



Bupa

Response to Working Paper on Insured Price Analysis

July 2015

1. INTRODUCTION

- 1.1 Bupa welcomes this opportunity to comment on the Insured Price Analysis (“IPA”) Working Paper published by the Competition and Markets Authority (“CMA”) on 11 June 2015. This submission contains commercially sensitive information and information that is subject to the CMA confidentiality rings and should not be published.
- 1.2 Bupa welcomes the detailed and thorough way in which the CMA has responded to the criticisms of the original IPA by Hospital Corporation of America (“HCA”) and its advisors. The Working Paper assesses criticisms in turn and in each case finds that the IPA’s main conclusion remains valid – HCA obtains higher prices than its largest rival in Central London The London Clinic (“TLC”). This conclusion is statistically significant and robust to a series of sensitivity tests.
- 1.3 The Working Paper’s conclusion accords with Bupa’s own experience in commissioning care in Central London.
- 1.4 There is firm evidence of Adverse Effects on Competition (“AECs”) in Central London, with the IPA being just one element of this evidence base. There is no reason for the CMA to change its Final Report findings on the existence of AECs in Central London. The scale of these AECs may, however, have increased since April 2014. HCA has grown and gained strength. It is now significantly stronger than the years covered by the IPA and the CMA’s profitability assessment.
- 1.5 The CMA must take urgent and effective action in Central London. In Bupa’s view, the remedies package proposed in the Final Report must be broadened in scope if it is to effectively and proportionately improve competition in Central London.
- 1.6 Our response is structured as follows:
 - a. Part 2 explains some important points on how the conclusion of the IPA may be weighed in the CMA’s decision making.
 - b. Part 3 sets out additional analysis the CMA could conduct that, we believe, would reinforce the conclusions of the IPA and the various other pieces of evidence underpinning AECs in Central London.

2. ASSESSMENT OF THE INSURED PRICE ANALYSIS

- 2.1 In weighing the implications of the IPA findings, Bupa believes that:
- a. There are some disadvantages to the ‘common basket’ methodology used in the IPA which will likely understate the market power of HCA.
 - b. The findings of the profitability assessment should carry significant weight in the CMA’s assessment.
 - c. Although the CMA has found HCA to have higher prices than TLC, which underscores the market power of HCA, evidence of a significant price differential between HCA and TLC may not be essential to a finding of an AEC in Central London.

The common basket approach

- 2.2 In comparing the prices of HCA and TLC the CMA constructs common baskets of treatments that the two hospital groups provide to different insurers. A treatment is included in the common basket only if each hospital group delivered 5 or more (or in a finer filter, 30 or more) episodes of that treatment for the insurer in the year.
- 2.3 There are advantages to this approach, in particular helping to control for treatment and complexity mix. However, there are also some disadvantages that may understate the power of HCA.
- 2.4 First, some of the smaller insurers do not have sufficient activity with TLC during each year to have many treatments included in the common basket (particularly at the 30-episode filter where some smaller insurers have no common baskets in some years). With a small (or no) common basket in that year, the pricing experience of the smaller insurer across its services is not fully captured in the analysis. It is, however, likely that HCA’s prices would have been higher than those available at TLC in those years, meaning there would have been cost savings had the smaller insurer’s activity at HCA been done at TLC instead¹.
- 2.5 Therefore, the experience of these smaller insurers – insurers with little or no buyer power – is not fully reflected in the IPA². So the IPA findings likely underestimate, potentially substantially, how much more expensive HCA is at a market-wide level.
- 2.6 Second, the common basket may capture ‘common’ treatments, but the ‘non-common’ treatments and specialisms that very few private hospital operators do – such as Oncology, Cardiology, and Cardiothoracic Surgery – are not captured appropriately in the analysis. Treatments where one operator is super-dominant – a near monopoly – are unlikely to be captured in the price analysis, because they would not be in the common basket, although on these treatments market power is likely to be greatest.

¹ There is empirical evidence from the CMA’s analysis that, where sufficient data is available, the price differentials between HCA and TLC for smaller insurers were [><].

² Put slightly differently, it means that the experience of the larger insurers have a disproportionate influence on the calculated differential.

- 2.7 [X]. The CMA's profitability assessment does, however, help capture some of the effects of these specialisms not in the common basket.

The Profitability Assessment

- 2.8 The IPA is just one element of the evidence to take into account when assessing competition in Central London. It should not, alone, take on disproportionate importance in the CMA's assessment or the decision-making process. The evidence of persistent excess profits earned by HCA must be given appropriate weight.

- 2.9 In particular we note that:

- a. The CMA's Final Report finds that HCA had "*earned returns substantially and persistently in excess of the cost of capital*"³. The Final Report notes also that returns for hospital groups during the five year period considered – January 2007 to January 2012 – may have been depressed by the severe recession in the UK and would have been even higher in normal market conditions⁴. Indeed, across hospitals, the CMA finds that the average estimated differential between ROCE and cost of capital was on a rapidly rising trajectory over the five year period.
- b. This upward trajectory is likely to have continued over the period to 2015, particularly in Central London which has seen much faster private hospital revenue growth than the rest of the UK⁵.
- c. The CMA found that HCA's profitability was "*significantly higher*" than its next largest competitors TLC⁶ and Bupa Cromwell, which the CMA found were earning profits around cost of capital on average⁷.
- d. HCA comprises a substantial part of the Central London market and its excess profitability could indicate significant market power and prices that do not reflect costs.

- 2.10 Bupa believes the CMA should update its profitability assessment and that this would likely show that persistent and substantial excess returns remain in Central London and that these may have grown significantly since the period covered by the CMA's existing analysis.

- 2.11 The profitability assessment suggests competition in Central London is weak and barriers to entry are present. It also has bearing on how the IPA is assessed. The IPA differential between HCA and TLC may be narrower in a market with weak competitive forces, as TLC would be able to price higher or run less efficiently than it would be allowed to in a more vibrant and dynamic market.

³ Final Report, page 6, paragraph 38. The CMA subjected its profitability analysis to sensitivity testing and found it to be robust.

⁴ Final Report, "*It seems probable, therefore, that under more normal economic conditions the relevant firms would have earned higher revenues and therefore higher profits than they did between 2007 and 2012*" (page 6-101 para 6.473).

⁵ LaingBuisson, "*Private acute medical care in Central London, Market Report*" (February 2015).

⁶ Final Report, "... we note that HCA does not appear to have invested over recent years more than its closest competitor, TLC, and HCA's profitability is significantly higher" (page 6-86, paragraph 6.409).

⁷ Final Report, page A6(13)-40, paragraph 172.

The Price Differential

- 2.12 The CMA has found HCA to have higher prices than TLC with the result statistically significant to a very high level of confidence. The differential underscores the market power of HCA. However, the differential itself and its size may not be essential to a finding of an AEC in Central London – even if the differential was small this does not rule out an AEC.
- 2.13 From a theoretical perspective, there are several scenarios in which there may be a small (or no) differential between the prices of a large firm and a smaller rival, and yet competition in the market is not working well or at all. As examples:
- a. If the larger firm has a first-mover or other strategic advantage over its smaller competitor, this may lead to a competition dampening effect whereby the smaller firm has limited incentives or ability to undercut the prices in order to gain market share.
 - b. The service propositions of the two firms are highly differentiated meaning there is little in common between the two (limited overlap) and each is able to act as a super dominant firm for its own services.
- 2.14 The above scenarios resonate with the experience of private healthcare in Central London. In particular:
- a. The market is highly concentrated with HCA more than four times larger than its next largest rival (and larger still in strategically important specialisms such as [3<]).
 - b. There is evidence of substantial barriers to entry in the market.
 - c. There is sustained excess profitability in the market which suggests competition is not driving prices and costs downwards effectively.
 - d. There is high differentiation in the treatments offered by different players in the market, as is illustrated by the fact that significant activity falls outside the common basket in the CMA's IPA analysis.
 - e. TLC may have limited incentive to undercut HCA because (i) insured patients and consultants are not sensitive to the hospital prices, (ii) insurers 'must have' HCA facilities if they are to offer credible corporate offerings (and HCA is in a position to negotiate on an 'all or nothing' basis for its facilities), (iii) [3<] and (iv) TLC has its own capacity constraints.
 - f. There is little objective evidence that HCA delivers significantly superior quality.
- 2.15 The above suggests that the price differential is not a necessary indicator of an AEC in Central London. It would also be an error for the CMA to conclude there is no AEC on the basis of finding only a small price differential between HCA and TLC.

3. FURTHER ANALYSIS THE CMA COULD CONDUCT

3.1 We believe that the CMA's analysis of market shares, pricing, profitability, and internal documents, looked at in combination, shows robustly that there are AECs in Central London. However, should the CMA wish to undertake further analysis, we consider that it could assess:

- a. **Contractual price increase:** The CMA could review the annual price increases agreed ex ante in contracts between HCA and insurers and how these compare with those of other hospital operators. Figure 2 in our May 2015 submission (replicated below) showed how the price increases agreed with HCA are [redacted]. Examining contracted price increases in this way across insurers may help ensure that the experience of the smaller insurers is captured more fully – see our concern raised in paragraph 2.4 above.

[redacted]

- b. **Contractual variation:** Bupa has emphasised throughout the inquiry that price is not the only dimension through which hospital operators can use market power⁸. Hospitals can also seek preferential (often anticompetitive) non-price contractual terms. [redacted]⁹. The CMA could examine non-price contractual terms experienced by other insurers.

4. CONCLUSION

4.1 Bupa supports the findings of the CMA's Working Paper, which reflects our own experience in commissioning care in Central London. The IPA provides further evidence of the strength of HCA but it is just one element of a wider set of evidence supporting the finding of AECs in Central London. There is no reason for the CMA to change its findings of the existence of AECs in Central London and the need for an effective remedies package.

⁸ For example, see Bupa's July 2013 response to the Original Issues Statement by the Competition Commission.

⁹ The CMA could also assess the terms on High Cost Drugs (HCD) reimbursement in contracts that hospital groups negotiate with insurers. For Bupa, HCDs are a list of drugs that the hospital group is allowed to charge the insurer separately (i.e. not included in the accommodation fee of the hospital). [redacted].