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Dear Miss Hawes,

We understand the work and pressures confronting the CC as the Market Investigation into Private Healthcare continues, but we are writing again to inform the CC that the situation referred to in our in most recent previous correspondence to the CC ~~is~~ has in fact deteriorated further to the point where we now consider that it will become irreversible, to the detriment of private healthcare as a whole.

In the last few weeks there has been a massive new targeted assault on consultants who are being threatened with de-recognition (without appeal) for doing their jobs. This may be on alleged over-prescribing or following up with their patients or for setting their own charges (e.g. purely on grounds of costs). This acceleration of de-recognition by Bupa and indeed now other insurers can be linked to the failure of the CC's Provisional Findings Report (PFR) to address some of the critical issues affecting patients who are policyholders such as the lack of transparency and inability for properly informed patients to choose their medical care, paying a shortfall if necessary "portability of benefits". This has emboldened Bupa in particular, (and to a lesser extent ~~is~~) in the relentless pursuit of a market where all fees are set by the PMIs, who, even more importantly, are also dictating the quality of care (or reduction in care) received by their policyholders.

FIPO urges the CC to consider the difficulty of undoing at a later stage what seems to be fast becoming the new enforced norm. We are at the "tipping point" and the situation, if left un-remedied, will become irreversible.

The purpose of this letter is therefore to bring to the CC's attention that the situation created is worsening all the time. The CC must consider, as part of the remedies, a clear obligation on the part the PMIs to allow portability of benefits, which will **not** disadvantage the PMIs but which will advantage the patients.

1. FIPO considers that it is of paramount importance that the CC takes into account the current and rapidly changing situation. We have not previously referred to all of these matters.
 - I. Bupa is attacking consultants over their management of patients, basing this on nothing more than a volume evaluation, and at the

same time suggesting that reducing such care to their patients will lead to Bupa referring more patients to them – an example of a totally unethical approach of “gain-sharing”.

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- II. Bupa are being less than transparent in their dealings with policyholders and their inroads into clinical practice are often made behind the smokescreen of a “consultant recognition” issue or, failing that, an issue with the “referral pathway”. The CC will have seen one such complaint from ✂), but there are many other examples.
- III. Bupa is stating that if consultants join a Premier Partnership with Bupa (i.e. fixed fees for consultation and treatment procedures, with no possibility of patient involvement in either choice of consultant or decision to top up fees) they will be allowed to perform out-patient diagnostic tests in their consulting rooms and be reimbursed but otherwise they will not. We presume therefore that non-fee assured consultants must work at a hospital or deny their patients immediate testing. This, of course, is assuming that non-fee assured consultants will be able to see Bupa patients at all. Moreover this is also assuming, due to the often mentioned effects that de-recognition even by the smaller insurers has, that non-fee assured consultants could even exist in the near future. The inability to perform tests would prevent proper patient evaluation and further erode the competition that small medical practices provide to hospitals, especially in outpatient care.

The situation therefore has moved on rapidly, to the detriment of patients, from the situation that the CC noted in the PFR (paragraph 2.48), namely that *“PMIs tend to have fewer rules regarding outpatient consultations than for daypatient or inpatient treatment. They tend to recognize all or most private hospitals for outpatient consultations or treatments and set annual outpatient consultation fee maxima rather than operating a procedure-based fee schedule as they do for day patient or inpatient treatment”*.

- IV. If the number of consultants who can conduct tests or perform minor diagnostic procedures in consulting rooms is going to be curtailed, a further complication arises when a PMI decides to stop recognition of a hospital or a hospital group for operations. Where are the consultants going to have their patients’ tests performed then? For example, ✂ Apart from the detrimental effects on incentives for hospitals to innovate, non-recognition by Bupa will of course also have a knock on effect on consultants’ ability to operate ✂.

We have come across the issue of recognition of facilities before and urge the CC to look carefully at the effect this has on patients. One example we would like to highlight to the CC is the FOS decision ~~X~~ involving Bupa's refusal to reimburse an MRI scan because it was undertaken at a facility that was not part of Bupa's MRI network. The FOS went as far as saying that it was unfair of Bupa not to pay for the cost it was prepared to pay for a scan at an alternative facility and refusal to pay this could amount to unjust enrichment. The FOS also pointed out that this was a point it had iterated before in similar situations and expressed its surprise of Bupa's bullish stance in refusing to compromise ~~X~~.

- V. As the CC will already be aware, Bupa continues to attack and derecognise consultants for being in the top 10% of consultation charges, whether they in fact are or not in this category. Our evidence shows that they are often not, based on the specialty and geographical location of the consultant.

~~X~~, and where these differ from a list of average rates the threat of de-recognition is levied. Although the stance taken is less aggressive than Bupa, this is still an indication of other insurers following Bupa's lead in removing individual consultants' freedom to price their services, as they have always said they would (the CC is referred to paragraph 5.15 of FIPO's reply to the AIS published on 5 April 2013, where WPA's submission to the CC published on 6 February 2013 is quoted).

- VI. Bupa is now threatening simply to derecognise existing consultants who do not wish to sign up to their Premier Consultant Partnership and this is not even a question of existing consultants being in the top 10 percentile anymore. The conditions for entry are incontestably set by Bupa and the consultants' only choice is to exit. This shows the absolute power of the insurer in relation to the consultant.
- VII. The CC is reminded of the evidence FIPO submitted that derecognition by one insurer means that the consultant loses his or her practice in its entirety (~~X~~).

2. ~~X~~ is also de-recognising consultants, and engaging in campaigns to "choose the appropriate consultant" for their policyholders (which can only mean that the ~~X~~ policyholders will be directed to junior or other consultants, based entirely on price (~~X~~)).
3. The CC is aware that WPA, who would wish to hold themselves to the traditional and ethical stance of PMIs, has said that it will be obliged to set fees at a level equivalent to Bupa rates and that it cannot allow "top-ups" for

commercial and competitive reasons for all consultants who become “Bupa fee assured” (by force or voluntarily).

This strategy, apart from constituting an example of Bupa exerting its market power over consultation fees, is not sustainable unless all consultants charge exactly the same amount. There will always be a “top 10%” of charges. If Bupa derecognises the “top 10%” another “top 10%” will take their place. Clearly, as we have stated previously there would then be no competition on cost for consultant services as all consultation and procedure prices would be the same. There will also be no competition on quality: quality can only go one way in private healthcare, and that is down.

FIPO has made the argument very clearly to the CC about the sustainability of consultant practice and all these measures are merely confirming the case FIPO made about “trend analysis” of consultant income and costs. We would urge the CC to review that vital information which has been excluded from consideration in the PFR.

Transparency and portability

As the market continues to be eroded for consultants, policyholders also suffer at the lack of transparency and portability of their benefits. The CC has alluded to the need for greater transparency from insurers, and notes, at paragraph 7.80 of the PFR, the importance of policyholders understanding the terms of their policies at purchase and renewal, and that this *“includes being made aware and fully informed about changes to reimbursement rates and the recognition of consultants which will have a direct impact on the nature of and value of benefits available under their policies”*. Hospitals and consultants are being required to publicise their fees or to make patients aware of these whenever possible, but not insurers. This means that patients would be quite unaware of their benefits under their insurance.

FIPO believes this is quite wrong. If benefits granted under private healthcare policies were visible (such as a published list of benefits available to policyholders for, say, the top 50 procedures, both for the surgeon and the anaesthetist) then there would be scope for comparison between the premiums paid and the benefits received (⌘). In fact, transparency of benefits should be extended to publication of the amount that ALL insurers are willing to reimburse for a consultation, by geography and by specialty. This would also ensure equality of treatment between consultants (see Provisional Remedy 6) and insurers (currently not obliged to publish any information).

FIPO considers that information on surgical and anaesthetic benefits, including consultation fee benefits should be available in the public domain and comparable for patients. Where an insurer does not reimburse for something it should be clearly

stated along with the benefits available for multiple procedures. This data could be organised into sub sets for ease of access, along the following lines:

1. All codes displayed in alphabetical order (irrespective of specialty);
2. All codes sorted by specialty; and
3. The Top 50 most common procedures.

This data could then be built into a website (funded by the insurers themselves) and patients could enter their operation (i.e. cholecystectomy, hip replacement etc.) via a search engine. Examples of costings to patients could be made available akin to the "Which?" model allowing comparisons to be made between different patient groups: for example a 40 year-old married man with two children or a 30 year-old single woman etc..

Currently this is not the case, (many consultants have agreed fees with the PMI (even at different levels) policyholders do not know what they are getting at the point of sale of a policy or what they will get at the point of redemption (as they do not see a bill). We have asked the CC to consider how visibility and portability could be attained, in the light of remedies designed to achieve greater transparency.

FIPO is aware that the percentage of revenue paid out in benefits is low. This is a stark contrast to the position on the US following the Affordable Care Act in 2011 which requires all plans to spend at least 80 per cent of subscribers' premiums on medical care and related quality improvement activities. The remaining 20 per cent is to cover administrative costs and return to investors in profits. In addition, FIPO is aware that the UK is among the highest when quoting for corporate rates to businesses (UK).

In summary we have made two new points to the CC.

The first is the wholesale attack across the country on a massive number of consultants by Bupa who is enforcing its strategy by threats and actual de-recognition of consultants. This is based on alleged overtreatment but is actually a cost based volume exercise or is simply based on consultant fee levels. FIPO considers that there is no logic to either of these as some consultants are forced in to fee levels which are much lower than those that Bupa accept from their colleagues. The purpose of the exercise is simply to get the consultant to be "fee assured". FIPO has made its case about the impact this will have on competition, future sustainability of consultant practice and the quality of care. FIPO is very concerned that the private medical sector in the UK may be heading toward an irreversible market outcome unless Remedies to ensure the proper functioning of the market are imposed.

Our other suggestion is that in line with the CC's call for greater transparency that the PMIs should be asked to publish in total clarity the benefits they offer on consultant fees based on procedure codes. This would allow a greater understanding

on the part of subscribers. Of course the full free market would only flourish where there was portability of such benefits to any willing provider.

APPENDIX 1 ✂

APPENDIX 2 ✂

APPENDIX 3 ✂

APPENDIX 4 ✂

APPENDIX 5 ✂

APPENDIX 6 ✂

APPENDIX 7 ✂

APPENDIX 8 ✂