



Insufficient Assessment of Patient Benefits from Intervention

21 February 2014

1. Requirements of the Enterprise Act 2002

- 1.1 The CC provisionally considers that in a number of areas throughout the UK high barriers to entry and a lack of competitive constraints amount to a structural AEC in the market for private healthcare services. In some of these areas, the CC considers that divestitures may be an effective remedy.¹
- 1.2 Having provisionally decided that there is an AEC, the CC must have regard to its statutory duties when determining whether a remedy – and if so, what remedy – will be appropriate. In particular, the CC has a duty to, “*in relation to each adverse effect on competition, take such action ... as it considers to be reasonable and practicable – (a) to remedy, mitigate or prevent the adverse effect on competition concerned; and (b) to remedy, mitigate or prevent any **detrimental effects on customers** so far as they have resulted from, or may be expected to result from, the adverse effect on competition.*”²
- 1.3 In taking such action, the CC must also “*have regard to the need to achieve **as comprehensive a solution as is reasonable and practicable** to the adverse effect on competition concerned and any detrimental effects on customers so far as resulting from the adverse effect on competition.*”³
- 1.4 When considering the above, the CC is obliged to consider countervailing customer benefits arising from the features identified.⁴ A key question in the assessment of both customer detriment and relevant customer benefit is: who are “*customers*” for these purposes?
- 1.5 The Enterprise Act defines a “*consumer*” as “*any person who is –*
 - (a) *a person to whom goods are or are sought to be supplied (whether by way of sale or otherwise) in the course of business carried on by the person supplying or seeking to supply them; or*
 - (b) *a person for whom services are or are sought to be supplied in the course of a business carried on by the person supplying or seeking to supply them;****and who does not receive or seek to receive the goods or services in the course of a business carried on by him.***”⁵
- 1.6 Therefore, consumer means the final consumer/customer; in the context of this market investigation, consumers mean patients.
- 1.7 The definition of “*customer*” “*includes a customer who is not a consumer.*”⁶

¹ Provisional decision on Remedies, Section 2, paragraph 2.2 and Table 2 following paragraph 2.99.

² Enterprise Act 2002, section 138(2).

³ Enterprise Act 2002, section 138(4).

⁴ Enterprise Act 2002, section 134.

⁵ Enterprise Act 2002, section 183(1).

⁶ Enterprise Act 2002, section 183(1).

- 1.8 This raises the question of whether it is enough for the CC to evidence benefit being conferred on immediate *customers* (i.e. private medical insurance companies) – or must the CC show that such benefits will be passed on to eventual *consumers* (i.e. patients).
- 1.9 The ultimate objective of UK and EU competition law is to enhance *consumer* welfare; this is clear from the discussion below. No social, political or economic purpose is served by simply transferring wealth from private hospitals to private medical insurers, especially without any evidence of wrongdoing on the part of private hospitals. In fact to do so would be counter-productive. It would suggest to businesses, investors and new entrants that the executive powers of the state could take it upon themselves to re-order the division of the “pie” between actors in the economy simply because the state thinks that is for the best. Such action would also provoke – even more than is currently the case – complaints and counter complaints from firms seeking the state’s assistance with obtaining benefits for themselves.
- 1.10 It is not enough for the benefits of the CC’s intervention to stop half way down the chain of production and remain with a downstream intermediary. The central concern must be to assess detriment and benefits as they relate to the consumer. This is clear from: (i) statements of policy from the CC and European Commission; (ii) the broader landscape of UK and EU competition legislation; (iii) Parliamentary intent; and (iv) academic consensus, as detailed below.

Competition Commission and European Commission policy

- 1.11 In its consultation on reforming the UK’s competition regime, the government sought opinions on “*whether the CMA should have a clear principal competition focus?*” The CC responded that “*[t]he CMA should have the **interests of consumers at heart in its application of competition law.***”⁷ The CC recognises that consumer interests are fundamental to the application of competition law, and by logical extension, that the application of its remedies must necessarily be to the benefit of final consumers. This fundamental idea is not new to the CC, which has previously explicitly recognised that its statutory duty relates to consumers. For instance, Peter Freeman, speaking as Chairman of the CC, has made this position clear on a number of occasions:
- (a) in the context of market investigations, “*[t]he CC is under a statutory duty to achieve as comprehensive a solution as is reasonable or practicable to the AEC and/or resulting harm to **consumers.***”⁸
- (b) “*I am assuming that we all agree on the aims and objectives of a competition policy and that the contribution to economic efficiency and **consumer welfare** of markets being competitive and open is accepted and understood.*”⁹

⁷ “A Competition Regime for Growth: A Consultation on Options for Reform” – Response by the Competition Commission, 13 June 2011, available at http://www.competition-commission.org.uk/assets/competitioncommission/docs/pdf/non-inquiry/press_rel/2011/may/pdf/cc_response_competition_regime_growth.pdf.

⁸ “*The UK experience of divestment remedies in market investigations*”, Peter Freeman CBE, QC, 7 October 2010.

⁹ “*What is a competitive market? The United Kingdom experience and lessons for Hong Kong*”, Peter Freeman CBE, QC, 9 September 2010.

- (c) *"It is more important than ever to be able to show that competition authorities' activities are effective and valuable **to consumers**."*¹⁰

- 1.12 This objective is shared by the European Commission, articulated clearly by Neelie Kroes, speaking as European Commissioner for competition policy:

*"Consumer welfare is now well established as the standard the Commission applies when assessing mergers and infringements of the Treaty rules on cartels and monopolies. **Our aim is simply: to protect competition in the market as a means of enhancing consumer welfare and ensuring an efficient allocation of resources.**"*¹¹

Broader landscape of EU and UK competition legislation

- 1.13 This interpretation is consistent with other legislative provisions, such as Article 101(3) of the Treaty on the Functioning of the European Union and section 9 of the Competition Act 1998, which both refer explicitly to the requirement for "*consumers*" to receive a fair share of the benefit in order for the agreements to qualify for exemption. For context, the full text of each provision is set out below:

- 1.14 Article 101(3) TFEU:

"The provisions of paragraph 1 may, however, be declared inapplicable in the case of:

- *any agreement or category of agreements between undertakings,*
- *any decision or category of decisions by associations of undertakings,*
- *any concerted practice or category of concerted practices,*

*which contributes to improving the production or distribution of goods or to promoting technical or economic progress, **while allowing consumers a fair share of the resulting benefit**, and which does not:*

- (a) *impose on the undertakings concerned restrictions which are not indispensable to the attainment of these objectives;*
- (b) *afford such undertakings the possibility of eliminating competition in respect of a substantial part of the products in question."*

- 1.15 Section 9 CA 1998:

"This section applies to any agreement which—

(a) contributes to—

- (i) improving production or distribution, or*
- (ii) promoting technical or economic progress,*

while allowing consumers a fair share of the resulting benefit; but

(b) does not—

¹⁰ "The effectiveness of competition authorities: prioritization, market inquiries and impact", Peter Freeman, CBE, QC, 4 September 2009.

¹¹ "European Competition Policy – Delivering Better Markets and Better Choices", Neelie Kroes, 15 September 2005.

- (i) impose on the undertakings concerned restrictions which are not indispensable to the attainment of those objectives; or
- (ii) afford the undertakings concerned the possibility of eliminating competition in respect of a substantial part of the products in question.”

Parliamentary intent

1.16 It is also consistent with the intentions of Parliament when drafting the provisions on "relevant customer benefits" in section 134(8) of the Enterprise Act 2002. The debate, as recorded in Hansard, documents that the term "relevant customers" was intended to be interpreted widely to include final consumers. In discussing a proposed amendment to the s 134(8)(a) of the Enterprise Bill, Lord Hunt of Wirral stated:

“The amendment would add:

(iii) improvements to production or distribution; or

(iv) promoting technical or economic progress”

*If the Minister were to accept the amendment it would align the Enterprise Bill with the Competition Act 1998 and Article 81 of the European Community's competition law, which specifically require such benefits to be taken into account. **Without that change there is a probability that the benefits to customers will be interpreted as only the benefits to the immediate consumer and the potential benefits to customers or consumers at large will not be taken into account.**”¹²*

1.17 In response, Lord Sainsbury of Turville stated:

*“Our definition of "a relevant customer benefit", covering lower prices, higher quality or greater innovation or choice, **follows the definition used in the mergers clauses of the Bill** rather than the criteria set out in Article 81(3) of the EC treaty, also to be found in Section 9 of the Competition Act 1998, for exempting anti-competitive agreements where they bring wider economic benefits.*

***The two sets of criteria look different on paper. This is a difference primarily in perspective rather than substance. We are satisfied that in practice they will lead to the consideration of much the same issues in much the same way.**”¹³*

1.18 Parliament plainly intended benefits to final consumers to be the key metric and following this reassurance, Lord Hunt of Wirral withdrew the proposed amendment. The evidence is quite clear that the statutory intent was to ensure that the CC considered the benefits and detriment as they applied to eventual customers (i.e. consumers) – not immediate customers.

Academic consensus

¹² House of Lords Hansard, 18 Jul 2002, Column 1524, available at <http://www.publications.parliament.uk/pa/ld200102/ldhansrd/vo020718/text/20718-34.htm>.

¹³ House of Lords Hansard, 18 Jul 2002, Column 1524, available at <http://www.publications.parliament.uk/pa/ld200102/ldhansrd/vo020718/text/20718-34.htm>.

- 1.19 In the late 1960's, Bork wrote his famous article 'The Goals of Antitrust Policy' and concluded that antitrust "*statutes can be legitimately interpreted only according to the canons of consumer welfare.*"¹⁴ While there may be other legitimate objectives of competition law, a clear consensus has now emerged. In 2005, Hovenkamp wrote "*[m]ost now agree that the protection of consumer welfare should be the only goal of antitrust laws,*"¹⁵ while Whish and Bailey (2012) summarise that "*[a]s a general proposition competition law consists of rules that are intended to protect the process of competition in order to maximise consumer welfare.*"¹⁶ Thus the literature reports a consensus among antitrust scholars that consumer welfare is the appropriate standard for antitrust intervention.
- 1.20 Among academic economists, a broader perspective is sometimes debated between those who argue for a total welfare standard and those who argue for a pure consumer welfare standard; see, for example, Motta (2004).¹⁷ Reasons for such a debate can include, for example, ensuring that there are proper incentives for investment by firms under investigation: a total welfare approach very generally leads to a less interventionist policy stance because profits of firms under investigation are afforded weight, while they are not under a pure consumer welfare standard.¹⁸ However neither policy standard, and therefore no mainstream economist, would advocate pure redistribution of wealth from one firm to another – of the form defended by the CC – as a motivation for an interventionist competition policy.
- 1.21 The weight of all the evidence above demonstrates unmistakably that the prevailing view is that the objective of competition law is to protect and promote consumer welfare. It is insufficient for the CC to confer benefits on immediate customers; its assessment of the effectiveness of its remedies should focus on consumers.
- 1.22 If the CC disagrees with this and believes that it is legitimate to concern itself with conferring benefits on PMIs it should make a straightforward statement to that effect in the Final Report. If no such straightforward statement is made, we will assume the CC accepts that it may only impose remedies if they result in identifiable benefits for consumers.

The current Market Investigation

- 1.23 In the context of the statutory duty to achieve as comprehensive a solution as reasonable and practicable for customers, the focus should be primarily on the effects the remedy will have for the final consumer.

¹⁴ Bork, R H (1967) "The Goals of Antitrust Policy", *The American Economic Review*, Vol. 57, No. 2, p. 242.

¹⁵ Hovenkamp, H. (2005) "The Antitrust Enterprise: Principle and Execution".

¹⁶ Richard Whish & David Bailey, "Competition Law", Seventh Edition (2012), Oxford University Press, page 1.

¹⁷ See, for example, Motta, M. (2004) *Competition Policy: Theory and Practice*. Cambridge University Press, UK, in particular pages 20-22.

¹⁸ In attempting to reconcile the difference, some economists note that in the long run the difference between the approaches can be overstated as economic profits may be competed away and, if they are, there is no difference between these two policy objectives.

- 1.24 In the present market investigation an analysis of pass through will therefore be required if the CC is to make any assessment of the consumer detriment it claims currently exists. A letter from the Treasury Solicitor to the Competition Appeal Tribunal dated 7 October 2013, admits that “[the CC] nevertheless recognises that the level of such **consumer detriment will depend in part on the extent to which any reductions in insured prices would be passed through to consumers.** This is an issue which the CC will be considering as part of the remedies phase of its investigation.”¹⁹
- 1.25 The Treasury Solicitor recognised the reality that consumer benefits and detriment are the concern, not only as a matter of policy, but also in the context of the current market investigation, and that an analysis of pass through is required to inform its assessment of the effectiveness of its remedies. To the extent that the CC is unable to rationally conclude on the basis of full and proper consideration of the evidence that its intervention will alleviate detriment suffered by final consumers it will have failed to comply with its statutory duty.

2. Full and Proper Assessment of Consumer Benefit / Detriment

- 2.1 The importance of ensuring benefits reach final consumers is heightened in the current market investigation due to the unusual features of the market and the CC’s decision not to seek a variation to the terms of reference to include PMIs.²⁰
- 2.2 The CC identified two structural features of the market, high barriers to entry and weak competitive constraints in many local markets. In respect of both it found these features were likely to lead to higher prices for self-pay patients **and** higher prices to insured patients by those operators with market power opposite insurers, including BMI. It made no attempt to assess the AECs on the basis of service quality and innovation. As such the CC can come to no reasonable evidence-based view on the likelihood that the structural features identified lead to adverse effects on quality. Indeed the only empirical evidence before the CC relating to quality is the study undertaken by Dr Peter Davis on solus hospitals. The evidence from this study showed no difference in quality outcomes for solus hospitals (i.e. those facing comparatively low local competition) versus other BMI hospitals.
- 2.3 Hospitals interact directly with consumers in that they provide services directly to them – much like a retailer does. Consumers therefore benefit directly from higher quality services and service innovation offered by hospitals.
- 2.4 Hospitals are unusual however, in that unlike most industries, the consumer often does not pay for the service directly. Therefore, while private patients are treated directly at a hospital, for the vast majority of these patients – representing [X] of BMI hospital revenues – a financial intermediary pays for the service on the patient’s behalf. In the majority of cases, representing [X] of revenues, this is done by an insurer. The insurer’s incentives are plainly not therefore aligned with the patient’s. An insurer’s primary goal is to make profits (which are basically the difference between costs paid to hospitals and consultants and income received from policyholders). An insurer therefore is incentivised to reduce both the rate of claim

¹⁹ Letter from treasury Solicitors to Competition Appeals Tribunal dated 7 October 2013, paragraph 33.

²⁰ BMI requested a variation of the terms of reference to include the PMI market in its response to the Issues Statement, 23 July 2012, paragraph 2.3(c).

and the costs of claim. One of these is potentially in patients' interests (reducing costs) but only if these cost reductions: (i) do not adversely affect the quality of the service that the patient has paid for; and (ii) are passed on to the patients. Insurers' incentives to reduce rate of claim act directly against patients' interests by reducing the 'volume' or 'type' of benefit patients receive. There is a huge volume of evidence about the techniques PMIs use to place barriers in the way of consumers accessing the benefits paid for. These include:²¹

- (a) Outpatient claim limits;
- (b) Pre-authorisation (and sometimes cumbersome) requirements;
- (c) GP referral requirements;
- (d) Hospital and consultant networks;
- (e) Large numbers of excluded conditions (maternity, psychiatric, chronic illness, emergency care, any pre-existing conditions, etc.);
- (f) Annual excesses; and
- (g) Refusal to allow policyholders to pay 'top-up' fees (or co-payment) to see the consultant of their choice.

2.5 The combined effect of these techniques is to reduce access and impose barriers to patients seeking access to their policy benefits – i.e. they make claiming more difficult, inconvenient and costly for patients and hence reduce the rate of claim. The PMIs act in their own interests. That is not a criticism – merely a statement of fact. They are not consumers and they are not agents for consumers.²²

2.6 Further, in cases representing [~~8~~] of revenues, the service is paid for by the NHS. It is common ground that BMI is a price taker in respect of NHS workload. No price effect (benefit or detriment) will be felt as a result of the CC intervention for these consumers.

2.7 Hospital prices therefore only have the potential to result in **indirect** consumer detriment or benefit via PMIs. The CC notes there are exceptions to this, such as self-pay, corporate trusts²³ and those insured patients that are allowed to make co-

²¹ The CC has acknowledged the large body of complaints on these issues in its "*Summary of consultant and trade body/professional association submissions by theme*", Appendix 7.3 to the Provisional Findings. We note many of these concerns have been voiced direct by patients. The Private Patients' Forum highlighted some of these specific issues on a number of occasions (see letters dated 20 September 2013, 3 December 2013 and 5 February 2014), and noted that "*almost all the complaints received through the PPF website have involved patient problems with PMIs as premiums rise inexorably and patient choice is diminished*" (letter dated 3 December 2013).

²² We note in this regard the submissions from the Private Patients' Forum. See, for example, its letter dated 3 December 2013, which states: "*[Private Patients' Forum] has always contended that insurers have a very significant effect on patient benefit in the use of private healthcare which does not always operate in the interests of patients. This should, in our view, have been a whole market investigation.*"

²³ Although BMI notes that corporate trusts pay the price negotiated between the hospital and the insurer plus an additional negotiated margin, meaning that 100 per cent pass through is not (at least as a matter of principle) immediate.

payments under their policy terms, however these form a minority of the market (as implicitly acknowledged by the CC²⁴).

- 2.8 Hospital quality has the potential to result in **direct** consumer detriment or benefit.
- 2.9 The CC in seeking to establish what effect the AEC and proposed remedies have on consumers could have focussed on either price or quality, or both. The CC chose price. As noted above, there has been no work done to establish whether the structural AEC has any effects on quality. It is impossible therefore for the divestment remedies to be motivated by purported consumer benefit in respect of quality. The CC's claim that "*any quality or innovation benefits would accrue directly to the patients treated at these facilities, whether self-pay, insured or NHS*"²⁵ is correct as a theoretical statement but does not replace evidence-led assessment of what such benefits might be and whether any detriment is suffered in the first place.
- 2.10 Having focussed on price effects, the CC must acknowledge that these are primarily indirect in their effect on consumers. Any examination of the consumer benefit or detriment for intervention must consider the extent to which such price effects reach final consumers through the relevant intermediaries. That assessment will need to include the reality that insurers act in their own interests, not those of patients. Hence why pass through becomes so important.
- 2.11 In *Tesco v Competition Commission*,²⁶ Tesco successfully argued that the CC had failed both to: (i) make any assessment of the possible benefits to consumers; and (ii) properly take into account and to evaluate certain detrimental effects to consumers, which would result from the application of the CC's remedial 'competition test'.²⁷ Tesco submitted that by failing to carry out a cost-benefit analysis, the CC was not in a position to decide the questions contained in section 134 of the Act.²⁸
- 2.12 The Competition Appeals Tribunal agreed, concluding that, while the CC has a margin of appreciation to decide what methodology it uses to investigate and estimate that various factors which fall to be considered in a proportionality analysis (including the effectiveness of any proposed remedies), "*[u]ltimately the Commission must do what is necessary to put itself into a position properly to decide the statutory questions.*"²⁹ The CC had failed in this duty, the CAT noted:

*"the Commission seems simply to have based its proportionality assessment on an assumption that the whole of the estimated customer detriment would be remedied by the test, in combination with the other remedies (see paragraph [140] above). There is in the Report no recognition or weighing of the now-acknowledged possibility that the existing AEC might not be satisfactorily remedied."*³⁰

²⁴ Provisional Decision on Remedies, Section 2, paragraph 2.74.

²⁵ Provisional Decision on Remedies, Section 2, paragraph 2.73.

²⁶ (2009), CAT 6.

²⁷ (2009), CAT 6, paragraph 129.

²⁸ (2009), CAT 6, paragraph 132.

²⁹ (2009), CAT 6, paragraph 139.

³⁰ (2009), CAT 6, paragraph 162.

- 2.13 The CC has made a similarly fatal omission in the present investigation by failing to conduct a proper evaluation of pass through. Such an analysis is essential for the CC to properly consider whether its proposed remedies will have the effect of enhancing consumer welfare, as recognised in the 7 October 2013 letter from the Treasury Solicitor detailed in paragraph 1.24 above. The CC has had both the time and resources to conduct a proper analysis, yet it instead merely assumes any benefits resulting from its proposed remedies will flow through to consumers without any evidential basis. Without due investigation and analysis of this important consideration, the CC's assessment of the impact of its proposed remedies on consumers is clearly deficient.
- 2.14 For the CC to justify remedies as drastic as the divestments it has proposed, its analysis must also satisfy the "double proportionality" standard as laid down by the CAT in *Tesco v Competition Commission*.³¹ Clearly the assessment to date is wholly inadequate to satisfy the CC's legal obligations in this regard.

3. Failure to Assess Pass Through Sufficiently

- 3.1 Consumers will not benefit from the price effects the CC claims its divestments will achieve if insurers do not pass through these savings. The CC must therefore have a rational evidence-based belief based on full and proper assessment of the evidence that benefits will be passed through to consumers, otherwise there is no basis on which it can claim the remedies will be effective.
- 3.2 Empirically, one way to evaluate pass-through would include consideration of the way in which significant movements in upstream prices translated into downstream price changes. Here for example one could examine the impact of significant changes in contractual arrangements between hospitals and insurers on downstream PMI prices. To establish a degree of pass-through one would hope to observe that retail prices moved following the direction of change in upstream or wholesale prices.
- 3.3 Such an evaluation could also potentially take place using the assumptions embedded in strategic pricing decision documents that PMIs generated in the ordinary course of business. Such documents could be available following a negotiation with (say) BMI which led to a cost reduction for a PMI and contemplate the degree to which PMI prices should be cut. Ideally such documents would provide the basis for actual decisions about PMI prices that have been taken by the PMI in the ordinary course of business. Of course the absence of such a decision to cut prices following clearly demonstrable declines in costs may also be informative – suggesting that cost reductions were not passed on in the form of lower PMI prices.
- 3.4 The CC has failed to give this issue due or indeed any material consideration. At the time of the abovementioned letter from the Treasury Solicitor, it was stated that "*the CC does not currently envisage a detailed empirical or quantitative analysis of the extent of pass through, nor does it have the data which would be required for such an analysis.*"³² This is despite the fact that this analysis should have been front and

³¹ (2009), CAT 6, paragraph 139, "*it may well be sensible for the Commission to apply a 'double proportionality' approach: for example, the more important a particular factor seems to be in the overall proportionality assessment, or the more intrusive, uncertain in its effect, or wide-reaching a proposed remedy is likely to prove, the more detailed or deeper the investigation of the factor in question may need to be.*"

³² Letter from treasury Solicitors to Competition Appeals Tribunal dated 7 October 2013, paragraph 34.

centre of the analysis of the effectiveness of the remedies. It is obviously not enough for the CC armed as it is with statutory evidence-gathering powers to simply state it does not have the relevant data. The CC has collected vast quantities of data throughout the course of this investigation and has statutory powers to compel parties to provide it with such data it requires to conduct its analysis under section 109 EA 2002. The CC had both the time and resources to conduct this analysis, the importance of which BMI has made clear.³³ Treasury Solicitor did however state that “[t]he most pertinent evidence the CC has is evidence requested from the insurers on the interrelationship between their prices and the prices charged to them by hospital operators, which the CC will review.”³⁴ This has not yet happened. The CC has not conducted even this minimal level of analysis on the level of pass-through to patients. To this end, BMI conducted, and submitted to the CC, its own comparison of BMI revenue against the average price of private medical cover.³⁵ This initial assessment showed a widening gap, with insurance increasing at a greater rate than BMI's prices. This is inconsistent with the notion of PMIs passing on the discounts they extract from hospitals to patients. Something was driving PMI prices higher – but it was not BMI's charges.

[REDACTED]

- 3.5 A further problem created by the CC, by not bringing the PMI market within the scope of the investigation, is that it has conducted no financial analysis with respect to the PMI industry. There may well be excess profits being made by PMIs above even the levels the CC has incorrectly attributed to certain private hospital operators. The CC has no idea whether any price benefits arising to PMIs as a result of its proposed remedies, which are not passed on to patients, will potentially serve only to increase excess profits already being made by some PMIs.
- 3.6 There is other evidence – summarised below – to suggest that pass through would be low.

PMIs will not conduct local tenders

- 3.7 The CC anticipates divestitures enabling insurers to achieve lower prices in local ‘cluster’ areas. To realise lower prices from divestitures, the CC relies on insurers conducting local tenders to drive competition between the hospitals for network recognition. Currently, AXA PPP is the only insurer that undertakes local tendering in this way. Bupa has told the CC that it would be prepared to conduct local tendering. However, BMI notes that not only has Bupa never done so in nearly 30 years of commercial negotiations with BMI, [REDACTED].³⁶
- 3.8 Furthermore, many smaller insurers with less countervailing buyer power (i.e. those which might benefit most from the remedy) have opposed the CC's Remedy 2b – that would have entailed local tendering – on the basis that the transaction costs would be excessive. If PMIs thought that the additional discount from BMI would

³³ BMI Response to Provisional Findings, 11 November 2013, paragraphs 2.5.8 to 2.5.10.

³⁴ Letter from treasury Solicitors to Competition Appeals Tribunal dated 7 October 2013, paragraph 34.

³⁵ BMI's analysis is based on PMI prices from Lang & Buisson 2013 (Table 1.11) plotted against BMI revenues from insured patients divided by the volume of insured patients.

³⁶ [REDACTED].

compensate for these costs they would have every incentive to support the remedy as they would be net beneficiaries. This also accords with the experience of AXA PPP, which has not (with some local exceptions) repeated the regional tender exercise conducted in the 1990s due to significant time and costs entailed.

3.9 PruHealth explained that:

“[t]he introduction of multiple tariff negotiations would require an increase in resources (i.e. staffing both at insurer and provider) – and impact most at the smaller insurers, with restricted resources and limited budgets,” before concluding *“...PruHealth believes that this remedy is onerous, in addition to the above, significant system development work would be required to modify the claims system.”*³⁷

3.10 Simplyhealth is equally dismissive of the idea that local tendering is a credible option for the smaller insurers, stating that such a remedy:

*“would be not a practicable option for any other than the two largest PMIs in the market. The scale and complexity involved with hospitals being priced separately ensure that this remedy is not economically sustainable. The immediate consequence, for most PMI providers, would be that significantly higher investments would have to be made into the work force and systems, in order to cope with the increased workload. Simplyhealth believes that the effect on competition would, accordingly, be detrimental, as some providers might have to leave the market altogether, with the consequence that consumer choice would be reduced.”*³⁸

Pass through would be less likely if the majority of PMIs do not conduct local tenders

3.11 If only one or two large or medium-sized insurers operate local tendering there is little reason to believe that they should be expected to pass on all or most of the resulting price benefits to consumers. Discounts to large or medium sized insurers will not affect the costs of smaller PMIs whose costs will be important determinants of market prices for PMI.³⁹

PMIs with relatively greater or full countervailing buyer power would realise smaller or no price benefits from divestitures

³⁷ PruHealth response to Provisional Findings and Remedies Notice, page 8.

³⁸ Simplyhealth response to Provisional Findings, pages 6-7.

³⁹ The analogous position is recognised by the European Commission in its guidance on quantification of damages caused by upstream cartels where a key issue is pass-on. Specifically, the Commission considers that pass-on will normally be zero or only “very limited” when a downstream firm is subject to a cost increase (in that case from a cartel) but his rival downstream firms are not subject to the same cost increase. Specifically, the Commission write: “169. *Where the direct customer of the infringing undertakings uses the cartelised goods to compete in a downstream market, it is likely that the direct customer will normally not be able to pass on this increase in cost (or only to a very limited degree) if his own competitors in that downstream market are not subject to the same or a similar overcharge (for example, where they receive their input from a market that is not subject to the cartel).*” Source:

http://ec.europa.eu/competition/antitrust/actionsdamages/quantification_guide_en.pdf.

- 3.12 Indeed, if the insurers that do decide to use local tendering are AXA PPP and Bupa, these insurers already benefit from countervailing buyer power. Even if the CC is correct that divestments will result in lower prices (which they will not), AXA PPP and Bupa prices will fall by a smaller amount – and in Bupa's case by nothing at all – than PMIs without buyer power.

PMIs do not anticipate lowering premiums

- 3.13 Insurers have also commented that the divestment remedy will not result in lower premia for their policyholders. Aviva has stated that it “*does not believe that there is likely to be an immediate effect on prices as a result of the changed competitive dynamic from the proposals*”⁴⁰ – yet this is exactly what the CC’s divestitures are designed to achieve; it is why the CC favours divestiture over information remedies in cluster areas,⁴¹ and the CC states “*divestiture remedies can generally be expected to address the AEC identified (and the customer detriment arising) in a timely manner*”.⁴² Bupa has made a similar statement; that consumers are unlikely to benefit from the CC’s intervention through lower premiums. Speaking to the Financial Times, Bupa CEO Stuart Fletcher said “*It will make a significant difference, but it’s not the only driver*” ... “*I don’t think we’re going to see a reduction in premiums.*”⁴³
- 3.14 The CC is relying on insurers passing on to patients savings it says will come from hospital divestments. We have set out above direct evidence from the insurers on which the CC relies (including the dominant firm Bupa) that premiums to consumers will not be lowered. The CC cannot ignore the doubt this casts on the effectiveness of pass through of price benefits from divestitures.

[REDACTED]

- 3.15 [REDACTED]:

[REDACTED].⁴⁴

- 3.16 [REDACTED]:

[REDACTED].⁴⁵

- 3.17 [REDACTED]:

- [REDACTED].⁴⁶

⁴⁰ Aviva Health UK Response to PFs and Possible Remedies, page 4.

⁴¹ “[W]e did not think that this customer response would be sufficiently strong within the foreseeable future to address substantially the AECs identified in local markets” – Provisional Decision on Remedies, Section 2, paragraph 2.59.

⁴² Provisional Decision on Remedies, Section 2, paragraph 2.53.

⁴³ “Bupa examines single-condition policies to reverse patient exodus” – Financial Times, 26 January 2014.

⁴⁴ [REDACTED].

⁴⁵ [REDACTED].

3.18 [REDACTED]:

[REDACTED].⁴⁷

3.19 [REDACTED]:

[REDACTED].⁴⁸

3.20 [REDACTED].

3.21 [REDACTED].

PMIs would incur significant costs conducting local tenders

3.22 The costs of a local tender would need to be netted out of the benefit that could be passed through. BMI estimates that a single local tendering exercise involving one insurer and two hospital chains in a single cluster would involve expenditure of at least [REDACTED]. The CC could and should have collected evidence of such costs. To keep the calculation simple, suppose that such tenders occurred once every three years and that we can therefore think of the average cost as [REDACTED] per cluster area per year. This would then correspond to a discounted net present value of economic cost over 20 years at a 3.5% discount rate of around [REDACTED]⁴⁹ in a single cluster, a total of 7 times [REDACTED], or approximately [REDACTED] in real economic costs across the 7 divested hospitals. Of course, if more than one insurance company used local contracting or more than two hospitals bid for the work, then the costs of local tendering would multiply accordingly.

3.23 These costs are obviously significant and real. They were the reason why the insurers rejected Remedy 2b – a remedy the CC originally conceived to help the PMIs.

3.24 The CC's statutory obligations to properly assess the impact of its remedies on *consumers* plainly have not been satisfied. In the vast majority of cases, hospital prices – the focus of the CC's analysis – only have the potential to bring about indirect benefits for patients. The CC has thus far failed to conduct an evidence-based assessment of pass through; without which it has no rational basis on which to claim its remedies will be effective in conferring benefits to consumers.

⁴⁶ [REDACTED].

⁴⁷ [REDACTED].

⁴⁸ [REDACTED].

⁴⁹ Note that the NPV of a [REDACTED] per annum cost for 20 years at a discount rate of 3.5% is approximately [REDACTED].