

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with AXA PPP held on 19 March 2013

Background

1. AXA PPP stated that its recent experience in relation to the new [redacted] provided a good illustration of how the market was developing. After several meetings with [redacted] to discuss recognition of the new hospital onto AXA PPP's network, it became apparent that the hospital was [redacted] per cent owned by a group of [redacted] surgeons who operated from the hospital. AXA PPP was unable to confirm after further investigations for certain who these consultants were, but became aware of a group of consulting [redacted]. It had not been informed of their financial interest in the hospital and, it seemed likely, nor were their patients. In pooling together in this way it had made it [redacted].
2. AXA PPP saw the private medical insurance market (PMI) market as being very challenging since the start of the economic crisis and had suffered from two problems. The first one was in the large corporate area where employers were less inclined to cover, for instance, dependants of their employees. The second was in the individual market, where it had seen a decline of between 3 to 5 per cent a year in revenue. One way AXA PPP was seeking to address this was by introducing new policies whereby the customer traded some choice for reduced premiums, as well as its new distribution capability through Health Online business. [redacted]

Market trends

3. AXA PPP considered that the trend towards offering different products at different premium levels depending on the extent of choice would continue as a key trend even when the UK came out of recession. Given the ever increasing cost of private healthcare there would continue to be a significant percentage of the market that would not be able to afford the full choice product.
4. A further trend AXA PPP perceived was greater patient involvement in referral decisions. Open referrals provided patients with greater choice to determine, irrespective of their insurance policy, who they saw and where. On the corporate side AXA PPP saw increasing use of directed products with employees topping up in some way if they wished. There was certainly a risk that there might come a point that a few employers took the view as with other employee benefits in the past that PMI was no longer necessary and a lot of business would be lost very quickly. In addition, AXA PPP considered that there would be growing interest in managing, in particular, depression and back problems in the workplace, which were widely perceived as high cost and being managed more effectively than currently to the benefit of employers.
5. The individual market, in particular, had seen a steady downward drift over the last two decades. There was a severe risk that individuals with savings of, for example £20,000, which most individual customers tended to have, would opt for self-pay. Those doing this would be those who were not claiming in the first instance. However, their exit from PMI would have a significant impact on premium levels which in turn would increase the problem of affordability. It would not always be possible for insurers to come up with new products in an effort to keep premiums down.

6. There was a change in the pattern of policies, such as large excesses. This had risen from 10 per cent of corporate clients having excess on policies to nearly 99 per cent. There might also be a trend towards co-insurance where customers paid towards the first 20 per cent of the treatment costs, for example.

Competition among insurers

7. AXA PPP found that a big impediment in its first Pathway product was that it needed national coverage, particularly if it wanted to market to larger corporate organizations. It therefore went out to a wider group of hospitals to essentially gain national coverage and relaunched the product to provide a more complete service with a tailored referral procedure.
8. AXA PPP pointed to a wide range of different reasons why individuals would be in an NHS hospital and not claiming on their PMI including terms of their policy (excluded treatments, excesses, pre-existing conditions etc) and proximity of the local private hospital providing the relevant treatment. It considered that the recent Laing & Buisson report exaggerated the situation significantly and was deeply flawed. AXA PPP's research suggested that 20 per cent of people would never buy PMI. The remainder of the population would buy it if they had enough real income and would use it. The income elasticity of demand for health was very large. In addition reasons for buying PMI had been changing over the years. Waiting lists were a key concern for more routine elective treatments but increasingly policyholders were looking to PMI to cover them for more serious treatments.
9. Real claims inflation in PMI had been steadily increasing at around 6 per cent a year, reflecting increases in claims due to more treatments being available and increases in the average costs of treatments. Costs for standard elective treatments such as hip replacements and cataracts had been pretty stable in real terms over many years and in some instances had decreased. The issue was that the newer treatments were generally more expensive and increasingly accounted for a greater proportion of claims. Moreover, the more MRI scanners and CT scanners there were that needed to be utilized, the more costs were driven up.
10. In terms of competing against the NHS, AXA PPP focused on the benefits of having direct access to a consultant, hospital safety following the MRSA outbreaks and having access to high-tech drugs, especially for cancer. AXA PPP agreed that these changes could lead to different products being developed, for example policies with very large excesses to cover the disasters. Previously only 10 per cent of large corporate customers might have had excesses on their policies; currently the position was that less than 1 per cent did not have excesses and many were getting quite material excesses. In the individual sector, pricing excesses were more difficult. Those not claiming would choose products with excesses which then materially affected underwriting. There had not been a material demand for individual policies with excesses larger than £500.
11. AXA PPP did share some office services with other parts of the business including on the finance teams and legal as well as best practice with AXA PPP's other medical insurance companies globally.
12. In terms of market shares, AXA PPP identified four competitors that operated in three main segments: individual, SME and large corporate. The companies were BUPA, AXA PPP, Aviva and PruHealth. In the next layer down, the smaller insurers were either individual and SME or large corporate and SME and they operated in niche areas. For the large corporate customers, the smaller insurers could generally provide a more bespoke service and often hospital groups would provide the smaller

insurers with very attractive deals to help them win business from AXA PPP and BUPA.

13. AXA PPP considered that BUPA had been rather conservative in its strategy and recognized that its market share and profitability had been slipping in the course of the early part of this century. In trying to reverse this trend it had gone to the other extreme and had alienated not only the medical profession but also brokers and corporate customers. BUPA's directed product in particular had not been handled well. For example, BUPA sent out its renewal terms to brokers two to three weeks late this year and then a few weeks later had to clarify that the renewal terms were only for directed products. For standard products, there was a price increase of 5 per cent or more. Brokers were incensed and AXA PPP understood that some corporate customers found themselves on directed products without realizing.
14. [✂]
15. AXA PPP also noted that there needed to be a sense of perspective. About 10 per cent of doctors had a tendency to over-intervene around the UK but there was a concentration in London with certain hospital providers. There seemed little point in antagonizing the remaining 90 per cent to address a problem with 10 per cent. [✂] Unlike PruHealth and WPA, BUPA and AXA PPP could not simply be 'pro-consultant' and guarantee to reimburse all specialists fees. They would go out of business. The no-shortfall guarantee was seen by BUPA as one of its key selling points but this required careful cost management of consultant charges.
16. Other insurers also had their different selling points. Aviva pushed its proactive managed care options such as its musculoskeletal programme. WPA pushed service a lot.
17. AXA PPP identified that there was an interrelationship between consultants and hospitals that could provide perverse incentives for over-treatment. It also identified unnecessary extra procedures being undertaken by consultants specifically as a result of the financial incentives they faced, given their relationship with hospitals.

Hospital market power in local areas

18. It was not possible to be convincing to corporate clients without national coverage. All the large hospital operators had what AXA PPP would perceive as must-have hospitals. Nuffield, the smallest operator, had a significant stranglehold in the South-West of England. AXA PPP was not aware of any solus independent hospitals outside London. Similarly, AXA PPP indicated that many customers wanted a strategy to encourage policyholders to be treated where they lived rather than worked in the London area. Such a strategy was difficult as around London BMI owned a lot of hospitals. Whilst in the Manchester area there were a lot of hospitals, it would not be credible to have a policy without BMI Alexandra.
19. AXA PPP's approach was different to its competitors. It had different prices for each hospital right across the country. Whilst a hip replacement would, for example, always be 20 per cent more expensive than a knee replacement, the price of each would vary between Reading and Bath. In tendering for its network AXA PPP's strategy was to go around the country, catchment area by catchment area, and carry out a bidding process. In its view a flat contract could potentially create barriers to entry to a new competitor and AXA PPP would end up with a weighted average price. In discussions with, say, BMI Bath, which at the time was a solus operator, the discussion was along the lines of: if BMI wished to charge more that was fine, but that would be reflected in the pricing of AXA PPP's insurance products. In

competitive areas the discussion was different and hospitals were excluded balancing price, quality and choice. Beginning the process had been relatively straightforward, but as time had passed it had become more difficult to manage the process as effectively, especially as the hospital operators were constantly seeking to negotiate discounts on a one-in all-in basis.

20. For private and SME customers, AXA PPP essentially offered a local product, tailored to premiums in relation to postcode and customers' age. AXA PPP had about 150 areas by hospital catchment areas and each area would have a loading or discount driven mostly by the local hospital's pricing. Outside London private patient units (PPUs) were not an effective constraint anywhere. In some areas quite often the PPU would have a monopoly on the higher acuity treatments and AXA PPP would have little choice but to deal with them.
21. In London the position in relation to PPUs was slightly different. There were a few PPUs that might in the future provide some kind of reasonable competition to the other incumbents in central London. Guy's & St Thomas' was a key example and could be a rival to London Bridge. However, the trusts were increasingly going out to tender and in so doing would pick the tender that gave the best return. HCA would be able to provide that as it was the most efficient at driving high income per patient. Even if a trust had the temerity not to award the tender to HCA, in the intervening period before the PPU opened, HCA would have approached all the key consultants and set them up in very pleasant private practices at one of HCA's other facilities. This was what occurred at [redacted].
22. For AXA PPP, hospital costs accounted for 50 to 55 per cent of its premiums, so a 10 per cent discount from a hospital was 5 per cent or less on premium.

Consultant incentives

23. AXA PPP raised concerns that some hospital groups might provide financial incentives to consultants, in the form of a commission, each time that they carried out a test on a patient. AXA PPP was concerned that such arrangements might provide consultants with the incentive to complete more testing than was required leading to 'over treatment' of patients. As a consequence, the consultant would charge AXA PPP more to interpret test results, with the net impact of higher prices for patients.
24. AXA PPP considered this practice to be widespread in the industry, in particular in London. It believed that approximately 10 per cent of consultants routinely over treated patients by carrying out unnecessary tests. Patients typically had a lack of information about such incentive arrangements and they were not disclosed to them at the time of treatment.
25. The real basis for competition between hospital groups was for specialists and not competition for patients. Incentives provided to consultants or GPs had the effect of distorting competition, as the doctor would refer patients to the hospital group or facility where they would receive a financial incentive.

Competition in central London

26. AXA PPP would benefit greatly from increased competition in the central London market, from other hospital groups or new entrants managing PPUs entering the London market. This would provide the opportunity for it to improve price-based competition and deliver better value for its customers.

27. For a large number of AXA PPP's customers, HCA was considered a 'must-have' hospital and it therefore must deal with HCA. In AXA PPP's view, HCA's prices in central London were in the range of [X] per cent higher than its key competitors.
28. AXA PPP had previously considered sponsoring a new entrant to enter the London market. However, it had encountered a number of issues surrounding sponsorship, as the hospital operator would typically seek a guarantee concerning referral volumes, which AXA PPP was not able to give until it was aware that the new entrant was able to attract a sufficient consultant base and the facility would be of the requisite quality.

Negotiations with hospital groups

29. AXA PPP considered three criteria in entering negotiations with hospital groups—price, quality and choice. Its annual negotiations with hospital groups were usually concentrated on negotiating price, as year on year there were not significant differences in the number of providers entering the market and new developments in services. AXA PPP indicated that its annual claim increases usually ranged from 6 to 8 per cent, although unit cost inflation was at a rate of 2 to 3 per cent, the difference being expensive new treatments.
30. AXA PPP approached price negotiations with hospital groups at a local hospital level, and therefore there might be a deviation in prices for a particular treatment between hospitals owned by the same operator. Differences in pricing were typically a combination of the actual price being paid for the procedure and how that hospital charged for a particular procedure. A number of hospitals offered fully inclusive prices, whereas other hospitals might charge separately for the procedure, pathology and other testing. Prices would typically vary by more than [X] between hospitals owned by the same operator.
31. AXA PPP also said that there was a difference in the price paid to different hospital operators for the same procedures. The extent of this price difference might be greater in relation to central London hospitals compared with hospitals outside of London.
32. AXA PPP would face a significant challenge if it were to lose its contracts with any of the hospital groups. In particular, it would be difficult to divert its customers to another hospital operator within an appropriate timescale. HCA and BMI were 'must-have' hospitals for its network.
33. AXA PPP indicated that some of its contracts with hospital groups contained clauses which acted as a disincentive to them recognizing a competitors' hospital. For example, if a new entrant were to enter a local market, AXA PPP could lose the discount it received from the hospital in that area.

Service line tenders

34. AXA PPP had conducted some service line tendering for specific procedures. For example, since the early 2000s, it had conducted service line tenders for services including scanning, oral surgery procedures and oral surgery procedures for cataracts. AXA PPP's aim in conducting service line tenders had generally been to achieve an all-inclusive price for a particular procedure but had not been successful in all instances in achieving this.

35. AXA PPP indicated that its service line tender for cataract surgery in 2006 resulted in a dispute with Spire. Spire argued that AXA PPP was taking business away from it by conducting a tender for this service. Spire was not willing to participate in that tender as it wished AXA PPP to continue to pay the current price it had negotiated. The outcome was that AXA PPP was required to [✂] for not including it in its cataract network.

Profitability and costs

36. AXA PPP indicated that its return on capital in its personal insurance business was considerably higher than the return it earned in its corporate business. Although the corporate business was important for AXA PPP's volumes, it did not generate as much profitability as its personal customers. The corporate business was important to AXA PPP in ensuring that the business itself in the round was thriving.
37. AXA PPP's pricing for its personal customers were typically higher than for corporate customers. A key reason for this was that individuals were likely to claim more on their insurance policy than the average member of a corporate scheme. In AXA PPP's estimate, personal customers claimed up to two and a half times more frequently. The average age of AXA PPP's personal customers was higher than members of corporate schemes.
38. AXA PPP aimed to control its costs in insurance claims by offering no-claims discounts and excesses to its customers, which were available on all of its new products. AXA PPP aimed to share its costs with its customers, to limit unnecessary claiming by its members. AXA PPP's focus going forward would be on reviewing costs of its suppliers and hospital groups, as it considered it had taken appropriate steps to limit its costs on the customer side.
39. AXA PPP suggested that patients did not have a very good understanding of the costs which hospitals incurred at the time of treatment. Although it provided customers with a statement after every treatment they undertook, it was not necessarily easy for a customer to understand, nor to understand the different components of the costs which they had incurred.
40. AXA PPP estimated that its percentage profit earned in the London market was likely to be slightly less than the profit which it earned elsewhere in the UK.

Customer switching

41. It would be relatively easy for a customer to switch between PMI providers, unless a patient had a serious pre-existing medical condition which might pose a barrier to switching. This approach was also taken in many other countries. The insurance system would be unmanageable if consumers were to take out low-cost insurance cover and then switch to higher-value schemes at the time that they were diagnosed with a condition.

Consultant fees

42. AXA PPP did not have a contractual relationship with the majority of consultants that it utilized. In 2008 it introduced contracts only for consultants recognized after that date, which provided for an agreed rate which AXA PPP would pay the consultant for a particular procedure. If consultants wished to charge more, then they would put their prices up, but AXA PPP might question them. However, its main focus at the

moment was providing its members with the maximum possible choice of consultants.

43. The process by which AXA PPP identified what it considered to be a reasonable range of fees for a procedure was looking at prices it paid various consultants and identifying those at the extremes of that distribution. It would then consider whether the fees charged were reasonable in light of factors including their practice and whether they were the only specialist in a particular area. If it deemed a consultant's fees to be too high, it would then negotiate with the consultant to bring their fees in line with its desired range. If the consultant did not agree to reduce their price, then AXA PPP might remove the consultant from its 'fee assured list' and inform its members in advance of a procedure that a shortfall would need to be paid to use that consultant. AXA PPP might also make arrangements for its customers to use another consultant in these circumstances.
44. Since 2008, AXA PPP introduced a requirement that any new consultants wishing to be recognized in its network must agree and adhere to AXA PPP's fee schedule. This was to limit the need for its customers to pay a shortfall when visiting a consultant. AXA PPP did not consider that this strategy created a barrier to entry, as it had not seen a material change in the number of consultants it was recognizing before and after the strategy was introduced. Shortfall or top-up fees were now only payable by its members to consultants who had supplied services to AXA PPP for a period of five years or more. AXA PPP's longer-term goal was to have 'no surprises' or shortfalls for its members.
45. AXA PPP did not consider that the fees it paid to consultants were at such a level that consultants would be unable to continue in the market, drawing a distinction between its practices and what it believed Bupa's to be. It considered that its fees were at a level that any consultant in private practice would be willing to do. What AXA PPP paid consultants was significantly higher than the hourly rate that would be available to them in the NHS.

Consultant groups

46. AXA PPP indicated that it had had problems with anaesthetist groups, providing an example of an anaesthetist group in the [redacted] region. In [redacted], the anaesthetist group comprises 80 to 90 per cent of all anaesthetists' billing in the region. In AXA PPP's experience, anaesthetist prices in [redacted] were some 50 per cent higher than prices in the comparable locality of [redacted] which did not have an anaesthetist group.
47. When patients were receiving an anaesthetic, they were also required to undergo a pre-anaesthetic assessment, which in its view should form part of the total fee charged. However, AXA PPP was seeing anaesthetists in [redacted] charging customers directly with an additional fee for this assessment. Such practices typically occurred in around 3 per cent of cases UK-wide, but in 15 per cent of cases in [redacted].
48. Customers were not usually informed that they would be billed separately for pre-operative assessments. The only choice the customer had to avoid paying a shortfall would be to switch to another consultant and start the process from the beginning, which they were often reluctant to do by that point.
49. AXA PPP had generally not seen the sorts of issues arising concerning anaesthetist groups in relation to other groups of consultants in the industry.

Information asymmetry

50. AXA PPP did not consider that further data collection would solve the problem of lack of information held by GPs and patients. It would be extremely difficult to obtain data which proved that one doctor was better than another. It would be very difficult to measure the performance and quality of a consultant given that a significant part of what doctors did was based on judgement, a range of treatments might be given to a patient and patient responses to a particular treatment might be varied. AXA PPP said that most of what doctors did had not been subject to rigorous evaluation.
51. It would be difficult to measure consultant performance based on readmission rates for patients, as readmissions rates would be influenced by the type of patient which the consultants were treating. For example, a consultant might treat a higher proportion of patients with a more serious scale of a condition, therefore patients in this category might be more likely to require readmission.
52. The price paid for a consultant was not an indicator of quality. Higher consultant fees might be the result of the ability for the consultant to market themselves, rather than based on performance or quality.