

Response of



to

the CC's Provisional Findings:
Bargaining and insurer negotiations

11 November 2013

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1. Introduction

- 1.1 The CC recognises that "[t]he relative strength of parties' positions in negotiations depends upon their options if an agreement is not reached (their 'outside options')." ¹ At its most extreme, the outside option will be assessed by both insurers and hospital providers in terms of the impact, relative to their counterparty, of a full or partial delisting. The evidence comprehensively demonstrates that with respect to BMI: (i) not only does Bupa have, in fact, far superior outside options; but (ii) it is also fully cognisant of the comparative strength of its outside options; and (iii) it is willing to resort to its most extreme outside options to achieve its desired objectives. The CC's statement that the evidence "does not indicate that for [Bupa] the bargaining strength conferred amounts to fully countervailing buyer power" ² is untenable in respect of BMI. The only way the CC could come to this view is by disregarding a significant amount of relevant evidence provided to it throughout the course of the investigation. The evidence patently shows Bupa does have fully countervailing buyer power opposite BMI.
- 1.2 This paper compares the outside options of Bupa and BMI, showing that it is both indisputable and demonstrable that Bupa has far superior outside options, which gives it far superior bargaining strength amounting to fully countervailing buyer power.

2. Summary

- 2.1 Bupa has very strong outside options, which enhance its buyer power. This results from the following facts:
- (a) Bupa (and indeed every insurer) has proven alternatives to each of BMI's hospitals, suitable for treating its policyholders and able to meet its demand; Bupa may not tell the CC this, but this was the message it communicated to its policyholders when it delisted 37 BMI hospitals in early 2012. This is demonstrably true even in:
- (i) Solus and rural areas. Bupa was able to divert away over [X] of demand from BMI Lancaster and [X] of demand from BMI Gisburne Park.
- (ii) BMI's supposed 'cluster' areas. Bupa delisted three alleged clusters in their entirety and diverted patients away from each and every BMI hospital within these three alleged clusters. By doing so, Bupa showed it did not need to use any hospitals in these supposed clusters. BMI clearly cannot therefore leverage any of

¹ Provisional Findings, paragraph 6.155.

² Provisional Findings, paragraph 6.189.

these hospitals in negotiations with Bupa; if it could you would expect to see evidence of this in negotiations. The CC has presented no such evidence.

- (b) Bupa (and indeed every insurer) has a range of tools available to direct patients to these alternatives. Bupa's stated strategy is to direct patients and all insurers are making increasing use of these tools, which are proven to be effective in enabling insurers to direct patients, in particular:
- (i) restricted networks. BMI saw corporates' acute healthcare spend with it [redacted] after switching to the AXA PPP Pathways product, showing patients were being directed to BMI. Further, following its tendering exercise, which focussed on the creation of restricted networks, PruHealth stated it had been "*very successful in securing 'excellent pricing submissions from the main five hospital groups'*", such pricing reflects the fact hospitals believe insurers can use these networks to direct patients;³
 - (ii) service line tenders. The number of Bupa patient episodes for cataracts treatment [redacted], indisputably demonstrating these networks can be used to divert patients. The CC has quoted examples of networks which have saved insurers [redacted] on a single service line, as insurers have directed patients to hospitals on their networks;
 - (iii) guided referrals. The CC has seen "*examples where some PMIs have negotiated preferential rates for directing open referrals to specific hospital operators.*"⁴ Such price reductions can only be explained if open referrals are viewed as a credible way to direct patients. Bupa has developed sophisticated techniques to enable it to direct patients more effectively, such as its 'finder' tool, which its staff use to match patients with a consultant and a hospital, based on a comparative scoring system (determined by Bupa). BMI believes these methods are effective and has developed its strategy around facilitating directional policies (for example by [redacted] and incentivising increased volumes with discounts).

The evidence available to the CC shows these tools are very effective at directing patients; insurers and hospital operators are fully cognisant of this which is why they feature in the market more and more. The CC has failed to make the obvious conclusion that this puts insurers in a very strong position in negotiations.

³ Provisional Findings, Appendix 6.11, paragraph 147.

⁴ Provisional Findings, paragraph 6.179.

- (c) The ability to divert patients allows insurers to mitigate the financial impact of delisting. Bupa's internal documents estimate that it could [REDACTED]. This shows that Bupa's threat to delist is not only very credible (as proven in practice) but that Bupa has confidence in its ability to use it.
- (d) Bupa has exaggerated the reputational harm caused to it by delisting, which is in reality minor. Bupa received fewer than [REDACTED] complaints following the BMI delisting (an estimated [REDACTED] of its policyholders). There is no compelling evidence of quantifiable damage. Through the delisting Bupa has gained a reputation as an uncompromising negotiator and has demonstrated not just the strength of its outside options but its willingness to resort to a delisting. A number of hospital operators have expressed concern about this, with St Anthony's agreeing that Bupa has "unacceptable market power".⁵ What matters in a negotiation is the credibility of the threat - this threat is a powerful tool that Bupa can leverage in future negotiations.

2.2 BMI has very weak outside options, which undermines its bargaining position. This results from the following facts:

- (a) [REDACTED]. BMI believes Bupa can direct away [REDACTED] of its business, causing BMI [REDACTED]. Bupa too believes that [REDACTED]. BMI could not endure a sustained delisting; this has since been proven in practice.
- (b) The financial impact of a delisting is disproportionately more serious for a hospital operator than an insurer. A sudden loss of a large number of patients chokes crucial cash flow required to cover the high fixed costs associated with running a hospital (associated particularly with the equipment and staffing needed to safely operate a hospital). [REDACTED]. By contrast, an insurer continues to receive a steady income throughout a delisting as policyholders' PMI subscriptions are on an annual basis. [REDACTED].
- (c) BMI has no ability to mitigate the effects of a delisting, as the CC already recognises.⁶ In the event of delisting, due to the refusal of insurers to cover pre-existing conditions, patients who want to continue treatment for a pre-existing condition will be unable to go to their regular hospital and consultant. If patients are unable to switch insurer, BMI is not able to recover these lost volumes. During delisting BMI therefore has only two (theoretical) mitigation strategies:
 - (i) Raising prices. BMI knows raising prices during a delisting is not an effective or credible mitigation tactic; proof of this is that BMI did not impose a pricing penalty on Bupa during the January 2012

⁵ Response to Provisional Findings, St Anthony's Hospital, dated 20 September 2013.

⁶ Provisional Findings, Appendix 6.11, paragraph 241.

delisting. Indeed there is no evidence BMI has ever used or threatened this tactic. Bupa knows [REDACTED] of BMI's losses could be recouped through increased prices.

- (ii) Denying access to hospitals. This is also not credible as it: (A) raises the risk of litigation under the Competition Act 1998; (B) causes unacceptable disruption to patients; (C) damages relationships with consultants; and (D) results in further lost revenues.

BMI's theoretical mitigation strategies are therefore not credible or viable in practice.

- (d) BMI suffers a number of aggravating factors as a result of a delisting, in particular consultant drag, which haemorrhages patients away from BMI, the effects of which are serious, abrupt and long-lasting. Worse still, in order to compensate for patient losses, BMI would have to offer other insurers deeper discounts in return for any increased volumes. By contrast, insurers are able to gain discounts for directing patients to alternative hospitals. A delisting therefore undermines BMI's position opposite all other insurers, while it strengthens the position of the insurer imposing the delisting opposite all other hospitals.

2.3 Bupa has far superior outside options compared to BMI, especially in the context of a delisting scenario. Irrefutable evidence in support of this includes the following facts:

- (a) The financial cost of a delisting is far greater to BMI than to Bupa. [REDACTED].
- (b) The internal documents of [REDACTED][REDACTED] show a sustained delisting would [REDACTED][REDACTED]; this is an entirely credible threat that Bupa has leveraged in its negotiations with BMI.
- (c) The internal documents show that [REDACTED][REDACTED]. This proved true in the event of the actual delisting. [REDACTED]. There is no evidence to suggest the delisting was exceptional, dependent on the circumstances of the particular negotiation, or dependent on BMI's financial position at the time.
- (d) Bupa's ability to hold out longer than BMI when relying on its outside options is indisputable. Bupa's proven willingness to follow up on its threats and rely on its most extreme outside option gives it tremendous leverage in negotiations.

2.4 The conclusion that Bupa has fully countervailing buyer power is inescapable. Bupa's assertion that no insurer has countervailing buyer power against the large hospital groups is simply not credible for the following reasons:

- (a) Bupa's evidence is contradicted by statements made by smaller insurers, many of which acknowledge their own countervailing buyer power, both opposite BMI and outside central London more generally. This evidence must be particularly compelling given it is contrary to the self-interest of insurers.
- (b) The CC claims that hospital clusters constitute a feature of the market capable of conferring market power on hospital operators. If this were true you would expect a hospital operator to have attempted to leverage this strength in negotiations with insurers. Not only has the CC provided no evidence that the alleged clusters are leveraged in negotiations, it has provided no evidence that either hospital operators or insurers have ever considered hospital clusters to be a feature of the market. Without any such evidence, the CC cannot credibly maintain its hospital cluster theory.
- (c) Bupa is a 'must have' insurer. The insurer market is highly concentrated, much more so than the hospital market. For a long time, Bupa has maintained a market share of around 40%, meaning hospital operators are reliant on Bupa for patient episodes necessary to sustain the viability of their hospitals. Over [X] of BMI's revenues come from Bupa. [X].
- (d) [X]. Bupa successfully used delisting as a tactic to secure a [X] reduction from BMI on a like for like basis over the contract period – i.e., at equivalent volumes.
- (e) The CC's own insurer pricing analysis demonstrates that HCA (the only hospital operator each insurer claims it does not have countervailing power opposite) charges higher prices than The London Clinic (TLC) [X]. The only logical explanation for this is that [X] can exercise countervailing buyer power even against HCA.

2.5 It is abundantly clear from Bupa's internal documents at the time of the negotiation with BMI that [X]. This gives Bupa fully countervailing buyer power.

3. Bupa's outside options in a dispute

3.1 There are a number of factors which make Bupa's outside options particularly strong in the event of a dispute.

Bupa has proven alternatives to BMI's hospitals

3.2 The CC notes that "[t]he outside options for the PMIs are the other hospitals they could use to replace those hospitals they currently use or are contemplating using"⁷ and that in assessing this in the context of a contemplated delisting,

⁷ Provisional Findings, paragraph 6.155.

insurers had regard to “*the availability and suitability of alternative hospitals for each hospital which the PMI may consider delisting in the event of a dispute.*”⁸ Bupa has proven alternatives to BMI’s hospitals. At the start of 2012, Bupa delisted 37 BMI hospitals. In the lead-up to the delisting, Bupa published on its website a customer Q&A, which included a list of hospitals it told its policyholders it considered as suitable alternatives to the delisted BMI hospitals.⁹ For each delisted BMI hospital Bupa told its policyholders that there are at least two¹⁰ suitable alternatives recognised by Bupa, often several more. This is also true for the four solus hospitals (as identified by the OFT) that Bupa delisted.

- 3.3 Bupa delisted hospitals within three of what the CC terms ‘clusters’ in their entirety: [X] Bupa clearly thought that there were sufficient alternatives to BMI’s alleged cluster hospitals in these regions. [X] other supposed clusters had at least one hospital delisted by Bupa, yet the alternatives specified by Bupa did not even include other BMI facilities, even where these had not been delisted. For example, three suitable alternatives were listed for [X] but these did not include [X] or [X](the other hospitals contained in the CC’s identified cluster) even though these were not delisted by Bupa. Therefore the alternatives for a delisted BMI hospital which the CC classifies as part of a supposed cluster, which allegedly faces insufficient competition, did not include other BMI hospitals in said cluster. This completely undermines the CC’s contention that clusters of hospitals are essential for adequate coverage in a region such that they can be leveraged.
- 3.4 The graphs below demonstrate that there are in fact sufficient alternatives to BMI’s hospitals, even in supposed cluster areas. They plot the number of Bupa patients admitted to various alleged BMI hospital clusters since January 2011. The red rectangle highlights the delisting period as well as the months immediately prior and subsequent. If clusters are a feature of the market that give hospital operators market power, you would expect that when one or more hospitals in an alleged cluster are delisted, the lack of suitable alternatives in that region would necessitate diverting some patients to the other BMI hospitals that remain listed in the supposed cluster. The evidence below clearly shows this did not happen.
- 3.5 The graph below shows the alleged cluster of [X] Bupa delisted all of these hospitals except [X]. While each of the four delisted hospitals experienced a clear trend of declining Bupa volumes around the time of the delisting, there is no corresponding rise in Bupa volumes at [X] across the same timeframe. This proves Bupa is capable of diverting patients to alternative facilities outside the said cluster.

⁸ Provisional Findings, paragraph 6.157(a).

⁹ See BMI response to MQ, Section 5, Annex 21.

¹⁰ Except for BMI Castle Consulting Centre, which has since closed.

[X]

- 3.6 Further, if the CC's cluster theory were correct, where Bupa delisted all the hospitals in a supposed cluster, you would expect that it would nevertheless have no option but to continue sending patients to these hospitals due to the lack of suitable alternatives. Again this is not the case. In fact we see volume declines across all the delisted hospitals without exception, meaning that Bupa was able to divert patients away from each and every hospital in these alleged clusters. This again completely undermines claims that the supposed clusters could confer market power or in any way be leveraged.

[X]

[REDACTED]

[REDACTED]

- 3.7 BMI has also submitted extensive evidence, including in contemporaneous internal documents prepared in the ordinary course of business, demonstrating how each of its hospitals faces competitive constraints.¹¹ We refer to BMI's submission titled Response to PFs: Local Assessments for extensive representations on the alternatives to BMI's hospitals and the competitive constraints posed by these.

Bupa is able to divert large numbers of patients away from BMI's hospitals

- 3.8 The CC understands directionality is key to understanding bargaining power.¹² Insurers are able to divert patients to alternative hospitals. Bupa recognises its ability to steer patients, having represented to BMI "*[w]e have explained to you our vision of a market returning to growth. This is facilitated through our strategy to reduce the overall number of hospital facilities recognised in our networks, coupled with the ability to direct volume to those hospitals that represent best value and quality. The tools to deliver this are available today.*"¹³
- 3.9 This is supported by an analysis Bupa conducted presented in a slide titled [REDACTED]¹⁴ This anticipated that it could divert in total [REDACTED]% of patients away from BMI, demonstrating [REDACTED]. BMI's own contemporaneous business planning documents anticipated that Bupa would be able to divert demand equating to up to [REDACTED] of revenue away from BMI hospitals in the event of a complete delisting. This, on a worst case scenario, would [REDACTED]. Clearly [REDACTED] [REDACTED] consider Bupa is able to divert the [REDACTED] of business to alternative hospitals [REDACTED].
- 3.10 The [REDACTED] in Bupa volumes following the 2012 delisting, even at BMI's solus and rural hospitals, confirms the ability of Bupa to direct patients. Evidence provided by BMI in its response to the MQ and the AIS demonstrates that Bupa's diversion tools, combined with the availability of alternative facilities, mean that [REDACTED] of patients can be, and in early 2012 a [REDACTED] of Bupa referred patients in fact were, diverted away.

¹¹ See, for example, BMI response to MQ: Section 2, Annex 7 (catchment area analyses); Annex 12 (competitor analyses); and Annex 13 (list of competitors compiled after interviews with Executive Director's of BMI's hospitals); Section 3, Annex 5 (catchment area analyses for potential acquisitions); Annex 6 (national competitor analyses); Annex 7 (corporate review presentations); and Annex 8 (BMI 5 year plans).

¹² Provisional Findings, Appendix 6.11, paragraph 172.

¹³ [REDACTED]

¹⁴ [REDACTED]

3.11 [X].¹⁵ When Bupa delisted Lancaster it was nevertheless able to divert patients to competing hospitals such that demand dropped from [X] inpatient and day cases from Bupa per month prior to delisting to [X] in May 2012.

[X]

3.12 Gisburne Park, a rural hospital, [X]. The graph below shows that, within six months, Bupa was able to divert from this hospital [X] of demand. From [X] IP and DC episodes in the October prior to the delisting, the hospital [X] IP or DC episode from a Bupa patient in June or July 2012. Given the IP and DC episode levels prior to the delisting, it is simply not feasible to suggest the reason for the [X] is related to anything other than Bupa actively diverting its subscribers who required treatment in that locality to alternative (non-BMI) facilities.

3.13 The CC has persistently ignored this evidence and still maintains Gisburne Park is a hospital that is [X]. No regard has been had to the evidence of actual insurer choices. Bupa delisted Gisburne Park hospital, did not mention [X] as an alternative and removed all its demand from it. There is no rational basis for the CC's Provisional Finding in respect of this situation.

[X]

3.14 The delisting demonstrates unequivocally that Bupa was able to divert over [X] of patients away from BMI Lancaster and up to [X] away from BMI Gisburne Park. Both these hospitals are in remote locations; if Bupa is able to direct such a high proportion of patients away from these hospitals (for which it listed three and two alternative hospitals, respectively) there must be equally compelling evidence that Bupa can readily direct a high proportion of patients from BMI hospitals situated in locations for which it identified even more alternative competitor hospitals. The CC's Provisional Findings suggest the CC has seen evidence to the contrary and BMI would ask that this be shared with BMI, so BMI has an opportunity to comment on it.

3.15 Insurers realise controlling the patient pathway will increase their bargaining power. There is an abundance of evidence that insurers engage in directionality as a main strategy against hospital operators. The internal documents of insurers reveal strategies focussed on [X].

3.16 The ability of insurers to control where patients are treated is a feature of the market which will only become even more prominent. A Bupa Board update during its 2011 negotiations with BMI set out its strategy for the negotiations, which included [X]. This is because a hospital operator is not only heavily dependent on consultants to bring patients to its hospitals, but is severely impacted by the effects of consultant drag when a consultant splits or moves

¹⁵ [X]

their practice. Bupa's strategy is clearly geared to [REDACTED]. A slide from a 2011 internal Bupa briefing document in preparation for negotiations with BMI, [REDACTED].

[REDACTED]

- 3.17 The evidence shows directional strategies increasingly being used in practice by insurers, demonstrated by the increase of restricted networks¹⁶ and service line tenders, which also rely on open referrals¹⁷ and other directional techniques. We discuss each in turn, but note that the CC is unreasonably understating the effect of each of these individually and also their effect collectively. The resulting conclusion is unsupported by evidence.
- 3.18 Service Line Tenders: Bupa's Ophthalmology network has resulted in savings in cataract treatment of around £[REDACTED] per year. The ability to guide patients using service line tendering is demonstrated by the graph below, which shows the number of Bupa cataract episodes recorded at BMI hospitals:

[REDACTED]

The launch of Bupa's Ophthalmology network caused [REDACTED] in the number of cataract episodes carried out at BMI hospitals, as patients were directed to hospitals that were on the network. Not only did [REDACTED] in volumes occur almost immediately but volumes remained [REDACTED] for the entire duration that BMI was outside of the network. This is clear evidence of the effectiveness of service line tendering as a means of directing patients.

- 3.19 The practice of service line tendering is now commonplace. AXA PPP has successfully launched networks creating savings in the range of just under £[REDACTED] per year and Aviva has achieved savings of £[REDACTED] per year from its MRI network. The trend is that insurers are making increasing use of these networks. In 2012 Bupa launched a new Trans Aortic Valve Implantation (TAVI) Network. In addition, Bupa is [REDACTED].
- 3.20 The CC does not appear to conclude in Provisional Findings in Chapter 6 on service line tenders despite providing a range of evidence at paragraphs 209 – 220 of Appendix 6.11 which demonstrates how insurers have introduced a number of successful service line networks, each [REDACTED], and that this is clearly a continuing trend. It is not open to the CC to ignore the weight of this evidence, as it apparently has done, when this supports the central premise that insurers have strategies which clearly enhance/utilise their bargaining power.

¹⁶ At paragraph 6.172 the CC state that restrictive networks "appear to be growing in attractiveness."

¹⁷ At paragraph 6.179 the CC state "Guided referral policies are becoming more established and more common."

- 3.21 That Bupa and other insurers are increasing their use of these innovations demonstrates belief in their effectiveness to shift the balance of negotiating power even further in favour of insurers. A dynamic analysis of the market would include consideration of this.
- 3.22 Guided referrals: the CC accepts that “[g]uided referral policies are becoming more established and more common”¹⁸ and that they have seen evidence of better prices being obtained: “[w]e have also seen examples where some PMIs have negotiated preferential rates for directing open referrals to specific hospital operators.”¹⁹ However, the CC goes on to argue that it has seen “no evidence that PMIs have successfully used this device to divert significant numbers of patients from or to specific operator’s hospitals.”²⁰ The CC’s reasoning in this regard does not to rely on or refer to its own bargaining framework. Specifically, the CC accepts that price reductions are being achieved. Unless there was a credible threat of moving volumes, presumably the CC would not expect those price reductions to occur. If it is a credible threat then the threat will not need to be carried out and so the CC should not expect to see actual volumes moving. The CC is irrationally moving the goalposts of the analytical framework it has itself established when it encounters evidence it seeks to downplay or dismiss.
- 3.23 The evidence of actual price reductions therefore is contradicted by the CC’s proposition that “*whilst [guided referrals] may have the potential to change the balance of negotiating power, we do not think this has happened yet to any significant degree.*”²¹
- 3.24 Moreover, the CC’s evidence shows that:
- In 2012 Bupa introduced mandatory open referral for large corporate customers. It is currently voluntary for smaller corporate clients, and could become available for individual customers in the near future.²²
 - In addition, in 2012 Bupa introduced direct referral for cataract procedures, bypassing the traditional GP referral process.²³ Direct referral also exists for services where Bupa is vertically integrated such as MSK and physiotherapy in London Barbican.
- 3.25 Bupa has developed a 'finder' tool which its staff use to match patients with a consultant and a hospital, based on a comparative scoring system (determined

¹⁸ Provisional Findings, paragraph 6.179.

¹⁹ Provisional Findings, paragraph 6.179.

²⁰ Provisional Findings, paragraph 6.179.

²¹ Provisional Findings, paragraph 6.179.

²² Laing & Buisson, Health Cover 2013, page 35.

²³ Laing & Buisson, Health Cover 2013, page 35.

by Bupa). This finder tool not only enables Bupa to guide open referrals, but it can be used to influence a patient's choice of consultant even when they have been given a named referral. The purpose of the scoring system is to inform Bupa staff about Bupa's views on hospital and consultant referral choices. The higher the score a consultant or a hospital achieves on the finder tool, the more likely Bupa staff are to refer a patient to them. [§] The CC will recall that BMI has no terms in its agreements with Bupa that would require Bupa to score BMI in this way, this is Bupa's own assessment of BMI hospitals. Depending on the scores achieved by other hospitals, BMI is therefore more likely to be referred patients in these regions. [§] It is not only hospital scoring that enables Bupa to guide patients to one hospital or another; Bupa can also achieve the same effect by influencing a patient's choice of consultant. BMI has received reports [§] that Bupa has been actively re-directing patients away from its hospitals by changing a patient's appointments to a consultant practicing at a competitor hospital.

- 3.26 Bupa has therefore developed a number of effective ways to increase its control over the patient journey and to enable it to direct a greater number of patients to its preferred hospital providers. The CC will note that Bupa's practices in increasing control over the patient journey have been the subject of a large volume of highly critical evidence provided by consultants and patients to the inquiry. It is clear patients' are unhappy that their healthcare choices are becoming increasingly curtailed as a result of Bupa's actions. As Bupa exerts greater control over the relationships between key market participants (consistent with its stated objective), so its bargaining strength and market power grows further still.
- 3.27 Restricted networks: the CC's Appendix 6.11 to the PFs contains a number of examples of successful use by insurers of restricted networks, perhaps only with the exception of central London. The success of AXA PPP Pathways demonstrates that, when properly executed, restricted network products and open referral tools are extremely effective in driving volumes to selected hospitals. To create the product, BMI offered additional discounts to the AXA PPP existing tariff [§] which it was agreed would be used to offer lower premiums to AXA-PPP subscribers. Once the network was expanded, adding Nuffield, TLC and other hospitals, to achieve sufficient geographical coverage, product take-up increased and BMI saw its share of a company's acute healthcare spend [§] after a switch to Pathways. PruHealth has also stated that, when tendering for its networks of varying degrees of inclusiveness, it had been "*very successful in securing 'excellent pricing submissions from the main five hospital groups'*,"²⁴ demonstrating the ability of restricted networks to drive discounts.
- 3.28 Given restricted networks clearly have the potential to increase volumes, driving discounts and ultimately supporting hospital rationalisation, the CC must consider

²⁴ Provisional Findings, Appendix 6.11, paragraph 147.

carefully why certain restricted networks are not as successful. In particular, BMI has demonstrated that the reason for the failure to reach agreement on Bupa's low cost network was that Bupa was not prepared to engage seriously in negotiations.²⁵ We have not seen [REDACTED] in that regard but BMI's concern, among others, not to cannibalise its existing customer base is clearly a legitimate one that in a situation of potential mutual gain one would expect an insurer to be willing to discuss. Nothing in [REDACTED] contradicts BMI's submissions in this regard.

- 3.29 On 18 July 2011, BMI made a number of offers in an attempt to make Bupa's product work in BMI hospitals, these [REDACTED]. Bupa refused all BMI's offers the following day. [REDACTED].²⁶
- 3.30 The CC has again failed to reflect in its conclusions that the weight of evidence demonstrates the ability of insurers to formulate restricted networks to enhance their buyer power and secure lower prices from hospital operators.
- 3.31 The evidence clearly shows that both the incentive and the ability of insurers to improve their outside options clearly exist and that these are being acted upon more frequently as are the use of effective directional strategies such as: (i) service line tenders; (ii) guided referral policies; (iii) the use of restricted networks; and (iv) guidance tools for normal policies (e.g. Bupa 'finder' tool; cash incentives for patients who do not make a claim).

Bupa will obtain discounts from other hospitals for providing increased volumes

- 3.32 The CC states a further consideration of insurers when contemplating a delisting is "*the cost of sending patients to these alternative hospitals, taking into account the terms that would apply or could be agreed.*"²⁷ Insurers are able to secure deeper discounts from the hospital operators in return for directing additional volumes to their hospitals. This mitigates the financial impact of a delisting on an insurer and further enhances the viability of its outside option.
- 3.33 BMI has witnessed this strategy being used when in 2009 Bupa enquired about obtaining deeper discounts from BMI for additional volumes. BMI believes that at the time Bupa was in a negotiation with Spire and was attempting to use the discounted rates quoted to it as leverage in that negotiation. Bupa said in a letter to BMI, "*[f]inally we require you to confirm in writing the precise discount you will commit to provide Bupa in the event of Bupa electing to secure these [additional] services from you in future.*"²⁸

²⁵ [REDACTED]

²⁶ [REDACTED]

²⁷ Provisional Findings, paragraph 6.157(b).

²⁸ [REDACTED]

3.34 Bupa's internal analysis focuses on [REDACTED]. [REDACTED]:

[REDACTED]

3.35 [REDACTED].

3.36 Clearly the financial impact of the delisting to Bupa was manageable. It is important to understand that in a dispute with a hospital an insurer will still retain a stable cash flow from policyholders with, at worst, an increase in variable costs in the very short term as it diverts demand elsewhere (although even these costs can be mitigated through additional discounts). Furthermore, an insurer's variable costs will reduce immediately on the settlement of the dispute to a 'normal' level. The insurer can in reality therefore expect short term depressed operating profit; by contrast, [REDACTED]. BMI explained this in its AIS response²⁹ and [REDACTED]. The CC's interpretation of the evidence in this regard is neither rational nor reasonable.

The reputational damage to Bupa caused by a dispute is small and overstated

3.37 The CC states that insurers claimed that in practice delisting can "*seriously damage*" their business.³⁰ However, no evidence of serious damage is offered. The CC has stated that the "*net benefit Bupa derived from the delisting*" cannot be quantified, especially as the net reputational damage (and benefit) caused by the delisting is not quantifiable.³¹ While the costs may not be quantifiable, the CC can still use the evidence to make an informed comparison of the seriousness of the reputational damage to Bupa and BMI.

3.38 Moreover, the evidence demonstrates Bupa has overstated the reputational harm it suffers as a result of the delisting. Bupa states it received "*close to [REDACTED] customer complaints relating directly to the dispute in January 2012.*"³² This is an insignificant number of customers in the context of Bupa's business. In 2011 Bupa's share of the market of over 3 million policyholders was over 40%³³ by revenue (i.e. taking revenue market share as a proxy for market share by number of policyholders, Bupa received complaints from an estimated [REDACTED]% of its policyholders).

²⁹ AIS response, paragraph 8.29(b).

³⁰ Provisional Findings, paragraph 6.164.

³¹ Provisional Findings, paragraph 6.166.

³² Provisional Findings, Appendix 6.11, paragraph 83.

³³ Health Cover UK 2012, Laing & Buisson.

- 3.39 There is no evidence that any of these “close to [redacted]” customers took any action over and above merely expressing concerns, such as switching provider. The CC notes that Bupa has claimed it was particularly difficult to manage its relationship [redacted]. The CC explains [redacted].³⁴ Be that as it may, if this is the most serious example of client dissatisfaction Bupa has received (and it must be assumed it is), this is not at all compelling evidence of quantifiable damage of any kind.
- 3.40 The CC acknowledges that “[s]everal hospital operators also noted that the recent Bupa delisting of BMI confirmed to other suppliers that Bupa was willing to carry out delistings and confirmed the credibility of any threat to delist.”³⁵ The CC must explicitly recognise that Bupa has enhanced its negotiating power opposite hospital operators by demonstrating that it can successfully carry out large scale delistings to achieve its objectives. As St Anthony’s hospital observed “[t]he only conclusion to be drawn is that Bupa has chosen this action in order to give credibility to its future threats.”³⁶ Indeed, while the CC appears reluctant to acknowledge it explicitly, this has proved to be extremely effective; St Anthony’s again notes “[t]he Competition Commission appears to be trying not to have to say what it surely knows is true, which is that one delisting event is insignificant in itself but it has established the precedent which allows the insurer to threaten providers and consultants. This constitutes unacceptable market power.”³⁷ The impact on Bupa’s reputation among hospital operators from delisting BMI is therefore clear and clearly positive to Bupa by augmenting its power.
- 3.41 Not only do the documents make clear that Bupa [redacted], moreover [redacted] BMI are aware of the strength of Bupa’s outside option. What matters in a negotiation is the credibility of the threat. The only reasonable interpretation of this evidence is that its stronger outside options gives Bupa considerable advantages in negotiations opposite BMI.

4. BMI’s outside options in a dispute

- 4.1 There are a number of factors which demonstrate that BMI’s outside options are comparatively weak in the event of a dispute. Further, Bupa has argued that its delisting of BMI hospitals in 2011: (i) was exceptional; (ii) depended critically on the circumstances of that particular negotiation; and (iii) depended on BMI’s

³⁴ Provisional Findings, Appendix 6.11, paragraph 84.

³⁵ Provisional Findings, Appendix 6.11, paragraph 68.

³⁶ Response to Provisional Findings, St Anthony’s Hospital, dated 20 September 2013.

³⁷ Response to Provisional Findings, St Anthony’s Hospital, dated 20 September 2013.

financial difficulties at the time.³⁸ Bupa's internal documents [X] yet the CC's analysis does not reflect that fact in any material manner.

[X]

- 4.2 The following slide,³⁹ shows that BMI anticipated that Bupa could divert demand equating to up to [X] of revenue away from BMI hospitals in the event of a complete delisting. On a worst case scenario, this would [X].

[X]

- 4.3 Bupa also modelled the financial impact on BMI of various delisting scenarios. [X]

[X]

- 4.4 Bupa notes [X]. Clearly the financial impact of a complete delisting would be even more severe. However, Bupa's outside option opposite BMI is strengthened because [X]. Bupa had invested in designing a model to identify the most effective strategy to [X].” We have not seen to which hospitals Bupa is referring and so cannot comment on how these compare to the delistings that actually took place.

- 4.5 Clearly Bupa's analysis of its bargaining strength has little or nothing to do with either the “particular negotiations” or BMI's “financial difficulties”. Rather Bupa is [X]. [X]. There can be no conclusion other than that this gives Bupa clear countervailing power in its negotiations with BMI.

Cash flow issues arising from fixed costs and declining revenues

- 4.6 [X]. The CC also states that “*the financial strength or weakness of a hospital operator would have a strong bearing on the outcomes of a delisting and therefore on the credibility of it as a threat.*”⁴⁰ In fact, the particular financial strength or weakness of the hospital operator *per se* is unlikely to have a significant bearing on the outcome of a negotiation with Bupa.

- 4.7 As stated in BMI's response to the AIS,⁴¹ the relative weakness of a hospital operator's negotiating position from a financial perspective is due instead to the simple arithmetic of losing large numbers of customers en masse combined with a very limited ability to “turn off” significant on-going fixed costs. BMI's ability to

³⁸ Provisional Findings, paragraph 6.165.

³⁹ PMI Commercial Strategy and Pricing Project, 21 June 2011, slide 73, see BMI's response to MQ, Section 4, Annex9a.

⁴⁰ Provisional Findings, paragraph 6.166(c).

⁴¹ AIS response, paragraph 8.29(b).

withstand a protracted dispute with Bupa was critically undermined by the severity of the loss of patients and revenues that resulted from the delisting. BMI is caught in a position where, in a market already characterised by overcapacity, in addition to the patient losses caused directly by a delisting, it will suffer losses caused by indirect aggravating factors such as consultant drag (see below), but will have no ability to mitigate its losses through increasing revenues from other sources (see below).

- 4.8 By contrast, an insurer’s negotiating position is enhanced by the financial impact of a delisting relative to hospital operators. Insurers continue to receive a steady stream of income in the form of premia from policyholders, which means they have a significant advantage in terms of access to working capital during an out of contract situation.⁴² Further, insurers such as Bupa are mostly a component part of insurance businesses that are factors of magnitude bigger than BMI with balance sheet and cash flow strength to outlast BMI in any conceivable dispute. Bupa, AXA PPP, Aviva and PruHealth in particular each have recourse to deep global cash revenues should they be required in the event of a dispute. Of course, Bupa’s analysis presented in Figure 1 (above) is clearly relevant in respect of the extent to which the CC can consider Bupa [§<]. This is a structural difference, BMI has repeatedly made this point and it has not been heard. There is no rational basis whatsoever to consider that the delisting represented a “unique opportunity.” The CC has noted that it is merely “not convinced that this was a unique opportunity for Bupa.”⁴³ In the face of this unequivocal evidence, BMI cannot understand why the CC would wish to equivocate on this important point.
- 4.9 This inequality of arms is made even more acute by the different impacts a dispute has on cash flow and profitability of an insurer and a hospital provider.⁴⁴ A hospital provider has a high proportion of committed and operational costs that it needs to fund through cash. A dispute with an insurer disrupts that cash flow and creates immediate difficulty in financing the business's working capital requirements. [§<] If the CC has a coherent alternative narrative it is not included in its Provisional Findings.

Inability to mitigate impact of delisting

- 4.10 While it has been shown an insurer is in a position to mitigate losses, this is not the case for a hospital, as the CC recognises when it confirms that it “*has seen no evidence in internal documents from hospital operators to suggest that they considered they would be able to replace lost insured revenue from other*

⁴² AIS response, paragraph 8.29(b).

⁴³ Provisional Findings, paragraph 6.166(c).

⁴⁴ AIS response, paragraph 8.29(b).

sources, such as NHS revenue or self-pay patients.”⁴⁵ With the PMI market declining and the industry already being characterised by overcapacity, it is crucial for hospitals to retain existing volumes to help cover high fixed costs. This gives PMIs enormous leverage.

- 4.11 Where an insurer directs patients away from a hospital through a delisting, patients are not free to carry on all future treatment at that hospital by switching insurer. Indeed, not even Bupa believes switching insurer is a realistic prospect for the vast majority of its members, having publically stated that the idea that customers may switch away from Bupa was “*misguided and ridiculous*”⁴⁶ given other insurers would not cover pre-existing conditions. If patients cannot switch insurer, BMI is not able to recover these lost volumes during delisting. This is despite the fact patients may want to continue to receive their future treatment at BMI.
- 4.12 Without recourse to alternative sources of income, in the event of a delisting by an insurer, a hospital operator’s negotiating position opposite all other insurers is weakened. This is because to recover lost income caused by the delisting, a hospital’s main option is to offer even deeper discounts to other insurers to encourage them to direct more patients its way. The hospital providers other choices are to [~~✗~~] or to seek to recover increased costs from the remaining private users. These other insurers will know that a hospital will be struggling to cover its fixed costs, which will enhance their ability to command additional discounts; this will either further squeeze the margins of hospital operators [~~✗~~]. This is in stark contrast to the position of an insurer which enforces a delisting: its negotiating position is strengthened opposite all other hospital operators as it is able to command additional discounts in return for directing increased volumes to their hospitals. The disparity of the impact of a delisting on the parties’ negotiating positions in the wider market could not be more acute.
- 4.13
- 4.14 BMI’s potential strategies to improve its outside option opposite Bupa are ineffective. BMI has two potential strategies: (a) increase prices at hospitals retained or still used by Bupa; or (b) deny access to hospitals retained or which Bupa still requires to send patients. Note these strategies are alternatives, they could not both be used to mitigate losses. However, neither would be an effective mitigation strategy, nor has either strategy been used in practice.

(a) Increasing prices

⁴⁵ Provisional Findings, Appendix 6.11, paragraph 241.

⁴⁶ Natalie-Jane Macdonald, interview with Health Insurance, 25 November 2011, see <https://www.healthinsurancedaily.com/health-insurance/product-area/pmi/article385126.ece?page=2>

- 4.15 There is no evidence to suggest the increasing of prices by BMI would be effective at protecting overall revenue. BMI does not believe it would be effective, estimating that a [§<] price increase would increase Bupa's claims costs by [§<]. The increasing of prices by BMI does not work in practice – it is not credible to suggest this would impose significant costs on Bupa so as to bring them back to the negotiating table.
- 4.16 The CC notes that in assessing outside options in the event of a delisting, insurers have regard to “*any anticipated increase in price imposed by the hospital operator that faces having some of its hospitals delisted at any hospitals retained on the network.*”⁴⁷ What the CC fails to conclude is that Bupa does not perceive the threat of price increases by BMI as credible or effective. This conclusion is inescapable. Bupa has modelled that [§<]. If a (theoretical) threat to raise prices is not taken seriously by Bupa, then it cannot be used as leverage by BMI to enhance its bargaining strength opposite Bupa. Bupa recognises that [§<].⁴⁸ Bupa knows it is the [§<]. Bupa also knows [§<]. Note that none of this is particular to the BMI negotiations or specific to BMI's financial position. By contrast, as demonstrated above,[§<].
- 4.17 In practice, when BMI's hospitals were delisted, BMI did not impose a pricing penalty. This is consistent with the views of both BMI [§<]. Even after an agreement had been reached, and Gisburne Park, Lancaster and Castle Consulting remained delisted, pricing at these hospitals remained the same as for all other hospitals in BMI's portfolio. Furthermore, BMI also allowed any volume that went through these delisted hospitals to contribute to Bupa's discount thresholds. Despite this, Bupa continued to divert up to [§<] of patient demand from these hospitals.

(b) Denying access to hospitals

- 4.18 Denying access to certain hospitals in local markets could put BMI at risk of being sued under the Competition Act 1998. This risk is heightened by the fact that Bupa has a particularly aggressive reputation and has shown its willingness to use litigation and the threat of litigation against BMI in order to increase its bargaining leverage. [§<].
- 4.19 Nor does BMI believe there are sufficient benefits in such a strategy. Both BMI's actions to date and its internal documents support this view. As the CC recognises “*the high fixed costs of hospital businesses make their profitability very sensitive to variations in patient volumes.*”⁴⁹ BMI's objective has always been to encourage Bupa to send patients to all of its hospitals, regardless of

⁴⁷ Provisional Findings, paragraph 6.157(c).

⁴⁸ Provisional Findings, Appendix 6.11, paragraph 98, [§<]

⁴⁹ AIS Appendix E 'Barriers to Entry', paragraph 36.

whether they are in Bupa's network, so that BMI may more effectively cover its fixed costs. Further, there are a number of key disincentives in adopting this approach, including: (i) the potential aggravation and disruption caused to patients, who would be denied treatment at their chosen hospital and who may consequently decide not to use BMI in future; (ii) the potentially irreparable damage to consultant relations (especially where the hospital itself has made the decision not to allow consultants to treat certain patients) and the resultant longstanding impact of consultant drag; and (iii) the impact of lost revenues on [redacted] (as shown in the examples of Lancaster and Gisburne Park).

- 4.20 Bupa factored in [redacted]. This is consistent with the evidence BMI has presented.
- 4.21 Finally, there is no evidence this is a tactic that has ever been used or even suggested. When Bupa continued its delisting of Lancaster and Gisburne Park, even after reinstating BMI's other hospitals, BMI actively encouraged Bupa to send volumes through these hospitals by allowing these to contribute to Bupa's discount through its volume-discount curve. Far from attempting to prevent the use of these hospitals, BMI offered an incentive to use them. Bupa was not penalised for the delisting despite the increase in average costs it had imposed on these businesses and BMI did not seek to leverage these hospitals or deny access to them.

Aggravating factors make BMI's outside option even weaker

- 4.22 BMI faces additional disadvantages with its outside option, particularly in respect of reputational costs. Perhaps the most significant of these is the loss of consultant loyalty and the impact of consultant drag. This is a problem of which insurers are also acutely aware. Evidence from [redacted]. The CC states "*Bupa also considered that this 'consultant drag' effect, whereby consultants move all of their practice to another hospital after a delisting by one PMI, [redacted].*"⁵⁰ Therefore PMIs realise [redacted]. The impact of consultant drag further increases the bargaining power of insurers in negotiations.
- 4.23 BMI has presented the CC with examples of consultant drag having occurred and the longevity of the effect. The risk that consultants may never (or never fully) return their practice to BMI is very serious. Such examples include the exclusion of BMI's hospitals from Bupa's and AXA PPP's ophthalmic networks.⁵¹ Eventually, BMI was forced into agreeing to terms in order to have its hospitals recognised on these networks. The need to retain its ophthalmic consultants was one of the main drivers behind BMI's decision.⁵²

⁵⁰ Provisional Findings, Appendix 6.11, paragraph 103.

⁵¹ The background details are contained in BMI's responses to questions 33 and 43 of the Market Questionnaire, respectively and not repeated here.

⁵² BMI response to MQ, Section 5, page 42.

- 4.24 Even following the accession of BMI's hospitals to Bupa's and AXA PPP's ophthalmic networks, the effects of consultant drag continued to be felt years later. The graph of Bupa cataract episodes (provided at paragraph 3.18 above) shows that during the period January 2006 to the end of April 2007 (prior to the network launch), BMI hospitals received on average [redacted] Bupa episodes per month. Following BMI's accession to the network, during the period May 2009 to end of December 2010, BMI's hospitals received on average only [redacted] Bupa episodes per month. This represents a [redacted] decline in volumes that was not recovered.
- 4.25 The following extract, communicated to BMI's regional and executive directors, highlights the concern:
- [redacted]
- [redacted]
 - [redacted]
- 4.26 [redacted] because the consultant has no way of knowing how long the delisting may last or whether it will happen again. [redacted] Consultants are dependent on insurers (particularly Bupa) for patient volumes and ultimately they will seek to ensure they are able to treat these patients. It is not difficult for consultants to split or move their practice between hospitals and consultants frequently have practising privileges at more than one hospital to facilitate such switching.
- 4.27 The graph below shows the longer term impact of delisting 37 of BMI's hospitals for just 18 days on total Bupa patient volumes across BMI's portfolio. This evidence supports how a targeted delisting, for a relatively short time period (sufficient to force the hospital operator to agree terms), has a disproportionately serious longer term impact.
- 4.28 [redacted] Consistent with the Lancaster and Gisburne Park graphs included in section 3 above, it shows [redacted] Total Bupa volume had fallen by over [redacted] by the end of the year, despite the fact that BMI's hospitals (bar three) had been delisted for only [redacted] days. By 'consultant drag' we mean consultants taking other – and sometimes the whole – of their remaining (non-Bupa) work to competitors, either to make more efficient use of the theatre sessions there (rather than carrying out procedures on Bupa patients in one facility and on non-Bupa patients in another facility) or simply because they were mitigating the risk of continued disruption and financial 'pain' to their own practices brought about by Bupa's delisting of the consultant's BMI hospital base.
- 4.29 [redacted]
- [redacted]

Bupa's reputation and behaviour make it impossible to know which hospitals it considers most important for its network

- 4.30 Bupa has built a reputation as an aggressive counterparty. A comparison of the documentary evidence around the actual situation clearly indicates that despite over 30 years of commercial relations BMI found predicting Bupa's best alternative to a negotiated agreement (BATNA) very difficult; BMI was over-optimistic about its own bargaining position – [REDACTED].
- 4.31 In a business planning document, BMI attempted to [REDACTED]. However, BMI was [REDACTED]. Bupa [REDACTED] delisted 15 of these and was able to do so until BMI was forced back to the negotiating table. Further, [REDACTED] including both Gisburne Park and Lancaster, which remained delisted even following conclusion of an agreement. Despite [REDACTED] the experience of many years of commercial relations with Bupa, BMI could not correctly predict which hospitals Bupa would and would not delist. It is self-evident that it is very difficult to exercise any leverage without an accurate view on which hospitals, if indeed there are any, Bupa considers "must haves". Moreover BMI's actual bargaining power depends on what Bupa believes BMI's true position to be. Bupa clearly believed [REDACTED].
- 4.32 There is no correlation either between the hospitals the CC has identified as of concern and those Bupa delisted. Bupa delisted [REDACTED] of the BMI hospitals the CC has identified as being of concern i.e. subject to insufficient competitive constraints. Further, as stated, of the [REDACTED] alleged BMI clusters the CC identified for which it proposes divestitures; [REDACTED] of the alleged clusters were delisted in their entirety, [REDACTED] alleged clusters had no hospital delisted and the remaining [REDACTED] alleged clusters had from [REDACTED] delisted by Bupa. From the evidence available to BMI, there appears to be no consensus between the insurers, hospitals operators or indeed the CC as to what BMI's supposed "must have" hospitals are. If there is no consensus on the issue, BMI cannot plausibly leverage its hospitals.
- 4.33 The CC states that "*this delisting does not indicate that all of the BMI hospitals that were delisted were dispensable to Bupa in the medium or long-term or that they have no market power.*"⁵³ The relevance of this statement is completely undermined if Bupa is able, and prepared, to delist BMI's hospitals for sufficient time that the result is that BMI must either concede to Bupa's demands [REDACTED]. Bargaining power is about using a strategy to force a favourable outcome in negotiations. It is not about what hospitals are dispensable in the medium or longer-term, or otherwise. The CC misinterprets its own test. Bupa is able to delist these hospitals for long enough to achieve its aim. There is no evidence to suggest this strategy would not work in the future. On the contrary, the internal documents of both BMI and Bupa show [REDACTED].

⁵³ Provisional Findings, paragraph 1.168.

5. Evidence on the balance of bargaining power demonstrates Bupa is in a far stronger position

Bupa has far stronger outside options compared to BMI

- 5.1 When the outside options of Bupa and BMI are compared, it is clear that Bupa is in a vastly stronger position in negotiations. Bupa is also [REDACTED]. Bupa's willingness to rely on its outside options will depend on whether it believes it will be able to "hold out" longer than BMI. Before the delisting Bupa wrote to Netcare SA (BMI's ultimate parent company) signalling this intent, explaining "*we are prepared to operate indefinitely without the majority of BMI hospitals on our recognised lists.*"⁵⁴
- 5.2 This demonstrates that the financial cost of delisting is [REDACTED]. Bupa believes [REDACTED].
- 5.3 Bupa is aware that it [REDACTED]. The CC notes "*Bupa estimated that were it delisted, BMI's profit on a per annum basis could [REDACTED].*"⁵⁵ The CC also notes that one internal document "[REDACTED]."⁵⁶ Bupa has used this threat as leverage in its negotiations with BMI, having previously stated "You can cause us pain; we can put you out of business."⁵⁷ [REDACTED].
- 5.4 The credibility of the threat to delist is manifest and compounded by the fact that [REDACTED] Bupa is in a far superior position. To suggest, as the CC does "*[w]e did not find the evidence on bargaining on its own indicated whether hospital operators had market power or that PMIs had buyer power*"⁵⁸ is clearly untenable and irrational insofar as the statement relates to Bupa.

Bupa has the ability to rely on its outside options (to "hold-out") for longer than BMI

- 5.5 The CC states, "*[i]n our view the credibility of the delisting threat depends upon the relative strengths of the PMI and hospital operator and their ability at the relevant time to 'hold out' and not be forced back to the negotiating table.*"⁵⁹ The evidence in respect of the outside options of Bupa and BMI shows categorically that Bupa is able to hold out longer than BMI. Not only does the CC fail to acknowledge this explicitly in its Provisional Findings, but it does not acknowledge the only conclusion that is then reasonable in light of this

54 [REDACTED]

55 Paragraph 98 of Appendix 6.11.

56 Provisional Findings, Appendix 6.11, paragraph 97.

57 BMI hearing transcript, page 70.

58 Provisional Findings, paragraph 6.189.

59 Provisional Findings, paragraph 6.169.

indisputable fact: that Bupa is able to use the tactic of delisting (or the threat of delisting as leverage in negotiations) to force a hospital operator to concede to its demands.

- 5.6 Internal Bupa documents prepared in the build-up to the delisting [REDACTED].⁶⁰ [REDACTED]. In the event BMI held out for under three weeks, [REDACTED].
- 5.7 That [REDACTED]. BMI has told the CC that it felt Bupa did not enter into the negotiations in good faith. BMI [REDACTED]. The evidence supports this view and shows that Bupa [REDACTED].
- 5.8 When considering Bupa's claims that the BMI delisting was an extraordinary and unique event, the CC should be mindful that this is not the first time that Bupa has used this tactic. In fact it seems it is not even the second time Bupa has anticipated using this tactic; as the CC notes, [REDACTED]⁶¹
- 5.9 [REDACTED]. The relevance of this to the current investigation is obvious. When Bupa delisted 37 of BMI's hospitals, BMI held out for just under three weeks. Far from being a unique opportunity for Bupa, delisting is in fact a tried and tested course of action. Bupa knew of its effectiveness from its previous experience and [REDACTED].
- 5.10 Both disputes show Bupa is able to use delisting as a means of achieving its aims in a negotiation with a private hospital operator. The CC states "*we are not convinced that this was a unique opportunity for Bupa,*"⁶² the evidence shows clearly that it was not. Bupa has now done so on two occasions, each time forcing the hospital operator into submission within just three weeks. There is no evidence to suggest that Bupa would not be able to make use of this tactic again. There is no evidence to suggest that, if it did, the outcome would be any different. Bupa's ability to hold out longer than BMI when relying on its outside options is indisputable.

Conclusion on relative bargaining positions

- 5.11 The evidence above clearly shows that [REDACTED][REDACTED] unambiguously show that Bupa has the upper hand in negotiations. It has better outside options and it has a far superior ability to hold out. It has also shown repeated willingness to rely on the most extreme of its outside options. There is no tension in the evidence with regard to Bupa – it is unambiguous.
- 5.12 The evidence above completely undermines the credibility of the CC's neutral conclusion: "*[i]t is not possible to predict the outcome of future negotiations, or who generally holds the upper hand in negotiations, on the basis of this one*

⁶⁰ Provisional Findings, Appendix 6.11, paragraph 97.

⁶¹ [REDACTED]

⁶² Provisional Findings, paragraph 6.166(c).

*delisting event.*⁶³ That the CC has based its conclusion on “*this one delisting event*” also shows that it has not properly considered the evidence of the [§<] delisting.

6. The conclusion that Bupa has fully countervailing buyer power is inescapable

6.1 In coming to its conclusions on bargaining, the CC has ignored not only the evidence submitted by BMI and other hospital operators, but also the factual accounts given by the majority of insurers. This evidence paints a clear picture of insurers having sufficient buyer power opposite hospital operators:

- (a) AXA PPP has told the CC that it does not consider itself to be in a weaker position opposite BMI.⁶⁴
- (b) AXA PPP has not expressed concerns outside of central London.⁶⁵
- (c) AXA PPP has stated that hospital market power is “broadly counter balanced”⁶⁶ outside London and that “[i]n our experience this has mitigated against providers charging significant amounts in areas of solus provision.”
- (d) PruHealth has stated: “[a]t our hearing we advised that we did not believe that competition outside of London caused us any adverse effect.”⁶⁷
- (e) The CC notes from PruHealth’s hearing, “*PruHealth considered that it was relatively successful in negotiations*”;⁶⁸ “*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*”;⁶⁹ and “*PruHealth did not see examples of hospital groups being able to exert market power because of individual local strengths.*”⁷⁰

⁶³ Provisional Findings, paragraph 6.167.

⁶⁴ Appendix D to AIS, paragraph 30.

⁶⁵ AXA PPP response to IS, paragraph 9.1.

⁶⁶ AXA PPP response to provisional findings report and notice of possible remedies, paragraph 2.56.

⁶⁷ Response to Notice of Possible Remedies.

⁶⁸ PruHealth hearing summary, paragraph 12.

⁶⁹ PruHealth hearing summary, paragraph 14.

⁷⁰ PruHealth hearing summary, paragraph 16.

- (f) The CC reports of Simplyhealth's hearing that "*Simplyhealth did not believe that it was disadvantaged by its size.*"⁷¹
- 6.2 Furthermore, none of these insurers have referred to hospital operators gaining bargaining strength or market power as a result of owning supposed hospital clusters. If the alleged hospital clusters had this effect, you would expect a hospital operator to have attempted to leverage this strength in negotiations with insurers. Not only has the CC provided no evidence that the alleged clusters are leveraged in negotiations, it has provided no evidence that either hospital operators or insurers have ever considered hospital clusters to be a feature of the market. Without any such evidence, the CC cannot credibly maintain its hospital cluster theory.
- 6.3 The above comments are particularly striking given that the insurers have a clear incentive to *exaggerate* the market power of hospital operators in a proceeding such as the CC's Market Investigation. The CC has been wilfully blind to [§]. In this instance it is starkly telling that the evidence does not suggest that the majority of insurers feel there is any significant imbalance in bargaining power, this consistent view apparently contrary to self-interest ought to substantially increase its weight in the mind of the CC.
- 6.4 It is also striking that none of the smaller insurers refer to the alleged hospital clusters as being a feature of the market.
- 6.5 Moreover, the CC should not be surprised that the evidence shows insurers consider that outside London they have a sufficient bargaining position. Each faces the same alternatives that Bupa does and are able to rely on the same alternative strategies. Many of the factors identified by [§].
- 6.6 Where Bupa is concerned, its buyer power is fully countervailing. The observed outcome from the 2011-12 Bupa negotiation supports this. Bupa was able to use the delisting to reject BMI's offers and attain its own objective, which the CC described as "to get lower prices."⁷² Bupa secured a [§] real price reduction as a result of the negotiation on a like for like basis over the contract period – i.e., at equivalent volumes.
- 6.7 Even the CC's insurer pricing analysis reveals [§]. HCA is the only hospital operator for which each insurer has claimed it does not have countervailing buyer power in negotiations. However, the CC has found that: "*HCA's insured prices on the basis of the price index are also significantly higher than those of TLC, its closest competitor in central London (on average and for individual PMIs, with the exception [§]).*"⁷³ The CC's own analysis reveals that even HCA is not able

⁷¹ Simplyhealth hearing summary, paragraph 31.

⁷² BMI hearing, page 68.

⁷³ Provisional Findings, paragraph 6.247.

to secure a better price than TLC – a standalone hospital which the CC implicitly at least must consider not to have market power [§<] (the CC uses TLC as a cost benchmark for HCA; see paragraphs 20-23 in Appendix 6.9).

- 6.8 Bupa is able and willing to leverage its superior financial strength in negotiations with BMI, knowing its outside option is far superior to BMI's and that it will inevitably hold out longer in any dispute. Indeed, the very fact that Bupa went ahead with delisting, having modelled the likely impact on both itself and BMI, shows Bupa was confident in its ability to use this tactic successfully against BMI. It has been shown, as played out in a real-world delisting, that Bupa has a greater ability to 'hold-out' vis-à-vis BMI. Put simply, Bupa did hold out longer than BMI and [§<]. Unsurprisingly, the outcome of the negotiation was that Bupa gained a [§<] real terms reduction in its pricing on a like-for-like basis over the contract period. Furthermore, Bupa has previous experience of carrying out a complete delisting and has demonstrated its ability to outlast a hospital operator in such a scenario, boosting its reputation for being able to negotiate hard with hospital operators.
- 6.9 The evidence shows overwhelmingly that Bupa's outside option is both viable and effective. It does not expect to suffer a great deal of harm from a delisting event – not least because it expects that it can drive a hospital operator like BMI (and [§<]) back to the table – and do so very rapidly indeed. Hospital operators find out – to the extent that they don't already know (BMI did) that they are in a weak negotiating position very quickly. The hospital operator's outside option is a poor one – it simply cannot afford to lose material revenues and has little ability to adopt strategies to mitigate the losses associated with delisting. Since the losses are so enormous for hospital operators, they cannot last long in a dispute with Bupa. The evidence leads inescapably to the conclusion that Bupa has fully countervailing buyer power opposite private hospital operators.
- 6.10 Moreover, we submit that the CC should not be surprised given a dispassionate view of the evidence that insurers consider that outside London they have a sufficient bargaining position. Many of the factors identified by Bupa in [§<].
- 6.11 Any conclusion that Bupa does not have fully countervailing buyer power opposite BMI would be contrary to evidence and plainly irrational.