



Private Healthcare Remittal

Response to Provisional Decision on Remedies

Bupa

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Executive Summary

- 1.1 This submission sets out Bupa's response to the Competition and Markets Authority's ("CMA") Provisional Decision on Remedies ("PDR") published on 22 March 2016 and the subsequent revisions published by the CMA on 6 April 2016. The submission contains commercially sensitive information that should not be published without Bupa's permission.
- 1.2 Bupa has significant concerns about the analysis underpinning the PDR and the CMA's provisional conclusion that it can find no effective and proportionate remedies that address, in any way, the Adverse Effects on Competition ("AECs") for self-pay and insured patients that the CMA has provisionally found. The effect of this provisional conclusion, if upheld, will be that these AECs (and all associated significant customer detriment) will continue in full. In particular, Bupa has identified multiple errors in the CMA's NPV analysis which, together, undermine the robustness of the CMA's provisional conclusion on the proportionality of a divestment remedy. Separately (and notwithstanding Bupa's concerns with the NPV analysis), Bupa considers that, in circumstances where the CMA has provisionally concluded that a divestment is disproportionate, it remains incumbent on the CMA to achieve as comprehensive a solution to the identified AECs as is reasonable and practicable: it is not clear to Bupa that the CMA has fulfilled this statutory duty, by failing to consider both the efficacy of the remaining 'live' remedies, as well as the efficacy and proportionality of alternative new remedies.
- 1.3 Under the Enterprise Act 2002, if the CMA finds that there is an AEC, it is required to decide whether action should be taken by it, or whether it should recommend the taking of action by others, for the purpose of remedying the AEC (or any detrimental impact on customers that has resulted from or is expected to result from the AEC). In deciding whether action should be taken, and as noted above, the CMA is required to have regard, in particular, to the need to achieve as comprehensive a solution as is reasonable and practicable to the AEC and any detrimental effects on consumers. This requires an assessment of the efficacy and proportionality of remedy options but given these statutory duties (and as the CMA recognises in its guidance on market investigations) it is wholly exceptional for the CMA to reach the provisional conclusion that there are no possible remedies - including remedies that only partially address the AEC - that are both effective and proportionate. Bupa would expect the CMA to require clear and compelling evidence before reaching such a conclusion.
- 1.4 Bupa agrees with the CMA's provisional finding that a divestment of the London Bridge and Princess Grace hospitals, or the Wellington hospital together with the Platinum Medical Centre, would be effective in addressing the AECs identified, albeit that Bupa still considers (as set out in its response to the Provisional Findings and Remedies Notice) that a more extensive set of divestments would be required to address the AECs in full.
- 1.5 However, Bupa has significant concerns in relation to the analysis set out in the PDR on the proportionality of a divestment remedy, which rests on a number of finely balanced findings that Bupa is not convinced have been tested robustly. Specifically, the CMA's provisional finding that a divestment remedy would not be proportionate appears to rest on the grounds that:
 - i. The Cleveland Clinic is expected to open a facility in central London in late 2019/early 2020 that will provide (together with other hospitals) an effective competitive constraint on HCA within two years of opening i.e. by early 2022 (although the CMA recognises that there is "*some uncertainty*" as to this timing). In Bupa's view, there are significant uncertainties associated with the timing of the Cleveland Clinic's entry – indeed the Cleveland Clinic is already behind the CMA's proposed schedule since it has not yet

submitted its application for planning permission. It is experiencing delays even before commencing a major and complex building reconfiguration in the shadow of Buckingham Palace. In circumstances where there are real doubts as to the timing for entry – and indeed no guarantee that it will occur at all – Bupa does not consider that the CMA, acting as a reasonable decision-maker, can place the level of reliance that it does on this entry, in reaching its conclusion that a divestment remedy would be disproportionate on this basis. This is explored further in section 2(A) below.

- ii. The entry of the Cleveland Clinic is assumed to provide an effective competitive constraint on HCA by early 2022, in conjunction with other non-HCA providers. However, the PDR contains very little analysis or evidence to justify this conclusion. In Bupa's view, there are a number of grounds for doubting that – even if it has fully opened to patients in late 2019/early 2020 – the Cleveland Clinic facility would pose such a constraint on HCA by 2022 as to address the AECs in full. This is particularly the case in the event that HCA is subject to no divestments and therefore continues to operate intact, as the Cleveland Clinic would be competing against a very significantly larger, super-dominant entity than would be the case where the AEC caused by HCA's size is addressed directly with divestments. This will make it harder to compete against HCA, and even less likely that the Cleveland Clinic will develop in any meaningful timeframe additional specialisms including those – such as Oncology – in which HCA holds particular market power.¹ This is explored further in section 2(B) below.
- iii. The CMA's NPV analysis shows some scenarios in which the NPV of divestment is marginally negative. However, we have identified twelve key issues and errors in this NPV analysis that undermine substantially its provisional conclusion that the costs of a divestment outweigh its benefits. Correcting these errors means that, **even if** one accepts the CMA's provisional conclusion on the likelihood of full and effective entry by the Cleveland Clinic by 2022, the benefits of a divestment of HCA hospitals **significantly outweigh** the costs of such a remedy in all relevant scenarios. This is explored further in section 3 below.

1.6 Bupa's firm view is that the CMA cannot be sufficiently confident in the robustness of its provisional conclusions on any of the points that are put forward to support the view that a divestment remedy is disproportionate. A divestment of HCA hospitals remains the most effective and proportionate remedy in order to address the AECs that the CMA has provisionally found in Central London. Bupa therefore considers that the CMA should revisit its conclusions.

1.7 Moreover, even if the CMA continues to consider a divestment remedy to be disproportionate (albeit effective), Bupa notes that the CMA's legal obligation is to achieve as comprehensive a solution to the AECs as is reasonable and practicable. Against that background, Bupa does not consider that the CMA's subsequent provisional conclusion that there are no suitable alternative remedies – including time-limited remedies taking into account the possible entry by the Cleveland Clinic – is sufficiently reasoned or correct. It is extremely unusual for the CMA to find the existence of an AEC but then to conclude that there are no remedies that would, fully or partially, remedy that AEC in an effective and proportionate manner, and before reaching this conclusion Bupa would have expected a much more thorough review of the possibilities.

¹ [redacted]

- 1.8 In particular, Bupa notes that the CMA recognised in the Final Report of the original market investigation that the remedies were seen as operating in complementary ways to address the various AECs identified by the CMA. Bupa considers that the provisional decision to remove the major remedy – divestiture of HCA hospitals – from the overall remedy package puts in question whether the remaining remedies together in their current form, represent an appropriate solution to the AECs they sought to address. Bupa therefore urges the CMA to consider whether the remedies that remain ‘live’ require amending or expanding so as to represent a sufficient solution to the AECs in central London in the absence of the complementary effect of divestiture of HCA facilities. If the CMA then considers the effectiveness of these remedies to be decreased as a result of the removal of the divestiture remedy, it is Bupa’s view that the CMA’s statutory duty requires that it consider how these remedies could be amended or otherwise supplemented.
- 1.9 Additionally, and as explored in section 4 below, Bupa urges the CMA to consider the following alternative remedies:
- i. A narrower divestment packages focussed on The London Bridge and / or Oncology (such as The Harley Street Clinic, Leaders in Oncology, and/or London Radiotherapy).
 - ii. A short-term price control on HCA, which could take the form of a price cap at current tariff levels with insurers.
 - iii. A substantial strengthening of the constraints on HCA’s relationships with consultants.
 - iv. The removal of all contractual clauses imposed by HCA on insurers that have the actual or potential effect of foreclosing competition.
- 1.10 Throughout the five years of investigation by the competition authorities, Bupa has been consistent on the urgency and importance of external intervention by the CMA (and before it the OFT and Competition Commission). This is the only way to give customers better value for money in private healthcare in central London. Every major report published by the authorities during the inquiry has identified competition problems in Central London. The PDR itself makes clear that HCA has enjoyed nine consecutive years of substantial excess profits. We find it wholly remarkable that the CMA should provisionally decide to take no action on the basis of the speculative and uncertain effects of possible entry by 2022 and a flawed NPV calculation. We ask the CMA to revisit its analysis and look forward to engaging further with the CMA on this matter.

1. Introduction

- 1.1 This submission sets out Bupa's response to the CMA's Provisional Decision on Remedies ("PDR") published on 22 March 2016 and the subsequent revisions published by the CMA on 6 April 2016.
- 1.2 We look forward to discussing the contents of this submission further with the CMA and are, of course, willing to provide any additional evidence the CMA requires to deliver a comprehensive and effective remedies package to address the competition concerns provisionally identified in Central London.
- 1.3 Please note that this submission contains commercially sensitive information and should not be published in this confidential format.
- 1.4 This submission is structured as follows:
 - i. **Section 2** explains our concerns about the likelihood of entry by the Cleveland Clinic in the envisaged timeframe and explains why it is unlikely that the Cleveland Clinic, even once it enters, will offer a sufficient competitive constraint on HCA.
 - ii. **Section 3** explains our concerns about the Net Present Value analysis the CMA relies on in reaching its proportionality decision on divestments.
 - iii. **Section 4** sets out further considerations for the CMA in respect of alternative remedies.
- 1.5 **Annex A** contains a legal assessment as to why HCA is incorrect in its characterisation of the alleged economies of scale arising from its hospital portfolio as a relevant customer benefit.
- 1.6 **Annex B** – the "**Confidential Annex**" – contains information prepared by our named economic and legal advisors who have seen additional information in Confidentiality Ring 1. Bupa has **not** had sight of this Confidential Annex.

2. The entry of the Cleveland Clinic

- 2.1 The conclusions of the PDR rest critically on the CMA's view that the Cleveland Clinic will open its hospital in late 2019/early 2020, and that the Cleveland Clinic will pose an effective competitive constraint on HCA by 2022.²
- 2.2 Bupa has significant concerns about the robustness of this analysis.
- 2.3 First, there remains substantial uncertainty about when (and even if) the Cleveland Clinic will actually enter the market. This is explored in section 2(A) below.
- 2.4 Second, there remains strong reasons to doubt, even assuming that the Cleveland Clinic enters the market in the timeframe envisaged by the CMA, as to whether the additional competitive constraint posed on HCA by such entry would be sufficient to neutralise the AECs that have been identified. These points are considered in more detail in section 2(B) below.
- 2.5 In all, there is significant uncertainty both as to the timing and the effect of the Cleveland Clinic's entry into the Central London market. On this basis, Bupa's view is that the CMA cannot reasonably conclude, on the evidence available to it, that entry by the Cleveland Clinic will address the AECs effectively and thus that the divestment of HCA hospitals is a disproportionate remedy in these circumstances.

A) The timing of the Cleveland Clinic's entry is uncertain

- 2.6 The CMA provisionally considers that that Cleveland Clinic will open its hospital in late 2019/early 2020, and that it will have established itself as an effective competitor to HCA across a range of specialisms by 2022.³
- 2.7 There are, however, several uncertainties associated with these timeframes:
 - i. The Cleveland Clinic does not have a strong track record of international expansion outside its home market in the US. Indeed, the CMA cites only one example of recent international expansion by the Cleveland Clinic (in Abu Dhabi), and this facility "*took longer than expected to build*" (seven years in total).⁴
 - ii. While the CMA notes that the delay in the construction of the Abu Dhabi facility "*was due in part to the global financial crisis*", it is clear that construction, conversion or other expansion plans are subject to significant uncertainty, and that developments in major urban centres such as central London face additional challenges. It is over-simplistic of the CMA to assume that the time taken by the London Clinic to construct its Cancer Centre over a decade ago is the "*relevant comparison in terms of timing*" when looking at

² PDR, paragraph 2.58.

³ We note that in the Provisional Findings in November 2015 the CMA stated: "[...] at this stage, we do not have sufficient evidence to determine if and when their entry is likely to take place and the time frame over which these facilities may start to exert any competitive constraint on HCA." (paragraph 25). It seems very unlikely that in less than six months the Cleveland Clinic plans have become sufficiently certain that the CMA is now confident that they will have opened by late 2019 / early 2020.

⁴ PDR, paragraph 1.62(b).

the likely timeframe within which the Cleveland Clinic's London facility could open, and the CMA offers little justification for this.⁵ Indeed, this timeframe is only six months longer than the Cleveland Clinic's current internal estimates, and the CMA does not in the PDR provide any detailed analysis of the robustness of the Cleveland Clinic's estimates.⁶ The CMA also does not consider other examples of recent expansion in the UK market – for example, in 2010 Circle opened a new facility in Bath (with only 57 beds), the construction of which was delayed by six months due to “*certain additional building works*”.⁷ If the construction of a hospital roughly a quarter of the size of the Cleveland Clinic's proposed London facility can be delayed by six months, it follows that the construction of a larger facility is subject to potentially much more significant delays. The CMA does not appear to have considered this possibility in the PDR in any depth.

iii. [§<]

iv. The Cleveland Clinic is (as far as Bupa is aware) yet to submit its application for planning permission. The Cleveland Clinic is, therefore, already behind the CMA's proposed schedule in the PDR, which posits that the Cleveland Clinic would have submitted their application in March 2016.⁸ Not only does this mean that the Cleveland Clinic is not yet in a position to understand any constraints that may be imposed on its proposals (e.g. by the Council or neighbours), but it also demonstrates the inherent uncertainties associated with the timing of conversion.

v. Macroeconomic changes over the next three to five years could negatively affect the appetite of the Cleveland Clinic to enter (or, if it does enter, the speed of its doing so). Such unforeseen changes are analogous in nature to the reason for the delay in the construction of the Cleveland Clinic's Abu Dhabi facility (the global financial crisis). It follows that there is no significant degree of certainty that the Cleveland Clinic's current conversion estimate of three years (or the CMA's marginally longer estimate of three and a half years) is robust.

2.8 Overall, Bupa therefore considers that the robustness of the CMA's estimates as to the timing of the Cleveland Clinic's entry is highly questionable. Indeed, the CMA acknowledges that there is “*some uncertainty*” as to this timing.⁹ Given that, in Bupa's view, the scale of this uncertainty is such that a potential delay could be very significant indeed, the CMA cannot rely on its estimates in assessing the market impact. It is therefore very important that the CMA tests its provisional conclusions on these timing issues, including by taking into account all of the Cleveland Clinic's sensitivity and risk analysis associated with projected timings.

⁵ PDR, paragraph 1.63.

⁶ [§<]

⁷ Final Report, Appendix 6.1, paragraph 27.

⁸ PDR, paragraph 1.61.

⁹ PDR, paragraph 10.

B) The ability of the Cleveland Clinic to provide an effective competitive constraint on HCA in 2022 is wholly uncertain

- 2.9 The PDR provisionally concludes that new entry by the Cleveland Clinic “*is likely to be effective in addressing the AECs and that, while there is some uncertainty about timing, this is likely to occur by early 2022*”.¹⁰ Such entry, in the CMA’s provisional view, is “*likely (in combination with other non-HCA hospitals) to result in an effective competitive constraint on HCA (comparable to that of the divestment we proposed in the Final Report)*”.¹¹
- 2.10 Bupa disagrees with the PDR’s provisional conclusion that the Cleveland Clinic’s entry is sufficient to address the AECs, and considers that the CMA has failed to carry out a full and robust analysis of the effects of such entry:
- i. The PDR presents no analysis of how the Central London market and HCA itself will evolve in the period up to 2022, and thus in what competitive landscape the Cleveland Clinic will need to compete. **On current trends, HCA could more than double its 2014 revenue size by 2022. It will likely occupy [3<] of Bupa’s central London claims spend and will have even higher revenue shares in the most important specialisms.** Without undertaking any detailed analysis of the future state of the market, and HCA’s projected scale in particular, the CMA simply does not have sufficient evidence to justify the provisional conclusion that the Cleveland Clinic (with other non-HCA hospitals) will pose a sufficient competitive constraint on HCA in 2022;
 - ii. There is insufficient evidence in the PDR to conclude that the entry of Cleveland Clinic in 2022 will be sufficient to neutralise the AECs that have been identified, including as compared with a divestment of HCA hospitals in 2017 (which would address the AEC directly);
 - iii. Cleveland Clinic will not be an effective constraint in Oncology, which is a critically important specialism in which HCA holds considerable market power, and there is no evidence that any other provider will fill this gap. [3<]. Absent divestments, HCA will still be able to leverage its power in Oncology across all of its business with insurers, thereby substantially weakening the ability of the Cleveland Clinic to compete effectively. **Moreover, the Cleveland Clinic is not planning to offer Medical Oncology by 2022,**¹² further undermining its ability to compete with HCA in this core specialism within any reasonable timeframe. Indeed, it is wholly unclear that any other operator currently active in central London has any plans to develop additional oncology provision at the necessary scale and pace to constrain HCA, and the CMA provides no view on the likelihood of such a development taking place – in Bupa’s view, it is highly unlikely given entry barriers and HCA’s considerable market power;
 - iv. There is significant uncertainty as to how the Cleveland Clinic will choose to compete once (if) it has entered. **There is no guarantee it will follow its current pricing intentions, and the CMA cannot not rely on this non-binding intention;** and,
 - v. The CMA has failed to assess how HCA would likely respond to entry by the Cleveland Clinic, and the likelihood that such a response would materially reduce the Cleveland

¹⁰ PDR, paragraph 1.85.

¹¹ Ibid.

¹² Indeed, the Cleveland Clinic has explicitly told Bupa that it has no plans at all of offering Medical Oncology.

Clinic's ability to compete effectively. HCA has over three years to plan and put into action its defensive strategy. It has a range of options available, and there is clear evidence it has previously pursued strategies aimed at reducing the competitive effect of new entrants (and, absent divestments and in light of its projected growth in size and market power, would be able to do so from an even stronger position). In these circumstances it is all the more important for the CMA to carry out such an assessment.

2.11 Each of these points is considered in turn below.

The evolution of the Central London market

2.12 The PDR presents little analysis or evidence of how the Central London market and, in particular, HCA will evolve in the period up to 2022, and thus in what competitive landscape the Cleveland Clinic will need to compete. This lack of analysis and evidence significantly undermines the CMA's conclusions that the Cleveland Clinic could be an effective competitor that would address the identified AECs in full.

2.13 We have previously explained that HCA has rapidly expanded and has a series of planned expansions already in progress [redacted].¹³

2.14 **Figure 1** and **Figure 2** illustrate this growth and project forward the trends to 2022. The solid lines show the hospital groups' annual revenues over the period 2006 to 2014 as reported in LaingBuisson. This illustrates that HCA is already orders of magnitude larger than any other hospital operator in Central London. **Figure 1** projects forward the revenues using each group's historic compound average growth rate. **Figure 2** fits a linear best-fit-line for each group.

2.15 In both the CAGR and linear cases, HCA is projected to have revenues of [redacted] by 2022. It would be more than double its 2014 size. [redacted].

¹³ See Confidential Annex.

Figure 1: Historic and Projected Hospital Operator Revenues, £millions, CAGR

[✂]

Source: LaingBuisson, "Private acute medical care in Central London, Market Report".

[✂]

Figure 2: Historic and Projected Hospital Operator Revenues, £millions, Linear extrapolation

[✂]

Source: LaingBuisson, "Private acute medical care in Central London, Market Report".

[✂]

- 2.17 HCA's share within the Central London market will also **likely grow significantly**.
- 2.18 **Table 1** shows HCA's rapid market share growth within Bupa's claims spend in Central London. In 2015:
- i. HCA accounted for [X] of Bupa's Central London hospital spend – **an increase of [X] percentage points in five years**. HCA's share is even higher when looking at inpatient activities only.
 - ii. The growth is particularly substantial in Oncology, where revenues [X] in five years.¹⁴ [X].
 - iii. Across each of the main specialisms, HCA accounts for over [X] of Bupa's claims spend in Central London.

Table 1: HCA's shares in Bupa's Central London hospital spend

[X]

Source: Bupa claims data

[X]

- 2.19 Given this growth trajectory, **it is highly likely that HCA will occupy in excess [X] of Bupa's hospital spend in Central London by 2022**. Shares will be even higher in the most important specialisms, such as Oncology.
- 2.20 This will create **a very highly concentrated hospital market in Central London**. By 2022 the HHI will be [X] in revenue terms.
- 2.21 There is also material risk that the PMI market contracts before 2022. As Bupa has previously explained:
- i. There are now fewer people covered by PMI in the UK than 20 years ago, with PMI penetration within the UK population at its lowest level in 20 years. The Personal PMI market has been in decline for over 20 years.
 - ii. Affordability remains the single largest factor limiting uptake of PMI in the market. Conjoint analysis suggests Personal customers are the very top end of what they are willing to pay for PMI. On the corporate side, a 2013 survey by Employee Benefits of B2B customers found that 78% cited cost as the most important factor in determining the healthcare benefits (including PMI) they offered employees. Rapid price inflation in Central London is choking off demand.
 - iii. HM Treasury has increased Insurance Premium Tax (IPT) on two occasions in the past year – increasing the tax on insurance premiums from 6% to 10%. The existing constraints on Government finances, together with Government pledges¹⁵, means that it is likely IPT will increase again during the next 5 years, further suppressing demand for PMI.

¹⁴ [X].

¹⁵ The Government has pledged a 'tax lock' for the duration of this Parliament on its main sources of tax income – Income Tax, National Insurance, and VAT (see <https://www.gov.uk/government/publications/tax-lock-income-tax-national-insurance-contributions-and-vat>) and has also pledged to achieve a budget surplus by 2020.

- iv. If PMI volumes continue to fall, insurers' bargaining power against HCA will continue to weaken.
- 2.22 In this challenging market, HCA's 'must have' status and its habit of negotiating increases in its total "[redacted]"¹⁶ means that insurers will continue to be forced to include HCA in products and that HCA will squeeze out other hospital operators – either through contractual restrictions imposed on insurers or 'indirectly' through price rises and its "must have" position. HCA will consume an ever greater share of the market.
- 2.23 Further, HCA's control of the area next to the City – critically through the London Bridge Hospital but also through the Shard and Guy's and St Thomas's – will give it increasing bargaining power as the market becomes increasingly reliant on Corporate customers.
- 2.24 Given the above, by 2022, HCA will in the absence of divestments likely be a massive, super-dominant competitor, several orders of magnitude larger than any other player and with materially more bargaining power against insurers.

There is insufficient evidence in the PDR to conclude that the entry of Cleveland Clinic will be effective in addressing the AEC in 2022

- 2.25 In light of the failure to consider how the central London market (and HCA itself) will evolve in the period up to 2022, the CMA has therefore not adequately considered whether the Cleveland Clinic's ability to compete in 2022 would be effective in addressing the AEC in the way that a divestment of HCA hospitals in 2017 would be.
- 2.26 As explained above, the Cleveland Clinic will be entering into a highly concentrated and challenging market environment in central London. Against this backdrop, it is extremely unlikely that Cleveland Clinic's entrance will be sufficient to constrain HCA effectively in 2022.
- 2.27 First, the Cleveland Clinic will be a new, untested entrant trying to compete against a very much larger rival with a high degree of market power, in highly concentrated market conditions (with an HHI of [redacted] in overall revenue terms). The effect of these market conditions will be that the Cleveland Clinic's ability and incentives to compete will be weak, and it would need to grow its capabilities substantially and across a range of specialisms before it could similarly reduce concentration and HCA's power. It is therefore difficult to see how the Cleveland Clinic could be effective in addressing the AEC caused by HCA's size and its dominance across specialisms.
- 2.28 Second, the Cleveland Clinic is likely to struggle to attract and retain the necessary consultants given that HCA has had time to 'lock-in' these consultants e.g. through employment and equity-style relationships. Given that, as explained above, HCA will control the vast majority of private activity in Central London (both UK and international), it will become increasingly challenging for key consultants to maintain robust practices at smaller private hospitals (including the Cleveland Clinic). **HCA will be a 'must have' gateway for consultants to access sufficient private activity in London.** Given HCA's status as 'must-have' for consultants, it will also be in a better position to employ consultants directly (as it will occupy so much of consultants' work already), thereby encouraging them into exclusive relationships with HCA. HCA's market power

¹⁶ [redacted]

and its must-have status with consultants will therefore jeopardise the Cleveland Clinic's ability to constrain HCA.

2.29 In this respect, Bupa disagrees with the CMA's provisional conclusion that *"in addition to its intended purpose, [the remedy prohibiting certain forms of clinician incentives] should also limit the ability of HCA to prevent competitors from attracting and retaining consultants in order to compete across a full range of services"*.¹⁷

- i. As the PDR recognises, the clinician incentives remedy was not intended by the CMA to address HCA's market power, and the CMA offers no reasoning in the PDR (or elsewhere) as to how the remedy would do so. As noted above, HCA's market power and its must-have status grants it the ability to 'lock-in' consultants in a manner that is unaffected by the clinician incentives remedy. Further, consultants who enter into employment relationships with the Cleveland Clinic – its expected business model – will have to forgo a substantial share of activity if they no longer work with HCA, disincentivising them from working in this way with the Cleveland Clinic.
- ii. The CMA is clear in its Final Report in the original market investigation that *"our restrictions on clinician incentives would not on their own solve the AECs in central London as, absent the divestitures that we are requiring HCA to make, private medical insurers and self-pay patients would still have few outside options"*.¹⁸ It is therefore clear that the CMA considered the full effectiveness of the clinician incentives remedy could only fully arise *in conjunction with* a divestment of HCA hospitals. Given that the CMA has now provisionally decided that a divestiture is disproportionate, Bupa considers that, *even if* the Cleveland Clinic enters the market in the timeframe estimated by the CMA, the PDR places too much confidence on an assumption that the clinician incentives remedy will on its own remain fully effective.

2.30 Third, and as the PDR recognises, the Cleveland Clinic is not planning to offer medical oncology or radiotherapy, a fact which *"would reduce the extent to which it could constrain HCA"*.¹⁹ While the CMA notes that it would be open to the Cleveland Clinic to develop its oncology offering, it offers no evidence whatsoever to support this assertion beyond noting that the Cleveland Clinic *"would adapt its services to serve the market"*.²⁰ Bupa does not consider that the CMA can rely on this assertion to conclude that the Cleveland Clinic will eventually develop its oncology services, but even if it does, such services will only be introduced some years after 2022, meaning that HCA's very significant market power in this specialism – which it is able to leverage across other specialisms – will remain unchallenged for some time. It follows that the Cleveland Clinic's entry would have a limited impact on Oncology, and the market would have to rely on planned entry/adaptation of other hospitals to see HCA's market power eroded. The position in respect of Oncology is examined in more detail below. We note also that the Cleveland Clinic has specifically told Bupa that it will not offer medical oncology.

2.31 Fourth, there is a very real risk – as discussed in paragraph 2.50 below – that insurers will simply not be able to reward Cleveland Clinic's lower prices with more volume, due to direct and indirect restrictions by HCA. Similarly, the highly concentrated market may mean that Cleveland Clinic simply "follows" the pricing of the leader in the market, softening its pricing

¹⁷ PDR, paragraph 1.76.

¹⁸ Final Report in the original market investigation, paragraph 13.6.

¹⁹ PDR, paragraph 1.75.

²⁰ PDR, footnote 43.

intentions compared to what the CMA has been told now. This is explored further in paragraphs 2.45 *et seq.* below.

2.32 By contrast, the divestments in 2017 will have a substantially different impact on the market than the Cleveland Clinic could have in 2022. Notably:

- i. A divestment would directly target the AEC created by HCA's size – it will create a new entrant that can compete effectively on a standalone basis with HCA, including by growing over the five years to 2022 to keep pace with HCA's expected growth over the period, and will reduce the dominance of HCA directly and immediately.
- ii. A divestment would directly lead to a reduction in concentration in the market – in overall revenue terms, the HHI of the market could fall by over [X] points.
- iii. A divestment would have some direct and immediate impact on Oncology, a key source of HCA's overall market power, as explored in greater detail in paragraphs 2.34 *et seq.* below.
- iv. A divestment gives insurers more ability to deliver value for money to customers from 2017 onwards, rather than HCA continuing to impose substantial annual price increases and restrictive clauses through the period before 2022.

2.33 The CMA notes that the Cleveland Clinic expects to earn “*significant revenues*” by 2022. It does not report these in the PDR or benchmark them against the likely 2022 earnings of the divested sites or rivals such as The London Clinic. That information has of course not been disclosed but we find the CMA's conclusions surprising. We note that:

- i. For Cleveland Clinic to be an effective competitor to constrain HCA (given its future size), it would need to expect to be the second largest competitor in Central London by 2022. It would need to have revenues in the [X]. This rate of growth seems highly unlikely even on the most optimistic of scenarios.
- ii. The CMA must take care to benchmark the Cleveland Clinic's revenues correctly – to compare like-with-like – because its revenues may appear inflated by its employment of consultants. Consultant fees will typically be separate with respect to other hospitals as insurers will pay these directly, rather than as part of the revenues to the hospitals. Consultant fees comprise around a third of Bupa's claims spend. Therefore, Cleveland Clinic's revenues in its business plan could be substantially overstated when considered on a like-for-like 'hospital' activity basis.

Cleveland Clinic will not be an effective constraint in Oncology, which is a critically-important specialism in which HCA is dominant

2.34 Bupa agrees fully with the CMA's assessment that:

*“the combination of a specialty-level product market, and prices which are negotiated jointly across a full range of services, suggested that a strong market position in one or a small number of specialties would allow a private hospital operator to exert market power”.*²¹

2.35 Indeed, Bupa has previously explained that even the CMA's currently proposed divestment packages do not go far enough within the key specialisms to address effectively HCA's dominant shares and resulting market power.

2.36 **Figure 3** shows that HCA already has revenues shares of [X<] for the vast majority of specialisms. The specialisms are ordered in terms of total overall spend.

2.37 The three largest specialisms by claims spend in 2015 ([X<] account for [X<] of Bupa's claims spend with HCA in Central London and in each HCA has a share [X<].

2.38 **Figure 4** orders the specialisms in descending order of HCA's market share. It shows that [X<] of Bupa's spend with HCA is in specialisms where HCA already has [X<] share. This is an extremely strong bargaining position for HCA. Entrants would need to form an effective constraint across all of these specialisms to address the AEC caused by HCA's size.

²¹ PDR, paragraph 2.21.

Figure 3: [X]

[X]

Source: Bupa claims spend

Figure 4: [✂]

[✂]

Source: Bupa claims spend

[✂]

2.39 Figure 3 and Figure 4 show that **Oncology** [§<] **important specialism**:

- i. It accounts for the [§<] share of Bupa's spend with HCA in Central London – [§<]. Oncology alone accounts for more claims spend with HCA than [§<].
- ii. It has been rising rapidly (as shown also in **Table 1**):
 - a. Bupa's claims spend with HCA in Oncology in Central London was [§<].
 - b. HCA's share of Bupa's claims spend in Central London in Oncology [§<].
- iii. To give some perspective:
 - a. Bupa's spend on Oncology with HCA is, on its own, larger than our total annual spend with [§<].²² [§<]
 - b. Bupa's total spend on Oncology with the next largest rival in Oncology in Central London – [§<]
- iv. By 2022 we expect our Oncology spend with HCA and HCA's share of our total Oncology spend in Central London will be very much larger. For example, HCA new cancer centre at Guy's and St Thomas' Private Patient Unit is still to come fully on line. Oncology is also a top priority sector for HCA:

"HCA's Cancer Strategy document noted that cancer was a top of mind issue for health consumers: 76 per cent of people ranked it as their foremost health concern and 91 per cent gave cancer as their main reason for taking out PMI. It said that demographic data indicated that cancer would be the fastest growing health sector, +26 per cent by 2025."²³

- v. [§<].

2.40 [§<].

2.41 The Cleveland Clinic has said that it will have limited activities in Oncology – it has no plans of offering medical oncology or radiotherapy. This is consistent with its experience and capability in the US.²⁴

2.42 **The Cleveland Clinic will therefore not be an effective constraint in this critically-important specialism.** This means that HCA will continue to be able to leverage its strength in Oncology across all of its spend during negotiations. This significantly undermines the effectiveness of the constraint the Cleveland Clinic might offer, and suggests it will not be able to address the AEC in full.

2.43 The CMA argues that another hospital operator might invest in adapting its hospital to provide Oncology services, in particular radiotherapy.²⁵ However, this is a purely speculative

²² [§<].

²³ CMA Final Report, page A6(3)-12.

²⁴ As the CMA notes, the US News & World Report's Best Hospital Rankings do not place The Cleveland Clinic in the top 10 providers of oncology in the US.

²⁵ PDR, paragraph 1.75: "We considered whether the fact that Cleveland Clinic was not currently planning to provide medical oncology or radiotherapy would reduce the extent to which it could constrain HCA, particularly in light of the emphasis placed

assessment and we are not aware of credible plans by other operators considering or costing significant expansion in Oncology. Indeed, the CMA presents no credible evidence of any material entry relating to Oncology in the PDR nor any reasoning as to why such entry may be likely (given that it has not occurred to date).

- 2.44 It follows that neither the Cleveland Clinic nor any other provider is realistically likely to constrain HCA effectively in respect of Oncology. Given that the CMA itself recognises that HCA's market power in Oncology grants it the ability to exert market power across other specialisms, it is unclear that the Cleveland Clinic's entry would therefore be sufficient to address the AEC effectively. The CMA would need to present and rely on credible evidence from other operators entering Oncology **at significant scale and pace** to reach a conclusion that the AEC would be addressed effectively by entry of the Cleveland Clinic.

There is significant uncertainty around how the Cleveland Clinic will choose to compete once it has entered and the CMA cannot depend on the Cleveland Clinic's claimed pricing strategy

- 2.45 We understand that the Cleveland Clinic has told the CMA how it intends to price relative to HCA (the strategy is redacted from the published version of the PDR and so Bupa is not in a position to assess the impact of the pricing directly). However, we note that this intention, stated five years in advance, and before they have even started building the hospital, will not be binding on the Cleveland Clinic. As a result, following its actual entry into the market, its optimal strategy may be substantially different.²⁶
- 2.46 First, there is a significant risk that its pricing will simply 'follow' the leader HCA. HCA will be a massive and super-dominant competitor, in a highly concentrated market still protected by entry barriers. HCA will remain a 'must have' group to insurers, blunting the incentives of the Cleveland Clinic to price aggressively against HCA. Insurers may also be restricted in their ability to send high volumes to The Cleveland Clinic (see paragraph 2.50).
- 2.47 **It is, therefore, wholly uncertain whether the Cleveland Clinic will bring lower prices to the market.** Even if it does price below HCA, it would need to price very substantially lower than HCA's prices to neutralise the effects of the price rises that HCA will be able to achieve (from its already inflated level) before the Cleveland Clinic is a viable constraint. To illustrate:
- i. [redacted].²⁷
 - ii. [redacted].

on a competitor needing to provide the full range of oncology services in the submissions from some PMIs. In the Final Report we concluded that it would be possible for a hospital operator to adapt a hospital's service offering to incorporate new treatments and specialisms, for example by attracting consultants in different specialisms, hiring new specialist staff, or acquiring new equipment, but that this process would be likely to take time, and it would require sufficient spare capacity to facilitate such an expansion of the service offering. We considered that TLC's development of the Cancer Centre (which took three and a half years) provided a relevant example in this context. Our current view is that this development was similar to the construction of a new hospital and that an expansion by an existing operator of the range of services offered, including adapting buildings to accommodate radiotherapy facilities, would take less time than this."

²⁶ In economic terms, there is a risk of 'dynamic inconsistency' in these strategic plans. The firm may state a plan for a future period, but that plan may no longer be optimal when that future period arrives (e.g. due to changed preferences or new information). There is no commitment mechanism that would bind the Cleveland Clinic to its stated plan.

²⁷ Revenues can rise faster as these include also volume effects and the effects of new products.

- iii. The Cleveland Clinic pricing would, therefore, need to be very much lower than HCA's pricing to correct or reverse the effects of the AEC on pricing in the market.
- 2.48 If the CMA has doubt that the Cleveland Clinic will deliver substantially lower prices than HCA, then it can have no confidence that Cleveland Clinic will address the AEC effectively, or deliver the equivalent effects to divestment of HCA hospitals (which would have curtailed HCA's ability to impose these significant increases).
- 2.49 Second, we understand that the Cleveland Clinic plans to use an innovative employment model with consultants, as it has used in the US. Innovation is welcome, but the risk remains that this approach is untested in the Central London market. It is not clear that it will be sufficiently attractive to retain the high earner, senior consultants necessary to establish the success of the hospital. As noted, these consultants may have strong economic reasons to stay with HCA. If Cleveland Clinic has to get into a salary war with HCA to win and retain the best consultants, then it will face additional costs that will limit its ability to compete on the market.

The CMA has failed to assess how HCA would likely respond to entry by the Cleveland Clinic, and the likelihood that such a response would materially reduce the Cleveland Clinic's ability to compete effectively

- 2.50 HCA has significant advanced warning of the Cleveland Clinic's entry, and has over three years to plan and implement a defensive strategy that will limit the impact of this entry on its business.²⁸ This would be a rational business response but, given HCA's size and importance, may significantly reduce the effectiveness of any entry. The CMA does not meaningfully assess or address this risk in the PDR.
- 2.51 HCA will be able to deploy various tactics to secure its dominant position:
- i. [REDACTED].²⁹
 - ii. [REDACTED].
 - iii. [REDACTED].
 - iv. [REDACTED].
 - v. [REDACTED].
- 2.52 There is clear evidence that HCA has sought to pursue similar types of defensive strategies before. The CMA's case study on the opening of The London Clinic's Cancer Centre, for example, explains:

"48. AXA PPP told us that HCA had sought contractual arrangements which would have had the effect of 'locking out' new provision in London and that HCA wanted AXA PPP to 'guarantee not to recognize' the new cancer facilities being developed by TLC. AXA PPP submitted email exchanges between HCA's then Commercial Director and AXA PPP's Head of Provider Management in 2006 in which, on 13 October, HCA set out how it saw the goals of the two parties: 'We [HCA] are looking to

²⁸ HCA pursued a defensive strategy when The London Clinic sought to build its Cancer Centre.

²⁹ See Section 3 of Bupa's response to invitation to comment in May 2015 for examples of these clauses and how they restrict Bupa's activity.

have new facilities recognized and have network integrity within central London in tertiary services, and you [AXA PPP] are looking for an ability to offer wider access to your members.’ AXA PPP told us that ‘network integrity’ referred to a situation in which AXA PPP should not add further radiotherapy facilities to its current network in London.

49. HCA told us that in the negotiations with AXA PPP which led to the revised 2010 contract there was discussion of a pricing formula based on whether AXA PPP was proposing to recognize TLC’s newly opened Cancer Centre and the impact that this would have on the volume of cancer referrals to HCA hospitals. HCA told us that its position reflected its concern that the forecast volume of patients through its radio-therapy facilities, in which it had invested very heavily, might be impacted. As the economics of capital-intensive facilities such as these are very sensitive to volume, additional radiotherapy capacity could therefore undermine their profitability.’³⁰

- 2.53 HCA’s massive size by the point of the Cleveland Clinic’s putative entry gives it the scale and bargaining power to put into effect a range of actions to frustrate volumes to rivals. By contrast, a divestment that directly reduces the size of HCA would reduce the risk of many of these defensive actions being put in place in the first place – for example, insurers would have greater ability to rebuff proposed restrictive contractual clauses from HCA.
- 2.54 The CMA does not assess this risk effectively in the PDR. We would encourage the CMA to engage directly with the Cleveland Clinic and other London hospitals – such as the London Clinic – on these risks.
- 2.55 A further function of HCA’s market power is its status as ‘must have’ gateway for consultants to access sufficient private activity in London. Given HCA’s status as ‘must-have’ for consultants, it will also be in a better position to employ consultants directly (as it will occupy so much of that consultant’s work already), thereby encouraging them into exclusive relationships with HCA. HCA will therefore be able to leverage its market power and must-have status to prevent sufficient consultants from developing relationships with the Cleveland Clinic.
- 2.56 As explained in more detail in paragraph 2.29 above, Bupa strongly disagrees with the CMA’s provisional conclusion that the clinician incentives remedy will prevent HCA from restricting the Cleveland Clinic’s access to consultants. First, this remedy was not intended by the CMA specifically to address HCA’s market power, and the CMA offers no reasoning in the PDR (or elsewhere) as to how the remedy would do so. Second, the means by which HCA can, by virtue of its market power, lock-in consultants in ways which fall outside the ambit of the remedy. Third, and in any event, the CMA considered in its Final Report in the original market investigation that the full effectiveness of the clinician incentives remedy could only fully arise *in conjunction with a divestment of HCA hospitals* - the PDR therefore places too much confidence on its assumption that the clinician incentives remedy will on its own remain fully effective in constraining HCA.

³⁰ CMA Final Report, page A6(3)-10.

3. Proportionality of divestments

3.1 The PDR explains that:

- i. The CMA Group has provisionally found that either of its two divestment packages would be effective in addressing the AEC. This appears to be a unanimous decision.
- ii. The Group was split, however, on the proportionality of the divestment remedies. The view on proportionality was informed by a NPV calculation which compares the present value of the (one-off and ongoing) costs of the divestment against the present value of the price benefits to UK inpatient and day-case patients. The methodology of the NPV analysis is set out in the Appendix to the PDR.
- iii. Four members of the Group believed that entry by the Cleveland Clinic would constrain HCA effectively from 2022. These members, therefore, focussed on the “Year 5” point in the NPV analysis.
- iv. One Group member, however, was not convinced about the impact of the Cleveland Clinic’s entry.³¹ That Group member, therefore, “*considered that the benefits of the divestiture remedy should be calculated over a longer period and, in contrast to the majority of the Group, provisionally concluded that a divestiture remedy would be both effective and proportionate.*”

3.2 As explained in Section 2, there are strong reasons to believe that entry by Cleveland Clinic will not constrain HCA effectively by 2022. For example, it will have little effect, if any, on HCA’s dominance in Oncology. The Cleveland Clinic is also already behind schedule on the CMA’s timetable for entry. Therefore, the CMA must now place more weight on points in the NPV beyond “Year 5”.

3.3 Further, this section explains **twelve key points** in which the CMA’s current NPV analysis is flawed. These points are labelled **A** to **L** below and we have grouped them into three broad categories: *Assessing Benefits*; *Assessing Costs*; and, *Assessing the NPV in the round*.

3.4 We discuss each point separately below, although **their effects will be in combination**.

3.5 If these issues are addressed, the CMA’s NPV modelling will be strongly positive at the 5-year point on which the CMA currently places weight. **Divestment will be proportionate irrespective of the view taken on the entry of the Cleveland Clinic** i.e. even if the Cleveland Clinic were to enter and be a successful constraint in 2022, divestment in 2017 would still be proportionate.

3.6 On 6 April 2016, the CMA also provided our advisors in Confidentiality Ring 1 with three spreadsheets of data that underpin the NPV analysis. Our advisors have used this Confidentiality Ring information to inform the comments in this report. However, they have not shared this analysis or information with Bupa. So the outputs of this analysis are included in the

³¹ PDR, paragraph 1.86: “One of the Group members did not agree with this provisional conclusion and considered that new entry, even if it were to take place within the timescales set out above, which that Group member felt was not certain, was unlikely to be an effective competitive constraint on HCA such as to remedy the AEC (in contrast to the divestment we proposed in the Final Report).”

Confidential Annex **which Bupa has not seen**. This section cross-references further analysis in the Confidential Annex where appropriate.

Background

- 3.7 Before explaining the flaws in the CMA’s current NPV analysis, we set out briefly below some key features of the CMA’s methodology that we refer to repeatedly in this section.
- 3.8 The PDR updated the profitability analysis for HCA to cover a nine year period. It presents three key scenarios for ROCE, referred to as:
- i. **Base Case** – Property is revalued by Altus Edwin Hall on the basis of commercial property alternative use.
 - ii. **KPMG 1** – Property is revalued by KPMG on the basis of residential property alternative use (increasing Capital Employed) and the capital gains are recognised in the P&L.
 - iii. **KPMG 2** – Property is revalued by KPMG on the basis of residential property alternative use (increasing Capital Employed) but capital gains are not recognised in the P&L.
- 3.9 In each case, the CMA finds HCA earned substantial and sustained excess economic profits. However, KPMG 2 gives the lowest estimate of HCA’s profitability, so KPMG 2 is by far the most conservative view on customer detriment caused by the AEC. We include in **Table 2** of the Confidential Annex the resulting estimates of customer detriment over the period in each scenario and explain the reasons why we believe the CMA should reconsider its reliance on the KPMG 2 scenario.
- 3.10 The CMA uses the Economic Profits to estimate the scale of price reduction to include in the NPV modelling. Below we replicate “**Table 4 of the PDR Appendix**” in which the CMA uses the economic profits in the KPMG 2 scenario and Base Case scenario and two of the four cost allocation scenarios it modelled (“77/22” and “73/26”) to estimate the required price reductions.

Table 4: ROCE and economic profit by customer type

Cost allocation (UK/overseas)	UK patients		International patients	
	'Base case'	'KPMG 2'	'Base case'	'KPMG 2'
77/22				
ROCE (%)	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Economic profits (£m)	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
EP / revenues (%)	7.9	3.1	[REDACTED]	[REDACTED]
73/26				
ROCE (%)	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Economic profits (£m)	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
EP / revenues (%)	10.7	6.2	[REDACTED]	[REDACTED]

Source: CMA analysis.

- 3.11 We see that, on the CMA’s current analysis, the KPMG 2 range is 3.1% to 6.2%, and the Base Case range is 7.8% to 10.7%. So KPMG 2 provides a substantially lower range.
- 3.12 The CMA then uses these price reductions to estimate the NPVs of divestments, under different assumed cost scenarios faced by HCA, and presents these in the “**Revised NPV Table**” (this is the table published on 6 April 2016 after errors were identified in its earlier modelling in the PDR report). The CMA only shows price reductions of 3% and 6%, which relate to the KPMG 2

range estimated above (they do not fall into either the Base Case or KPMG 1 price ranges – as shown in **Figure 6** of the Confidential Annex).

Revised Table 2.1: NPV of divestiture

NPV estimate	UK self pay & insured sensitivities			
	Year 3 (2019/20)	Year 5 (2021/22)	Year 7 (2023/24)	Year 10 (2025/26)
	3.0%			
Loss of economies of scale				
£[X] million – downside case	(35,855)	(38,770)	(41,492)	(45,238)
£8.2 million – base case	(23,248)	(18,453)	(13,976)	(7,813)
£0 million – upside case	(274)	18,571	36,163	60,383
	6.0%			
£[X] million – downside case	(20,801)	(4,871)	10,000	30,473
£8.2 million – base case	(8,194)	15,446	37,515	67,898
£0 million – upside case	14,779	52,470	87,654	136,094

Source: CMA analysis.

Note: The dates set out in the table assume that divestiture takes place within nine months of the date of our Final Order, ie by September 2017.

- 3.13 As explained in the Confidential Annex – paragraph B.16 *et seq.* and paragraph B.31 *et seq.* – there are substantial data and logical inconsistencies between the two spreadsheets the CMA uses to model the two tables above.
- 3.14 **Both the ‘Revised NPV Table’ and ‘Table 4 of the PDR Appendix’ are wrong and need to be restated after correcting these inconsistencies.** Indeed, we show below that fixing just one of the inconsistencies would make the NPV positive at Year 5 across all likely price reductions.
- 3.15 So, even if the CMA sticks with KPMG 2 as its preferred scenario and can find evidence to support the Cleveland Clinic becoming a fully effective constraint after Year 5, the NPVs at the 5 year point in the base case for losses of economies of scale are substantially positive. **Divestment is proportionate.**
- 3.16 We now turn to the further specific issues that we have identified in the CMA’s modelling.

Assessing Benefits

A – Benefits to self-pay patients arise immediately

- 3.17 The CMA models the price benefits arising gradually over the two years after divestment because (it is assumed) insurers and HCA would need time to renegotiate contracts. The CMA states:

“The price benefits of divestiture are realised partially in the second year (50%) and fully from the third year onwards [i.e. zero benefit in the first year]. This reflects the assumption that prices at both the divested hospital(s) and HCA’s remaining hospitals would be renegotiated gradually over the three years following divestiture as agreements with the insurers came up for renewal.”³²

- 3.18 However, this is clearly incorrect as regards the price benefits for self-pay patients which would arise immediately and in full once the divestment takes place. With increased choice in the London market, HCA and others would immediately after the divestment start competing harder for self-pay patients. There would be no delay.
- 3.19 In its modelling, the CMA computes the self-pay price benefit separately to the insured price benefit. So it is straightforward to correct the model so that the price benefit to self-pay patients arises in full in the first and second years.³³
- 3.20 This increases the present value of benefits across all scenarios, meaning all NPVs become more positive (or less negative). The corrected table is included as Table 4 in the Confidential Annex.

B – The treatment of outpatient revenues is inconsistent, substantially underestimating the price benefits

- 3.21 In the NPV analysis the CMA estimates the price benefit from the divestment by applying the price reduction to inpatient and day-case revenues (in central London) only:

“We have applied this price reduction to UK self-pay and insured revenues from inpatient and day-case treatments. We have assumed that divestiture would have no impact on the prices charged by HCA for outpatient treatments. This approach is based on our assessment of the level of competitive constraint across the different treatment modalities as set out in our PFs.”³⁴

- 3.22 So the NPV analysis excludes outpatient revenues.
- 3.23 However, this introduces an inconsistent logic to the estimation of the price reduction in ‘Table 4 of the PDR Appendix’. In that table, the CMA calculated the percentage price reduction – the 3.1% to 10.7% estimates – by dividing the economic profits earned by HCA in each scenario by the full revenues (including outpatient revenues).³⁵

³² PDR paragraph 2.49b.

³³ The current treatment omits the benefit in the first year and only partially reflects the benefit in the second year.

³⁴ PDR, paragraph 2.44. [3<]

³⁵ In fact, the CMA’s current denominator includes all HCA UK revenues (including from outside central London), which is a further inconsistency as the NPV Sheet uses only HCA’s central London revenues.

- 3.24 If the CMA wishes to make the assumption in the NPV analysis that there would be no price impact on outpatient treatments (as this market is assumed to be well-functioning and so no excess profits arise in this segment), then the logical consequence is that the economic profits in Table 4 of the PDR Appendix are derived only from HCA's inpatient and day-case activities. Therefore, the required price reductions estimated in Table 4 of the PDR Appendix should be estimated as Economic Profits divided by inpatient and day-case revenues only.
- 3.25 The CMA's current (inconsistent) approach is reflected in the equation below. Two elements of the same step of calculation use different approaches.

$$\text{Annual Price Benefit} = (\% \text{ Price Reduction}) \times (\text{Inpatient} + \text{Day-Case Revenues})$$

From PDR Table 4:

$\frac{\text{Economic Profit} \times 100}{(\text{Inpatient} + \text{Day-Case} + \text{Outpatient Revenues})}$

↑ Includes Outpatient Revenues

↑ Excludes Outpatient Revenues

- 3.26 The effect of the inconsistency is to bias downwards the estimated annual benefits from divestments.
- 3.27 It is illogical for the CMA retain its current price reduction estimates from Table 4 of the PDR Appendix if it believes that outpatient activities are well-functioning and so no excess profits are earned by HCA in that segment. Retaining the CMA's current approach would attribute a significant fraction of HCA's economic profits to outpatient activities; and then it would miss these economic profits in the NPV analysis when it assumes no price impact on outpatient treatments. It would result in substantial customer detriment simply not being addressed.³⁶
- 3.28 The CMA must, therefore, correct this logical inconsistency of approach between Table 4 of the PDR Appendix and its NPV analysis. We note that these two analyses were calculated in two separate, unlinked spreadsheets which may be why the inconsistencies have arisen in the first place.
- 3.29 This correction substantially increases each of the percentage price reductions estimated in Table 4 of the PDR Appendix:
- 3.1% is no longer the lower bound of the price reduction range;
 - The lower bound of the KPMG 2 range would now be over 5%;³⁷
 - The upper bound of the KPMG 2 range would rise from 6% to over 10%; and,
 - The upper bound of the Base Case range would rise from 10.7% to over 17%.
- 3.30 **This correction very materially changes the conclusions of the NPV analysis.** Using the logically consistent estimates significantly increases the quantified size of the price reduction benefits from divestment. **In particular, based on the CMA's modelling, the NPV at the 5 year point in the Base Case (with ongoing costs of £8.2 million) would become positive**

³⁶ In the CMA's current modelling this is obvious because its estimated annual divestment benefits address only a small fraction of HCA economic profits; see Table 3 in the Confidential Annex.

³⁷ More precise estimates are provided in Table 5 and Figure 7 of the Confidential Annex.

in all relevant price scenarios. So fixing this error alone would make the divestment proportionate.

3.31 We present the results of correcting this inconsistency in Table 6 of the Confidential Annex.

C – The economic profits are substantially underestimated

3.32 The CMA chooses the lowest possible ROCE scenario, with the most conservative (smallest) estimate of customer detriment.

3.33 The CMA selects the 'KPMG 2' scenario in which HCA's owned property is revalued upwards to residential property alternative use and all capital gains are excluded. The CMA, in effect, gives full weight to this scenario in presenting in its Revised Table only 3% and 6% reductions. It does not show HCA's higher profitability scenarios (KPMG 1 or the Base Case) in the NPV results.

3.34 There are two substantive concerns about why the economic profits are underestimated.

3.35 First, relying on the residential-alternative use valuation by KPMG is a strong assumption when evidence suggests this may overstate HCA's capital employed. The PDR Appendix explains:

"12. we noted (a) the price differentials between residential and commercial property have not disappeared (to date) and we would expect such convergence in prices to take a number of years to be realised (if at all); and (b) several of HCA's properties were located within the Westminster Central Activity Zone, which is currently exempt from the new planning development rights This indicates that the value of HCA's buildings is likely to be somewhere between the Aldus Edwin Hill and KPMG valuations.

16. The evidence that we collected indicated that the value of HCA's land and buildings was likely to be between the Altus Edwin Hill and the KPMG valuations. C&W's report, together with the information on the purchase price of 33 Grosvenor Place, suggested that a value approximately midway between these two points may be the most appropriate. However, when taking into account the potential costs of converting a building to hospital use, this suggested that more weight should be placed on the KPMG valuation."

3.36 Second, excluding capital gains in full is an extremely conservative assumption by the CMA that would be contrary to the market experience and would violate the principle of Financial Capital Maintenance (FCM) – the comprehensive income approach.

3.37 The value of HCA's property portfolio has risen substantially over the CMA's nine years of profitability analysis. There have been very significant estimated capital gains in almost every year. However, in selecting the KPMG 2 scenario for the NPV modelling, the CMA selects a scenario where HCA's profitability appears artificially low because these capital gains are not included in the P&L. The CMA says that the increase in value of Central London hospital buildings may represent a 'windfall' that was unrelated to competitive conditions in the market and that:

- i. *"[C]apital gains made in previous years may not be repeated in future ... if property prices stabilise at the current level"; and,*

- ii. *“[R]egardless of property value appreciation or depreciation over time, we would not necessarily expect such changes, which are only discovered at the end of a period, to be reflected in the pricing of HCA or other competing hospital groups, ie we would not expect a private hospital operator to base its pricing on an estimate of its costs plus or minus any expected change in the value of its property over the coming year”.*³⁸

- 3.38 The reasoning in (i) is weak and unsupported by evidence. It is highly unlikely that property prices in Central London will remain at current levels for the 5 to 10 year period relevant to the NPV analysis. In the absence of credible independent specialist evidence that London property prices will not rise over the course of the NPV analysis, the reasonable conclusion is that it is more likely than not that property prices will continue to rise.
- 3.39 The reasoning in (ii) is also weak because of the sustained nature of the appreciation and the expectations this will have created. There was significant capital appreciation and capital gains in almost all of the years in the KPMG 2 scenario (despite the financial crisis and recession). This pattern, together with expectations of future capital appreciation and economic growth, means it would seem highly likely that managers and their shareholders (and potential new entrants) will factor capital appreciation into their commercial strategies which will impact pricing. HCA often negotiates multi-year contracts, and entry is a multi-year commitment, so market players will likely form expectations on future capital appreciation (and capital gains across periods) in their pricing behaviour. These are not “unexpected” windfalls.
- 3.40 If capital appreciation in Central London is more likely than not and therefore ‘expected’, then the CMA is being unreasonably conservative in assuming HCA’s future profitability is best reflected by KPMG 2 rather than the much higher and comprehensive KPMG 1 scenario. This choice would be heavily in favour of HCA instead of the consumers experiencing detriment.
- 3.41 In the *Aggregates Inquiry*, the CMA considered the matter of FCM/comprehensive income and impairments/capital gains in detail. For example, the ‘windfall’ profits from carbon credits were included in the profitability estimates as they were expected and sustained. We note that the CMA took expert academic advice on its treatment of capital gains / impairments in that case, and we would ask that the CMA does so again in this case and publishes the opinion.³⁹
- 3.42 We believe the CMA’s choice is therefore unsupported by the facts and is inconsistent with its standard practice in profitability modelling. Choosing either of the other two scenarios (or even a blended level across the three), **would increase the NPVs of the divestment in all cases.**

³⁸ PDR Appendix, paragraph 17.

³⁹ The opinion provided by Professor Geoffrey Whittington in the *Aggregates Inquiry* is on the CMA website, at: https://assets.digital.cabinet-office.gov.uk/media/5329dfb6ed915d0e600002bf/131015_commentary_on_the_cement_profitability_analysis_prof_whittington_summary.pdf

D – The cost allocation places disproportionate excess profits on to the international patients segment

- 3.43 We have raised concerns in Point B above about the estimates in Table 4 of the PDR Appendix (see paragraph 3.21 *et seq.* above).
- 3.44 However, the CMA must also consider whether the profit allocations between UK and International patients in the “**77/22 KPMG 2 scenario**” in Table 4 of the PDR Appendix can be justified. This is the scenario that sets the lower bound of the price reductions considered by the CMA – the 3.1% price reduction currently reported in the table.
- 3.45 The details of our concern are set out in paragraphs B.45 *et seq.* of the Confidential Annex. However, the gist is that the 77/22 allocation attributes a disproportionate amount of HCA’s earned economic profits to International customers. It is difficult to reconcile this outcome with: the other financial data the CMA reports; where the AECs arise; or, the dynamics of competition in the international market that HCA alleges.
- 3.46 See Table 8 in the Confidential Annex.
- 3.47 This “77/22 KPMG 2” scenario is the most extreme of the four cost-allocation scenarios the CMA models and it drives the most unexpected and inexplicable profitability results. It becomes, however, the focal point of the NPV analysis as it sets the lower bound for divestment benefits. Were the CMA to place greater weight on the other cost allocation scenarios it modelled (as we believe it should), which drive more reasonable allocations of profit between UK and International customers, **the NPVs would substantially increase across all cases as higher price reductions would be implied.**

E – The assumed counterfactual on HCA’s growth causes benefits to be underestimated

- 3.48 The CMA calculates the annual price benefit by multiplying the estimated price reduction with HCA’s 2015 day-case and inpatient revenues in central London. This annual benefit is fixed at this level, and applied across future years in the NPV analysis.
- 3.49 However, in reality, it is more likely than not that HCA’s revenues will continue to rise rapidly year-on-year going forward in the absence of divestment, as they has done in the past – see

3.50 in Section 2 above. HCA's revenues have increased at a rate of [X] per annum. Over five years HCA's revenues could rise by over a third. So HCA's 2015 revenues are not the appropriate basis to calculate expected annual benefits from the divestment in, say, 2020 or 2022.

3.51 The appropriate divestment benefit in a future year should be the percentage price reduction multiplied by that future year's projected revenues. This would substantially increase the divestment benefits that society could expect in future years. **This would increase the NPVs in all cases.**

F – Assuming annual benefits fall to zero from Year 5 due to the Cleveland Clinic is an extremely strong assumption that cannot be justified

3.52 The CMA assumes that the Cleveland Clinic will fully constrain HCA from 2022 and so benefits from the divestment fall to zero thereafter. This is an extremely strong and overly optimistic assumption. We have explained in Section 2 above why there is significant uncertainty that the Cleveland Clinic will, in 2022, have equivalent competitive effect to the divestment of assets in 2017.

3.53 In particular:

- i. There is a high risk that the Cleveland Clinic will have little impact against a significantly larger HCA that has had years to prepare and put in place a defensive strategy.
- ii. There is little evidence that HCA's dominance in Oncology will be constrained, and so HCA will be able to continue to leverage higher prices in this specialism (which currently accounts for a quarter of Bupa's claims spend with HCA in central London) and across other business activities, even if the Cleveland Clinic enters.
- iii. The Cleveland Clinic may change its stated pricing behaviour once in the market. The market will, for example, be very highly concentrated (an HHI [X]) and the Cleveland Clinic may simply follow the pricing of the leader.
- iv. Given the [X] inflation ratchets HCA achieves in its pricing each year, even if the Cleveland Clinic follows its promised pricing rule, prices would more likely than not be higher in 2022 that would have arisen following divestments in 2017. The Cleveland Clinic's pricing will not be able to correct or reverse the series of higher price increases that HCA would accumulate between now and 2022.

3.54 So a counterfactual that assumes price benefit falls to zero after the Cleveland Clinic enters is an extreme assumption. **Any softening of this assumption, as we believe is justified by the evidence, increases the NPVs of the divestment in all cases.**

3.55 For example, the CMA could assume that the price benefit would at least continue to arise on Oncology spend. [X].

G – The CMA can bring forward in time the insurer price benefits

- 3.56 As noted in paragraph 3.17 above, the CMA assumes that insurer prices will adjust slowly, with zero benefit in the first year and only half in the second. However, it would be possible for the CMA to mandate HCA, the new entrant(s), and the insurers to come to new pricing arrangements more quickly.
- 3.57 Indeed, we see no reason why the CMA should tolerate a period before which insured prices do not adjust. This simply protects hospital producer surplus at the expense of consumers. It is an overly conservative assumption.
- 3.58 Insurers would be highly motivated to put in place new contracts and pricing if given the opportunity.
- 3.59 Insurers could give the prospective acquirer of the divested assets forward guidance on the likely range of prices they will seek (this is what Bupa does when a new hospital operator wishes to enter). This will assist buyers of the divested assets in modelling the returns for the assets, and more competitive pricing can be 'priced into bids' in advance. Contracts with new prices could be in place **from day one** of the divested hospital 'opening'. **So these benefits could arise in full and immediately.**
- 3.60 Insurers and HCA could also negotiate new pricing terms in advance of divestment or immediately thereafter. The CMA could direct HCA and insurers to commit to complete negotiations within a specific time-frame.
- 3.61 Bringing the price benefits forward by six months or a year would add several millions to the welfare of consumers. It would seem a reasonable and proportionate action, with no real barrier to implementation. **It would make the NPVs significantly more positive.**
- 3.62 It would be unreasonable to find the divestment disproportionate when a small, ancillary commitment ordered by the CMA for insurers and HCA could bring forward in time several millions of benefit for consumers. The CMA would need very strong grounds to maintain this assumption of a delayed accrual of benefits when the issue can be easily addressed through an additional commitment and, indeed, should be addressed to, as comprehensively as possible, resolve the customer detriment.

H – A range of benefits that will flow from the divestments are not taken into account

- 3.63 The CMA models the divestment benefit as arising only from the reduced prices on HCA's 2015 day-case and inpatient revenues. However, there are a range of additional benefits, some potentially very substantial, that would arise in addition:
- i. **Price effects across the market** – When HCA and the new entrant compete more aggressively with lower prices, it will naturally lead others to respond and compete more aggressively too. The feedback effect will likely see price reductions across the market, increasing substantially the net benefit consumers will experience. The CMA currently does not include any of these consequent benefits from across the market.
 - ii. **Reduced deadweight loss for consumers** – When prices are above the competitive level, society faces losses that are not fully reflected in the excess profits of the producers. There will be consumers willing to participate in the market when prices are

at more-competitive levels who are currently priced out of participating (and lose welfare as a result⁴⁰). The increased welfare of these customers should be factored into the benefits analysis, and could be very substantial. Further, with these increased patient volumes, hospitals across the market (including HCA) will be able to achieve further economies of scale, lowering prices further.

- iii. **Quality and innovation benefits** – the CMA notes that it has not sought to quantify these dynamic benefits, but that they would likely exist in a well-functioning market. We emphasise particularly the innovation benefits that will arise from insurers being able to launch new, lower cost network products for consumers and being able to use mechanisms to control costs (e.g. service-line tenders) that are currently restricted by HCA. We have repeatedly emphasised to the CMA that HCA's scale and dominance has allowed it to restrict the activity of insurers – e.g. through contractually restricting our ability to send patients to better value for money providers. With HCA's bargaining position reduced, we would seek to remove these clauses, which would help create a more dynamic and efficient market for insured customers.
- iv. **Benefits to international patients** – With more rivalry in London, international patients will also benefit. Currently, the CMA attributes zero benefit to these customers in this segment. Improving the outcomes for international patients will also have positive effects for the wider UK economy. With lower prices in London, there may be greater flows of international patients to London which will increase employment and demand in related sectors of the local economy.

⁴⁰ They also place additional strain on the NHS.

Assessing Costs

I – The economies of scale losses are not a Relevant Customer Benefit

- 3.64 It is important that the CMA rejects HCA's assertion that economies of scale associated with its portfolio of hospitals are relevant customer benefits ("RCBs") that "*would be lost (or at least reduced) as a result of imposing divestitures on the business*". The CMA has done so previously in its Final Report and the CMA should not change this position.
- 3.65 As explained in further detail in Annex A, the Enterprise Act 2002 makes clear that a RCB arises in circumstances where it is a benefit to customers (or future customers) in the form of lower prices, higher quality or greater choice of, or innovation in respect of, goods or services. Moreover, the RCB needs to have accrued as a result of a feature(s) giving rise to an AEC and must be unlikely to accrue in the absence of the feature(s) giving rise to the AEC.
- 3.66 In the present instance, it is clear that any economies of scale available to HCA cannot be treated as an RCB since no benefit – notably in the form of lower prices – is passed on to consumers as a result of such economies. This fact has been effectively recognized by the CMA in its profitability analysis, which shows a significant producer surplus for HCA and that prices do not reflect costs, and its Insured Price Analysis (IPA) which shows HCA was significantly more expensive than its much smaller rival the London Clinic. There is no compelling or credible evidence that HCA's economies of scale are passed on to consumers in the form of lower prices.⁴¹
- 3.67 In this context, it is telling that in the Competition Commission's Final Report in the BAA airports market investigation, the CC also found that "*we would expect the benefits of economies of scale to be passed on if there is effective competition. However, we have found that this is absent due to BAA's common ownership [of airports]*". Similarly and by analogy, the very high concentration in the London market due to HCA's considerable market power means that it is implausible for there to be an RCB, in particular in circumstances where the CMA has provisionally found that HCA in fact charges higher prices than would be expected in a well-functioning market.
- 3.68 Accordingly, given that there is no evidence that HCA has passed on any of the alleged economies of scale to customers, in the form of lower prices, it is wholly unclear that HCA will in the future have any incentive to do so.
- 3.69 Further, while HCA argues that there is no guarantee that the economies of scale could be fully replicated by a purchaser of the divested hospitals (particularly where that purchaser does not have a significant presence in central London), it is worth noting that since the majority of the economies are associated with "recharged central costs", it is entirely plausible that a purchaser with activities outside central London could replicate these costs savings across its enlarged portfolio. In such circumstances, these economies could not be treated as RCBs since they are replicable by third parties (including potential purchasers of divested HCA hospitals). HCA itself could replicate these economies of scale by expanding outside of central London, as it is doing already.

⁴¹ Bupa has also previously submitted patient survey data that shows HCA does not out-perform smaller hospitals on quality of service. This demonstrates that the alleged benefits of economies of scale are not passed through to customers in the form of higher quality.

3.70 There are strong grounds that the losses of economies of scale are not a RCB and should not be included in the CMA's assessment on that basis.

J – The levels of costs in each year are substantially overestimated

3.71 Bupa has significant concerns that the divestment costs included in the NPV analysis are overstated and, more importantly, that the economic effects that these costs have on prices is incorrect. There is a significant risk that the CMA's current approach will simply reward and protect HCA's inefficiency at the cost of continued detriment to consumers.

3.72 We note that there are two categories of costs included in the NPV analysis:

- i. **One-off costs** of £16 million including:
 - a. **Transaction costs** incurred by the seller (HCA) and the buyer. HCA proposed a breakdown of costs, which the CMA assessed to arrive at an estimate of around £8 million.
 - b. **Re-organisation costs** related to "*the need to reduce the central business functions to reflect the smaller size of the business*". HCA did not provide an estimate of these costs, so the CMA assumed they would be around £8 million.
- ii. **Ongoing costs** which relate to the 'loss of economies of scale' HCA would allegedly experience on an 'ongoing' basis as a result of the divestments. These would include recharged central and group costs that would now need to be recovered by the remaining facilities, and costs relating to HCA's laboratories and the Sarah Cannon Research UK. HCA proposed an estimate of annual costs. The CMA notes this estimate "*was likely to overstate the actual losses*" and so reduced it to £8.2 million per annum.

3.73 We comment on each category of cost further below. However, first we note a more general concern that the cost figures are likely to be overstated. The CMA has found an AEC in the market resulting in "*weak competitive constraints on HCA*" and a market insulated by high barriers to entry and expansion. The PDR shows that HCA has earned substantial excess economic profits for nine consecutive years, demonstrating that its prices are not reflective of costs.

3.74 This environment of weak competition raises two concerns.

3.75 First, HCA's costs are unlikely to have faced sufficient downward pressure at the point when they were incurred or over time. HCA could remain inefficient, protected by its own size and conduct, and entry barriers. Rather than compete with lower costs (and prices), it has used:

- i. A 'must have' negotiating position to, for example, demand annual increases to its "financial envelope" that far exceed the increases of other hospital operators;

- ii. Contractual clauses to limit insurers' ability to launch products or networks that encourage efficiency,⁴² and,
 - iii. Consultant inducements and incentive schemes to attract and lock in consultants.
- 3.76 **There is a significant risk that HCA's cost base is bloated compared to what it would be in a well-functioning market.** So any of the alleged increases to this cost base due to the divestment are overstated.
- 3.77 Second, HCA UK's contribution to HCA group costs could be higher than it would be had the market been well functioning. HCA in the UK faces weak price sensitivity in the market – its 'must have' status allows it to demand higher prices without losing volumes. HCA UK's business will also have been inflated in revenues, costs and profits due to this market power. **These two outcomes of the AEC may have resulted in HCA UK receiving a disproportionate allocation of HCA's group costs.** Cost allocations across an international group are often done on the basis of regional revenues/costs/profits, and in some cases on the basis of price elasticity of markets (where the resulting higher prices would have least demand impact). Therefore, HCA UK's contribution to group costs could be higher than it would have been had the market been well functioning (and the group costs may themselves have been greater overall because the company could benefit from the 'quiet life' due to the AEC).
- 3.78 The risks of existing inefficiency and over-allocation suggest that the CMA should be highly sceptical of the quantum of reorganisation and ongoing costs claimed by HCA. This will be inflated to begin with because of the AEC; and so should not be counted by HCA in defence of remedying the AEC.

One-off costs

- 3.79 Bupa notes that the £8 million of reorganisation costs were not submitted by HCA, but were assumed by the CMA. These costs are unsupported by evidence that they are necessary or appropriate in size.
- 3.80 Bupa has significant concerns about the fairness of including in the NPV analysis the £11.75 million of costs HCA would incur in addressing an AEC from which it has been profiting for nine years.⁴³ In present value terms, HCA has earned hundreds of millions of pounds of excess profits over the period.⁴⁴ It will earn hundreds of millions more in excess profits if the divestment is ruled out on proportionality grounds. HCA is a beneficiary of substantial profits (producer surplus) at the expense of consumer welfare. Yet the costs incurred by HCA to 'put right' this situation are now included in full in the NPV, making divestment substantially less likely.⁴⁵
- 3.81 Further, on the CMA's analysis, HCA is expected to continue to earn substantial excess profits even after the divestment.⁴⁶ It could, therefore, easily absorb these increased one-off costs, without any need to pass them through to consumers.

⁴² Insurers use hospital networks and service line tenders to improve efficiency by directing more volume to better value for money providers. [3<]

⁴³ £11.75m comprises £8 million in reorganisation costs and £3.75 million in HCA's disposal costs.

⁴⁴ See the Confidential Annex, Table 2, for more precise estimates.

⁴⁵ These costs have a material impact on the outcome of the NPV analysis. Removing £11.75 million of costs from the calculation would substantially change all scenarios, moving the majority of scenarios substantially positive, particularly at the 5 year mark.

⁴⁶ This is explained further in paragraphs B.23 et seq. of the Confidential Annex.

3.82 It is perverse in the modelling that including these one off costs to HCA apparently reduce the benefit to consumers from the divestment, even though they contribute substantially to condemning consumers to a continued AEC in future.

3.83 This approach protects the producer surplus of HCA at the expense of the consumer surplus.

Ongoing costs

3.84 HCA put forward its claimed 'losses of economies of scale' due to divesting the hospitals. There is a clear risk that HCA's estimates are biased upwards by the desire to inflate costs to prevent the divestment. It is highly likely, therefore, that HCA's estimates represent an extreme "worst-case scenario" rather than a reasonable downside.

3.85 The CMA considers HCA claimed costs and reduces them to £8.2 million per annum, which it calls "the Base Case". We have noted above concerns about inefficiency and over-allocation which would suggest these Base Case costs are themselves likely to be overstated.

3.86 The CMA then explains that "*our current view is that the potential loss of economies of scale should be taken into account in estimating the NPV of the divestiture remedy*" with the reasoning:

- i. "*[T]o the extent that divestiture increased the cost base of one or more operators in the industry, this could increase the 'competitive' level of prices*"; and
- ii. "*Including the loss of economies of scale effectively reduces the price benefit of a divestiture remedy*".⁴⁷

3.87 Bupa has significant concerns with this reasoning and will explain below:

- i. The CMA should not include any ongoing costs in the NPV calculation as they would not counteract the effect of the divestment on prices for consumers in the market;
- ii. If any ongoing costs are included, they should fall rapidly to zero over time.

3.88 In relation to paragraph 3.87(i) above, we note:

- i. The divestment will create greater choice and competition for consumers in the Central London market. Customers (and insurers) will be able to shop around for better value from hospitals. Prices will be more reflective of costs, with efficient hospitals winning share and gaining economies of scale of their own. Rivalry will drive efficiency. Prices in the market will come down as the market mechanism, rather than the distortive AEC, sets the price.

If in this competitive market one firm sees its costs increase (here HCA), it will still have to accept the (lower) market price – the price being set by competition and the more efficient firms. The costs for other firms will not have increased, indeed they may have reduced as these firms achieve their own economies of scale that were previously not available to them due to the AEC. The firm (HCA) will have to become more efficient if it wants to survive and thrive. It will no longer have the luxury of passing through its higher costs on to customers or insurers that now have more choice. It would be perverse to protect this firm from the market mechanism

⁴⁷ PDR Appendix, paragraph 31.

by allowing it to count its higher costs as a defence – this would simply protect inefficiency at the cost of consumer welfare.

- ii. Even on the most significant price reduction from the divestment assumed by the CMA, HCA appears to continue to earn substantial excess economic profits. This is shown at paragraph B.23 in the Confidential Annex. Therefore, HCA clearly has significant capacity to ‘absorb’ any higher costs within its producer surplus. It will not be ‘forced’ to pass these alleged higher costs on to inpatient and day-case customers in the form of higher prices.
 - iii. The CMA’s IPA analysis showed that HCA charged prices higher than a substantially smaller competitor, The London Clinic. If the London Clinic can compete without the economies of scale, then it is unclear why after the divestment HCA – which would still be three times larger than The London Clinic at that point – would have to set even higher prices.
- 3.89 Therefore, we believe that there are strong grounds to conclude that HCA’s alleged higher costs will not “*increase the competitive level of prices*” in the market or “*effectively reduce the price benefit*” to consumers of the divestment. **Consumer welfare will be substantially larger post divestment.** Consumers will have substantially more choice, and so will get much better value.
- 3.90 Including HCA’s ongoing costs in the NPV analysis as if it will pass them through in full (pound-for-pound) to customers simply protects its inefficiency and is inconsistent with the well-functioning market the CMA is seeking to create. It gives HCA’s producer surplus the same weighting as the consumer surplus.
- 3.91 In relation to point 3.87(ii) above, if the CMA remains minded to include some ongoing costs in the NPV, then they should rapidly fall towards zero:
- i. HCA will be able to recover quickly some of these alleged losses in economies of scale through growth in London and elsewhere. The lower prices across the market will increase the size of market. HCA will be able to compete harder for increased volumes in London. HCA is also expanding elsewhere in the UK (e.g. Manchester), where growth will allow it to recover these alleged losses.
 - ii. HCA will be able to re-scale its costs over time – either through organic growth or through reconfiguring its central functions and Group costs. **Shared and / or fixed costs become variable and scalable over time.** HCA’s management must be expected to make reasonable efforts to mitigate these costs e.g. through rescaling Group costs and functions.⁴⁸ So assuming the losses are permanent is incorrect. It, in effect, ‘rewards’ HCA for remaining inefficient and failing to take management action to mitigate the costs rapidly.
 - iii. The improved process of rivalry and innovation in the market will lower cost bases (for HCA and other hospitals) over time. This process of improving efficiency again suggests that losses cannot be considered ‘ongoing’.

⁴⁸ As a simple thought-experiment, had HCA itself decided to sell the (divested) facilities, it would have quickly put in place plans to mitigate any resulting cost effects.

- 3.92 We note that given HCA's size, even after divestment, an increase in HCA's cost base of £ 8.2 million per annum would be very small – a tiny percentage of the cost base. HCA could very rapidly recover these costs with growth or reconfiguration. **It would seem extremely unlikely that HCA would face any ongoing costs from the divestment for more than five years.**
- 3.93 HCA argues that it will face reduced contributions to Group costs of “*running of HCA's headquarters*”⁴⁹. The PDR does not say whether these are HCA's US headquarters, although the 2014 Final Report suggests HCA submitted costs related to its US Head Office.⁵⁰
- 3.94 As noted above in paragraph 3.77, there is a risk that the UK will have received a disproportionate allocation of these global costs given (i) the low price elasticity of demand that HCA has secured here through its ‘must have’ status; and (ii) the UK's inflated revenues, costs and profits (which are often a basis for dividing global costs between territories). Therefore these Group cost allocations could be substantially inflated by the AEC. HCA clearly has the option of reconfiguring its US headquarters, or collecting larger contributions from other territories, or simply continuing to make these contributions out of its remaining excess profits in the UK. It is also not clear that HCA would be obliged to pass these costs on to UK customers (as they could be collected from other territories).
- 3.95 Finally, HCA's costs should be discounted at HCA's own cost of capital (around 10%) rather than the lower social discount rate (at 3.5%). The benefits of lower prices in the market accrue to consumers over time and so can be discounted at the social rate. However, any ongoing costs for HCA affect HCA's cost base and price formation only. When HCA makes its pricing / commercial decisions it will rely on its own cost of capital. So the ‘best estimate’ the CMA could form on how any ongoing costs might affect HCA's pricing would be to discount these costs at HCA's cost of capital.

Conclusion on costs

- 3.96 Fundamentally, Bupa considers that it is inappropriate, in circumstances where HCA is the long-term beneficiary of the AEC that has been identified, for the CMA in considering remedies that treat the cost to HCA of remedying this situation as equivalent to the cost savings and other benefits to end consumers of price reductions and increased competition in the market. It is inappropriate for society to have to bear HCA's higher profits simply because HCA has been allowed to run inefficiently in the past and might not reconfigure efficiently in future.
- 3.97 Bupa also believes that the market mechanism will drive efficiency and growth across the market that will counter any alleged losses in economies of scale by HCA. If HCA cannot compete at lower ‘market prices’ after the divestment – even though it will still be three times larger than any other operator in the market – it would be perverse to protect this inefficiency by including these costs in the NPV calculation as if they are passed on in full to customers. HCA would not have the luxury of passing these costs on to customers if the market is well-functioning and customers/insurers have sufficient alternative choices following the divestment.
- 3.98 At a minimum, the ongoing costs would fall rapidly to zero over time – they would not be permanent. It would seem extremely likely that HCA could recover in full these costs, through growth or scaling its cost base, within a short period (and five years at the most). HCA's management should be expected to take reasonable and swift action to mitigate any cost effects.

⁴⁹ PDR Appendix, page A12.

⁵⁰ Final Report, paragraph 11.207.

- 3.99 If the CMA removes the ongoing costs from its NPV assessment (as it should), the divestment is clearly proportionate in all cases.

Looking at the NPV in the round

K – The CMA must remove the Year 3 column from the NPV table

- 3.100 The CMA chooses to show a “Year 3” column in the NPV table, despite there being no compelling evidence presented that HCA will be constrained effectively by Year 3.
- 3.101 Even on the CMA’s ambitious timetable for the entry of Cleveland Clinic, it would not be a fully constraining force within the year 2019/2020.
- 3.102 Including this column in the table could bias the CMA’s reading of the table. The smaller (or more negative) NPVs in this column may lead the reader to consider that the results appear ‘mixed’, even though this is not a credible scenario on any of the evidence presented in the PDR.
- 3.103 In the Confidential Annex, we grey out this column and we believe the CMA should remove this column entirely from its results tables.

L – The CMA must fairly probability weight the scenarios

- 3.104 Bupa is concerned that in placing weight on the NPV modelling with the 3% reduction (the lower bound in The Revised Table), the CMA is selecting a scenario that compounds the extreme lower bounds of many variables:
- i. It chooses the lowest bound of the price range; AND
 - ii. It chooses the lowest possible profitability series (KPMG 2); AND
 - iii. It chooses the most extreme cost allocation scenario of those modelled; AND
 - iv. It choose to estimate the benefits based on HCA’s 2015 with no growth over time; AND
 - v. It chooses to zero all benefits from the point at which the Cleveland Clinic *may* become an effective competitor; AND
 - vi. It chooses to apply the price reduction to HCA’s revenues only (rather than capturing effects across the wider market).
- 3.105 As noted above, some of these bounds are wrong. For example the lower bound of the price reduction should be around 5%.
- 3.106 However, with each of these variables the CMA must recognise that it has repeatedly chosen the extreme lower bounds shown by the evidence. Yet, for each of these variables, there are considerable and plausible upside scenarios which must also receive a fair probability weighting.

3.107 What matters is that ‘the expected’ (probability weighted) NPV scenario is positive, not that the scenario which repeatedly combines the downside case assumptions (and so compounds low probability on low probability) may be marginally negative.

3.108 For example, Figure 9 in the Confidential Annex shows the CMA’s analysis of the NPV at Year 5 in the base case of ongoing costs for various price reductions in its range of 3% to 10.7%.⁵¹ The Figure shows:

- i. The NPV is negative only when the price reduction falls at the very bottom end of this range (between 3% and 4.1%).
- ii. Price reductions in the 4.2% to 6.2% range, which are all possible given the CMA’s evidence for KPMG 2, would have a positive NPV.
- iii. The expected value of the distribution between 3% and 6% is therefore positive i.e. it would be ‘*more likely than not*’ that the divestment would generate positive welfare gains in this scenario.
- iv. Further, price reductions between 6.2% and 10.7% may also be plausible, and these would all have substantial positive NPVs.
- v. The CMA would need to believe that the price reduction would fall in the 3% to 4.1% segment of the range **over 95% of the time** for the ‘expected value’ of the distribution of NPVs to be negative. This is a very highly skewed distribution, not supported by the evidence.

3.109 The CMA has found an AEC and substantial consumer detriment. It must weigh the possible upside scenarios for customers fairly. It must not focus only on the extreme downside scenarios that repeatedly compound low probability downside assumption on top of low probability downside assumption.

3.110 The evidence suggests that **the “expected” NPV from divestment at Year 5 is very strongly positive. Divestment is, therefore, proportionate on a balance of probabilities standard.**

⁵¹ Please note that we believe this range should in fact be much higher, as explained in Points B, C, D above. We have made one amendment to the CMA model, which is to assume that self-pay benefits arise immediately and in full (Point A above).

4. Further considerations on remedies

- 4.1 The scale and persistence of the customer detriment in Central London from the AECs means that the CMA must explore all available options to improve outcomes for customers. Even remedies that are only partially effective in resolving the AECs must be considered, as this would be a superior outcome for consumers than the CMA deciding to take no action.
- 4.2 Bupa firmly believes divestment is still effective and proportionate. Sections 2 and 3 explained why the CMA's own evidence justifies the proportionality of its proposed divestment packages of the London Bridge and Princess Grace hospitals, or the Wellington hospital together with the Platinum Medical Centre. Further, Bupa maintains that a broader divestment package – including the London Bridge and the Harley Street Clinic – should be implemented to address effectively HCA's dominance in aggregate and in strategically important specialisms.
- 4.3 However, if the CMA chooses not to order its proposed divestment packages then, in order to discharge its statutory duty to find as comprehensive a solution to the AEC as is reasonable and practicable, it must consider in more detail the scope for further remedies including the scope to amplify or strengthen existing remedies.
- 4.4 Such further re-consideration is supported by the CMA's own findings in the Final Report, where it notes, in respect of its final remedies package at that point, that "*the remedies in our package work together to address the AECs that we have found. None in isolation would be fully effective but in combination will address the AECs so far as is reasonable and practicable*". Moreover, the CMA considered in the Final Report that "*all of the remedies in this package are necessary to its effectiveness since they work on aspects of the AECs in different, though complementary, ways*".⁵² In light of these statements, the provisional decision to remove the major remedy – divestiture of HCA hospitals – from the overall remedy package puts into question whether the remaining remedies together in their current form represent a sufficient solution to the AECs in Central London during the period prior to the Cleveland Clinic's (putative) entry.
- 4.5 Bupa therefore urges the CMA to consider whether the remedies that remain 'live' require amending or expanding so as to represent a sufficient solution to the AECs in central London in the absence of the complementary effect of divestiture of HCA facilities. In circumstances where the efficacy of these remedies would be partially decreased as a result of the removal of the divestiture remedy, the CMA's statutory duty requires that it consider how these remedies could be amended or otherwise strengthened so as to restore their full effectiveness in such circumstances: the CMA has failed properly to undertake this assessment to date.
- 4.6 In addition to reviewing the scope of the existing remedies, Bupa considers that the CMA should also examine the alternative remedies outlined below.

⁵² Final Report, paragraph 13.41.

A narrower divestment package

- 4.7 If the CMA's decision turns on the scale of divestment costs on HCA (although, to be clear, we believe these should not be relevant – see paragraphs 3.71 *et seq*), then the CMA should consider smaller scale divestments.
- 4.8 Two narrower packages that the CMA must consider are:
- i. Divest the London Bridge Hospital to reduce HCA's control over the Corporate market segment.
 - ii. Divest (a) Leaders in Oncology Care (The London Oncology Clinic) or The Harley Street Clinic and (b) The London Radiotherapy Centre to address HCA's control over Oncology.

The London Bridge Hospital

- 4.9 The London Bridge Hospital is critically important to corporate customers given its location. If it remains in HCA's control it will continue to confer 'must have' status on all of the facilities in the HCA group.⁵³ Indeed, the London Bridge accounts for a disproportionate share of HCA's market power compared to its revenues and activities (which are nonetheless large).
- 4.10 Corporate customers will likely become an increasingly high proportion of the PMI market, given the 20 years of sustained decline in Personal customer volumes. Therefore, the importance of the London Bridge will grow over time.
- 4.11 Divestment of The London Bridge would have a significant impact on pricing in Central London. It offers a broad range of specialisms, including Oncology and Cardiology. It would increase competitive rivalry across the market and in key specialisms.
- 4.12 Insurers could credibly offer products to some customers that excluded the remainder of the HCA group (i.e. offered only The London Bridge, The London Clinic and The Cromwell etc. in the product). This would impose some discipline on the remaining HCA group.
- 4.13 Insurers would also have more bargaining power against a standalone London Bridge hospital. For example, HCA would itself have competing facilities in the area at the Shard and the PPU at Guy's and St Thomas and rivalry between these facilities may grow over time. Insurers would also be able to manage a dispute situation with a single hospital more easily than fighting a dispute across many geographic fronts when negotiating with that same hospital as part of the HCA group (chain of hospitals).
- 4.14 This remedy would not fully address the AEC or customer detriment, but would still deliver much improved outcomes to customers.

Oncology

- 4.15 In Section 2 (paragraph 2.34) we have explained that:
- i. [REDACTED];
 - ii. Oncology is growing rapidly [REDACTED];

⁵³ See Figure 4 of our Response to Provisional Findings and Notice of Possible Remedies (December 2015) which shows that The London Bridge accounts for the majority of spend amongst our top 20 corporate clients.

- iii. Oncology contributes significant market power to HCA. [REDACTED];
 - iv. The Cleveland Clinic will place little constraint (if any) on HCA in this specialism and no other compelling evidence is presented in the PDR of other operators expanding their oncology services at scale and pace.
- 4.16 Therefore, the AEC will clearly persist in Oncology, even if the Cleveland Clinic enters, and HCA will be able to leverage this power across other aspects of its business with insurers. HCA would remain must have in Central London on the basis of this specialism alone. A divestment targeted at this specialism would, therefore, be appropriate.
- 4.17 As shown in Figure 5 below, HCA derives the majority of its oncology revenues at [REDACTED].
- 4.18 A divestment of the London Bridge would go some way to addressing concerns in Oncology.
- 4.19 However, a divestment of (a) The Harley Street Clinic or “Leaders in Oncology Care” (the London Oncology Clinic), and (b) the London Radiotherapy Centre would be more effective in Oncology. These would also likely to have lower cost impact on HCA. For example, “Leaders in Oncology Care” is run on a more standalone basis from the HCA Group.

Figure 5: [REDACTED]

[REDACTED]

[REDACTED]

A price control and arbitrator

- 4.20 In circumstances where a divestment is rejected as disproportionate, the CMA should undertake more detailed consideration of a price control on HCA than it appears so far to have carried out, before it can reasonably conclude that no such remedy is feasible.
- 4.21 The scale of customer detriment that will arise over the next 5 (or more) years if no divestments are ordered will be very substantial – several hundred millions of pounds even on the most conservative of the CMA’s profitability estimates for HCA. A price control is, therefore, highly likely to be proportionate and even if only partially effective a price control will be better for customers than the CMA taking no action.
- 4.22 The CMA considered three types of price control in the PDR:
- i. a cost-plus/bottom-up price control where prices for all treatments are decided based on an analysis of (efficient) costs plus a margin for HCA;
 - ii. a price control based on NHS tariff schedules; and
 - iii. a price control based on adjusted versions of existing tariff schedules that have been negotiated between HCA and the PMIs (i.e. a “light touch” price control).

- 4.23 In relation to option (i) above, the CMA considered that due to the complexity of setting a price control for all treatments on a cost-plus basis, it is unlikely that it could be implemented in a timely manner, meaning that the remedy would be ineffective.⁵⁴ We acknowledge that this option may be challenging, but it deserves fuller analysis, as discussed below.
- 4.24 In relation to option (ii) above, the CMA considered that the differences between the NHS and the private healthcare sector meant that the tariff schedules developed by Monitor were not appropriate for this purpose and could have unintended consequences on the market.⁵⁵ We agree that a price control based on NHS tariffs would be inappropriate given the differences between the public and private healthcare sectors.
- 4.25 In relation to option (iii), the CMA considered that a “light-touch” control could be implemented within a reasonable time period – e.g. six months – given the simplicity of its structure. However, the CMA was concerned about the effectiveness of the control because:
- i. it may be difficult to identify the prices that would mitigate the customer detriment as fully as possible, while allowing HCA to cover its costs and to earn a reasonable rate of return.⁵⁶
 - ii. it may be difficult to identify the level of cost inflation faced by HCA over the period of the price control to ensure that prices tracked costs over the period. Therefore, there was a risk that the remedy would become less effective over time.⁵⁷
 - iii. it was difficult to design a mechanism to monitor and enforce the remedy and to prevent circumvention by HCA. It would require the hiring of an independent arbitrator, which would need the right capabilities and funding.⁵⁸
- 4.26 Bupa accepts that there may be challenges to overcome in managing a light-touch control, but given the huge detriment to customers that will result if no action is taken, it is necessary to consider this price control option as a safeguard for customers (even if such a safeguard only partially addresses the AECs that the CMA has provisionally identified). More intensive scrutiny and control of HCA’s conduct will almost certainly be proportionate and necessary. The fact that the remedy may be only partially effective does not mean that it should not be pursued if no better alternative is available. We consider that a price control remedy could be designed that would at least be partially effective.
- 4.27 First, we are confident that an arbitrator could be set up with the appropriate capabilities to assess whether HCA’s charges and annual increases appeared fair and reasonable. The arbitrator could act as a ‘monitoring trustee’, observing HCA’s conduct in the market and raising concerns to the CMA immediately if there were signs of abuse by HCA.
- 4.28 This arbitrator should be given access to:
- i. HCA’s cost data for all central London facilities;
 - ii. HCA’s management information for central London facilities;
 - iii. All correspondence between HCA and insurers, in particular during negotiations;

⁵⁴ PDR, para 2.113.

⁵⁵ PDR, paras 2.114-2.115.

⁵⁶ PDR, paras 2.118-2.119.

⁵⁷ PDR, para 2.120.

⁵⁸ PDR, para 2.121-2.125.

- iv. The CMA's current profitability analysis and the capability to roll forward annually the CMA's analysis to ensure that controlled prices continue to cover HCA's reasonable costs; and,
- v. Sufficient funding as decided by the CMA to perform its functions and to be paid for by HCA.

4.29 In terms of how prices could be set:

- i. Prices would be linked to existing tariffs each insurer and HCA has in place;
- ii. Prices for existing services could be capped at current levels for a period of five years (insurers and HCA would retain the options to lower prices over time);
- iii. Prices for any new services during this period could be negotiated bilaterally between the insurer and HCA, but under the supervision of the arbitrator;
- iv. Prices would remain capped until (a) HCA could objectively show that it can no longer cover its cost of capital as determined by the arbitrator (using, for example, the CMA's profitability analysis methodology), or (b) HCA could demonstrate to the CMA that effective competition had returned to the Central London market (and the cap could be lifted).
- v. If (a) arises, HCA would have opportunity to make representation to the arbitrator for a price increase, with a consultation process with insurers. At this point, it may be necessary to move towards a cost-plus approach to the price control, as discussed in option (i) by the CMA above. We note also that there may be options to agree a fixed rate of increase in HCA prices – for example, [3<].

4.30 The control would remain in place until the CMA finds that entry has in fact addressed the AECs in the Central London market. This would be at least five years on the CMA's current analysis although, given the significant uncertainty as to the timing and effectiveness of the Cleveland Clinic's entry (as to which see section 2 above), this could be significantly longer.

4.31 Bupa accepts that a price control is an imperfect solution compared to divestments. Price control may only partially address the customer detriment, will have monitoring costs, and may have higher risks of circumvention. However, a light-touch control would certainly be better than 'no action' by the CMA (which has maximum circumvention risk), and would be proportionate given the huge annual customer detriment that will otherwise arise.

Stronger constraints on HCA's relationships with consultants

4.32 A significant risk to the successful entry of the Cleveland Clinic, and others, into the Central London market is the significant control HCA can exert over consultants (and private GPs). HCA's massive size and share (and involvement in primary care) will make it a critical gateway for private consultants in Central London.

4.33 HCA has a number of avenues to increase the 'stickiness' of consultants, many of which are not covered by the CMA's existing Final Order on the clinician incentives remedy. For example, HCA could 'employ' doctors with salaries/payments for consultancy/administrative services offered. These may act as a form of 'retainer' that smaller entrants cannot match.

4.34 The CMA must amend and expand the scope of the clinicians incentives remedy as it applies to HCA to make sure that all HCA's relationships with consultants and GPs are published and can be scrutinised publicly. This will allow the cumulative effect of these relationships to be

understood and monitored. HCA should be required to publish all financial arrangements it has in place with, or payments it has made to, practicing doctors (both consultants and GPs). This should be published at an individual doctor level on, at least, a quarterly basis.

- 4.35 HCA should also be required to publish all dealings it has with doctor representative bodies, such as FIPO, as these would be indirect channels through which HCA could influence consultant behaviours.

Removal of all restrictive contractual clauses with insurers

- 4.36 HCA is in a position to impose contractual clauses on insurers that limit the insurer's ability to deliver value for money in the market. These clauses have an anti-competitive effect as they foreclose opportunities for other providers. Insurers do not have the bargaining power to remove these clauses on their own (or without conceding further significant price rises).
- 4.37 HCA uses these clauses already and there is a significant risk that it will do so more often if the CMA does not address the AEC directly. We note:
- i. HCA will grow significantly over the next 5 years, further strengthening its position in aggregate and across key specialisms. The insurance market, by contrast, will likely shrink or remain stagnant. Therefore, HCA's bargaining power will continue to grow.
 - ii. HCA will seek to mitigate the impact of any entry by the Cleveland Clinic's or other providers.
 - iii. HCA will no longer be under the spotlight of the CMA process, which we believe has been a significant discipline on its behaviour in recent years.
- 4.38 If the CMA does not address HCA's market dominance directly, the CMA should immediately order HCA to remove all existing clauses that have or could have actual or potential foreclosure effects.
- 4.39 [REDACTED].
- 4.40 [REDACTED]:
- i. [REDACTED]
 - ii. [REDACTED]
 - iii. [REDACTED]
- 4.41 [REDACTED].

Annex A: Economies of scale losses are not a Relevant Customer Benefit

- A.1 This annex assesses HCA's assertion, as cited by the CMA in the PDR, that the economies of scale that HCA enjoys by virtue of its hospital portfolio give rise to relevant customer benefits ("RCBs") that should be taken into account when assessing the proportionality of a divestment of HCA hospitals. As the CMA explains in the PDR:

"HCA told us that the economies of scale and scope that it was able to achieve from operating a network of hospitals resulted in lower prices for patients and therefore constituted an RCB that would be lost (or at least reduced) as a result of imposing divestitures on the business".⁵⁹

- A.2 Bupa considers that HCA's characterisation of any economies of scale it enjoys as an RCB is incorrect as a matter of law. While the CMA's approach in the PDR appears to be consistent with this position, the point is not addressed explicitly. Bupa notes that the CMA directly addressed the same issue in the Final Report in the original market investigation, and **explicitly concluded that HCA's economies of scale were not RCBs.**⁶⁰
- A.3 Bupa would, therefore, welcome explicit confirmation from the CMA that it has, in its assessment of HCA's economies of scale in the context of the Remittal, maintained its conclusion in the Final Report in the original market investigation that these economies cannot be treated as RCBs.

Assessment

Legislation

- A.4 Under s.134(7) of the Enterprise Act 2002, the CMA may in reaching its decision on remedies have regard to the effect of any action on any RCB of the feature or features of a market. S.134(8) of the Enterprise Act 2002 provides that a benefit is an RCB of a feature or features of a market if:

"(a) it is a benefit to customers or future customers in the form of:

(i) lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom (whether or not the market [or markets] to which the feature or features concerned relate); or

(ii) greater innovation in relation to such goods or services; and

(b) the [CMA or (as the case may be) the Secretary of State] believes that--

(i) the benefit has accrued as a result (whether wholly or partly) of the feature or features concerned or may be expected to accrue within a reasonable

⁵⁹ Appendix to the PDR, paragraph 25.

⁶⁰ Final Report in the original market investigation, paragraphs 11.202 – 11.208 *passim*.

*period as a result (whether wholly or partly) of that feature or those features;
and*

*(ii) the benefit was, or is, unlikely to accrue without the feature or features
concerned.”*

- A.5 It is therefore clear from the statutory provisions relating to RCBs that the benefit in question must accrue to customers. Producer surplus, to the extent that it is retained by the producer and not passed on to the consumers, would not meet the statutory threshold to qualify as giving rise to a RCB in the form of lower prices.

CMA guidelines

- A.6 The Market Investigation Guidelines also indicate that the CMA will “ascertain that the market feature(s) with which it has been concerned results, or is likely to result, in lower prices, higher quality, wider choice or greater innovation, and that such benefits are unlikely to arise in the absence of the market feature(s) concerned”.⁶¹
- A.7 It is for the party asserting the case for the consideration of RCBs to “provide convincing evidence regarding the nature and scale of any RCB that they claim to result from the market feature(s) concerned and to demonstrate that these fall within the Act’s definition of such benefits”.⁶²
- A.8 Specifically in relation to economies of scale, the Market Investigation Guidelines provide that “aspects of market structure that could adversely affect competition, such as a high level of concentration, might enable economies of scale and/or scope to be obtained that would not be available if there were a larger number of firms in the market. Whether scale or scope economies would constitute an RCB in a particular case would depend partly on the extent to which, in practice, any cost economies were being passed on to customers as lower prices, improved quality, greater innovation or more choice (emphasis added)”.⁶³

Precedent

- A.9 The CMA has considered relevant customer benefits arising from economies of scale in the context of a proposed divestment remedy in a number of cases and has consistently found that cost savings that are not passed on to end consumers are not a RCB.
- A.10 In the BAA market investigation,⁶⁴ the Competition Commission (CC) considered that, in principle, it was possible for economies of scale associated with BAA operating its airports under common ownership to qualify as RCBs, if these economies were passed on to customers and if they were not replicable by a potential purchaser of the divestments; the CC also noted that it would expect such benefits to be passed on in the presence of effective competition.⁶⁵ However, the CC had found that BAA’s common ownership of the relevant airports resulted in an absence of effective competition and that, as a result, economies of scale were not passed on to consumers.⁶⁶

⁶¹ Market Investigation Guidelines, paragraph 358.

⁶² *Ibid*, paragraph 359.

⁶³ *Ibid*, paragraph 362.

⁶⁴ BAA airports market investigation (2009).

⁶⁵ BAA Final Report, para 10.99.

⁶⁶ BAA Final Report, para 10.99.

- A.11 The CC also noted that BAA's arguments in relation to the loss of RCBs arising from economies of scale were based on the assumption that any divested airports would operate as stand-alone entities following their sale.⁶⁷ However, the CC concluded that given the value of the airports under consideration (and the requirements with respect to purchasers), it was likely that any divested airports would be acquired by large companies/institutions with previous experience in running airports.⁶⁸ As a result, a purchaser would potentially also be able to deliver substantially the same benefits such that much of the economies of scale associated with common ownership could not be considered to be relevant customer benefits since *"they could plausibly be generated in the absence of common ownership"*.⁶⁹
- A.12 The CC also considered relevant customer benefits in the form of economies of scale and scope in the *Aggregates* market investigation.⁷⁰ In that case, the CC considered whether divestiture could result in the loss of any RCBs in the form of economies of scale associated with operating a network of cement plants. The CC found that benefits arising from the common ownership of a network of plants might exist, and went on to consider the extent to which these benefits had been passed on to customers in the past and, in the absence of effective remedies, whether such benefits could reasonably be expected to be passed on to customers in the future.⁷¹
- A.13 In considering the extent to which benefits had been passed on to customers in the past, the CC examined the margins and prices of the top 3 cement suppliers.⁷² The CC found that it was not clear that benefits had been passed on to consumers and that in a more competitive market (such as it was attempting to create through remedies) there would be stronger pressure to pass on efficiencies to customers.⁷³
- A.14 In considering whether benefits would be passed on to customers in the future, the CC considered that, in the absence of effective remedies, one of the cement producers (Lafarge Tarmac) would have little or no incentive to pass on any existing efficiency benefits to customers.⁷⁴
- A.15 As a result, the CC concluded that the economies of scale relating to the operation of multiple cement plants did not represent a RCB on the basis that *"we could not reasonably conclude that any such benefits had in the past been passed on to customers in the form of lower prices, and that the absence of an effective package of remedies (which, in our view, necessarily includes a cement plant divestiture) would not create the incentive for Lafarge Tarmac to start passing on any such benefits to customers in the future"*.⁷⁵

⁶⁷ BAA Final Report, para 10.100.

⁶⁸ BAA Final Report, para 10.100.

⁶⁹ BAA Final Report, para 10.102.

⁷⁰ *Aggregates, Cement and Ready-Mix Concrete* Market Investigation.

⁷¹ *Aggregates* Appendix 13.7(A) to the Final Report, para 4.

⁷² *Aggregates* Appendix 13.7(A) to the Final Report, paras 5-6.

⁷³ *Aggregates* Appendix 13.7(A) to the Final Report, paras 5-6.

⁷⁴ *Aggregates* Appendix 13.7(A) to the Final Report, para 10.

⁷⁵ *Aggregates* Appendix 13.7(A) to the Final Report, para 11.

Original Private Healthcare Market Investigation

- A.16 In the Final Report in the original private healthcare market investigation, HCA advanced the same arguments in respect of RCBs as it has in the Remittal, notably that *“the economies of scale and scope that it was able to achieve from operating a network of hospitals resulted in lower prices for patients and therefore constituted an RCB that would be lost (or at least reduced) as a result of imposing divestitures on the business”*.⁷⁶
- A.17 The CMA concluded expressly in the Final Report that *“we do not consider that any economies of scale or scope enjoyed by HCA qualified as a relevant customer benefit”*.⁷⁷ This was on the basis that:
- i. Given that the insured price analysis showed that HCA was charging higher prices than TLC (a smaller operator), HCA was clearly not passing on any economies to customers. Bupa notes in this respect that, while the CMA has not been able to conclude in its insured price analysis carried out during the Remittal as to the amount by which HCA prices higher than TLC (in contrast to its findings in the original investigation), the CMA’s conclusion in the original investigation still applies in the Remittal i.e. the fact that the insured price analysis shows that HCA charges higher prices than its smaller competitor demonstrates that these economies do not result in lower prices for customers.
 - ii. The CMA considered that, *“if there were significant economies of scale or scope (at the group level) in the provision of private healthcare services, we would expect that an advantaged suitable purchaser, or purchasers, of HCA’s hospitals, which would include national and international groups, would be able to ‘recreate’ in their own businesses any lost economies of scale suffered by HCA”*, and that it was not necessary for a purchaser *“to have a significant presence in London in order to recreate these economies”*.⁷⁸ Bupa considers that (subject to the CMA’s view on the identity of a suitable purchaser of divested HCA hospitals), precisely the same point can be made in the context of the Remittal i.e. that even if HCA enjoys economies of scale, these cannot be treated as RCBs since they can be replicated by a potential purchaser of the divestitures.
- A.18 The PDR also shows that HCA has made significant and sustained excess profits over nine years. This indicates that HCA’s prices are high relative to costs and that HCA is not under significant competitive pressure to pass cost savings through to customers. This further suggests that customers have not seen these alleged economies of scale passed through in the form of lower prices and, given the AECs, there would not be the expectation that cost savings would be passed through to customers in future.
- A.19 Bupa has also submitted patient survey information that shows that HCA does not systematically out-perform smaller hospital peers on quality of service metrics. This demonstrates that customers are not seeing any alleged benefits from economies of scale passed through in the form of higher quality of service.

⁷⁶ Final Report, paragraph 11.202.

⁷⁷ Final Report, paragraph 11.206.

⁷⁸ Final Report, paragraph 11.207.

Conclusion

- A.20 It is clear that the statutory framework in which RCBs are assessed requires that, in order for economies of scale to qualify as a RCB, these economies must be passed on to customers (in the present context, most relevantly in the form of lower prices), and should not be replicable e.g. by potential purchasers of the proposed divested assets. The CMA's decisional practice illustrates a number of previous instances in which, having assessed claims that economies of scale should be treated as RCBs, the authority has then gone on to reject these claims on both these bases.
- A.21 In the context of the Remittal, and as the CMA has already found in the original market investigation, it is Bupa's view that the economies of scale that HCA claims qualify as RCBs cannot in fact be treated as such since any economies that HCA enjoys as a result of its hospital portfolio are: (i) demonstrably not passed on to customers in the form of lower prices (as shown by the results of the insured price analysis); and (ii) replicable by potential purchasers of divested HCA hospitals.
- A.22 Bupa would therefore welcome explicit confirmation from the CMA that it is not, in the context of the Remittal, treating HCA's claimed economies of scale as RCBs.

Annex B: Confidential Annex

B.1 [X]