PRIVATE HEALTHCARE REMITTAL
SUPPLEMENTAL PROVISIONAL DECISION ON REMEDIES
RESPONSE OF AXA PPP

1 Introduction

AXA PPP is extremely disappointed by the CMA's Supplemental Provisional Decision on Remedies (SPDR) which it considers is vitiated by a number of material errors of reasoning (including a number of areas where no reasoning is provided at all) and fact.

As the CMA is aware, a number of parties (including AXA PPP) have invested a significant amount of time and resource into the remittal process, the market investigation, and the OFT's market study, over a period of more than five years. Against this backdrop (which also involves significant public expenditure and resource on the CMA side), AXA PPP is surprised and dismayed to find that, in reconfirming its remittal provisional decision on remedies (PDR)[1], the CMA is advancing a view that ignores and retreats from the CMA's own foundational analysis and basic findings of fact reflected through years of investigation, corroborated by AXA PPP and other relevant parties alike, and affirmed by the CMA itself in its remittal analysis published prior to the PDR.

AXA PPP is in no doubt that the CMA's failure to act in relation to the central London market will mean that consumers are worse off in the short and long term, and that the weaknesses in the CMA's reasoning and process in this case will undermine confidence in the market investigation regime as a whole going forward.

Given the significant evidence that AXA PPP has already submitted to this process, AXA PPP does not intend to respond to every detail of the SPDR. This response is therefore focused on a limited number of material errors of reasoning and fact, in particular:

- The absence of any reasoning, notwithstanding the evidence received from Cleveland Clinic itself and other parties, to justify an assertion of faith that "there is still the strong prospect of entry by Cleveland Clinic within the next five to ten years", and that "if and when it enters the market, Cleveland Clinic is likely to exert a competitive constraint on HCA … resulting in a significant downward pressure on HCA's prices".[2]
- The CMA's sudden new reliance on entry by a number of other providers, notwithstanding the absence of material developments since the provisional findings (PFs) and notice of possible remedies (NPR) in this remittal.
- The CMA's sudden rejection, without comment let alone evidence, of its own consistent and coherent conclusions from its Final Report through the remittal as to (i) how hospital/PMI bargaining sets prices across a bundle of hospital services as a whole;[3] and (ii) the importance of a strong (retained) market position in one speciality (notably acute specialties such as oncology) as allowing HCA to exert market power across that services bundle,[4] as well as the way in which PMI corporate trust schemes operate.

[1] Remittal Provisional Decision on Remedies dated 22 March 2016, as corrected on 6 April 2016.

[2] SPDR paragraph 29.

[3] See e.g. Final Report, paragraphs 6.276ff, readopted in Remittal Provisional Findings (Remittal PFs), paragraphs 27ff.

[4] See e.g. Final Report. paragraph 11.68 and Remittal Notice of Possible Remedies (Remittal NPR), paragraph 24(a)-(c).

This results in the CMA's reliance on a completely unrealistic set of assumptions for the purposes of its revised NPV analysis. AXA PPP also notes that there are many other examples of extremely weak or unsubstantiated reasoning throughout the SPDR. AXA PPP remains of the strong view that the CMA's original decision to proceed with a divestment remedy (that was confirmed in the Remittal PFs and NPR) should be properly reinstated, and that a failure to do so on the basis of the SPDR would be unsupportable on the published evidence, and therefore irrational.

2 Material errors

2.1 Cleveland Clinic

The CMA's conclusion in the original PDR that a divestment remedy would (contrary to earlier views) be disproportionate, was almost entirely reliant on the CMA's expectation that Cleveland Clinic would enter the market and become a credible constraint on HCA by early 2022. While the prospect of entry by other providers, including Spire, VPS and the Barts PPU, was acknowledged by the CMA, the CMA placed little weight on the prospect of such entry given the uncertainty of entry and / or the limited specialisms that such entry would represent:

> "[With respect to the Barts PPU] our provisional view is that entry is very likely to take place and is also timely (within two years), but insufficient in terms of size and specialism to constrain HCA effectively on its own, although we expect that it will add incrementally to the constraint on HCA.
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> [With respect to VPS] our provisional view is that although the likelihood and timeliness of entry … are difficult to assess, … , if entry were to take place, it could be sufficient in scale … to constrain HCA in the future, in combination with other potential entrants.
>
> In regard to Spire and other entrants, we consider that these potential new entries are either too uncertain to take into account in our assessment or are unlikely due to their specialised nature to exercise a sufficient constraint on HCA"[5]

In the SPDR, the CMA acknowledges that evidence received from Cleveland Clinic since the PDR has "caused us to reconsider our assessment of the likelihood, timing and scope of the potential Cleveland Clinic entry".[6] AXA PPP has not seen Cleveland Clinic's evidence in any detail, save for the summary of Cleveland Clinic's hearing of 15 April 2016, which was published in May 2016. It was abundantly clear from that summary, however, that there could be no expectation of entry by Cleveland Clinic over any certain timeframe (if at all), and that the scope of such entry – even if it did occur – would be limited to a narrow range of specialties. In particular, Cleveland Clinic clarified that oncology services would not be offered for "'years or decades', if at all".[7]

While the SPDR therefore concedes that the CMA "can no longer conclude that the Cleveland Clinic entry is likely to take place in 2019 to 2020 or, if it occurs, that it will be sufficient (in terms of the range of specialisms offered) to constrain HCA fully (together with other non-HCA hospitals) by early 2022",[8] it nonetheless goes on to conclude "[w]e still

[5] PDR paragraph 1.84.

[6] SPDR paragraph 25.

[7] SPDR paragraph 27.

[8] SPDR paragraph 28.

consider Cleveland Clinic to be a credible entrant, with a strong interest in entering the central London market" [emphasis added], that "there is still the strong prospect of entry by Cleveland Clinic within the next five to ten years" [emphasis added], and that "if and when it enters the market, Cleveland Clinic is likely to exert a competitive constraint on HCA … resulting in a significant downward pressure on HCA's prices".[9]

The use of the word "still" by the CMA in these two citations is extremely puzzling. The fact is that the essential evidence - of likely, timely and substantial entry - on which the CMA based its case in the PDR was proven to be incorrect, as the CMA now accepts. The CMA uses the words "still" to convey the impression that nothing of substance has changed. But the statements of intention that are said to "still" be the case are not likely, timely, and substantial entry but vague possibilities of unspecified facilities on an uncertain horizon. The vague aspirations now asserted do not have the same quantitative meaning as when imminent, full-scale entry by Cleveland was predicted, and cannot support the same NPV scenarios. Moreover these vague aspirations clearly fall far below the line when it comes to justifying the exceptional decision of not implementing a remedy to an AEC

Ultimately, the CMA provides no evidence whatsoever in support of these statements, which appear to be little more than assertion. From the face of the SPDR and other public evidence the CMA does not appear to have received any assurances from Cleveland Clinic that entry will indeed be forthcoming in the next five to ten years, if at all. Nor is any evidence cited, or reasoning provided, in support of the apparent likelihood that entry would result in a significant downward pressure on HCA's prices. Indeed, Cleveland Clinic's own evidence appears to point the other way. In particular, AXA PPP again notes Cleveland Clinic's statement that "a key planning assumption that had changed was that HCA would be restrained in the marketplace from its growth appetite of protecting its market share (i.e. that the CMA would impose a divestment remedy and/or constraints on HCA expansion)",[10] its view that "its effectiveness as a counterbalance (to HCA) would be limited" and its concern that HCA would pursue aggressive growth strategies in the period before Cleveland Clinic's entry (which is now acknowledged by the CMA to be a longer period than the original estimates set out in the PDR).[11] The likelihood or otherwise of entry resulting in downward pressure on prices is discussed further in section 2.3 below.

In AXA PPP's view, the CMA is therefore giving the impression that the revised evidence relating to Cleveland Clinic changes very little overall by continuing to reach the same provisional conclusion, couched in almost identical language. While the CMA may be afforded a significant margin of discretion in reaching its conclusions, this cannot extend to reaching decisions without evidence, or using linguistic devices as a means of continuing to uphold quantitative judgements, when the evidence underpinning such judgements is in fact erroneous.

2.2 Entry by other providers

Having previously placed little weight on the possibility of entry by other providers, the SPDR now considers that "in light of the increased interest [from third party providers] and the expected continued growth in demand in central London, we believe there is now an

[9] SPDR paragraph 29.

[10] Summary of hearing with Cleveland Clinic on 15 April 2016, paragraph 20.

[11] Ibid, paragraph 16.

increased likelihood of new entry in the future, compared with that which existed at the time of the Final Report".[12]

The only evidence that the CMA provides in support of this provisional conclusion is "entry by a small number of specialist operators, such as Optegra (in ophthalmology), Fortius (orthopaedic) and Nuada (initially focused on prostate imaging)"; "advanced entry plans from others, such as Schon Klinik (focused on orthopaedics) and Nuffield Health at the Barts private patient unit (PPU) (largely focused on cardiovascular)", and the fact that other hospital operators (namely VPS and Spire) "have announced plans to open large scale facilities in central London, although they have yet to acquire suitable properties".[13]

Again, however, the CMA's stance is patently inadequate. Nor is it correct for the CMA to compare the situation now against that which existed at the time of the Final Report in 2014, while failing to mention, let alone grapple with, the fact that the CMA has considered this explicit question much more recently in the remittal process and set out its views in both the PFs and the PDR. In particular, the CMA was aware of the forthcoming / recent entry of Optegra, Nuada and Fortius in the PFs and PDR, but did not consider them to be a material development sufficient to constrain HCA. Indeed they were not mentioned at all in the PDR. Similarly the plans and potential interest of the other providers mentioned have been known for some time but – as noted in section 2.1 above – dismissed by the CMA as being insufficiently certain and / or insufficient in scope, to provide a credible constraint upon HCA.

It is therefore misleading to suggest that entry prospects have changed to such an extent to justify a departure from the CMA's findings on this specific issue in the PFs/NPR or indeed the PDR. Rather, the CMA now appears to advance a retrofit interpretation of this evidence as bald assertion, but without providing suitable reasons for doing so.

Furthermore, as AXA PPP has explained a number of times,

- while entry by small providers is welcome in relation to their particular areas of specialty, such entry [✂]. In particular, less than [✂]% of AXA PPP's total spend in Central London in 2015 was on services from Fortius, Nuada and Optegra.[14]
- similarly the Schon Klinik and the Barts PPU (even if entry is forthcoming in the short to medium term, which is not certain) are focused on narrow specialties, and there is therefore no indication or expectation that they will exercise a constraint on HCA in other areas (and the SPDR does not present any evidence to the contrary);
- as discussed with the CMA a number of times, most recently at AXA PPP's hearing on 17 May 2016, VPS' and Spire's interest in entering the central London market has been raised a number of times over many years, and yet neither operator has secured a site, let alone planning permission. Nor has any other large scale facility entered the central London market in the past ten years. There is therefore no rational basis to conclude that there is "an increased likelihood of entry" compared to the situation that existed at the time of the PDR, the PFs, or the Final Report. In any event - as the CMA admits - it is equally not possible to predict the scale or potential timing of entry with any degree of certainty.

[12] SPDR paragraph 32.

[13] SPDR paragraph 32.

[14] [✂].

In AXA PPP's view, therefore, the CMA cannot plausibly rely on third party entry as sufficiently likely to justify an NPV analysis that has as its central case the expectation of sufficiently large scale entry in 5, 7 or 10 year time horizon. Again, AXA PPP submits that the CMA's margin of discretion does not amount to discretion arbitrarily and suddenly to change its own interpretation of evidence when other evidence falls away.

2.3 Likely impact on pricing

General expectation of downward pressure on prices

According to the SPDR, "if Cleveland Clinic enters the market, it is likely to exert significant downward pressure on HCA's prices in the future". The CMA adds "we consider that entry by other potential new entrants, if it occurs, could also result in downward pressure on HCA's prices, in particular if such entry is across a wide range of specialties" [emphasis added].[15]

As an initial remark, these statements have little or no evidential value because they are all prefaced by the word "if". However, they do affirm the CMA's view that what is needed is "entry across a wide range of specialties", consistent with AXA PPP's own views throughout the course of this inquiry, and indeed with the CMA's repeated recognition that individual specialties form separate relevant product markets.

Even leaving aside the absence of evidential value in these statements, the SPDR provides no evidence or reasoning in support of the CMA's expectation that such entry would be likely to result in downward pressure on HCA's prices, let alone the suggestion that any such downward pressure would be "significant". Rather, these statements appear again to be nothing more than assertions which ignore the reality of the market as described by AXA PPP and others on many previous occasions, and which the CMA has endorsed at all material stages prior to the SPDR, in particular the fact that prices are negotiated by HCA on a bundle / package basis across the full range of services.

In particular the Final Report concluded that:[16]

- when assessing the appropriateness of particular divestiture packages "we reasoned that the combination of a specialty-level product market, and *prices which are negotiated jointly across a 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*"';
- "… that divesting a general hospital i.e. one offering treatments across a broad range of specialisms, would be more effective in addressing the AECs than would divesting a more specialised one given HCA's high market shares across a broad range of specialisms";

-- while the NPR again recognised that:[17]

- "The *insurers and hospital operators negotiate a price across a 'bundle' of treatments, with hospital operators seeking to increase treatment prices for the remaining services in response to insurers' attempts to reduce the number of treatments for which they recognise a given hospital operator.* … The combination

[15] SPDR paragraph 33.

[16] Final Report, paragraphs 6.276, 6.484 and 11.68(b), emphasis added.

[17] NPR paragraph 24(b) - (c), emphasis added.

> of a specialty-level product market, and prices that 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."

It simply cannot therefore be expected that the entry of, for example, a specialist orthopaedic clinic, would have any impact on HCA's prices (either for orthopaedic services, or across the board), and the CMA's statement in the SPDR that

> "We would expect entry to exert downward pressure on prices for those specialties in which the entrant competes. Therefore, for a constraint on HCA to be fully effective, entry would need to cover a broad range of specialties. However, more limited entry could be expected to result in lower prices for some specialties, while prices for treatments in other specialties would be broadly unaffected"[18]

represents an unexplained departure from its previous views that "[price negotiation] *discussions typically focus on the price of the overall bundle of a hospital operator's services (i.e. associated revenue) with relatively little focus on the price of individual treatments*"[19] and the CMA's findings emphasised above (in italics) in relation to hospital leveraging of market power to retain overall revenue even if de-recognition were an option for a PMI for one speciality (e.g. due to a niche entrant).

In particular, with respect to the former part of the footnote 19 statement, it is clear from the information available to AXA PPP (which has been provided to the CMA previously) that neither Cleveland Clinic nor the other smaller entrants who have opened or have taken concrete steps towards entry are likely to provide anything close to a "broad range of specialties" (contrary to the assertion contained in paragraph 51 of the SPDR). As the CMA is aware, AXA PPP estimates that the specialties listed by the Cleveland Clinic in its hearing summary account for less than [✂]% of AXA PPP's overall spend in central London.[20] The SPDR does not contain any information to suggest otherwise.

With respect to the latter half of the statement, the SPDR provides no reasoning whatsoever for its assumption that "prices for treatments in other specialties [in relation to which there is no new entry] would be broadly unaffected".[21] In AXA PPP's view this statement is extremely puzzling given the CMA's previous conclusions on this topic, summarised above. It would be an entirely rational response for any hospital provider that is facing pressure to drop prices in one area due to increased competition, to then seek to recoup any reduction in margins in other areas where competition remains limited. Furthermore, such a response would be entirely in keeping with [✂] to the CMA a number of times.

There is therefore no credible basis for an assumption underpinning the revised NPV analysis of HCA's prices falling between 50% and 100% of the amount required to take its prices to the competitive level. Rather, AXA PPP's firm expectation remains that entry by Cleveland Clinic and / or the other entrants mentioned in the SPDR, even if it were to occur, would be unlikely to [✂].

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[18] SPDR, footnote 19.

[19] Final Report, paragraph 6.276, emphasis added.

[20] AXA PPP letter of 20 May 2016, Appendix 1.

[21] SPDR footnote 19.

Oncology

The SPDR states "Post-entry, even if there are some specialties where HCA retains a strong position (e.g. in oncology), greater competition in other services will reduce its overall bargaining position and so we would expect the total revenue paid to HCA to fall. We do not accept the argument that maintaining a strong market position in one specialty (e.g. oncology) means that increased competition in others will have no effect on HCA's overall prices."[22]

As above, the CMA provides no evidence or analysis to justify this assertion. This *volte face* is critical, not merely because it is completely contrary to the evidence provided by AXA PPP (among other PMIs) but most importantly because, at the eleventh hour, it renders the CMA's own thinking as suddenly internally contradictory and incoherent, given the CMA's consistent previous views emphasised above. In summary:

- As the CMA is well aware, AXA PPP is far from alone among market participants in explaining in detail the critical importance of oncology in terms of PMI take-up by end-customer; HCA's market share, the particular barriers to entry in this specialty (which Cleveland Clinic and others have confirmed); the control that HCA has over the flow of patients as a result of its ownership of Leaders in Oncology Care; and the high costs of oncology care. However, this evidence, together with that of a range of other parties including The London Clinic and HCA itself is completely ignored in the SPDR.
- In fact, a claim in the SPDR that "[the CMA does] not accept the argument that maintaining a strong market position in one speciality (e.g. oncology) means that increased competition in others will have no effect on HCA's overall prices"[23] contradicts the CMA's previous concerns regarding HCA's residual share of oncology. In particular, the CMA explicitly recognised in the Final Report that "following the divestiture of either the Wellington or the London Bridge and Princess Grace hospitals, HCA would retain a relatively high share of admissions and revenue in both oncology and obstetrics and gynaecology … We considered whether this high share in these specialisms would render the divestiture remedy ineffective as insurers would still be unable to switch a substantial amount of their volumes away from HCA"[24] Ultimately the CMA concluded that it was not necessary to increase the scope of the divestiture package as it considered that the new owner of the divestiture hospital(s) would be able to expand into these services. As the CMA is aware, AXA PPP disagreed with that conclusion, and continues to do so. But the SPDR does not even go as far as to suggest that the "likely" new entrants that it has identified will fill the oncology gap that it has previously identified; it simply dismisses this entirely rational concern without explanation.

AXA PPP does not intend to repeat the previous evidence provided, but remains of the firm view that it will continue to have no choice but to contract with HCA for oncology services, and that [✂], such that the impact on HCA will at most be revenue-neutral, while leaving customers at best no better off, and possibly worse off (as [✂]). It is therefore completely incoherent to suggest that entry or expansion in certain specialties can undermine market

[22] SPDR paragraph 51.

[23] SPDR paragraph 51.

[24] Final Report, paragraphs 11.137 onwards "We observed that".

power in other specialties, particularly where the specialties in relation to which market power is retained are quantitatively significant and lie at the core of user demand for PMI. Market power arising from a must-have treatment (cancer care) can only be eroded by material entry focussed at the core of that power so that, in the CMA's words, PMIs have "the ability to substitute away from HCA across the full range of specialties in order to generate a competitive constraint".[25]

The CMA's original analysis, which it endorsed through to the Remittal PFs/NPR stage, has in reality been neither discredited nor replaced by new evidence or reasoning associated with the PDR and SPDR. Instead, the CMA has asserted a diametrically opposite view so as to contradict itself and retreat from the central logic of the market investigation to date and has done so without any supporting reasoning or evidence.

2.4 NPV analysis

Assumptions are unrealistic and unsupported

If the CMA remains committed to an NPV analysis, it is critical that the assumptions used are fair and reasonable, based on the evidence before it. In AXA PPP's view, the NPV continues to be underpinned by unrealistic and unsupported assumptions which necessarily bias the analysis towards an uncertain result.

In particular, AXA PPP strongly disagrees with the assumptions that form the "central case" in the CMA's revised NPV analysis given the inherent uncertainty (discussed above) around (a) the prospect of entry; (b) the timing of entry; and (c) the resulting impact on prices. Certainly, the evidence from Cleveland Clinic fundamentally undermines the shorter term scenarios analyse, and for the CMA to place any reliance on these, or seek to use non-relevant scenarios to give the impression that the scenarios on which it ultimately places most reliance are somehow "balanced" is inexplicable .

Approach to economies of scale

It is also clear that the results are extremely sensitive to the extent to which economies of scale may or may not be replicated by the purchaser of the divested hospital(s). AXA PPP stands by its original comments on this topic. While AXA PPP is unable to comment on the estimated figures discussed between HCA and the CMA (as neither AXA PPP nor its economic adviser have had access to the confidential version of the SPDR), it considers that the CMA's general approach to this topic is flawed.

In particular, the SPDR concedes that there may – consistent with AXA PPP's submissions – be a scenario in which the purchaser of the divested hospital(s) is able to recreate HCA's scale economies. However, paragraph 48 of the SPDR states that the CMA does not consider this scenario to be "particularly likely", without providing any reason for this. Similarly, the Appendix to the SPDR states that the CMA considers the situation in which the buyer was smaller or new to the market, and therefore not in a position to replicate the lost of economies of scale to be "more likely" than an established player who *is* in a position to replicate such economies purchasing the divestiture hospital(s).[26] Again, no reasoning is provided, and in fact these statements are inconsistent with a later statement that "we cannot forecast with any degree of accuracy which would be the most likely outcome post divestiture".[27] In AXA PPP's view the CMA's approach results in an

[25] Final Report, paragraph 11.68.

[26] Appendix to the SPDR, paragraph 23.

[27] Appendix to the SPDR, paragraph 27.

unreasonable bias in the NPV analysis: there is no reason to believe (nor is any reason provided in the SPDR) that the most likely purchaser would be a small player or new entrant rather than a larger established player (even if a purchaser were a new entrant to London or the UK, it may well have overseas operations enabling it to replicate economies of scale). Clearly, the CMA would have approval rights over any potential purchaser and, if anything, it is more likely that a larger, established operator would satisfy the CMA's suitability criteria or would be able to bid a price for the divested assets reflecting some of the value of retained scale economies.

Delay in passing through price benefits to customers

AXA PPP is also surprised that the CMA continues to assume for the purposes of its NPV analysis that insured benefits will lag by 18 months. As AXA PPP has explained a number of times, a large proportion of its corporate customers (in relation to whom AXA PPP operates a trust scheme, whereby hospital charges are passed through directly to customers) would benefit immediately from any reduction in prices.

2.5 Conclusion

In conclusion, it remains clear – consistent with the evidence provided by AXA PPP over a number of years – that:

- There is no guarantee of entry sufficient to constrain HCA. Nor can it be said that there is a reasonable expectation of entry over any given time period. Expressions of "credible interest" are clearly insufficient to form the basis of the CMA's judgement on this issue given its statutory duties.
- Nor is there any evidential basis for an expectation that entry on a limited scale will be likely to result in material downward pressure on prices. The available evidence indicates that – given the approach to negotiations by hospital providers – such downward pressure could only be expected if a full-service operator enters.
- The CMA provides insufficient reasoning or evidence in support of its substantially revised views on entry and likely impact on pricing, which contradict the CMA's own previous findings without due explanation.

The CMA therefore cannot continue to place material reliance on the prospects of Cleveland Clinic entry or other providers over a 5- 10 year time horizon as a means of correcting the AEC. As a result, the NPV analysis continues to be unreasonably weighted towards an unlikely outcome. In particular,

- There is no basis whatsoever, given the CMA's own assessment of entry prospects, for assuming that effective entry may take place within a five year period (and there is also significant doubt that effective entry would take place within a seven or ten year period).
- Nor is it reasonable to base the central case on an assumption of "fully effective" entry given the absence of any evidence that entry in relation to a limited number of specialties would in fact result in downward pressure on HCA's prices.
- It is unreasonable to include economies of scale in the "central case", and confine a scenario whereby such economies may be replicated to an "upside" sensitivity analysis, when in reality the latter scenario should be judged as more likely (or at the very least both scenarios considered equally likely).

- There is no reason to introduce an 18 month time lag for price benefits to flow through to insured patients.

Rather, applying a fair and realistic approach to the assumptions used, the only reasonable expectation would be that on a balance of probabilities the NPV is positive, and a remedy should be pursued.

The CMA recognises how unusual it is not to impose a remedy when an AEC has been identified, and has now provisionally decided not to do so twice in this investigation, first in the PDR on the basis of evidence provided by Cleveland Clinic which was subsequently materially altered, and second in the SPDR, in relation to which no reasonable basis for refusing to impose a remedy is provided. In AXA PPP's view, therefore, the SPDR is unreasonable and irrational in its approach and its provisional conclusions, and cannot be relied upon to form a judgment that a divestment remedy (which was previously considered by the CMA to be effective and proportionate) would now be disproportionate.