

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Summary of hearing with PruHealth held on 12 April 2013

#### PruHealth's strategy

1. PruHealth had gone through quite a number of changes in the last decade, culminating in its acquisition of Standard Life. The two businesses had quite different cultures, PruHealth being a more innovative health insurer and Standard Life being more conservative. The focus of the last 18 months to two years had been on redesigning its products to focus on full-refund products. It no longer offered separate cash plans. PruHealth's experience in South Africa in managing costs and challenging the operators' tariffs were being applied in the UK. PruHealth, having now stabilized its book, was looking for growth and was optimistic that its newly-developed products would meet customers' needs. PruHealth was focused on offering its Vitality product to encourage all-round 'wellness' by rewarding policyholders who improved their lifestyles and fitness. Its Vitality product had been launched in many other jurisdictions including in China and the USA, as well as South Africa.
2. PruHealth saw the health market as being very different from other consumer goods and believed that those complexities needed to be understood. It considered that consultants and hospital operators had changed their behaviour as a consequence of the investigation. Consultants were increasingly discussing their charges etc with patients and generally being more open. Negotiations with the hospital operators this year had been a lot more amicable and open than previously.

#### The business

3. PruHealth had improved its loss ratio and profitability, particularly in the last 18 months. It saw growth in particular in the individual market. It saw more revenue in the individual market and SME markets. PruHealth attributed this improved performance largely to the success of its health and wellbeing programme, Vitality.
4. PruHealth had looked at specialist referral paths that some other insurers were adopting, but it was of the view that the GP was the best person to make referrals. The exception to this was in the London market where PruHealth had concerns due to the prevalence of locums who did not necessarily know who the best consultants were. GPs were increasingly aware of the need to know who the best consultants were as opposed to referring only to their golfing partners. Whilst GPs should be responsible for the initial consultant referral, diagnostic tests should be consultant rather than GP referred as it was the consultant who needed to interpret the tests and who needed ultimately to determine treatment.
5. For corporates, PruHealth's Premier network was for the most part broadly the same and included most hospitals. It offered its more restricted Countrywide network which, in particular, included only a selection of London hospitals but generally corporates opted for the premier network. PruHealth's focus was to offer choice, and therefore to be as inclusive and as open as possible. Although in London corporate trusts in particular were starting to question costs and looking for alternative providers, HCA coverage remained critical to the corporate offering. If a corporate took the Countrywide network, the premiums could be between 10 and 15 per cent lower. However, the drive-time distance could be greater.

6. PruHealth, following the acquisition of Standard Life, needed to bring together the two books, which had meant that it had a wide range of product offerings. It had sought to harmonize them, but there had been considerable push back from brokers, and therefore PruHealth had retained a range of products, in particular differentiating between full cancer cover and core cancer cover. This was also driven by differences in the regions and nations. For example, in Scotland, due to more limited NHS funding of certain cancer treatments, full cancer cover was preferred whereas in London core cancer cover might be sufficient given the strong NHS offering on cancer treatments across the board.
7. PruHealth previously had a 70 per cent exposure in London. This had been reduced to 33 per cent on new business and had enabled the company to improve its presence in other parts of the UK.

### **Competition among insurers**

8. PruHealth saw Bupa, AXA PPP and Aviva as its main competitors. It believed that in essence, all offered exactly the same types of product but with some key differentiators.
9. PruHealth saw no transparency around the pricing differentials for insurers. It advised that there was no line of sight as to either the base tariff or the tariffs that competitors enjoyed. The way in which tariffs worked across the market were quite complex, which made it difficult for PruHealth to draw any firm conclusions as to what the ultimate differential in pricing was between it and its competitors. Its acquisition of Standard Life enabled PruHealth to compare its rates with those of Standard Life and it had benefited in negotiations from this.
10. In relation to switching, PruHealth had been focusing on its underwriting and seeking to take a different approach to pre-existing conditions.
11. PruHealth usually made provision for an 8 to 9 per cent rate of medical inflation which had a direct effect on its customer prices. There was no incentive due to the way in which tariffs were structured and the way consultants were reimbursed to contain costs or stop over-utilization, including on prosthetics and drugs. Hospitals were, in its view, the primary drivers of medical inflation, as they controlled the mark-ups on drugs and prosthetics as well as their own costs rather than the consultants who comprised a small element of the bill.

### **Hospital market power in local areas**

12. PruHealth considered that it was relatively successful in negotiations because it analysed extensive data on, for example, hospital costs and utilization which it used in negotiations.
13. PruHealth advised that the vast majority of the agreements it had were national. As a result, it did not have differentiated prices within those agreements dependent upon the geographic area.
14. Since PruHealth currently had an inclusive hospital list, it believed it negotiated successfully on a national basis, and did not consider that this enabled those hospital groups with a greater number of solus or must-have hospitals to have market power in negotiations.

15. PruHealth had three networks: the Premier network, which included approximately 400 hospitals; the Countrywide network, which outside central London was the same as the Premier network but within central London excluded HCA hospitals, St John & St Elizabeth, the Bupa Cromwell and a number of central London PPUs; and finally the Local network, which had changed significantly since it was first tendered in 2006/07, and which now included all of the Nuffield, Spire, BMI, Ramsay and Circle hospitals. The Local network excluded all central London hospitals, all PPUs and most smaller groups and independents.
16. PruHealth did not see examples of hospital groups being able to exert market power because of individual local strengths. It did rank the pricing, and looked at the differential as far as a range of procedures were concerned. It saw some differences, but these were relatively low percentages. In terms of product offering, with the exception of central London, PruHealth did not consider that the national groups were particularly differentiated. It was in any event the consultant who selected the hospital rather than the patient or the insurer. Moreover for a weighted basket of treatments PruHealth did not see, with the exception of HCA, much difference in the relative pricing of each of the five operators.
17. PPUs were really the only significant competitors outside London. They competed in areas where they had highly specialist cardiac and cancer care services, primarily for acute neurosurgical work, and included the Christie in Manchester, the Centre in Newcastle and facilities in Bristol and Oxford. For more general acute treatments, waiting times were not generally as good as at private providers and the 'hotel' element was not perceived as particularly attractive. These considerations were far less relevant for, for example, cancer patients. PPUs could be more expensive than one of the main private operators for general acute treatments for PruHealth due to the administrative costs, the lower volumes and higher equipment costs.
18. PruHealth did not consider that the raising of the private income cap for PPUs would necessarily be beneficial as it would depend on the charges made, the environment in which treatments would be delivered, the range of services and the impact this might have on other operators who might need to increase prices as a result of losing market share.
19. However, PruHealth considered that there was a significant competition problem in relation to central London and, in particular, in relation to HCA's position in the London market.

## **Costs**

20. PruHealth had a preference for national pricing rather than local pricing. The biggest area it had identified to cut costs was around the cost efficiencies for particular procedures. Prior to negotiations, PruHealth identified a basket of diagnostic-related groupers (DRGs) enabling it to link particular procedures to identify by operator a basket price for such procedures which could then inform its negotiations with the operators. If a particular operator's charges were higher for a particular basket, PruHealth would challenge the operator to justify why this was the case in terms of quality outcomes. However, PruHealth experience internationally was that squeezing on tariffs resulted in an increase of over-servicing.
21. PruHealth believed that the larger insurance companies tended to get better terms in negotiations.

22. According to PruHealth, the hospital groups would like PruHealth to get a greater market share, since this would lead to greater profits on its part from the smaller insurers.

### ***Consultant market power***

23. In terms of the overall level of charges, from a fee schedule perspective, there were in the region of 5 to 10 per cent of consultants who charged over and above what PruHealth would deem to be reasonable. This was determined via a published fee schedule, which reflected the complexity of the procedures that were undertaken. This was available in the public domain.
24. When overcharging did occur, PruHealth would initially challenge the fees. It would then talk to the consultant and also look at what their worth was in terms of their overall practice costs, in terms of the fees that they could reasonably expect to charge and the salary that they could expect to earn. PruHealth would then benchmark those factors against the procedure that was being performed and how long it would take to perform the procedure.
25. When there was a shortfall, PruHealth would not seek a top-up fee from the client to cover this. PruHealth always sought to find a resolution.
26. PruHealth's policy was as that it did not actually recognize groups of practitioners and agree a rate with the group. It recognized individual practitioners within that group.
27. PruHealth's model usually contained a percentage differential between London and non-London consultant prices.

### **Information and referral processes**

28. PruHealth told us that it did not direct patients to different hospitals in any way within its network lists. It saw the treatment of the customer as being consultant led. However, where there were arrangements in place with, for example, somebody wanting to go to an HCA hospital which was not on their list, PruHealth would give alternatives as to where clients could go for treatment.
29. PruHealth offered policyholders an open referral process. If a policyholder did not have a referral to a named consultant, PruHealth offered a service whereby it would provide the policyholder with a list of consultants. It provided this service in conjunction with BMI through its national inquiry centre and also with Alliance Surgical. It was not always clear-cut, even for those clinically trained, to determine whether a person at the end of the phone needed an orthopaedic surgeon or a neurosurgeon for a slipped disc. Policyholders were not referred back to their GPs. In most instances, PruHealth would negotiate with the consultant over the final fee.
30. PruHealth did not hold a list of preferred consultants but did have a list of derecognized consultants, currently around 20. These were individuals who had been found to be upcoding, unbundling, inappropriately charging, or repeatedly making high charges. In these cases, PruHealth would try to reach a negotiated settlement with them before derecognizing. If this was not agreed, then the consultants would go on PruHealth's deregistered list. PruHealth considered that between 5 and 10 per cent of consultants charged over and above what PruHealth would regard as reasonable. This was based on PruHealth's published fee schedule. This would be the starting point for any challenge but PruHealth would also consider the consultants' overall

practice costs, the time required and nature of the particular procedure and their experience in terms of what they could reasonably expect to earn. This broadly equated to before tax average annual earnings for a full-time private consultant of £250,000 which compared to an average NHS salary of £135,000.

31. This £250,000 for average annual earnings in the UK was a generous figure. On the basis of this analysis, PruHealth attributed a professional worth to full-time private consultants working in the UK of £250 per hour. This figure took into account professional and practice costs and the expectation that a consultant would achieve a daily efficiency rate of 75 per cent (comprising 6 hours worked out of an 8-hour working day). 25 per cent of consultants would be under-remunerated and a further 25 per cent would be over-remunerated based on this figure. PruHealth then considered the basket of procedures that each specialty would perform in a given year. PruHealth was therefore able to run a whole economic model for an average hourly rate for all surgical procedures by specialty. A percentage adjustment to the economic model was applied for the geographical location of consultants practising throughout the UK. Rates needed to be reviewed every three years as was done in South Africa and the USA.
32. PruHealth recognized that because face-to-face contact time might decrease it did not mean that the consultant should earn materially less if the complexity of the procedure remained unchanged. In addition, PruHealth also recognized that some consultants might command a premium from experience, recognized expertise in their field and affability etc. As PruHealth policies were full refund policies, there were no issues relating to shortfalling or top-up fees for policyholders. PruHealth would negotiate individually with consultants looking at their overall practice rather than by procedure.
33. The ultimate sanction was derecognition, but the aim was to reach a compromise agreement with each consultant. PruHealth disagreed with the fee-assured approach to consultants adopted by other insurers, as it put all consultants in the same box, ignoring individual consultants' expertise as well as patient and surgical complexity. Some procedures might take twice as long for a particular patient and it was unfair to reimburse only half the time worked and expect the patient or the consultant to pick up the difference. Whilst PruHealth had approximately 18,000 regular consultants who invoiced, approximately 6,000 of them accounted for 75 per cent of invoices. PruHealth considered that it was extremely unlikely that any consultants had left private practice or would leave private practice because of reimbursement rates.
34. In relation to anaesthetist groups, PruHealth was of the view that an anaesthetist could not offer the best level of service as a sole practitioner. In the USA, most anaesthetists practised in groups. In the UK, PruHealth had no particular difficulties with anaesthetist groups. If there were restrictions on joining groups which therefore acted as barrier to entry, this would be a concern. PruHealth's data did not indicate that anaesthetist groups were driving prices up. PruHealth did not recognize groups of consultants, only individual practitioners within the group, even where rates were uniform across the members of the group. The main issue, in PruHealth's view, was that consultants did not know how to calculate their worth. In relation to other consultant groups, there should be economies of scale which should benefit patients. However, many groups did not carry out proper cost assessments, taking into account effective utilization rates. This meant that in some areas there might be an 80 per cent overprovision which then needed to be funded.
35. PruHealth did not have significant concerns over vertical integration and indeed it might be helpful to patients. The key was ensuring that there were systems in place

to check that there was no over-servicing or over-utilization. Agreed coding systems (ICD-10) were key to being able to collect data for these purposes.

36. Finally, PruHealth told us that unlike the NHS, while private specialists did keep records of the number and type of procedures that they carried out, they did not report these figures to insurers. However, the key issue was that consultants had very little idea not only how to value their own services but also the relative costs of pathology, diagnostic, drugs and prosthetics. Greater information was required for all, not just patients or GPs but also consultants.
37. With regard to incentives, in South Africa, doctors were able to own shares in hospitals, but were required to inform patients clearly of such an interest. An insurer would need to prove that the share ownership was driving up utilization. The ICD-10 coding could prove unnecessary admissions and prolonged stays. Kickbacks in particular from pharmaceutical companies for using particular prosthetics were also required to be declared. In addition, in South Africa hospitals were required to provide market-related rentals and administrative services to consultants.