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By Email

9 March 2015

Dear Lara

Private healthcare market investigation remittal

Further to your letter of 23 February 2015 to Fergus Craig, I am writing on behalf of AXA PPP healthcare Ltd (AXA PPP).

AXA PPP welcomes the opportunity to make preliminary remarks to the CMA in advance of publication of the likely two-stage consultation process to be set out in the forthcoming administrative timetable.

AXA PPP notes that during the initial phase of the remittal the CMA intends to focus on the reconsideration of the insured pricing analysis (IPA) to remedy the failure to consult. For the reasons set out below, AXA PPP believes that (leaving aside the IPA) the CMA's relevant original reasoning and evidence in its Report supports a fresh "insured AEC" decision[1] and is supported, and in no way undermined, by developments since the CMA's Report of 2 April 2014 (the Report). Accordingly, and in any event, as set out in the conclusion to this letter, we do not believe that it is necessary for any revised, corrected or "new" IPA to form a critical part of the reasoning for any new insured AEC decision.

AXA PPP summarises below its view of the current market conditions in Central London, including a number of developments since the Report.

Central London market features continue to give rise to an insured AEC

The CMA identified two key features giving rise to (an) insured AEC(s)[2] in central London, namely: (1) high barriers to entry and expansion; and (2) weak competitive constraints exerted on the main

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1 This letter uses this same "insured AEC" abbreviation as used in the CAT judgment ([2014] CAT 23) and remittal order in respect of the CMA's original finding in the Report of an adverse effect on competition (AEC) for privately-insured patients in central London.

2 AXA PPP supports the CMA's conclusion in the Report that the various specialties within hospital services in central London are separate product markets, and that "hospital services" is an umbrella or basket term used given that HCA (and other hospital groups) bargain with private medical insurers (PMIs) over the bundle of such services; as such, the CMA's original finding of a single overall AEC reflects a bundle, with HCA having market power in each of several distinct specialty markets. It was and remains open to the CMA to reach a new finding of an overall insured AEC across the bundle of hospital services given the nature of HCA/PMI bargaining. Alternatively, it would equally be open to the CMA on remittal to find separate (i.e., multiple) insured AECs concerning each respective specialty market embedded in the bundle. AXA PPP had no difficulty with the CMA's

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incumbent, HCA. As described further below, these features remain present across each specialty-based product market (and are particularly acute in respect of the complex specialties of oncology and cardiology). In terms of considering the insured AEC question afresh, it would assist all parties if the CMA could provide further clarity that its AEC analysis of the hospital services bundle incorporates market power (or high barriers to entry and weak competitive constraints) in relation to separate specialty markets. The IPA and other evidence should also be considered in this light.

(i) ***Barriers to entry and expansion remain particularly high, especially for oncology.***

Despite claims of HCA to the contrary (§§6.63 ff of the Report), there has been little expansion and development in central London with the exception of The London Clinic (TLC) and the PPU contracts won by HCA. HCA previously provided the London International Hospital as an example of a planned new entry in 2014 and claimed that both Spire and Nuffield are looking to expand and develop facilities in Central London,[3] but to the best of AXA PPP's knowledge no development has yet taken place in relation to these sites. The apparent inconsistency between the size and attractiveness of the London market and the lack of entry/expansion continues to indicate that there are significant barriers to entry or expansion in London.

In relation to oncology, as noted by the CMA, cancer services are a priority driver for PMI, reflected in HCA's Cancer Strategy document showing that 91% of people gave cancer as their main reason for taking out PMI (Report, Appendix 6.2, §60). Barriers to entry remain particularly high for radiotherapy services given the nature and size of the equipment involved. In particular, a linear accelerator (a necessary piece of equipment for any fully-functional cancer unit) requires a specially-designed vault or bunker with walls, floor and ceiling of lead and concrete of up to 3 metres thick. Such vaults or bunkers can weigh around 1000 tons and represent a major challenge in an existing building, which is why they are often sited underground or in a separate, purpose-built facility. This requires a suitable site to be found, with planning permission and other regulatory approvals to be obtained, as well as the necessary building works being completed and TLC will confirm that this is why launch of its Cancer Centre was as costly and took the time that it did.

(ii) ***HCA continues to face weak competitive constraints, especially in oncology.*** In AXA PPP's view, the aggregated and disaggregated share analysis summarised in §§6.204 ff of the Report remains broadly accurate, save that in some respects HCA's position has strengthened. In particular:

(a) HCA retains a very high market share in the complex specialties of oncology and cardiology (as noted in §§43-44 of Appendix 6(1) of the Report, HCA has a share of over 60% in both) as well as a high share of overall supply and capacity across hospital services in central London.

(b) HCA is actively marketing a new radiotherapy facility, the London Radiotherapy Centre, at Guy's and St Thomas' Hospital (GST) (in addition to the ongoing development of the private patients unit (PPU) at GST which remains scheduled to open during 2016). The London Radiotherapy Clinic is being marketed as a brand new purpose-built centre which offers comprehensive and sophisticated radiotherapy planning and treatment on one site.

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relevant AEC analysis in the Report as such but – as the CMA is aware from Grounds 1-2 of AXA PPP's Notice of Application – the basket approach does not obviate the need to arrive at a suitable remedy that effectively removes HCA's market power in respect of each relevant specialty, and in particular critical specialities such as oncology (and cardiology), not only to solve the competition problem for that specialty market but for the overall AEC across the bundle of services as a whole.

[3] See §§6.63-6.64 of the Report.

The centre also offers direct access to the London Bridge Hospital (described by the London Radiotherapy Centre as its "sister site") for in-patient and day case facilities if needed by radiotherapy patients.

(c) HCA has further expanded its capacity with the opening of new outpatient facilities at the Shard (thus freeing up capacity at the London Bridge hospital).

(d) As set out in our letter to the CMA of 25 November 2014, we also understand that HCA is the only bidder remaining in a tender process to operate a new PPU at St George's Hospital, which raises competition concerns for the reasons set out in that letter.[4]

(e) AXA PPP also believes that HCA has continued to acquire consultant practices, thus further strengthening the vertical integration between HCA and certain GP practices, and further strengthening its position relative to its competitors.

(iii) ***Given the above, PMIs corporate policies must still include HCA.*** Given the continued asymmetric structure of supply in Central London, AXA PPP cannot sell a credible PMI offer to corporate customers that excludes over 60% of Central London supply, not only of cardiology, but of oncology, a service that (as noted above) is the main reason that customers seek PMI cover. Accordingly, the must-have status of HCA's network remains to create an imbalance of negotiating power between AXA PPP and HCA, which HCA is able to exploit in pricing negotiations (as AXA PPP is not an unavoidable contracting partner for HCA). This imbalance is even more acute in relation to oncology, since episode costs are much larger than most other treatments and demand is high, as are barriers to entry. Our previous evidence in this respect remains valid (see e.g. AXA PPP Response Prior to the Provisional Findings of 21 June 2013 and AXA PPP Response to the Issues Statement).

The AEC analysis is powerfully supported by the fact that HCA earns returns substantially and persistently in excess of its cost of capital

As the CMA noted in the Report (§6.441), an "*important indicator*" of competition in a market is the level of profits of the firms involved. The CMA previously assessed the profitability of HCA and concluded that it had been earning "returns *substantially and persistently in excess of the cost of capital*" (Report, §6.491 and cf. CC3, §§118-19). The CMA confirmed that its finding of excess profitability "suggests that the price of private healthcare services may be high in relation to the costs incurred by private hospital operators in providing those services, and thus higher than we would expect to find in a competitive market" (Report, §6.476). The CMA also estimated consumer detriment resulting from the market power of HCA, Spire and BMI to be in the region of £155 million - £174 million per year on a conservative basis.

In AXA PPP's view, profitability levels remain a compelling indicator of market power and a finding of excess profitability is more than sufficient to support the analysis of market features establishing an overall insured AEC (or, alternatively, in AECs in several specialties). The Report's emphasis in this regard is wholly consistent with CC3 which describes profitability as a "fuller analysis" (cf. CC3, §112) than simply looking at prices or indeed prices and cost, e.g. via cost-price margins (*ibid*, §111-12) in assessing competitive intensity.

AXA PPP is not aware of any material change in circumstances that is likely to have reduced HCA's profit levels. As the CMA will recall, HCA argued in 2013 that results generated by the CMA's profitability analysis were overstated, and that the correct approach was to take the residential value of its land into

[4] St George's NHS Trust covers all major specialities with particular focus on paediatrics, orthopaedics and trauma, cardiothoracic, obstetrics and neurology services, so we would expect HCA to develop services in these specialities, further strengthening its dominant position in high acuity treatments, cardiothoracics and obstetrics.

account rather than the commercial value. AXA PPP remains strongly of the view that HCA's arguments in this respect were unfounded, and would refer the CMA to its submissions of 12 December 2013, 27 January 2014 and 6 March 2014.

Significance of IPA evidence for the new insured AEC analysis

As far as the original insured AEC decision is concerned, AXA PPP notes that the IPA was treated by the CMA in the litigation as a "critical part" of the reasoning supporting the original insured AEC decision (see CAT judgment, §3). While AXA PPP supports consultation on the IPA, which is useful to the proportionality assessment of the CMA's remedy, having established an adverse effect on competition (AEC) (cf. CC3, §351), we do not believe that it is necessary for any revised, corrected or "new" IPA to form a critical part of the reasoning for any new insured AEC decision, for the following reasons:

(i) The original insured AEC decision has been quashed and the IPA is acknowledged to contain errors whose significance will be examined on remittal. The CAT was clear that it was for the CMA itself to determine, in considering the insured AEC question afresh, the scope and course of the remittal without any blessing or direction from the CAT (cf. the terms of the remittal order and the CAT Transcript, pp. 67-69). There is, therefore, nothing to prevent the CMA from considering afresh the weight that it might attach to IPA evidence relative to the other evidence before it.

(ii) The CMA's guidelines are clear that pricing evidence such as the IPA is an "indicator" not a "feature" of the market giving rise to the AEC itself and "do[es] not on [its] own provide conclusive evidence" (cf. CC3, §126), while "prices and costs are not the sole indicators" of competitive intensity (CC3, §127). Just as positive evidence on indicators is not dispositive of an AEC, contested, questionable (or even a lack of any) evidence on a particular indicator is equally not dispositive *against* an AEC finding (cf. *ibid*).

(iii) As noted above, the CMA identified two *features* supporting the insured AEC in central London, namely (1) high barriers to entry and expansion; and (2) weak competitive constraints exerted on the main incumbent, HCA, and an important evidence base supporting this assessment is PMI evidence including from AXA PPP that it cannot threaten to delist HCA hospitals due to HCA's market power or must-have status. These findings remain valid, and (as also set out above) are reinforced by market developments since the publication of the Report in April 2014.

(iv) The CMA's robust analysis and evidence on features is supported by the "important indicator" of HCA's "returns substantially and persistently in excess of the cost of capital" (Report, §6.491).

(v) The above features, supported by the indicator of excess profitability, taken together, clearly support (a) fresh insured AEC decision(s).

In summary, the fact that the IPA was complex to run and assumed great procedural significance in the investigation and litigation phases does not alter the fact that, while evidencing higher prices may be sufficient to establish an AEC, it is *not* a necessary condition for a new AEC finding under s134(1) of the Enterprise Act 2002 (Act). Whatever the CMA may make of the IPA in any revised form, it should make this point clear and consistent with CC3 guidance (which is in turn consistent with the statutory distinction between market features and (adverse) outcomes in s134(1) and (4) of the Act).

AXA PPP would therefore strongly contest that revisions to the IPA (and/or other alleged material changes of circumstance) now make an overall insured AEC finding in central London unsustainable on remittal. Finally, we note that even if contrary to the above, the CMA were ultimately to be in two minds as to an overall AEC finding, the compelling evidence of weak competitive constraints on HCA, protected by high

barriers to entry and expansion, leaves no room for doubt that the CMA should, under any conceivable circumstance, find an AEC in relation to HCA's dominance of the oncology market in central London.

Yours sincerely

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Partner