COMPETITION COMMISSION

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Aviva Health held on 13 February 2013

Background

1. Aviva Health (Aviva) believed that the PMI product delivered real benefits to customers. However, the market was currently in decline and costs were subsequently rising. Many people were either leaving the market or reducing their cover due to the increasing costs of insurance.

2. Although Aviva had not been able to control hospital costs as well as it had hoped, it had reduced its expense ratio from approximately [✂] per cent over the last five years. It was keen to make PMI more affordable, while maintaining the quality currently offered.

3. Aviva currently had a turnover of approximately £580 million, with a net margin profit of approximately [✂] per cent, and although it considered the market to be static it had managed to increase its market share by one percentage point.

Corporate customers

4. Aviva offered three types of insurance to large corporate customers, including full insurance, cost plus arrangements, with a set claims fund and finally a trust insurance, similar to the cost plus arrangement but with a different vehicle funding it, namely a trust.

5. The corporate market was large and made up of the three types of customers: FTSE 100 companies; mid-market corporate customers; and SME customers. FTSE 100 companies typically offered insurance to their employees as part of a benefit structure. Of the approximately 20 FTSE 100 companies that were customers of Aviva, the majority were keen not to pay an annual policy increase, preferring to maintain as much of the benefit structure for their employees as possible without increasing costs.

6. Aviva had not lost any of its mid-market customers. Instead these corporate clients had, for example, preferred to reduce the benefits and/or increase the excess as a way of controlling costs. The SME segment was subject to a lot of customer churn, with some customers leaving the market completely. Of the SME customers that Aviva recently lost, half switched supplier and half had left the PMI market.

7. Aviva noted that around 90 per cent of corporate customers dealt with PMIs through intermediaries such as Mercers, Towers and Aon, although Aviva found that they had direct access to the majority of its corporate customers, with the intermediary just arranging the insurance policy.

8. Aviva had noticed that a number of the larger corporate customers in London were interested in shifting some of the spend away from the more expensive hospitals in London. One solution was to treat people closer to their homes or in smaller consulting practices. More generally, some of its corporate customers had asked for a smaller network of hospitals, with the aim of reducing the policy cost. However, with intervention from the hospitals this was proving difficult for Aviva to govern.

9. Some of the larger corporates had also opted to offer a flexible package. This involved employees receiving payment equivalent to the cost of the insurance in their salaries, which enabled them to choose whether to purchase their own insurance. Aviva had seen a significant number of people take up this flexible policy.

10. Over the last 12 months Aviva had conducted analysis into its new back-up scheme. The scheme, which aimed to deliver musculoskeletal relief quickly and conveniently, had seen a larger take-up from large corporates, and Aviva was extending the back-up scheme to include other similar conditions relating to the hips, shoulders and knees (currently called back-up plus) and hoped to extend it further.

Personal customers

11. Aviva was the first company to offer its personal customers a modular product. This product involved customers adding or removing benefits from a core list that did or did not meet their individual needs.

12. Aviva said that in addition to a number of personal customers leaving the market and switching to other insurers, it had also seen personal customers downgrading their insurance policies. The average consumer policy cost had dropped quite significantly by about [✂] per life.

Patient pathway

13. The typical patient journey started at the point of consultation with the GP who would then refer the patient to a specialist. Where a patient was given a named specialist, that, in a sense, almost predetermined what the likely treatment pathway was going to be, eg which hospital the patient would attend etc.

Competition

14. Aviva saw AXA and Bupa as its main competitors, although PruHealth and SimplyHealth were also strong competitors.

15. Aviva's main strategy for competing against other PMI providers was pricing sophistication. Aviva considered itself to be strong at pricing appropriately for both corporate and personal clients. Its approach included pricing by postcode, looking at the hospitals within an area where it believed it had stronger deals and pricing mechanisms to attract different customers. [✂] Aviva was interested in the different patterns around how people made claims and how this varied from region to region. Such information helped Aviva apply competitive prices for each area.

16. Aviva considered that pricing sophistication was a key part of its competitive advantage in targeting personal customers as it believed it had a better level of understanding of the relative costs in different regions from its competitors. With regard to large corporate customers, this was less of a consideration because typically all PMI providers had access to quite good and detailed data about the customer base, which made it more difficult for Aviva to achieve a competitive advantage through pricing.

17. Aviva also considered that innovation and customer service were very important to its competitive strategy. It believed that good customer service was rewarded with customer loyalty. It also told us that it had a strong relationship with the intermediary market for corporate customers.

18. [✂] Aviva considered that it was able to compete with Bupa on factors including innovation, its rehabilitation services, managing claims well and its pricing sophistication strategy.

Profitability

19. Aviva's net underwriting margins were about [✂] per cent. For its SME portfolio it was currently about [✂] per cent, and the large corporate portfolio was [✂] per cent. Corporates had significantly greater buying power with Aviva and there was a competitive market for that. They could negotiate their prices down. Aviva's large corporate schemes could have 250 members to a scheme, with 30,000 members. [✂]

20. [✂]

21. Between 2009 and 2012 Aviva improved its performance by addressing a number of control issues and making sure it got a much better effective underwriting process. Such a change had helped increase the size of its portfolio, [✂].

Switching

22. Aviva believed that around 50 to 60 per cent of its new customers were switching from an existing insurer. The remainder were new to the market.

23. Aviva believed that its switching terms for personal customers were quite generous and did not inhibit switching in the market. However, it did have some switching criteria, for example Aviva would not accept a new customer if they had had any heart or cancer conditions in the last five years or if someone was in the middle of a claim.

Prices

24. Aviva told us that its total claims cost was rising by about [✂] per cent a year when adjusted for the changing business mix. The cost of an average claim was rising by about [✂] per cent and the proportion of the customers that were claiming was also rising. This rise was due to increases in hospital and specialist costs.

25. Aviva had concerns about increasing hospital costs and believed that hospitals should be managing their capacity better and aiming to be more innovative. Aviva did not think it should be expected that hospital costs should rise each year.

26. Another concern raised by Aviva was in relation to the use of specialists, whereby a recent increase in discretionary treatment was causing costs to rise. It believed that there was also an element of over-treatment which was contributing to these cost increases, as well as treatments which were not previously covered under PMI being referred. Costs were consistently rising and causing premiums to become unaffordable for customers, something which Aviva had little control over.

Shortfall

27. Aviva was careful to ensure that it managed its processes so that customers were not faced with paying an unexpected shortfall for a medical procedure. On average, [✂] per cent of its customers were faced with paying a shortfall at the end of a process. However, Aviva was unaware whether in all cases of that [✂] per cent the

customer had to pay the shortfall, as it was not aware of whether the consultant actually pursued the customer for the shortfall amount or not.

28. Aviva had concerns regarding arrangements for anaesthetists and anaesthetist groups and the payment of shortfalls. In many cases, neither Aviva nor its customers would know who the anaesthetist would be until quite late in the process, and this made it difficult for the patient by this time to exercise a choice in their anaesthetist. There was a chance that the anaesthetist might not adhere to Aviva's fee schedule. It was Aviva's practice to absorb any shortfalls in cases where it had been unable to notify the customer of the fee prior to treatment.

Hospital market power

29. Aviva viewed hospital operators as having local market power where they were either a solus hospital in a particular area (that is, the only facility within a certain geographical radius), or where a large proportion of Aviva's revenue on a particular specialism (eg cancer treatment) went to a single facility in an area.

30. Aviva said that there were approximately 40 solus hospitals across the UK, where there was no competition within a 15-mile radius. It viewed both solus hospitals, and hospitals it was reliant on for a particular specialism, as 'must have' hospitals and as a result it was placed at a disadvantage when negotiating fees with the hospital groups. Knowing that Aviva would have to contract with them, the major hospital groups had clauses in their contracts that were index linked to increase prices year on year. The only leverage Aviva had with these hospitals in negotiations was to tell them that Aviva could route patients away from those hospitals.

31. Aviva did not have such problems negotiating with independent hospital operators, as it did not see them leveraging their power in the same way as the larger hospital groups. It was thought that this was because independent hospitals only operated in a local market, whereas hospital groups may have one or more solus hospitals which Aviva needed to provide a full service to its customers.

32. Aviva did not consider that PPUs were typically perceived as an attractive alternative for private patients, because they did not offer patients the same experience. For example, Aviva had a trust product, which offered customers 25 per cent discount off a premium if they opted to use PPU facilities. However, neither Aviva's corporate or individual customers seemed attracted by this offer, with only [✂] per cent of customers taking it up. However, Aviva was aware of some specialists recommending that patients use the PPU because of the intensive facilities available at certain NHS hospitals. HCA owned two-thirds of the hospital facilities in central London. Aviva considered that HCA was significantly dearer (approximately [✂] per cent) than other London hospitals. However, Aviva could not tie back HCA's prices to any differentiated quality or service it provided to customers.

33. Aviva had found that in negotiating with the major hospital groups, the hospital operator might request a price increase but would refuse to share any information with Aviva about how its costs in treating private patients had increased. Aviva had no real information on the breakdown of costs and how they were varying over time. It could make comparisons between the total costs of a specific treatment at different hospital operators, but did not have a level of detail to understand the drivers in those differences in costs.

34. Outer London hospitals were significantly cheaper than the inner London hospitals and Aviva was keen to direct patients to cheaper hospitals. However, with specialists working in central London hospitals this was a challenge.

35. In terms of recognizing new hospitals under its policies, Aviva noted that it always welcomed new entrants to the market and would consider their commercial proposals in detail. Aviva would negotiate on that basis, recognizing that at that point it would be the only time that Aviva would really have an opportunity to put downward pressure on prices.

36. Aviva saw its current growth in volume as a benefit when negotiating with a hospital group which had a number of solus hospitals. It was also considering offering an open referral policy. [✂]

37. [✂]

38. Aviva had a tariff agreement with all five of the hospitals which covered pre-operational procedures. [✂] It worked at continuing to grow and increase its market share and shift customers to go within that piece. Historically the contracts all contained punitive clauses.

39. Aviva was aware that Bupa and AXA were offered substantial hospital discounts, particularly where there was a very large corporate in the region. [✂] There was no evidence of a discount that was consistent across all the hospital groups.

40. Aviva confirmed that it had a guiding customer strategy, although this was very rarely used. For example, with a corporate customer in an area where there was competition for hospitals, Aviva had been able to deselect the hospital that was most expensive and select the hospital that offered more value for money, therefore passing some of those savings on to that corporate arrangement. Aviva was now focusing on building better capability around open referral and what it called directionality into the future. This type of referral would help Aviva find the right provider for a patient's best practice pathway and customers would have fast access to good-quality, evidence-based best practice.

41. Aviva was increasingly looking at its spend and splitting it down into categories, eg cancer therapy, complex spinal surgery. It hoped this would work towards lower-cost policies without constraining the quality of patient service. However, Aviva was experiencing resistance from the hospitals and specialists because of the potential influence on the patients' pathway.

Consultants

42. Aviva believed that consultants had a significant influence over the hospital a patient attended and the course of treatment a patient received. Once a GP had made a referral to a particular consultant, the patient was typically trusting of the consultant or specialist and the treatment path which had been decided by the consultant. In Aviva's view, consultants did not have an incentive to control costs and the patient was not typically in a position to challenge charges due to a lack of information. Research Aviva had carried out had shown that it was difficult to forecast consultant charges and Aviva had struggled to find evidence as to why one consultant would charge more than another.

43. With regard to anaesthetists and anaesthetist groups, Aviva was concerned that their fees were invisible to the customer until the point when they received the bill. It thought the customer should be given the option to switch consultants or the option to pick up any shortfall that they needed to pay to carry on seeing the specialist of their choice.

44. Aviva believed that the insurers should play a role in managing consultants' costs. However, it had been rebutted by the hospitals and ignored by specialists in its previous attempts to do so. Aviva believed that recently Bupa and AXA had made further inroads into the matter.

Fee schedules

45. Fee schedules had been in place for a long time. In response to queries from consultants about the appropriate level of fees for certain procedures, Aviva undertook a review in the 18 months from 1 January 2011 to mid-2012 of the fees payable to consultants for 128 codes in its fee schedule. Following its review, the fee for 63 per cent of the codes was increased, 26 per cent stayed the same and the remainder were decreased. When reviewing a procedure Aviva tried to get a view of the actual intensity of the input into that procedure. It used external practising consultants to double-check ideas around which gave Aviva a complexity level for each of those fees. It also looked at the benchmark against the other fees with similar complexity levels, which was how it reached its conclusion.

46. Aviva told us that although insurers each had set fees and costs which were made publicly available, how each insurer then applied those fees could in fact be totally different. Aviva's overall cost through the consultant supply chain had gone up by about [✂] per cent every single year. Irrespective of where Aviva's fee schedule fitted as a guide to where its fees were, its overall cost, over a consistent period of time, had gone up.

47. The number of consultants active in private practice had increased between 2007 and 2012, so private practice seemed to be still a very attractive business for consultants.

Incentives

48. Aviva said that there were incentives between hospitals and consultants. It had two main concerns regarding incentives. First, the patient might be unaware of any incentive agreements between the hospital and consultant. Secondly, as an insurer, such arrangements meant that Aviva had even less influence over where the individual went within the customer pathway. Aviva was aware of incentive schemes at Nuffield and Circle hospitals where consultants were part-owners of the hospitals. It considered that a significant number of clinical decisions were equivocal, and even though specialists would not think there was a conflict of interest, a difference in hospital could make quite a big difference to a patient and to the cost.

49. Aviva considered that the rates it had with Circle were competitive and that Circle's incentive arrangements had not been detrimental to Aviva. However, it noted that the impact of the arrangements in the long term remained to be seen.

Vertical integration

50. Aviva had concerns about hospital groups owning private GP practices. It considered that vertically-integrated hospitals would have the incentive to feed patients through their own patient pathway and considered this to be detrimental to not only the customer in terms of choice, but also Aviva which had no influence on how the patient passed through that pathway. This practice made it difficult for Aviva to control the cost of the service and to ensure that there was choice for patients.

51. By way of example, some of Aviva's large corporate customers had employed company GPs who had referral mechanisms linked to HCA or to certain hospital groups. [✂] Aviva assumed that it would see similar patterns if the hospital groups owned or operated GP and health facilities.

52. Aviva considered that owning and controlling the whole customer pathway might also create a barrier to other organizations establishing facilities in those geographical areas.

Referral process

53. Aviva believed that the GP played a strong role in diagnosing what treatment was required for an individual and considered this to be an important role. However, Aviva considered that GPs often did not have enough information about who their local consultants were and this had impacted referral processes. Currently, GPs were not making large numbers of referrals into the private sector and the data they might be relying on to make referrals could be anecdotal data, eg who they referred to last, which might not be reliable or current.

54. Aviva considered that patients should have information on the matters that were important to them, eg consultants, specialists and speed of access. All information should be transparent. At least, patients should know what the costs of a consultation were upfront. Aviva did not currently provide this information to its customers; instead it informed them where there was an excess to be paid to the specialist. Aviva believed that the insurance industry as a whole needed to work harder to make sure that people were aware of the cost of a claim and the impact that had on any future premiums.