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SENT BY EMAIL AND COURIER

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Dear Ms Stoimenova

Response to IPA Working Paper

1. Following the disclosure of the IPA in the disclosure room, we enclose two papers which are subject to confidentiality ring 1:

   (i) KPMG's Data Room Report which sets out the findings of HCA's advisory team on the CMA's pricing analysis; and

   (ii) KPMG's analysis of spare inpatient capacity in central London based on the data provided in the disclosure room.

Data Room Report

2. KPMG has demonstrated in its Data Room Report that there is no foundation for the CMA's allegation in the IPA Working Paper that "*HCA, on average, charges a higher price than TLC, taking into account different factors, and regression specifications, that might influence the price difference.*"[1]

3. The Tribunal noted in the recent judicial review proceedings that, given the weight which the CMA was placing on the IPA for its AEC findings, it is important "*to be able to examine carefully … whether – in constructing the IPA – prices have been correctly measured and the comparison has been performed on a suitable like-for-like basis.*"[2] In the light of KPMG's findings in the Data Room Report, the CMA cannot reasonably sustain its conclusion that, on a like-for-like comparison of prices, HCA charges higher prices than other hospital operators in London.

Line item analysis

4. KPMG's analysis of the Healthcode data provided in the disclosure room indicates that the information which is available in the data about the individual items of treatments and services provided to a patient within any given episode (the "line item" data) fully supports HCA's contention that on average HCA treats higher-complexity patients than TLC. An analysis of

[1] IPA Working Paper, paragraph 169.
[2] Ruling, 25 July 2014, paragraph 37.

individual line items in the invoices captures the difference in the individual treatments given to different patients which reflects differing patient needs, complexities and comorbidities. The Data Room Report demonstrates (Section 4) that once these differences in patient complexity are accounted for, there is no significant difference in the prices of HCA and TLC. This conclusion comprehensively undermines the principal empirical finding underpinning the IPA.

5. HCA has consistently argued that, because of its focus on high-acuity, higher-complexity treatments, and because of the more extensive clinical infrastructure which its hospitals provide, HCA attracts patients with more complex conditions and comorbidities. HCA has pointed out in previous submissions that any comparison of prices must take account of systematic differences between HCA and other operators in patient complexity, quality and scope of services. The CMA however has rejected these arguments without properly considering them. The CMA's position is that the Healthcode data does not readily provide any information on a patient's health status, and so it had no basis for testing this submission. Hence, the CMA argued in the recent judicial review proceedings: "*In any event, the data available to the CMA did not allow it to directly observe differences between patients on the basis of their underlying conditions (see Appendix 6.12, footnote 8), and that is a further reason why it would be reasonable for the CMA to approach the matter in which it did"* (sic).[3]

6. Even if the CMA were correct in this (which it is not), it does not follow that the CMA is justified in ignoring the impact of other variables in the pricing analysis merely on the grounds that the data does not capture this information. As the Data Room Report indicates, the R^2 results reported in the IPA Working Paper show that in nearly one-third of the regressions, the R^2 statistics were less than 50%. These results in and of themselves create serious doubts over the CMA's claims that age, gender and length of stay explain the price variations. At the very least, these results impose an obligation on the CMA to consider carefully and test what other factors are driving the price differences. The Tribunal specifically raised the prospect that if the "*R^2 point*" (i.e. the fact that the CMA had systematically over-estimated the R^2 levels it reported) were borne out "*the IPA could not properly be relied upon as a basis for any insured AEC decision or as a basis for any divestment decision."*[4]

7. In any event, as KPMG has explained in the Data Room Report, the CMA's claim – that the data does not allow it to observe any differences in patient complexity or conditions - is simply incorrect. It was, and is, open to the CMA to use the line item data to conduct a like-for-like comparison of the treatments received by HCA and TLC patients. Once the variables in the line item data – reflecting differences in the treatment and service-mix provided to patients – are taken into account, there is no significant price difference between HCA and TLC.

8. As you are aware, HCA requested disclosure of the correspondence between the CMA and Healthcode so that (amongst other things) it could better understand the reasons why the CMA had previously failed to conduct a line item analysis. The CMA rejected HCA's request for disclosure without proper justification. [✂]

9. In short, a proper analysis of the data available to the CMA to control for episode complexity demonstrates that there is no difference in the insured prices between HCA and TLC. As a result, the core conclusion reached in the IPA Working Paper cannot be maintained.

[3] CMA Defence of 12 August 2014, paragraph 187.
[4] Ruling, 23 December 2014, paragraph 12.

Other flaws in the IPA

10. Furthermore, and quite apart from the CMA's failure to carry out a line item analysis, the Data Room Report also identifies (Section 3) serious technical and methodological flaws in the CMA's analysis of insured prices:

    - There are a very limited number of CCSDs which drive the price differences estimated by the CMA. [✂]. These [✂] represented only [✂]% of HCA's revenues. There is no statistically significant price difference once these CCSD codes are removed, calling into question any extrapolation of the price difference estimated by the CMA to HCA as a whole. Based on [✂], the CMA cannot reasonably conclude that HCA on average charges higher prices than TLC.
    - The regression approach adopted by the CMA as a robustness check to their main analysis fails standard econometric tests on the validity of its underlying assumptions, showing that it its results cannot be relied on.

Effects on CMA's findings

11. In the 2014 Report, the CMA found that there were two structural features of the market in private healthcare in the UK: high barriers to entry and expansion; and weak competitive constraints. The CMA concluded that these structural features gave rise to AECs which lead to higher prices being charged by HCA to PMIs within central London. The CMA also concluded there was insufficient evidence that these structural features lead to higher prices being charged by BMI, Spire and Nuffield to PMIs outside central London. On the basis of these conclusions, the CMA made AEC findings, and imposed a divestment remedy against HCA in respect of central London, and not against any operators outside central London.

12. As set out in HCA's submission of 1 May 2015, HCA strongly disputes the CMA's findings as to the existence of high barriers to entry and expansion and weak competitive constraints in central London. However, even if these findings are correct, the CMA's assertion that these features give rise to higher insured prices in central London is wholly unfounded and in consequence the CMA cannot maintain its AEC findings in relation to insured patients or its divestment remedy in respect of HCA.

Spare capacity

13. In the 2014 Report, the CMA argued that there was insufficient non-HCA capacity available in central London to allow PMIs to switch their subscribers to alternative facilities and that this gave HCA negotiating power against PMIs. The CMA noted that "*The key factor in determining the effectiveness of a divestiture remedy would be ensuring that non-HCA hospitals are able to absorb insurers' volumes currently treated at HCA hospitals across the full range of specialities*".[5]

14. HCA has consistently submitted that, having regard to the number of PMI patients treated within HCA hospitals at any one time, there is likely to be sufficient alternative capacity, even during peak times, available at other private hospitals in central London for these patients to be accommodated. The CMA however has criticised HCA's analysis on the grounds that it did not take account of the existing number of patients in rival hospitals and that HCA has not shown how much capacity lies unutilised within other hospitals.[6] The CMA has acknowledged "*we*

[5] Report, paragraph 11.107.
[6] Report, paragraph 6.250.

consider rivals' spare capacity to be the most appropriate measure to consider"[7] but argued that there was no data on spare capacity.

15. [✂].

16. [✂].

17. [✂]

18. [✂].

19. [✂]:

    (i) [✂].

    (ii) [✂].

Scope of Working Paper

20. As HCA indicated in its letter of 22 June 2015, the CMA's IPA Working Paper is limited to certain technical issues relating to the IPA methodology. In particular, it fails to consider the question of whether there is any relationship between any alleged pricing differentials and local substitutability, and whether HCA's share of supply is the cause of any alleged pricing differentials. The Tribunal identified the issue of causation as a key factor in the IPA. HCA calls on the CMA, once again, to set out its views on these important issues before it adopts its Provisional Findings. The CMA cannot claim to be conducting a transparent, "two-stage" consultation process, allowing parties to comment on important aspects of its analysis before it adopts Provisional Findings, unless it is prepared to set out its views on these issues in a separate working paper and allow HCA the opportunity to comment.

Data errors

21. We further note that the data made available in the disclosure room contained several errors arising from the way in which it had sourced its data from Healthcode and from the CMA's data cleaning and aggregation process. These are set out in Section 3.2 of the Data Room Report. As previously indicated, it took the KPMG team approximately two weeks in the disclosure room to correct and resolve these errors (at considerable cost and expense to HCA) in order to run an analysis of pricing differences, limiting its ability to review and interrogate the CMA's model. This is now the third version of the IPA, and HCA finds it deeply concerning that, on every occasion on which the CMA has sought to disclose the IPA, the data has been found to be beset with errors arising from the CMA's processing of the data and its calculation and reporting of alleged price differences.[8]

Restrictions

22. We also put on record that KPMG has been required to prepare its Data Room Report under highly restrictive and unreasonable conditions imposed by the CMA:

    - For the reasons provided in our letter of 2 July 2015, the CMA has not provided sufficient time to allow HCA's advisers to prepare and finalise its response to the Working Paper.

[7] Report, paragraph 11.107.
[8] TSols' letter of 25 October 2013 in respect of the first data room; TSols' letters of 12 August and 3 September 2014 in respect of the second data room.

- In addition, as set out in our letter of 16 July 2015, the CMA has not allowed sufficient time in the disclosure room for KPMG to complete its analysis of the IPA.
- The CMA has also refused HCA's requests for disclosure of information which would have assisted HCA's review of the IPA, [✂].

23. These restrictions have impeded HCA's ability to prepare a fully comprehensive response and to pursue all relevant lines of inquiry in the disclosure room, and the Data Room Report has been prepared subject to these constraints.

24. In the event that the CMA questions, disagrees with or seeks to challenge any of KPMG's findings in the Data Room Report, it is important that HCA is given an opportunity to address any points raised before the CMA firms up its conclusions in the Provisional Findings.

25. If the CMA has any questions on any aspects of the two KPMG Reports, please do not hesitate to let us know.