- Does not consider the economics of running a consultant's practice in the context of the ever decreasing levels of reimbursements by PMI providers and concentrates (with good reason) on incentivisation of consultants without proper evidence of foreclosure and without reference to the economic reality on the ground.

- Does not sufficiently consider the differences in providing accessible transparent and comparable information on fees on the one hand and on quality outcomes on the other hand. This difference is important also in light of the potential conflict of interest between the wish of a patient to be treated and the incentive on the PMI provider in paying for that treatment.
- Does not take into account that the consultants are individuals confronted with big business: on the one hand, the PMIs; on the other hand, the PH providers. The negotiating position of the majority of consultants with the PMI providers is simply non-existent. The consultants have been unable to make their concerns and voices heard by the PMI providers.

## 2. Introduction

### 2.1 There are two aspects to a consultant role:

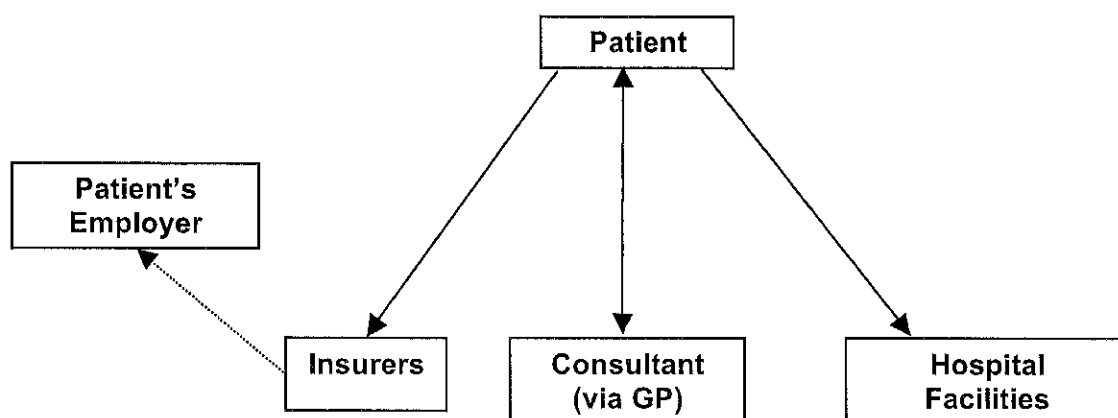
- Consultants are medical professionals with a duty of care towards their patients, from which flow several consequences: consultants have spent time and efforts in order to qualify; are regulated in a stringent manner by the General Medical Council; have a responsibility to select the most appropriate treatment for their patients; and incur liability (and need to insure against their liability risk - this being an increasing burden to consultants in some high risk specialties which is now making these specialties almost uninsurable or at an enormous cost).
- Consultants are engaged in a profession and need to be remunerated in accordance with their skills. Like for all professionals, their remuneration needs to cover for the costs incurred and needs to keep up with inflation.

2.2 On the first point, patients' choice and quality of care should be paramount. Any remedy that will result in or facilitate a break-up of the GP-to-consultant pathway (e.g. referring patients to consultants "approved" by an insurer) would fundamentally impact quality of care. We are concerned that this point has not been sufficiently understood. When the OFT states, for example, that an analysis of the impact of concentration of private healthcare provision at the local level on price and quality needs to control for "*preferences*" of consultants (para. 6.41 and footnote 208), it appears that these "*preferences*" relate to "*the drugs used, the prosthesis used and also the number of nights a patient would stay in hospital*". These are the fundamental parameters of treatment and we would be alarmed if, after this market investigation, the conclusion were reached that market players other than the consultants should be able to make these decisions. The OFT stresses that it is not its role to make clinical judgments (paras. 5.87; 5.89) but as a minimum it is important to bear in mind that "quality" in the PH sector can often be a matter of life or death for a patient (and of personal liability and reputational risk for a consultant).

2.3 Even if it is not the OFT's role to make clinical judgments, surely it would be the OFT's role at least to have considered the economics of the consultants' profession. If consultants' reimbursement by PMI providers are ever decreasing in real terms, premiums for liability insurance are ever increasing and consultants cannot be incentivised by PH providers, then there is a serious risk for the medical profession as a whole (not just for the provision of private healthcare services) that it will become purely a vocation. The OFT acknowledges (at para. 5.97) that these practices have an effect on supply of consultants but does not consider the matter in any detail. In particular, The OFT seems oblivious to the fact that these practices have a clear potential effect on supply, should they become more widespread.

### 3. Background

3.1 Private healthcare is a tripartite structure comprising hospitals, consultants and insurers each working in their own way for the benefit of patients. The following diagram can help visualise the issues.



3.2 The fact that healthcare is for the benefit of patients cannot be relegated to a secondary issue: central to this investigation is the provision of medical treatment (primarily short term treatment for acute procedures) to a patient by consultants and medical professionals (para.2.14). The provision in question is privately funded and provided in PH facilities.

3.3 The medical profession owes a duty of care to a patient. Consultants spend a considerable amount of time and effort qualifying; are regulated by the General Medical Council; are now facing the increased personal reviews through the process of appraisal and revalidation which is about to begin; are responsible for the patients' treatment and are liable for negligence (and need to ensure against tort liability).

3.4 The medical professionals also have a financial contract with the patients; in essence this means that the patient is responsible for the consultant's fee.

### 3.5 The OFT Report contains some interesting statistics:

- The total value of the market for private healthcare provision in the UK was estimated at just lower than £5 billion in 2010. Of this, about £ 2.89bn was generated by PH facilities and an estimated £1.59 billion was generated by fees to surgeons, anaesthetists and physicians, with the remainder accounted for by private treatment in NHS facilities (paras. 1.4; 2.16).
- The three main purchasers of PH are: PMIs (59%); the NHS (approximately 25%) and self-paying patients (16.6%). BUPA alone has a market share almost as high as the NHS (24%). (Report, table 6.4). Therefore, PMI funded patients account for approximately 59% of revenue generated by PH providers, on average (paras. 6.50 and 8.10).
- Approximately 78% of privately funded patients have a PMI policy (para. 1.4). BUPA and AXA PPP together insure 65% of PMI funded patients (para. 8.13). Publicly available figures suggest that 69% of PMI sales in 2010 were to corporate customers (para. 3.7) (and therefore FIPO infer that 31% of PMI sales must have been to the patients directly).
- Only 14% of patients are self-funded and this figure is decreasing (para. 3.9).
- 16% of GPs identified a patient's PMI provider as the most important influence on the choice of PH facility or consultant. Around 20% believed that the choice of facility or consultant was suggested by the PMI provider (para. 5.77).

## 4. The Role of PMI providers

4.1 Even on a cursory examination of the figures above, it should be apparent that PMI providers are crucial players in this market and that the vast majority of patients are dependent for the funding of PH medical treatment on the terms of an insurance policy. This dependency does not appear to have been properly considered by the OFT.

4.2 We are concerned that the OFT may be confusing patients and their PMI providers. When the OFT concludes that "*the shortage of accessible standardised and comparable information weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition between rival PH facilities and between consultants*" (para. 1.11), it is important to bear in mind that patients and GPs may be unable to drive efficiencies and stimulate competition if by the terms of the PMI policy they cannot in fact choose a consultant or a facility. Then, imposing a remedy, e.g., that would compel the provision of clinical information will not necessarily help the patients or the GPs but may help the PMI providers, in ways that are not necessarily helpful to patients (see point 7 below). It is important therefore to be clear about what is proposed and why and what the consequences are.

- 4.3 The Report does not consider in detail two aspects that FIPO believes are crucial, and their interplay:
- First, the purchasing patterns of buyers of PMI policies; and
  - Second, the terms of PMI policies and the unmistakable trend towards policies' terms which limit the ability of the patient and the GP to choose the consultant and the facilities at which the patient may be treated.
- 4.4 On the first point, FIPO has not found anywhere in the OFT Report an analysis of how customers (we refer to customers of PMI providers as "patients" in the context of this letter) purchase their PMI policies. It is reasonable to expect that the 69% of PMI funded patients who have a corporate policy do not have much of a say about the terms of their policies. It appears to FIPO that the employer's incentives may be more aligned to the incentives of a PMI provider to keep costs down than to the incentives of a patient seeking a policy that provides quality of cover. This has an impact on the way that PMI providers operate in the market place. When the OFT quotes (at para. 5.78) that "affordability" is a key issue for customers choosing to purchase PMI, it is not without consequences to ask who are the customers, the patients or their employers.
- 4.5 It would also be interesting for the CC to consider how the remainder 31% of patients purchase a personal PMI and in particular what percentage of this 31% effectively continues to pay the premiums on what used to be their corporate policy. Information available to patients at the point of sale of a policy is very important (FIPO applauds the OFT's initiative to cooperate with the FSA to ensure that patients are informed about the possibility of shortfalls) but if the patient is not the purchasing actor, the patient's ability to make an informed choice at the point of sale is impaired.
- 4.6 The CC may want to consider further the number of patients who are really free to change PMI providers and how many patients are locked into the terms of their policies, for example due to the existence of pre-existing medical conditions.
- 4.7 On the second point, FIPO would consider it important to have an assessment of the terms of the policies more widely used in the industry and the number of patients who are in fact empowered to make a choice about their treatment. FIPO would direct the CC to para. 6.73 and 6.74 of the Report and footnote 224. An open referral scheme which gives to the PMI provider the exclusive right to specify the consultant and the PH facility for the policyholder's treatment does not give to the patients much choice. More generally patients' choices are impacted by practices (detailed in point 5 below) such as:
- The introduction of fixed level of reimbursements and prohibition of "top-up" fees by both BUPA and AXA/PPP (which account for 65% of PMI funded patients as seen above);

- The recognition of only those consultants who accept those fixed levels of reimbursements;
- The relentless reduction in reimbursement rates for procedures commonly covered by an insurance which has recently occurred in a whole host of specialties including ENT, gastroenterology, dermatology, urology, gynaecology, and orthopaedics. In some, such as cardiology, the consultant MUST comply or be delisted by BUPA.

4.8 There is an interplay between these two points: it may be that the way in which the policies are negotiated, the preponderance of corporate policies and customer lock-in are a fact of life in the PMI market, but then it would be all the more important to ensure that patients have an option under the terms of their policy to agree to pay a top-up fee when the policies' reimbursement levels do not cover the costs of the treatment. This is because of course insurance benefits or reimbursements often do not equate with consultant fees (or the cost of provision of PH facilities). Even before the recent major reduction in reimbursements to patients for consultant fees the fact is that the BUPA reimbursement rates (the industry standard as the OFT recognises, e.g at para.3.32 and footnote 57; para. 5.79 and footnote 179) have not altered significantly in the last 18 years. Inevitably this will lead to further shortfalls for patients.

4.9 These observations should be borne in mind when evaluating some statements in the Report that FIPO finds surprising and worrying: for example, the OFT states that the fact that PMI providers are "*often not able to direct patients' choices*" is a "*difficulty*" (that may be reduced through the use of open referrals) (para. 6.75) and that it is "*all the more important that the ability of PMI providers to drive competition between PH providers through network recognition is unencumbered*" (8.54). FIPO is concerned that an impression has arisen that the PMIs are guardians of the patient's interests and whilst FIPO do not deny they have an interest, the consequences of breaking the pathway in the patients' journey need to be better understood.

## 5. PMI policy terms

5.1 Central to any meaningful discussion of the role of PMI providers in the PH sector is an understanding of PMI policy terms and their evolution over the years. We are frankly dismayed at the sections of the OFT Report entitled "PMI provider attempts to control consultants' costs"; "Managed care"; "Capping of consultants" and "Fee schedules" (para. 5.82 to 5.101). It is difficult for us to understand how a body such as the OFT can identify practices which it cannot but qualify as "blunt" and "potentially distortive" (para. 5.82; FIPO would consider these practices to be very distortive in practice, and not just "potentially" distortive) and yet seemingly excuse the PMI providers for engaging in these practices.

5.2 The practice of "managed care" is the most distortive. As the OFT states (para. 5.89) this refers to "*a situation where the PMI provider actively restricts the list of available consultants for their policyholder (rather than offering alternatives)*". This really needs to be considered in detail because it impacts the analysis and the whole sector.

- 5.3 The CC should consider a future situation of a female patient with an urgent problem such a newly discovered breast lump, who has done her research, maybe based on information which is made available as a result of this CC investigation and has selected who she believes to be the best consultant for her treatment, or wishes to see the consultant who has previously treated her. She goes to her GP and the GP cannot direct her to the consultant because the GP can only direct the patient generally to any consultant practising in the specialty and who will be selected by the PMI (“open referral”: the OFT found - para. 3.17 - that 85% of GP referrals for PMI funded patients are still to named consultants and it would be important to understand when the practice of open referral increased and why). Or, the GP directs her to a named consultant that he may know and recommend but when she calls the PMI provider (either at the time of pre-authorisation or subsequent authorisation) she is told that the consultant is not available due to the terms of her PMI policy. All the remedies indicated in the OFT Report will have virtually no effect to address this situation.
- 5.4 If 78% of privately funded patients have a PMI policy, consultants will be dependent on the PMI providers for reimbursement of their fees: the consultant must try to remain on the list of the PMI provider. In order to remain on the list it is increasingly necessary that the consultant accepts without question the levels of reimbursement decreed by the PMI providers (without any possibility to ask the patients to meet the shortfall). The reimbursement levels have not been increased by BUPA (the industry standard) for 18 years and are in fact decreasing in a whole host of specialties including ENT, gastroenterology, dermatology, urology, gynaecology, and orthopaedics. In some, such as cardiology, the consultant MUST comply or be delisted by BUPA. The recent changes in in benefits to patients of some 40 procedures show cutbacks by Bupa of on average over 30% with an average reduction in benefits to patients of over £200 per procedure.
- 5.5 FIPO cannot understand how the OFT can fail to see that the behaviour of the PMI provider must amount to an anticompetitive practice to be characterised either as an abuse of a joint dominant position, or as a number of anti-competitive agreements cumulatively entered into in the industry which affect the provision of medical services to patients in the PH sector in the UK.
- 5.6 Instead, we read in the Report that “*the use of open referrals may reduce the difficulties facing PMI providers of directing patients*” (para. 6.74); we read about the introduction of “*open referrals*” by “*a couple of the PMI providers*”, without any reference to the fact that these PMI providers happen to be BUPA and AXA/PPP. We read in the Report that the OFT cannot look into the issue of documented inappropriate referrals (and subsequent re-referrals) because it cannot make clinical judgments about the appropriateness of referrals (para. 5.87). Nevertheless, the OFT feels qualified to state that “*at least some of these adverse outcomes may be associated with the lack of consultant quality information currently available to private patients*” (para. 5.91), without any further analysis. FIPO considers that the adverse outcomes may well occur as a result of the GP being unable to direct the patient. In the whole of the OFT report

there is only one paragraph in praise of the role of the GP (para. 5.64) and this was added as an afterthought, following submissions. The knowledge of the GPs is qualified by the OFT as being “soft intelligence” (para. 5.68) and its advantages overshadowed by the risks of over-reliance on the GP’s knowledge (para. 5.69). Of the two, one: either the OFT can make judgments as to quality of clinical information and clinical outcomes, in which case it needs to see the evidence of inappropriate referrals; or it cannot, in which case it cannot make judgments about the availability of information on clinical outcomes.

## 6. The Imbalance of Power between consultants and PMIs

- 6.1 Therefore, if 78% of privately funded patients have a PMI policy, consultants will be dependent on the PMI providers for reimbursement of their fees. If, through opaque and unappealable decisions of a PMI provider (a private body not subject to an obligation to follow the rules of natural justice), consultants are delisted and cannot treat patients, harm is done to consumers through reduced choice and possibly lower quality of provision of services.
- 6.2 FIPO is concerned that consultants have very little negotiating power *vis-à-vis* PMI providers. FIPO has provided evidence to the OFT that PMIs unilaterally slash reimbursements to patients (thus creating extra shortfalls); pressurise consultants through threats of patient diversion to accept lowered reimbursements for their fees; present consultants with rigid options of accepting fee structures or being delisted. A recent example amongst many: reimbursements for cardiological procedures (not a small matter for most patients) are being slashed and consultants who do not comply, will not be recognised for these procedures.
- 6.3 Patient diversion occurs when, mainly through pre-authorisation or subsequent authorisation procedures, patients are encouraged to see a different consultant from the consultant that they seek to see. Delisting occurs when insurers decide not to recognise a consultant anymore. De-recognition by a major insurer may well spell the end of any independent practice by a consultant.
- 6.4 The OFT talks about asymmetry of information in the context of available information about costs and quality of consultants’ performance. The OFT totally ignores a huge issue about asymmetry of information between PMIs and consultants. The criteria for de-listing are sometimes opaque to the consultants and there is no independent appeals mechanism against a decision which has consequences comparable to a loss of regulatory qualifications.
- 6.5 Proposals by FIPO for a Code of Practice between all parties in the healthcare sector which could include a system of independent arbitration have been met by aggressive, threatening and demanding posturing by the main insurers. FIPO believes that the CC needs to consider the issue of the imbalance of power between the consultants and the PMIs.



## 7. Economics of Running a Consultant's Practice

7.1 It follows that the contract between the patient and the consultant is under threat and the consultants and the patients seem powerless to address this issue. In fact, the patients may not even know that there is an issue, if they believe the statement of PMI providers about the fact that their networks of approved consultants are based on quality criteria (on this, see point 8.4). FIPO would challenge this proposition by the insurers.

7.2 The commercial aspects of private practice need to be considered. There is variance in the earning potential of consultant. Whilst a minority of consultants may indeed command a premium for their skills, the vast majority of consultants does not and face lower rates of reimbursements and rising costs (including the costs of liability insurance). In particular, the difficulties faced by newly appointed consultants now to commence in private practice are becoming almost insurmountable due to the fixed fee restrictions imposed by insurers (newly appointed consultants are fully capped consultants). These consultants will not get recognition by either BUPA or AXA/PPP unless they adhere to the fee schedules imposed on them and this coupled with higher than average liability indemnification costs in certain high risk specialties makes independent practice now near-impossible.

7.3 FIPO have presented clear economic arguments to the OFT about the rates of reimbursements set by the major insurers, in particular BUPA (the OFT recognises that BUPA's benefit maxima is the "*industry standard*" as mentioned above (point 4.8)). The OFT makes some comments about whether the insurers may in fact be "*underinsuring*" (see for example footnote 172 and, in relation to anaesthetists, para. 7.10) but FIPO could not find a mention about the fact that BUPA's benefit maxima have not effectively altered in the last 18 years despite inflation.

## 8. Information Asymmetries

8.1 There are two points made in the Report about information asymmetries in the context of the consultants' role: "quality" (para. 5.48 and following) and "fee visibility" (para. 5.56 and following). The hopeless confusion in the Report about patients and GP on the one hand and PMI providers on the other hand makes it difficult to disentangle the issues.

8.2 Let's consider "fee visibility" first. We fully accept as is noted in the OFT report the need for fee transparency and for an estimate of fees to be given whenever possible to the patient by the consultant. Indeed, it is encouraging that the OFT has noted the work that FIPO has done in this regard (see for example footnote 152). There are difficulties in making standardised fee comparisons for example for consultations which may vary in length and complexity, and fees need to be adjusted for geography and consultants' expenses. However, fee visibility is probably more easily addressed than information on "quality".

- 8.3 On quality, the profession accepts the desirability of publishing outcome data but pointed out at the OFT Round Table and in other submissions that this is not a simple matter. The OFT noted in Annex B some of our concerns and the possibility of “perverse incentives” that measurement of clinical outcomes could lead to (para. 5.52). The difficulties of obtaining clinical outcome measures are many and although some quality outcomes can be measured, these are likely to provide broad generic data only. FIPO will be prepared to enlarge on the “Clinical Quality” issue and is prepared to work with the hospital providers to further develop the quality agenda. FIPO sincerely supports initiatives to provide more transparency but the CC needs to be aware that the issues are not easily dealt with.
- 8.4 PMI providers do not have any solid information on quality or clinical outcomes and therefore claims on the part of PMI providers to this effect are without foundation. The OFT in its initial report noted that the PMIs do not have this information and at the OFT Round Table meeting the Medical Director of BUPA stated clearly that they have NO quality information; they only have financial information. Moreover, due to the issues outlined above, obtaining information on clinical outcomes will never be easy. At the same time, price visibility will likely increase, and it is important to understand properly the incentive position in a situation in which prices may be more reasonably comparable than clinical outcomes.
- 8.5 The OFT states (para. 5.80 and 5.81):
- *One PH provider’s consultation submission asserted that the OFT had not sufficiently considered the potential conflict of interest between the wishes of a PMI funded patient to receive high quality treatment and the incentives of the PMI provider in paying for that treatment. The PH provider stated that the incentives of a PMI funded patient and PMI provider were not as closely aligned as the OFT had assumed in its consultation document, and that a PMI provider’s incentive to constrain costs could harm the quality of healthcare provision for patients.*
  - *In response, the OFT considers that whilst there may be potential for a conflict in incentives between PMI providers and policyholders (as perhaps evidenced elsewhere in this report), the OFT believes that this would be bounded by the PMI provider’s desire not to weaken the quality of its offering in comparison with competitors. Overall, the OFT believes that this broad argument cannot be concluded as part of a first-phase enquiry, and as such could be better examined by the CC. (emphasis added)*
- 8.6 FIPO welcomes the opportunity for an in-depth consideration of these issues. Even assuming that the OFT has a point in asserting that the PMI provider has a desire not to weaken the quality of its offering in comparison with competitors (a point that would be dependent, amongst others, on a thorough assessment of the purchasing patterns of buyers of PMI products and in particular the role of the corporate schemes), the objective difficulties in measuring quality mentioned above logically makes this point less cogent.

## 9. Incentivisation

- 9.1 Incentivisation of consultants cannot be considered independently of an analysis of the economics of running a consultant's practice mentioned above. If fee schedules are inflexible and prices have not increased in 18 years and PMIs are unilaterally implementing reduction in the reimbursement rates and patients are not able to decide on co-payments and top-ups, then some form of incentivisation could be pro-competitive. A lot more analysis of consultant incentives and their potential market foreclosure effects as compared to their potential pro-competitive effect is required and FIPO would welcome the opportunity to make representations to the CC.
- 9.2 Broadly, FIPO's position on incentivisation has been made clear to the OFT. FIPO is against incentivisation between consultants and GPs, which is likely to have important foreclosure effects. FIPO is in principle opposed to all forms of incentivisation which may lead to foreclosure (such as some form of straightforward payments by hospitals or other forms of financial inducements demonstrably anticompetitive).
- 9.3 There are some commercial situations in which doctors may have an equity partnership of some sort in a hospital and provided this is not linked to any specific anticompetitive agreement FIPO have no objection to this.
- 9.4 However, overriding these commercial considerations are the professional ones as laid down by the GMC in Good Medical Practice guidelines and it will be FIPO's intention to ensure that the final opinion over the various forms of incentivisation that we give to the CC will be fully compliant with our professional obligations.

## 10. Anaesthetics

- 10.1 FIPO has noted the OFT's discussion of anaesthesia. The Association of Anaesthetics (which is a member of FIPO) will respond in detail on the specific points raised.
- 10.2 FIPO is understandably alarmed at the suggestion apparently made by "some stakeholders" that "*all consultant groups ... represented a cause for concern*" (para. 7.13). The need for consultants to share resources, market themselves and provide access to a wide range of expertise, especially when consultants are confronted with the power of giant organisations such as the PMI providers, needs to be considered.
- 10.3 Anaesthetic groups were created for very good reasons: anaesthetists are called upon in emergency situations and there is a need for group practice to cover such exigencies. There is also a need for subspecialisation within anaesthetics which is best provided for in a group arrangement.

- 10.4 As the OFT recognises (at para. 4.15), anaesthetists are fully trained consultants in anaesthesia; intensive care and pain medicine, with a training that lasts for many years. It is important to consider specifically whether the fee schedule for anaesthetists may be too low, as recognised by the OFT (para. 7.10).
- 10.5 The Board of FIPO agree that whenever possible anaesthetic fees should be included in estimates given to patients (this is part of the template documentation recommended by FIPO on FIPO's website, as mentioned in the OFT Report at footnote 158). It needs to be recognised that this may not always be possible.
- 10.6 In terms of clinical practice, the CC should note that best practice in the operating theatre is achieved by surgeons and anaesthetists who work regularly together and who have the same specialty interests and that simple transfer of anaesthetists particularly in complex surgery would not be in the best interests of the patient.

## 11. **Conclusions**

- 11.1 FIPO would welcome the opportunity to develop its arguments and provide further evidence to the CC.