

**FEDERATION OF INDEPENDENT PRACTITIONER ORGANISATIONS**

**CMA CONSULTATION DATED 10 OCTOBER 2016: NOTICE OF INTENTION TO VARY THE PRIVATE  
HEALTHCARE MARKET INVESTIGATION ORDER 2014 AND TO BRING ARTICLE 22 OF THE ORDER  
INTO FORCE**

**SUBMISSION**

**8 NOVEMBER 2016**

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## LETTER FROM GEOFFREY GLAZER, CHAIRMAN, FEDERATION OF INDEPENDENT PRACTITIONER ORGANISATIONS

Dear Sir/Madam

I write to you in my capacity as Chairman of The Federation of Independent Practitioner Organisations (FIPO) and on behalf of both my colleagues in the medical profession and more importantly our patients. FIPO set out the standards expected of the profession and its relationship with patients in its Charter, launched in Westminster almost 10 years ago.<sup>1</sup> This Charter, backed by all the major Royal Colleges, the Patients Association, the GMC and other Specialist Associations defined clearly and reaffirmed, in line with best medical practice, this long standing consultant/patient relationship.

It should be of interest to the CMA to note that the Charter anticipated to a large extent some of the CMA's own findings in its report on private healthcare in terms of fee estimates and the need for an open and frank statement of possible costs for all patients and also by the strong line we have always taken against financial incentives for doctors.

Given the considerable effort that the CMA has put into its investigation of the private healthcare market it is indeed regrettable that the original terms of reference from the OFT did not recognise the tripartite nature of this market (hospitals, consultants and private medical insurers) and failed to include the private medical insurers (PMIs) in its review.

As we hope to demonstrate with this submission the market situation described in the CMA report in 2014 has changed significantly, largely owing to actions by the PMIs. This means that today any patient covered by private medical insurance whether they pay for it themselves or have a level of cover provided by their employer for them and often their dependents, may find that their cover is not at all what they expected when they fall ill. They will probably be unaware of this until they need help. By then, although they may have, for some time, contributed premiums (or their employer may have done so on their behalf) there will be disappointment that the anticipated benefits of the scheme are not realised.

FIPO has long observed the market for private healthcare and how it has changed. FIPO represents the private practice committees of several specialist associations and other groups of doctors in private practice. As a consequence we frequently hear of the experiences of both doctors and patients. Sometimes these relate to hospital issues but far more commonly to issues with private medical insurers. What we hear cuts across geographic region, medical specialty and age group of the consultants. Over time we have built up a reservoir of experience and market knowledge which informs our views.

The basis of consultant practice is both traditional and well tested. A family doctor (GP) refers a patient to a specialist who would be, in their opinion, best suited to diagnose their condition, at a hospital convenient and suitable for the patient, and who can recommend any necessary and appropriate treatment. Patients trust their family doctor and consultant to act in their best interest. That bond of trust between doctor and patient is the foundation of high quality healthcare and a cornerstone of medical ethics. This has recently been reiterated in the columns of the British Medical Journal.

Unfortunately, we increasingly hear consultants (and patients) tell a different story. Sadly patients will frequently find that it is not their family doctor helping them to make these decisions, but instead the PMI, who, acting as a 'gatekeeper', will step between them and the consultant and tell them whom to see, where to go, what treatment they will get and at what price. This is a Managed Care scenario which has caused much distress to patients in the USA but which now in the UK may be manifested through so called "Open Referral" or "Fast Track" PMI policies.

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<sup>1</sup> Please see: <http://www.fipo.org/resources/index.htm>.

FIPO feel that this interference in the doctor/patient relationship cannot be right. If patients choose to have private healthcare with benefits from a PMI, they trust they will get what they perceive as the benefits of this and thus what they pay for, as they would in any consumer market where choice is paramount. What we see suggests this trust is increasingly breached.

What has this to do with the CMA's fee information remedy in Article 22 of the Private Healthcare Market Investigation Order 2014? FIPO say: everything.

The CMA investigated the market for the provision of private healthcare, specifically, whether a feature or a combination of features of the market or markets for the supply or acquisition of private healthcare prevents, restricts or distorts competition.

In a market where competition is effective, we may expect better outcomes for consumers. Yet here, consumer outcomes are worsening. FIPO say this is directly related to the practices of private medical insurers, for which the proposed Fee/Performance Information Remedy – which is a basic principle we have long advocated – is a wholly inadequate response. FIPO shares the CMA's objective to help consumers choose well (with GP assistance), but this remedy will not help them because when consumers buy private healthcare, they do not realise that when they use their insurance cover, the PMIs have tipped the market in their own favour.

The PMIs will say they are looking after the consumer through fee capping practices which reduce the cost of private healthcare. If only it were that simple. Consultants in a given specialty are not commodities - undifferentiated in their ability to meet a patient's needs. In fact, the opposite is true because to find a treatment that is in the best interests of the patient involves creating a bespoke relationship with the right specialist.

Currently, consultants working in private practice find themselves increasingly constrained by the behaviour of PMIs, whether through fee capping, actual or threatened derecognition, redirection of newly referred patients both and those already under the consultant's care or by a direct and egregious interference in consultants' clinical decisions. This ultimately could put the future of private practice at risk as consultants are disincentivised from entering or continuing in practice in these changed circumstances.

If consumers benefitted from fee capping by paying lower premiums to PMIs or received enhanced benefits, we would understand. Unfortunately, instead we see many benefits being cut back. In this race to the bottom, the patients are losing.

Whilst the PMIs may point to the degree of competition in the PMI market as evidence that if the consumer is not happy, they may go elsewhere, in reality things are not that simple. Not only has the PMI market consolidated in recent years, but there has been a spread in fixed fee capping practices, increasing clinical interference and an overall reduction in the patient benefits being offered, despite the robust ongoing profitability of the PMIs themselves. The consumer is generally at a disadvantage from the outset. Furthermore, changing PMIs for patients who pay their own premiums, is almost impossible if they have any previous medical history; they are locked in.

In fact the consumer is unlikely to be aware of what differentiates one PMI from another, or at least, of how that differentiation may be relevant perhaps years later when they need medical help. There is no Fee/Performance Information Remedy for the PMIs and hence patients may find certain treatments are recognised by one PMI and not the other; that the meaning of acute or chronic conditions may be variably interpreted by the PMIs; that the benefits they receive are not related to their premiums when PMI comparisons are made and indeed that the premiums vary greatly and that their benefits are not "portable". This also means that they may be directed to a hospital which may not be the best choice for their condition or convenience.

Of course there may be policy excesses or specific exclusions for certain patients and the terms and conditions of corporate policies may be dictated by the HR or other Directors of the purchasing company. However, neither the company HR, buying a corporate policy, or the individual buying a personal policy will have a clear understanding of the merits of one PMI compared to another. There is a total lack of comparative information about the benefits and costs of the PMIs. Some consumer publications such as *"Which?"* do publish, and have again recently published, premium costs for a couple of standard individuals and this shows that premiums vary widely between PMIs. However, the modus operandi of the PMIs, the various restrictions and variations between them and the whole manner in which they are increasingly intruding in to patient choice and care are not clearly spelt out.

What is the appropriate regulatory response? If the problem were merely a lack of transparency in consultant fees, the proposed remedy would help. But faced with the prospect of growing consumer harm in years to come, it is inadequate. In the submission below, we set out the detailed reasons why, and suggest how the problems in the private healthcare market could be effectively addressed.

In the first instance we believe that the CMA must now address what we see as a major obstacle to the successful operation of the Fee Remedy. This cannot work as a meaningful tool to aid consumer choice when the fee structure is already fundamentally distorted by the present PMI strategies. There can be no competition on prices when all consultants' fees are fixed and dictated by the PMI and when the patient does not see their consultant's bill. The whole essence of the Fee Remedy, requiring an estimate of fees in advance of treatment becomes a meaningless and very expensive exercise for the consultants and indeed the hospitals who are required to monitor this, unless the basic conditions of a competitive market are re-established and consultant fees are set independently of PMI interference. In the current market this cannot affect patient choice or encourage competition.

Furthermore, given the dramatic changes in PMI strategies and their impact on the patient we would ask the CMA to consider in addition a wider market review of the provision of private medical insurance. This is to ensure that through greater transparency and clarity of the PMIs premium/benefits balance and with changes in the PMIs role in controlling the critical doctor – patient relationship and medical care, consumers will get what they believe, and in fact, they are paying for.

Given the millions of consumers of private healthcare in the UK, my colleagues and I would urge you to act now while the CMA can still make a difference, and before it is too late.

**Geoffrey Glazer MS FRCS FACS**  
**Chairman**  
**Federation of Independent Practitioner Organisations**

## CHAPTER 1

### SUMMARY

#### 1 SUMMARY

- 1.1** On 10 October 2016 the CMA issued a “Notice of Intention to vary the Private Healthcare Market Investigation Order 2014 and to bring Article 22 of the Order into force” (the “Notice”). The CMA has proposed a timetable for bringing into force the various parts of Article 22 of the Order, and invited submissions on whether there have been material changes of circumstances since the preparation of its Final Report, or whether the CMA otherwise had a special reason for deciding differently.
- 1.2** In this submission, the Federation of Independent Practitioner Organisations asks:
- (a) Has there been a material change of circumstances since the CMA's Final Report which is relevant to the remedies in Article 22?
- (b) If there has been a material change of circumstances, what are the particular consequences of this for the CMA's Fee Information Remedy?
- 1.3** The core of FIPO's submission is that the restrictive practices (including fee-capping, bans on top-up fees, the use of e-billing to enforce such bans, and derecognition etc) are now more extensively and rigidly applied than before; that the spread of such practices represents a material change of circumstances, which causes the consultant fees to converge around PMI fee schedules, and in turn, this prevents any meaningful comparison of price. The Fee Information Remedy cannot work as intended whilst this situation prevails.

#### MCC

- 1.4** In FIPO's view there have been substantial material changes of circumstance, which make the Fee Information Remedy in its current form ineffective in addressing the adverse effect on competition in the provision of private consultant services across the UK that the CMA identified in Final Report, citing "*the lack of sufficient publicly available performance and fee information on consultants*" as a feature of the market. The new evidence here fundamentally contradicts the assumptions that led to the imposition of the Fee Information Remedy as originally conceived. These circumstances require the CMA to consider what remedy, if any, can be effective to address a finding of an AEC to the extent that such AEC can be maintained in the current market environment. This submission presents the CMA with the options available to it to achieve a comprehensive, reasonable and practicable solution.

#### *FIPO not opposed to Fee/Performance Remedy in principle*

- 1.5** FIPO is not opposed in principle to the Fee/Performance Remedy. In fact, FIPO acts as the main professional adviser to PHIN and favours the production of clinical outcome information provided this is accurate, statistically reliable and professionally agreed. Similarly, FIPO has always favoured estimates of fees to be given whenever possible to all patients<sup>2</sup>, but this is now a pointless exercise as consultants are progressively forced into similar if not identical fixed fee structures (without any patient responsibility for shortfalls) and when the doctor-patient relationship has been redirected.<sup>3</sup>

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<sup>2</sup> See <http://www.fipo.org/resources/index.htm>.

<sup>3</sup> FIPO works actively with PHIN to promote the remedy. FIPO works with the wider profession at the highest level, for example, by initiating combined meetings with the National Clinical Registries with whom PHIN wishes to engage.

- 1.6** To activate the Fee Information Remedy in its current form without considering the options we present would achieve nothing and would perpetuate the market distortion. It would fail to address the root causes of the lack of price competition between consultants; in short the activities of the PMIs in controlling consultants' business through fee capping, bans on top up fees, open referral and derecognition, which the new evidence shows are extensively and rigidly applied. FIPO has always advocated that consultants provide fee estimates before treatment, as far as possible, and it has no objection to publishing fee levels when they are actually meaningful for comparing consultants.

## **2 FIPO'S LEGAL SUBMISSION**

### **2.1 FIPO submits:**

- (a) there has been an MCC within section 138(3), which relieves the CMA of its duty to ensure that its proposed Fee Information Remedy is consistent with its finding of a Consultant AEC. The MCC relates to changes in the market for the provision of private medical insurance, whose participants – the PMIs – substantially determine the market conditions in which private consultants operate. In particular:
- (i) the PMIs increasingly determine the fees which private consultants may earn;
  - (ii) these fees are increasingly undifferentiated according to quality, experience, expertise, location or other competitive benchmarks; and
  - (iii) patients are excluded from the financial “contract” between the consultant and the PMI and so are unable to pay any top up fee (if they so desire) and may even in some cases face an extra financial penalty imposed by an insurer for seeing a consultant who is not “fee assured” (i.e. lower levels of benefits under their policy).
- (b) to the extent there is an AEC concerning patients' inability to exercise effective choice in selecting consultants based on price, it is no longer correct (if it was before) that this AEC is caused only by the feature which the CMA identified, namely, the lack of sufficient publicly available information on fees. It is also caused by PMI practices, which are now more extensively and rigidly applied. Consequently, the CMA must reconsider its decision on remedy;
- (c) the proposed Fee Information Remedy might reasonably be expected to address an AEC caused only by a lack of sufficient publicly available information on fees. It cannot, however, reasonably be expected to address an AEC caused by conduct which itself distorts the prices: implementation of the remedy would result only in publication of distorted fee information which cannot promote patients' ability to exercise effective choice in selecting consultants. In any case, in most cases the patient will not see the consultant's bill, so it is hard to understand how publishing fee information will help the patient. Consequently, the CMA must consider supplementing the Fee Information Remedy by measures to restore effective price competition. In the absence of such supplementary measures, at best the Fee Information Remedy will make absolutely no difference. At worst, it will introduce further distortions into an already distorted market by entrenching the rigidity over fees which stems from the PMIs' conduct;
- (d) if the CMA considers itself unable to impose on PMIs the remedies necessary to restore effective price competition and is not willing to investigate the practices of PMIs separately, the Fee Information Remedy alone ceases to be reasonable, proportionate or practicable for achieving a comprehensive solution and must not be activated;

(e) given the MCC, the CMA should consider whether its report still fulfils its terms of reference, and if it concludes that it does not, should consider whether it should further investigate the conduct of PMIs – whether by market study or market investigation reference – before further harm is caused to the patient interest.

**2.2** This submission provides detailed evidence – based on actual case studies as well as a detailed survey of consultants – to support FIPO's view that market circumstances have materially changed to a degree which renders the proposed Fee Information Remedy ineffective and counterproductive in isolation. FIPO therefore invites the CMA either to devise a more appropriate remedy to promote the patient interest and consumer choice or to conclude that there is currently no remedy that is likely to be effective for this AEC unless and until the conduct of PMIs has been investigated and taken into account in devising the remedy. This remedy could prohibit PMIs from banning top-up fees and prohibit derecognition or the threat of derecognition by any PMI on financial grounds if a consultant wishes to charge a top-up fee (providing a suitable fee estimate has been agreed by the patient in advance whenever clinical circumstances allow). This would not be asking more of the PMIs than a return to the situation that the CMA expected to prevail when it concluded its Final Report. Of course, patients may decide not to pay a top-up fee. However, in a competitive market patients would be able to understand the precise value of their policy benefits for payment of consultants' fees (and indeed hospital and other charges such as physiotherapy) and be able to use their benefits in a portable manner to exercise their choice to be treated by their preferred consultant and at their preferred hospital. This choice – between being able to pay a top-up fee so as to be treated by a more experienced or more senior consultant whose fees reflect these dimensions, or being treated by a consultant whose fees are fully covered by insurance – is being increasingly denied. Events have shown that the CMA's original assumption that the practices of concern were isolated and did not present a risk to consumer choice cannot be relied on without the PMIs committing or being required to change their behaviour.



## CHAPTER 2

### DEFINITIONS USED IN THIS SUBMISSION

#### 1 GENERAL DEFINITIONS

"**Act**" means the Enterprise Act 2002.

"**AEC**" means Adverse Effect on Competition.

"**CC**" means the Competition Commission.

"**CMA**" means the Competition and Markets Authority.

"**Consultant AEC**" means the CMA's finding in the Final Report of a lack of sufficient publicly available performance and fee information on consultants which gave rise to an adverse effect in the provision of consultant services, by preventing patients from exercising choice, thereby reducing competition between consultants on the basis of price and quality.

"**Consultant Survey**" means the Consultant Survey commissioned by FIPO and launched in June 2016.

"**Court**" means the Court of Appeal.

"**Court of Appeal Judgment**" means the judgment in *Federation of Independent Practitioner Organisations v CMA* [2016] EWCA Civ 777.

"**Fee Information Remedy**" means the Fee Information Remedy contained in Article 22 of the Private Healthcare Market Investigation Order 2014.

"**Final Report**" means the CMA's Final Report *Private healthcare market investigation*, 2 April 2014.

"**FIPO**" means The Federation of Independent Practitioner Organisations.

"**MCC**" means Material Change of Circumstances.

"**Notice**" means the CMA's 10 October 2016 Notice of Intention to vary the Private Healthcare Market Investigation Order 2014 and to bring Article 22 of the Order into force.

"**OFT**" means the Office of Fair Trading.

"**Performance Information Remedy**" means the Performance Information Remedy contained in Article 21 of the Private Healthcare Market Investigation Order 2014.

"**PHIN**" means the Private Healthcare Information Network.

"**PMIs**" means Private Medical Insurers.

"**Tribunal**" means the Competition Appeal Tribunal.

## 2 DEFINITIONS OF RESTRICTIVE PRACTICES

**“delisting”, “derecognition” or “non-admission”** mean the PMI practice of removing a consultant from a PMI’s approved list of consultants which means a subscriber will not be reimbursed for any work carried out by the consultant.

**“e-billing”** means the electronic billing systems which PMIs require all consultants to comply with, which require consultants to direct their invoices directly to the PMI for reimbursement, (which now in many cases also excludes the patient from any involvement with the payment).

**“fee capping”** means the PMI practice of determining the maximum fee which a consultant may charge for a consultation or procedure. It may be present alone or in combination with other restrictive fee arrangements.

**“open referral”** means the practice, originated by Bupa, of allocating a specialist to a subscriber based on the PMI’s criteria (not necessarily those of the referring clinician) and such consultants are designated as "Fee Assured". AXA PPP’s “Fast Track”, introduced in 2015, is substantively equivalent and such consultants that are involved are designated as "Fee Approved".

**“recognition criteria” or “admission criteria”** are the criteria which consultants must satisfy to be admitted to the approved list of consultants to whom work will be directed. Such criteria may include adherence to the PMI’s fee schedules.

**“restrictive fee arrangements”** include a variety of arrangements between PMIs and consultants by which the PMI ensures that the consultant’s fees do not exceed the PMI’s schedule. These may include: fee-assured status (Bupa); “fee-restricted status” (Bupa); “fee-approved” (AXA PPP). Essentially all newly appointed consultants are obliged by both PMIs to accept this status and adhere to very similar and low consultation rates and the benefit rates dictated by the insurer. Established consultants (appointed before 2010) may have similar agreements with variable but generally lowered consultation rates but the same level of procedure benefit rates. In all these instances the patient is excluded from any financial involvement (unless their policy carries some excess or exclusions).

## 3 TERMINOLOGY USED IN THIS SUBMISSION

In this submission, FIPO uses terminology well understood by consultants and stakeholders in the private healthcare sector. Certain terms and expressions, however, may carry different connotations in other sectors and may create a misleading impression of the true market dynamics if not used correctly. For clarity, we use the following terms in this submission:

- (i) **Consultant fees:** These are the fees consultants charge patients for private healthcare. These fees may be paid directly by the PMI where the patient has insurance cover (as is now becoming the norm) or they may be paid by the patient and then reimbursed by the PMI according to the terms of the patient’s insurance policy (see above).
- (ii) **PMI benefits:** The categories of private healthcare treatment which insurance will pay for. PMIs provide benefits to patients as a financial contribution to the cost of consultant’s fees. In practice, the level of PMI benefits is equivalent to the consultant’s fees in the majority of cases as discussed in section 3 of chapter 4 below.
- (iii) **Portability of benefits:** The ability of a consumer/patient to enjoy benefits under their policy regardless of their choice of consultant, facility or type of recognised and proven medical treatment, subject to exclusions under the relevant policy.

- (iv) **Doctor-patient contract:** The doctor has a contract with the patient for private healthcare.<sup>4</sup>

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<sup>4</sup> Indeed, the consultant has a duty of care in relation to the patient's treatment.

## CHAPTER 3

### CONSULTATION ON MATERIAL CHANGE OF CIRCUMSTANCES

#### 1 ISSUES RELATING TO MATERIAL CHANGE OF CIRCUMSTANCES

1.1 This submission presents five issues:

- (a) **Issue 1 - Existence of MCC:** Section 138(3) of the Act relieves the CMA of its duty to ensure that its remedy decision is consistent with its AEC decision where there has been an MCC since the report. Here, the Consultant AEC decision has been undermined by extensive and rigid fee capping, derecognition (and the threat of derecognition) of consultants, a ban on top-up fees, an increase in “open referral” and “fast tracking” practices by the main insurers (now being followed by Vitality and to some extent Aviva) and market consolidation among PMIs. Has there been an MCC?<sup>5</sup>
- (b) **Issue 2 – Reconsidering the remedy:** *Ryanair Holdings plc v Competition and Markets Authority*<sup>6</sup> established that if a change of circumstances is material, the CMA must then consider what the decision on remedy ought to be in the light of that MCC. The MCC here has undermined price competition in the market, to which the proposed publication of fee information can be no adequate solution because the resulting price structure is distorted by PMI interference. Should the CMA reconsider the remedy?
- (c) **Issue 3 - Supplementing the Fee Information Remedy:** Sections 138(2) and (4) of the Act require the CMA to resolve the AEC as comprehensively as reasonable and practicable. The MCC has resulted in the destruction of effective price competition on consultants' fees such that publication of those fees alone cannot resolve the Consultant AEC. Must the CMA consider supplementing the Fee Information Remedy by measures to restore effective price competition?
- (d) **Issue 4 - Suspending the Fee Information Remedy pending an investigation of the PMI market:** Where a proposed remedy is not reasonable, proportionate or practicable for achieving a comprehensive solution, the CMA may choose not to pursue an effective remedy option or to take no remedial action.<sup>7</sup> If the CMA considers that it is unable following its report to restore effective price competition by supplementary measures directed at the PMIs, must it suspend any implementation of remedies pending a wider investigation of the PMI market in light of the changed circumstances?
- (e) **Issue 5 – Investigating the PMI market:** The CMA's power to investigate markets may be exercised where the market is of sufficient priority, in terms, among other things, of likely direct effect on consumer welfare from intervention. The OFT plainly considered the private healthcare market to be of sufficient priority to warrant investigation. The OFT failed to appreciate the significance of the fact that the market is composed of three strands: the consultants, the hospitals and the PMIs and by excluding one of them from the investigation the resulting report would be incomplete. Furthermore the PMIs' fundamental role in this market has changed significantly since the Final Report on 1 April 2014, with far reaching effects on patient welfare and consultant and hospital practice which has undermined the

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<sup>5</sup> It is equally open to the CMA to conclude on the basis of the evidence we present that the CMA otherwise has a special reason for deciding differently, under section 138(3) Enterprise Act 2002.

<sup>6</sup> [2015] CAT 14 at § 110.

<sup>7</sup> §354 of CC3 (Revised) Guidelines for Market Investigations.

CMA's reasoning and conclusions on the Consultant AEC. Should the CMA undertake a market study or refer the PMI market for its own market investigation reference, to ensure the consumer benefits of its private healthcare intervention are not lost?

## **2 PRESENTATION OF ISSUES IN THE SUBMISSION**

**2.1** Issue 1 is set out in Chapter 4.

**2.2** Issues 2-5 are set out in Chapter 5.

## **3 BACKGROUND**

**3.1** In this section we present:

- (a) the relevant background from the Final Report; and
- (b) legal context.

### *The Final Report*

**3.2** In the Final Report, the CMA found an AEC in the provision of privately-funded healthcare services by consultants owing to "*the lack of sufficient publicly available performance and fee information on consultants*".<sup>8</sup> The CMA concluded that "[t]his feature gives rise to AECs in the provision of private consultant services across the UK by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated" and that "[t]his reduces competition between consultants on the basis of quality and price".<sup>9</sup>

**3.3** The CMA therefore adopted "a combination of measures to improve the public availability of information on consultant fees and of information on the performance of consultants and private hospitals."<sup>10</sup> These measures are contained in Part 4 of the Private Healthcare Market Investigation Order 2014. Article 22 of the Order containing the Fee Information Remedy has not yet been brought into force. The remainder of Part 4, including the Performance Information Remedy came into effect on 6 April 2015.

**3.4** The CMA's findings of a Consultant AEC were based on the facts available to it in preparation of the Final Report. FIPO and the CMA disagreed over the meaning of those facts: FIPO argued that the facts – in particular, the buyer power of PMIs<sup>11</sup> – argued against the CMA finding a Consultant AEC and in favour of action addressed at PMI conduct. FIPO considered that the Fee Information Remedy contravened the CMA's duty to address the AEC. The Tribunal (by a 2-1 majority ruling with a strong dissenting judgment) and the Court supported the CMA, on the basis of the CMA's assessment of the facts at the time of the Final Report, but neither the Tribunal nor the Court considered facts thereafter.

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<sup>8</sup> Final Report, Summary, § 10.

<sup>9</sup> *Ibid.*

<sup>10</sup> Final Report, Summary, § 72(a).

<sup>11</sup> The CMA found that the major PMIs have market power. Final Report, § 38.

## 4 LEGAL CONTEXT

### *Duty to remedy an AEC; consideration of MCC*

- 4.1** The CMA has a duty to remedy, mitigate or prevent any AEC that it has identified in a market investigation "unless there has been a material change of circumstances since the preparation of the report or [the CMA] otherwise has a special reason for deciding differently".<sup>12</sup>
- 4.2** Where there has been MCC, the CMA must consider whether the remedies it has identified continue to be reasonable and practicable.<sup>13</sup> If they are not, the CMA is not obliged to ensure that the remedy it imposes is consistent with its decision on AEC. It must reconsider: it has a duty to take such action as it considers to be reasonable and practicable, and having regard to achieving as comprehensive a solution to the AEC, to remedy mitigate or prevent the AEC and resulting detrimental effects on customers.
- 4.3** The developments set out in Chapter 4 contradict the assumptions of the Final Report.
- 4.4** If the CMA's review of the MCC reveals that the AEC it found was contributed to – *inter alia* - by features of the market which had not been adequately considered at the time of the Final Report because they had not yet manifested themselves, the CMA must take such action as it considers reasonable and practicable: (a) to remedy, mitigate or prevent the AEC concerned; and (b) to remedy, mitigate or prevent any detrimental effects on customers so far as they have resulted from, or may be expected to result from, the AEC.<sup>14</sup> On 3 March 2015, FIPO asked the CMA to do a market study of the private medical insurance market taking account of new evidence since the Final Report (see **Annex 1**). FIPO pointed out, for example, that (i) patients' benefits were reducing, (ii) "open referral" practices were increasing, (iii) e-billing was increasingly associated with the imposition of a fixed fee and denial of the ability to bill the patient directly (unless they had an excess or exclusion on their policy) and (iv) the threat and reality of consultant derecognition had spread widely. Since that letter, and as this Submission shows, these and practices having equivalent effects are intensifying.
- 4.5** The CMA's duty to consider MCC has been acknowledged in a number of cases. We draw particular attention to the Tribunal's description of the law on MCC in *Ryanair Holdings plc v Competition and Markets Authority*:
- (a) a change can be material even if it would not necessarily lead to a change in the remedy;
  - (b) the first step is to consider whether a change is material in the sense that it *may* result in a different decision on remedy;
  - (c) a change which affects a significant aspect of the reasoning in the Final Report may also be considered to be material. However, a change which does not have any impact on the reasoning or appropriateness of the remedy would not in the ordinary course of events be likely to be considered material;
  - (d) the second stage is to consider what the decision on remedy ought to be in the light of that material change in circumstances.
- 4.6** As a general matter, the CMA must undertake a proper investigation into the evidence. When an interested party such as FIPO raises plausible concerns, the CMA is under a duty to investigate those concerns.<sup>15</sup>

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<sup>12</sup> Enterprise Act 2002, section 138(3).

<sup>13</sup> Enterprise Act 2002, section 138(4).

<sup>14</sup> Enterprise Act, section 138(2)(a) and (b).

<sup>15</sup> *Skyscanner v CMA* [2014] CAT 16, §§ 90-100.

- 4.7 Given the CMA's duties under section 138(4) of the Act and the evidence of MCC following the Final Report, the CMA may impose remedies only where necessary and appropriate (i.e. proportionate) following the changed circumstances.<sup>16</sup>

#### *Court of Appeal Judgment*

- 4.8 We highlight here those Court findings that bear directly on the CMA's assessment of the changed circumstances.

- 4.9 Although the Court found in favour of the CMA – based on evidence available to the CMA for its Final Report – it was careful not to exclude the possibility that the facts could change over time. The Court accepted FIPO's submission that "*in principle competition may be prevented, restricted or distorted within section 134 without any detrimental effects having **yet** become apparent*" (emphasis added).<sup>17</sup> Since, according to the Court the "*existence or absence of such detrimental effects*" is "*plainly a material indication of whether or not competition has in fact been prevented, restricted or distorted*", the stage of maturity of the market when it is examined is a relevant factor when determining such adverse effects for the purposes of section 134. Now, nearly three years after the CMA concluded its original investigation and more than six years from the earliest evidence cited by the CMA, it is time to reconsider the market circumstances. When referring to the submissions of Brian Kennelly QC, counsel for FIPO, the Court observed that he submitted that "*it was no answer to find, as did the CMA, that **currently** there is no lack of availability of suitable consultant services in terms of price, quality and expertise*" (emphasis added).<sup>18</sup>

- 4.10 In upholding the Tribunal's ruling on the Final Report, the Court accepted the core concern that "*if **extensively and rigidly applied**, fee capping consultants could lead to distortions in competition between consultants and to reduced consumer choice*" (emphasis added).<sup>19</sup> The Court referred to the CMA's acknowledgement in the Final Report "*that fee-capping and derecognition of consultants who do not abide by the PMIs' fee schedule had the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience and the local market conditions*".<sup>20</sup> The Court also accepted that the assessment of whether that "potential" restriction on competition was a reality "*involved an assessment of whether fee-capping was **extensively and rigidly applied** as warned in paragraph 7.106 of the Report*" (emphasis added).<sup>21</sup> It follows that whether fee-capping is "extensively and rigidly applied" is pivotal to whether competition is prevented, restricted or distorted in the changed circumstances. It then follows that those factors that the CMA considered previously should be reassessed under the changed market circumstances in order to determine whether and how far they now hold true. This includes the CMA's findings cited by the Court that:

- (a) consultant fees were not being constrained to such a level as to damage consumer choice or quality or to discourage innovation or otherwise to cause long-term consumer detriment.<sup>22</sup> In fact, consumer choice and innovation are seriously and adversely affected as outlined in section 7 of Chapter 4 below;
- (b) not all PMIs followed the same practices as Bupa and AXA PPP.<sup>23</sup> In fact, PMIs are increasingly following similar restrictive business practices as detailed in section 3 of Chapter 4 below;

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<sup>16</sup> See, for example, *Tesco v Competition Commission* [2009] CAT 6, § 137.

<sup>17</sup> *Ibid.*

<sup>18</sup> Court of Appeal Judgment, §37.

<sup>19</sup> Court of Appeal Judgment, § 41 referring to Final Report, § 7.106.

<sup>20</sup> Court of Appeal Judgment, § 41.

<sup>21</sup> Court of Appeal Judgment, § 42.

<sup>22</sup> Court of Appeal Judgment, § 42 referring to Final Report, § 7.108.

<sup>23</sup> Court of Appeal Judgment, § 42 referring to Final Report, §§ 7.79-7.81, 7.87 and 7.88.

- (c) it was not in the interests of PMIs to exercise their buying power to harm competition in consultant services.<sup>24</sup> In fact, PMIs are increasingly engaging in exclusionary tactics and they deal unfairly and non-transparently with consultants paragraphs 7.6 to 7.10 of chapter 4 below);
- (d) it should be expected that the actions of PMIs, presenting themselves as buyers of the consultants' services,<sup>25</sup> in promoting lower-cost consultants would benefit policyholders in the form of lower premiums.<sup>26</sup> In fact, patient benefits have been reduced: see further, **Annex 2**; and
- (e) there was no evidence Bupa's and AXA PPP's practices had led to any diminution in the number of consultants recognised by them;<sup>27</sup> not that the number of consultants in private practice as a whole was adversely affected by the actions of PMIs.<sup>28</sup> Although the picture is complex, the increasing intensity of the PMIs' restrictive fee practices, particularly in relation to younger consultants, renders private medical practice increasingly unattractive for consultants. This in turn may be expected to present future challenges for the maintenance of a vibrant private healthcare market which offers consumers a genuine choice in terms of speciality, experience, and expertise.

**4.11** The Court observed that "*the CMA described the consultant as the supplier of a service and the insurer as the buyer*".<sup>29</sup> The Court did not develop its observations on the economic relationship between consultants and insurers. The following are relevant to understanding how the PMI and private healthcare markets operate and interact:

- (a) *Private healthcare in the UK is a multi-sided market*: the provision of private healthcare should be distinguished from the provision of private medical insurance which correspond to different markets. The service providers of private healthcare are consultants who consult and treat patients in relevant facilities. In a free market, consultants provide their services to patients who might normally be characterised as the buyers (or consumers) of those services since the patient receives medical treatment from the consultant. The PMIs do not deliver private healthcare treatment to patients but provide "benefits" to the patient in the form of financial compensation which may fully or partially cover their medical costs (or may not if they have specific clinical exclusions). FIPO believes such benefits should be "portable" and understood by the patient (or employer) at the time of purchase. Benefit portability would allow patients to choose their consultant based on cost amongst other things and also their hospital (as there are certain networks of hospitals excluded in certain policies) provided that the patient was prepared to pay any shortfall. Portability of benefits is fundamental to patient choice. In this scenario the PMI is NOT the "buyer" of consultant services; the patient is, and is able to exercise choice in a competitive market.
- (b) *The incentives of the parties are important*: consumers have the incentive to receive the best possible care for their condition, and as they do not see the price, their choice is rightly driven by consultant quality and reputation. PMIs have the incentive for everyone to have private medical insurance and for no one to use it. Their incentives are to reduce to the fullest extent possible the amount that is reimbursed, and therefore, they have strong incentives to direct patients on price alone, and not on quality.

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<sup>24</sup> Court of Appeal Judgment, § 42 referring to Final Report, § 7.100.

<sup>25</sup> The traditional way of considering this relationship places the patient as the consumer of the service, even if the service is ultimately paid for by the insurer.

<sup>26</sup> Court of Appeal Judgment, § 42 referring to Final Report, § 7.109.

<sup>27</sup> Court of Appeal Judgment, § 42 referring to Final Report, § 7.107.

<sup>28</sup> Court of Appeal Judgment, § 42 referring to Final Report, § 7.108.

<sup>29</sup> Court of Appeal Judgment, § 20 referring to Final Report, § 7.93.



- (c) *Consumer detriment*: to the extent that consumers do not have a wide range of choice across insurers, who offer different policies, this leads to clear consumer detriment. Consumers want best quality and are instead steered to the lowest price.
- (d) *Consumers' ability to choose in a well-functioning market*: with the existence of portable benefits and the ability of consultants to charge top-up fees, there is a clearer way for consumers to make a choice: they can either go with the choice that the PMIs have made for them or instead take partial reimbursement and top-up themselves in order to receive the care they want. Consumers in this latter scenario can therefore exert some constraining effect on price as it is their willingness to pay a top-up fee which will serve as a signal to the consultant.
- (e) *Patients lack information about cost of treatment*: given the markets are multi-sided and that patients suffer information asymmetries, the patient may not know or care about the underlying cost of treatment funded by the insurer because it affects them only where their policy benefits fall short of the consultant's permitted charges, and where they see the bill. Where the patient does not know the fee, it cannot constrain those fees because they are set between PMIs and consultants.
- (f) *Patients' ability to make an informed decision*: without clear understanding of the amount covered and not covered by insurance, patients cannot make an informed decision about the balance between price and quality, and therefore constrain prices.
- (g) *PMIs' buyer power*: owing to the major PMIs' (buyer) market power - as found by the CMA<sup>30</sup> and not disputed by the Court of Appeal<sup>31</sup> - UK best practice as set out in the UK's submission to the OECD<sup>32</sup>, case law<sup>33</sup> and the CMA's Guidelines<sup>34</sup> is that the CMA must consider buyer power as a possible source of adverse effects to consumers, and therefore capable of leading to an AEC.

**4.12** The Court of Appeal observed that “the Information Remedy applied to the whole of the private healthcare market, which is not restricted to PMIs (which comprise only 55% of the market).”<sup>35</sup> The Court based its observation on Figure 2.5 of the CMA’s Final Report where it was noted that private hospitals have four main revenue sources: overseas patients (3%), self-pay patients (14.5%), NHS-funded patients (27.5%) and patients with private medical insurance (55%). However, as the NHS-funded patients are managed under an entirely different financial system and quite separately from privately funded patients (whether by PMIs or self-pay) they should be considered separately. Thus for the private market the PMIs represent approximately 75.9 % - a percentage which will vary geographically in the UK (because the amount of self-pay work and overseas patients varies geographically). A closer examination of the composition of the market will reveal the limitations of the Fee

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<sup>30</sup> Final Report, § 38.

<sup>31</sup> Court of Appeal Judgment, § 8.

<sup>32</sup> OECD Roundtable, Monopsony and market power (2008), available at <http://www.oecd.org/dataoecd/38/63/44445750.pdf> (pages 229 - 243) accessed 1 August 2016.

<sup>33</sup> See, for example, Competition Commission (2007), Final report on Clifford Kent Holdings Ltd and Deans Food Group Ltd. The Competition Commission (“CC”) concluded that increased buyer power as a result of the merger would eventually lead to higher prices for consumers. In the *Groceries Market Investigation*, the CC examined the impact of buyer power on consumers in a variety of ways, including demand withholding in the UK fruit supply chain and a waterbed effect on small retailers. Whilst overall the CC did not consider that buyer power was detrimental to consumers, the CC found that some practices lead to excessive risk being transferred to suppliers which would be “likely to lessen suppliers' incentives to invest in new capacity, products and production process... these practices will ultimately have a detrimental effect on consumers (Competition Commission (2008), Market Investigation into the Supply of Groceries in the UK, § 36.

<sup>34</sup> Competition Commission, Guidelines for market investigations: Their role, procedures, assessment and remedies April 2013 (CC3) (adopted by the CMA). The exercise of buyer power can sometimes be a feature harming competition (see §157 and footnote 86).

<sup>35</sup> Court of Appeal Judgment, § 53 referring to Final Report, § 2.30 and Figure 2.5.

Information Remedy as a tool to foster greater transparency over consultants' fees for each category of patient:

- (a) First, the fees that consultants charge for their services are irrelevant to NHS funded-patients. The NHS procurement arm will mandate a fee to consultants for their services for NHS overflow work and there is no question of individual negotiation over that fee; in addition the consultant is indemnified via the NHS (NHS Litigation Authority) and has no administrative costs. In effect this is simply NHS work which happens to be performed in a private hospital.
- (b) Second, for patients with private medical insurance, in the changed circumstances the benefits levels set by the PMIs operate as minima and maxima: they are effectively the fees charged by consultants. The question of divergence between the benefit levels under the policy and the consultant's fees becomes relevant only where there is a shortfall and consultants are able to charge a top-up fee. As Chapter 4 shows, bans on top-up fees are increasingly enforced. In these circumstances, the notion of a consultant's market rate that might be lower or higher than the benefit levels under an insurance policy is increasingly divorced from reality. A fee information remedy in its current form can make no difference to insured patients' ability to select a consultant on the basis of price because there is practically no scope for competition outside the PMIs' caps.

**4.13** We return to these matters in Chapter 5 below when considering their implications for the identification of an AEC and suitable remedy in the changed circumstances.

## CHAPTER 4

### MATERIAL CHANGE OF CIRCUMSTANCES

#### 1 RELEVANT LAW

##### *Application of Section 138(3) of the Act*

- 1.1** Section 138(3) of the Act states that: "the decisions of the CMA under subsection (2) shall be consistent with its decisions as included in its report by virtue of section 134(4) unless there has been a material change of circumstances since the preparation of the report or the CMA otherwise has a special reason for deciding differently."
- 1.2** Where there has been an MCC, it follows that the decisions of the CMA to take such action as it considers to be reasonable and practicable to remedy the AEC and its resulting detrimental effect on customers need not be consistent with its decision whether it should take action to remedy, mitigate or prevent the AEC or any resulting detrimental effect on customers. Consequently, taken in isolation, section 138(3) means that the CMA may decide to keep the existing remedy, supplement it, replace it or abandon it.
- 1.3** The first question therefore is whether section 138(3) is engaged at all. The Tribunal – in the (for these purposes) identical circumstances of section 41(3) of the Act concerning mergers – has defined a change of circumstances as material where it may result in a different decision on remedy (but it is unnecessary to show that it would have that result), or may affect a significant aspect of the reasoning in the Final Report (again, it is not necessary to show that it would have such an effect).<sup>36</sup>
- 1.4** Where a change of circumstances is material, it is then necessary to consider what the decision on remedy ought to be in the light of that MCC. Therefore, section 138(3) will be engaged here if the evidence FIPO presents on change of circumstances since the Final Report on 2 April 2014 may result in a different decision on remedy or may affect a significant aspect of the reasoning supporting the AEC.

#### 2 EVIDENCE AND METHODOLOGY

##### *Scope of Evidence*

- 2.1** We present evidence that changes in PMI practices since the Final Report at the very least:
- (a) may render the Fee Information Remedy ineffective (assuming it would have been effective in the absence of these changes of circumstance); and
  - (b) may call into question whether the Consultant AEC identified in the Final Report is correctly reasoned, in that the inability of a patient to compare consultant fees is due not (or at least, no longer) to the lack of publication of sufficient information, but to a market structure and PMI practices which remove both competition between consultants on price, and the ability of patients to carry out a meaningful comparison.
- 2.2** The features of the PMI market we have identified comprise three categories: those which directly affect the formation of the consultant fee, those which permit the PMIs to impose practices on consultants without fear of significant loss of business, and those which indicate that the patient interest is being increasingly harmed.

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<sup>36</sup> Ryanair Holdings Plc vs Competition and Markets Authority, *supra*, at §110.

## *Use of evidence and methodology*

- 2.3** It may be difficult for the CMA to gauge the full extent of the problems without seeing the underlying interactions between PMIs, consultants and patients, a representative example of which we provide with this submission. The message is clear: that in order to sustain a private practice the consultant must agree to conditions which have the effect of eliminating price competition.

## *Evidence for MCC*

- 2.4** These market changes are shown in a new survey on consultant practice, commissioned by FIPO and launched in June 2016. Its data cover the period 2014-2016, updating the last FIPO survey provided to the CMA during the CMA's *Private Healthcare Market Investigation*. Details of the Consultant Survey including the Consultant Survey Letter and Questionnaire, Consultant Survey Hypothesis, and Consultant Survey Qualitative Evidence can be provided to the CMA on request. **Annex 3** contains representative direct comments from respondents to the survey, which echo the themes outlined in this submission on MCC.

- 2.5** The changes can be grouped as follows:

- (a) ***Changes in how consultant prices are formed and enforced:*** the spread of fee-capping and equivalent practices, the strict and widespread enforcement of bans on top-up fees, e.g. through the consultant e-billing the PMI directly; PMIs increasingly using restrictive fee arrangements; PMIs increasingly determining patients' consultants through open referral practices; and growing use of derecognition and the threat of derecognition to force consultants to comply with these strategies.
- (b) ***Changes to market structure of PMIs:*** in particular, the growing market power of the largest PMIs through consolidation, alignment in business practices and the use of procurement alliances; this supports a move towards imposing fee reductions backed by threats of derecognition and other sanctions, and not constrained by fear of competitive response. The result is that even those smaller PMIs who remain in the market and who had provided a system of patient choice (for example WPA) have been forced to lower benefits and impose some degree of fee restrictions in order to compete effectively (on price) for business.
- (c) ***Changes in patient/consumer benefit:*** particularly, the reduction in patient policy benefits unhindered by the threat of a competitive response; the growing interference by PMIs in clinical decisions through rigid eligibility criteria for treatment funding and open-referral policies.

- 2.6** However these developments are viewed it is plain that the result is consumer detriment in that patients are being denied choices that would avail them in a competitive market where consultants can and do set their fees independently of interference and based on demand-led factors such as experience, expertise and location.

- 2.7** With consultants increasingly channelled to restrictive fee arrangements backed up by the threat of delisting should they veer from those limits and PMIs controlling access to the patient, consultants can merely accept the PMIs' terms.

- 2.8** The effect of these market changes is the PMIs – not the patients – increasingly determine the choice of consultant, and fee differentiation based on the GP's advice and patient choice, whilst consultant expertise, experience and performance is minimised if not eliminated. It is not the consultants but the PMIs, operating in a market characterised by growing concentration, alignment of practices and reduction of fees to a lowest common denominator, who limit the patient's ability to compare consultants. In that context, how can the Fee Information Remedy address the Consultant AEC? The resulting fees are the product of the

PMIs' choices and consumers will not be able to exercise effective choices merely by having information on those (distorted) and often identical fees.

### 3 CONSULTANT FEES

- 3.1 The practices drawn to the CMA's attention in its original report are now being "extensively and rigidly applied", in two dimensions. First, the category of practices has expanded beyond imposition by the PMI of a fixed fee which consultants may charge, and covers a range of practices which have equivalent effect and which tend to the same result. Secondly, they are more widely applied across the market. In consequence, the fee payable to a consultant for a given procedure by a PMI will not vary according to expertise, experience, location or other non-price factors, but will be the PMI's mandated fee. For the Fee Information Remedy to work, however, it must be possible for the patient to make meaningful price comparisons between consultants. Owing to the distortion of market prices by these practices combined with degree of market penetration, the consumer cannot make meaningful price comparisons, even with publication of fee information, as the remedy foreshadows. On its own, therefore, the fee information remedy cannot work as intended.
- 3.2 This section sets out, within each of the categories of restrictive practices contributing to fixed fees, the degree of market penetration of these practices and representative examples, taken from FIPO's extensive files, of how these practices manifest themselves.

#### *The spread of fee capping*

- 3.3 In the Final Report, the CMA noted the competition risks of fee-capping and similar practices:

*"[i]f extensively and rigidly applied, fee-capping consultants could lead to distortions in competition between consultants and to reduced consumer choice. Fee-capping (and derecognition of consultants who do not agree to abide by the insurer's fee schedule) has the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions."*<sup>37</sup> (emphasis added)

- 3.4 There have been material changes in the fee-capping practices of PMIs who gave evidence to the Final Report disclaiming such practices.
- 3.5 At the time of the Final Report, PruHealth (now Vitality) stated that it was "not proposing to introduce similar consultant fee-capping contracts."<sup>38</sup> In fact, with effect from 22 September 2015 Vitality has now introduced a new contract for consultants to charge only within the fee benefit rates of the company. Vitality also operates e-billing, which we discuss further below.
- 3.6 WPA and Simplyhealth told the CMA that "they did not cap the level of fees at which their consultants may charge. While both publish a schedule of customary and reasonable fees reimbursement maxima for their consultants, consultants are permitted to charge patients above published fee levels, on the basis that the patient is aware of and is willing to contribute any shortfall. In WPA's case, the consultant must also make their fees clear to the patient in advance in writing."<sup>39</sup> As far as the CMA was aware at the time of the Final Report "WPA [did] not have plans to introduce fee-capping contracts for its consultants."<sup>40</sup> In fact, since the Final Report, Simplyhealth has now been absorbed within AXA PPP's pricing model. This was confirmed in a letter to providers of 26 April 2016 where AXA PPP confirmed that their "relationship and associated fee arrangement with AXA PPP now extends to patients

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<sup>37</sup> Final Report, § 7.106.

<sup>38</sup> Final Report, § 7.81.

<sup>39</sup> Final Report, § 7.81.

<sup>40</sup> Final Report, § 7.81.

previously insured with or administered by Simplyhealth" (see **Annex 4**). FIPO understands that as of October 2015 WPA has not imposed fee capping or open referral but has now reduced benefits.

**3.7** As noted in FIPO's letter to the CMA of 3 March 2015, AXA PPP has in effect created two tiers of consultants ("Fee Approved" and other consultants). The Fee Approved group has agreed to the new lowered benefit rates and will receive patients by 'fast tracking'. This is the same as the Bupa 'open referral' system but the difference here is that the patients of consultants who are not in this Fee Approved group will actually receive lesser benefits for seeing their chosen consultant. In other words, their top-up fee will be allowed but may be increased even more because AXA PPP applies extra reduced benefit levels for consultants who do not adhere to their guidelines for Fee Approved Specialists. Thus a subscriber is subject to an added financial pressure to go to a Fee Approved consultant.

**3.8** It is telling that the degree of interference by the PMIs into consultants' fees (whether directly through their prescription of set fee levels or indirectly through the reduction in policy benefits) is correlated to the market power of the insurer. Yet the practices are not confined to the major insurers. The result is that over 80% of the market is covered by PMI determined restrictive fee practices as illustrated in Table 1 below.

**Table 1: PMI market share and fee practices**

PMI	Market Share	Fee practice
Bupa	38%	Open referral; fee assured
AXA PPP	30%	Fast tracking; fee approved
Aviva	13.5%	Fixed fees; e-billing; adherence to Aviva benefits required
Vitality	10%	Progressive approach to fixed fees; lower benefits
WPA	2.5%	Lower benefits

*Source: FIPO estimate based on current market intelligence and taking account of recent consolidation in the sector including AXA PPP-Simplyhealth. It is recognised that at any given time the market shares of the PMIs may fluctuate to some degree as smaller insurers' business is absorbed by the larger PMIs.*

**3.9** In order to try to understand the effect that PMIs evolving approach towards fixed fees and similar practices have on consultant practice, FIPO has conducted an analysis of benefit levels comparing old and new benefits (see **Annex 2**). The conclusions of FIPO's analysis is that overall consultant income will be severely restricted, in particular in these categories: newer consultants (since 2010); particular specialties; and particular regions (e.g. London).

**3.10** Fee-capping applies with particular intensity to new consultants. For new consultants this has become mandatory since this was rolled out by Bupa in 2010 and soon after by AXA PPP. Established consultants have been coerced by other methods to comply with new lower rates. This situation has resulted in consultants charging the PMIs reimbursement rates in the vast majority of cases (as anticipated by the CMA in paragraph 7.106 of the Final Report). As noted in **Box 1** below, for new consultants 280 out of 338 respondents (83%) reported that they have fixed fee schedules with at least one insurer. Those not fixed were most likely appointed early on as the PMI system was developing or escaped for other administrative reasons. It is now clear that all newly appointed consultants will be obliged to do this with Bupa and AXA PPP

and increasingly with the others. The data shown below indicate that 198 new consultant respondents were fixed by 3.8 insurers on average.

- 3.11** In other words, the 'benefits' or reimbursement rates set by the PMIs operate as minima and maxima fees, leaving practically no scope for competition on fees between individual consultants based on such factors as experience, expertise and location.

*Bans on top-up fees are strictly and widely enforced*

- 3.12** Where PMIs impose fixed fee reimbursement on consultants, consultants have previously been able to differentiate themselves on quality and local market conditions grounds by charging a top-up fee, where the patient was willing to pay. Increasingly, however, PMIs have curtailed this practice, forcing more consultants to accept PMI fee schedules without the ability to charge a top-up fee. Bans on top-up fees are therefore the complement of capped fees, which, as explained are considerably more widespread now. They also complement the other restrictive fee arrangements, including the threat and reality of derecognition/delisting, and it is reinforced by the spread of e-billing.
- 3.13** Patients are denied their choice of consultant or treatment even where they are willing to meet the funding shortfall themselves.
- 3.14** At the time of the original market investigation, Bupa, AXA PPP and Aviva all maintained a de facto prohibition on top-up fees. This represented 81.5 per cent of the market. Market coverage of PMIs does not mean it is absolutely comprehensive across whatever they do, but simply that PMIs are now known to have engaged in ban on top-up fees.
- 3.15** Since the Final Report, Vitality has now adopted e-billing practices which indirectly achieve a ban on top-up fees backed up by derecognition for failure to follow its terms and conditions.
- 3.16** It does not matter whether the PMI explicitly bans top-up fees since it is widely interpreted by consultants that PMIs strictly prohibit such top-ups. The perception of the consultant is critical as the party who risks being penalised for failing to comply.<sup>41</sup>
- 3.17** The following are representative examples of bans on top-up fees in practice:
- (a) A hip consultant was derecognised by Bupa as he was unable to agree to charge within Bupa's benefit limits. When the consultant was still recognised by Bupa, a patient agreed to a fee in excess of Bupa's limit. Bupa then pursued the consultant for the excess over the Bupa prescribed fee limit. There was no discussion whether the patient would have been willing to pay the excess as a top-up fee.
- (b) AXA PPP's adherence to its Fast Track Scheme (see paragraphs 3.21 and 3.22 below) whereby Fee Approved Specialists must charge within the AXA PPP fee schedules has sometimes resulted in complete denial of cover to patients choosing a specialist who charges above the prescribed levels. The subscriber's claim is then made worthless (i.e. it is not a cause of AXA PPP only funding up to the set level as no contribution at all will be made by AXA PPP). The subscriber is not given the option of paying a top-up fee. In one case, a patient wanted to see a consultant who had treated her successfully in the past and who was a leader in his field. This was a gynaecological matter and a sensitive personal issue, but the patient had to choose: go to another consultant, or pay for it herself. The policy was an employment benefit and its terms had been agreed by the patient's corporate services. As a result, the patient could not influence its terms.

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<sup>41</sup> In *De Post-La-Poste* the European Commission criticised the giving of a notice of termination of a preferential pricing agreement where the notice was to be understood as a warning to the other party to enter a collateral agreement. The Commission regarded the perception of the user as important. *De Post-La Poste*, OJ 2002 L61, page 32.

### *PMIs are increasingly steering consultants to restrictive fee arrangements*

- 3.18** There are various practices described below which are mutually-reinforcing and which serve to support the effect of fee capping. They involve PMIs steering consultants to restrictive fee agreements, whether by design or effect.
- 3.19** At their most subtle, PMIs exploit the patients' relative lack of knowledge by purporting to justify the arrangements in the interests of patients, whereas patients paying the same premiums may be discriminated against (i.e. they receive reimbursement at lower levels depending on their choice of consultant). Put higher, these cases frequently involve threats and intimidation, where the consultant who does not agree to the PMI's reduced fees faces loss of referrals, support and even derecognition.
- 3.20** Previously, Bupa led the market in these practices, but it is no longer alone. As these examples below show, AXA PPP, with 30 per cent of the market, is also now steering established consultants to restrictive fee arrangements.

### *Creating two-tier structures for fee reimbursement*

- 3.21** As noted above, AXA PPP through its Fast Track scheme has created in effect two tiers of established consultants – Fee Approved and Fee Limited where a Fee Approved consultant enjoys "*important benefits*" including "*reimbursement of fees at a higher level than other specialists and the confidence that your patients will not incur a shortfall if they claim, nor be offered treatment with an alternative specialist*" (see further the letter of 5 October 2015 from AXA PPP explaining to consultants how, through the Fast Track scheme, they have "*an opportunity to establish a stronger relationship with AXA PPP healthcare*" (**Annex 5**). FIPO has seen various similar letters that have been sent by AXA PPP to consultants.
- 3.22** Bupa has also tried to get consultants to become a Bupa Premier Consultant Partner with an implicit acceptance by the consultant of the Bupa fee maxima in return for security that their fees will be paid in full but at a lower level than they might previously have charged owing to reduction in the benefits paid. The correspondence at **Annex 6** is typical, where they "*ask that consultants charge within Bupa's benefit limits*".

### *Directing patients to the lower cost consultants based on open referrals*

- 3.23** PMIs are increasingly steering patients to lower cost consultants where the patient has little or no say over how their case is handled.
- 3.24** Although the documentation surrounding AXA PPP's Fast Track scheme is not entirely clear, it is apparent from the express wording of the October communication referenced above and attached at **Annex 5** that they aim to move 50% of corporate policies to Fee Approved. In these situations the consumer will be unable to influence the policy terms.
- 3.25** BMI Healthcare has developed a new service: an e-referral tool which provides an online service for insurers which allows them to book initial appointments with BMI (fee-assured) consultants. See, further the letter from BMI to a BMI consultant dated 21 September 2016 which states that insurers "continue to develop products and new pathways to care that results in GP's referring to a speciality rather than a specific 'named consultant' and attached at **Annex 7**.
- 3.26** Even where the consumer has chosen their own policy on an individually funded basis, it is questionable how much they know what they are getting. AXA PPP's Daily Telegraph advert (**Annex 8**) promises the consumer can "*avoid NHS waiting lists and get the treatment and drugs [they] need*". They do not explain the specific terms for access to 250 hospitals and



24,000 specialists<sup>42</sup> and “other practitioners” and when an individual’s choice of practitioner may be overridden by the PMI.

### *Threats and intimidation*

- 3.27** PMI conduct towards consultants is not a normal commercial negotiation on arm’s length terms. The perspective of the user – the consultant in this case – is important in categorising such interactions as coercive. In one case (which FIPO understands is not unusual) the consultant received two unsolicited emails and a letter from AXA PPP. They were ultimately told that if they did not agree to become a Fee Approved consultant: *"This means that you can continue to set your own fees but we will reimburse you from **our lower fee schedule** and our members will be liable for any shortfall. We will advise our members of this upon pre-authorization and offer to source them an alternative specialist. You will also be removed from our preferred list and therefore will not receive any further referrals from our fast track appointments team"* (emphasis added).
- 3.28** As a result, many consultants – and particularly newly appointed consultants who need to start and build up their practice cannot do this without PMI referrals and security of income – have no choice but to agree to the PMIs' terms which in the case of new consultants are at even lower levels of consultation fees than the established consultant group. These strategies limit patient choice and create consumer detriment. In particular:
- (a) PMIs are increasingly redirecting patients to lower cost consultants with scant regard to clinical need, expertise, experience or personal circumstances;
  - (b) AXA PPP provide different levels of benefits to different subscribers depending on which consultants the subscriber visits (even if the subscribers are paying the same premium);
  - (c) PMIs are interfering with clinical referral pathways between GPs and consultants and potentially affecting clinical care (see, further, paragraphs 7.2 to 7.5 below (interference with clinical decisions)).

### *Patients are increasingly channelled to consultants through open referral practices*

- 3.29** In the Final Report the CMA highlighted the risks to competition of open referral practices. Commenting on the detrimental effects of extensive fee-capping the CMA was prescient in noting:

*"[t]his distortion may potentially be increased, the greater the number of insured patients on policies that require open referrals from GPs as policyholders are channelled to lower cost consultants. Moreover, assuming that Bupa continues with its policy of derecognizing consultants who charge prices which are higher than 90 per cent of their peers [●] and not recognizing new consultants unless they agree to be fee-capped, **this is likely to lead to the majority of consultants being required to charge Bupa's standard national reimbursement fees** and the ability of policyholders to pay top-up fees to have a greater choice of consultant significantly limited irrespective of the terms of their policy."*<sup>43</sup> (emphasis added)

- 3.30** Recent history confirms this prediction. While Bupa claims to allow its subscribers to see their preferred (non-Fee Assured) consultant, in FIPO's experience, it does not, or it places obstacles to patients accessing the range of consultants. When searching in Bupa's consultant finder it

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<sup>42</sup> It is not evident what this number refers to. FIPO understands that there are 12,500 consultants in private practice according to PHIN.

<sup>43</sup> Final Report, § 7.106.

is not possible to find any non-Fee Assured Consultants unless they are searched for specifically by name.

- 3.31** Previously, Bupa led the market also in this practices; but AXA PPP – now with 30 per cent of the market as noted above - has since at least October 2015 adopted a similar practice, known as “fast tracking”.
- 3.32** As noted in paragraph 3.21 above, in October 2015 AXA PPP wrote to consultants about access to referrals from its "*growing Fast Track Appointments service*" (see **Annex 5**). It refers to the "*increasing proportion of patients with ‘open referrals’*". This letter implies by agreeing to become a Fee Approved consultant (including agreeing not to make any additional charges to AXA PPP or the patient outside the AXA PPP Contracted Fee Schedule), consultants will see an increasing proportion of referrals. However, as AXA PPP moves more and more consultants to Fast Track status, the scope for fee competition will further diminish. By contrast, for Fee Limited Consultants, AXA PPP will pay only up to a reduced level of benefits and they will be warning patients of a shortfall for that consultant. In this way, PMIs limit patients' choices and constrain consultants in charging based on demand-led factors through the mutually reinforcing tools of open referrals and express or implied bans on charging outside the agreed schedule.
- 3.33** The way in which AXA PPP promotes its Fast Track (the same as the Bupa open referral) scheme raises exactly the concerns that the CMA foreshadowed where patients are channelled to consultants based on cost considerations and without sensitivity to other factors such as experience, expertise or personal choice. **Annex 8** provides a copy of an unsolicited advertisement where AXA PPP is promoting the Fast Track/Fee Approved scheme. The result of the patient being steered or 'Fast Tracked' towards an AXA PPP nominated consultant (and indeed a hospital) is that there can be no competition on fees because all fees are covered and with e-billing the patient will not see those fees unless there is a specific excess or exclusion in their policy benefits.
- 3.34** Experience has confirmed open referral schemes help reinforce the drive to fixed fees for consultants. Operating alongside Fee Approved and Fee Limited status, they operate unfairly for subscribers. It seems that AXA PPP is providing different benefits to subscribers who paid the same premium or to the same subscriber depending on the consultant that they choose. This is shown by the communication at **Annex 9** from AXA PPP, relevant extracts of which are provided here for illustration.
- (a) On the one hand the Fee Limited Consultant is informed: "you can continue to set your own fees, however you will receive reimbursement from our lower fee schedule for your services and any shortfalls will be the patient's liability. You will never be added to our preferred list and you will not have access to our fast track referral services".
- (b) The consultant is then informed that the below message has also been added to their file:
- "It is possible that this specialist's fees will not be paid in full by AXA and you may be expected to pay any shortfalls incurred during the length of your treatment with them [...] If you would like us to, we can find you an alternative specialist whose charges will be paid in full. We can even book the appointment for you. Would you like me to arrange that?"<sup>44</sup>*
- 3.35** The Consultant Survey confirms that the PMIs are increasingly channelling consultants to restrictive fee practices as shown in **Box 1**. At the time of the Final Report consultants would tend to have fixed fee arrangements with one of their insurers (i.e. Bupa). With the spread of

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<sup>44</sup> Following implementation of the Performance Remedy, this is likely to worsen patient choice further: a patient may seek a particular consultant because of the consultant's outstanding record, only to be told that he/she is not available to the patient under the open referral policy.

fixed fees and restrictive practices, it is now the case that the consultants will have their fees fixed by multiple PMIs, and this is particularly acute for new consultants.

#### Box 1: Consultant Survey results on PMI channelling of consultants to restrictive fees

##### New consultants

- 280 of 338 new consultant respondents (83%) had a fixed fee arrangement and the minority were probably appointed early in 2010 as the system was gradually rolled out or escaped for other reasons. This is no longer the case and the remaining majority had fixed fees with one or more PMI; 73.5% (Bupa), 65.9% (AXA PPP), 339.3% (Aviva) and between 21% - 26% for the other insurers. On average these new consultants had fees fixed by 3.8 PMIs.

##### Established consultants

- 82.5% of established consultants have been approached by Bupa to enter into a fixed fee arrangement, and 32.2% have agreed to a fixed fee rate for both consultation and procedure fees. For AXA PPP, 69.7% of established consultants have been approached, and 31.3% have agreed to a fixed fee rate for both consultation and procedure fees. For Aviva, the corresponding figures are 36.6% approached and 9.9% agreed.
- 95.1% of established consultants are recognised by Bupa, of which 27.8% are in a Bupa Premier Partnership,<sup>45</sup> 29.6% are in a Bupa fee assured contract, and the rest have no fee agreement. Essentially, this means 57.4% are in a fixed fee arrangement with Bupa.

*The threat and reality of consultant non-admission or derecognition is more widespread*

**3.36** The Final Report discussed the PMIs' use of the threat of non-admission/ derecognition as a tool to lower consultant fees. For Bupa it noted, "*[s]ince August 2011, over [1000] Bupa-recognized consultants have been asked to provide a clinically valid reason for their high fees or to lower their fees when billing to Bupa customers. Twenty-seven consultants have been derecognized as a result of this process since August 2011, the remaining consultants having agreed to lower their fees or are still in discussions with Bupa.*"<sup>46</sup>

**3.37** The CMA was correct to conclude in the Final Report that "*at the very least Bupa and AXA PPP have buyer power in relation to consultants*"<sup>47</sup> and that "*[c]onsequently, Bupa and AXA PPP's actions in relation, in particular, to capping some consultant fees and the recognition of consultants has the potential to distort competition between consultants*".<sup>48</sup>

**3.38** Previously, this practice was already extensively applied across the market by Bupa and AXA PPP (together, covering 65 per cent of the market). Now, with Vitality and Aviva also starting to use this tool, the market coverage is at least 91.5 per cent.

<sup>45</sup> A Premier Partnership relationship is a fixed fee arrangement.

<sup>46</sup> Final Report, § 7.77.

<sup>47</sup> Final Report, § 7.105.

<sup>48</sup> *Ibid.*

- 3.39** The following are representative examples of the many cases where consultants have been asked to lower their fees or face derecognition, or have actually been derecognised or relegated to an inferior status as a result of them charging outside a PMI's fee schedules.
- (a) An orthopaedic surgeon was delisted by PruHealth who wrote to him alleging "overcharging" following a "benchmarking exercise". The surgeon had not increased his fees for 7 years. He is a nationally recognised expert with 20 years of experience. The effect of PruHealth's inflexibility was to require the surgeon to charge the same as a newly qualified surgeon.
  - (b) An orthopaedic surgeon was derecognised by Bupa when his fees were apparently less than other surgeons locally and nationally. The remuneration offered by Bupa was little different to that offered by Bupa 20 years previously, taking no account of inflation.
  - (c) A consultant ENT surgeon faced derecognition by Bupa because he would not accept £90 for a new patient consultation including relevant procedures. The practical effect of Bupa's policy changes and reduction in the fees it was prepared to reimburse was that a patient was asked not to attend for a follow-up consultation while in the taxi outside the hospital on their way to see the surgeon. The patient had been happy with the treatment so far and was displeased at Bupa's actions. The situation worsened and 3 patients insured with Bupa the following week cancelled their appointments on the day at Bupa's request.
  - (d) A consultant ophthalmologist was derecognised by Bupa after 20 years. Bupa demanded that he reduce his fees by 20%. His fees were similar to those of colleagues in the speciality and to other consultants in different disciplines. The consultant was derecognised with 7 days' notice. Even patients who were due to undergo surgery the day after the notice took effect had their cover withdrawn by Bupa and had to see other consultants. The consultant had accumulated a large number of patients over the years whom he was precluded from seeing on cost grounds alone.
  - (e) Bupa will also state to a consultant that their fees are in the top 10% of the range, to apply pressure to get them to reduce their fees. Clearly in any range of consultant fees (which is becoming less dispersed as a result of the restrictive fee practices discussed above) there will always be an upper (and a lower) 10%. Thus, the steering by PMIs of consultants to a fixed level without any regard to the factors that may differentiate the consultant's services (based on experience, geography or for other reasons) from others runs counter to a competitive market where consumers are presented with consultants at a range of fee options and can decide between them on the merits.
- 3.40** The PMIs' reasons can be opaque or arbitrary and can take insufficient account of individual circumstances. For example, a 62 year old consultant who had been recognised by Bupa for well over 20 years was informed in January 2015 that he could not be recognised by Bupa without some re-training within the NHS because he was not listed on the GMC Specialist Register. The consultant had qualified and left training before the Specialist Register existed. The consultant is recognised by other insurers and is a recognised international expert in his specific field of surgery.
- 3.41** Third, PMIs use e-billing to further control the financial relationship with the patient. As a result, consultants will be locked in to a system with the patient excluded and payments to the consultant entirely at the PMI's discretion. While the patient will be advised of any shortfall under their policy, the e-billing procedure does not typically give consultants the freedom to agree a top-up fee with patients outside the e-billing arrangements. The PMI will consider direct invoicing to be a breach of its billing guidelines, adherence to which is or may be a condition for recognition. As the practice of e-billing becomes more prevalent, PMIs will also use the threat of derecognition to enforce compliance with its e-billing requirements.

- (a) AXA PPP make clear that one of the conditions for being a Fee Approved Specialist is "[y]ou will bill us electronically either through one of our approved e-billing services such as Healthcode or through your own on-line portal". See further **Annex 5**.<sup>49</sup>
  - (b) Bupa has suggested or implied that a consultant's recognition with Bupa will be impaired if they send a bill directly to the patient. In one case, a consultant was informed in correspondence in February 2015 that "moving to paperless invoicing and an update to your Bupa recognition criteria" and that "all Bupa providers must bill electronically".
  - (c) In other correspondence with a consultant over recognition, Bupa has informed a consultant, "charging over our benefit limits and invoicing your patients, our customers, for any shortfalls is a breach of our agreements".
  - (d) Since the Final Report, Vitality has now adopted e-billing practices where consultants face derecognition if they fail to comply.
  - (e) Aviva makes clear under the FAQs on its website that consultants should bill electronically, within the benefit levels allowed and not send a bill directly to the patients.<sup>50</sup>
  - (f) The situation regarding shortfalls can be unclear. If there is any ambiguity, a consultant will err on the side of caution and will not tend to bill any amount above the fixed fee. This provides a further mechanism for the PMIs to enforce strict adherence to their fee schedules, thereby eliminating any scope for patients to pay top up fees, should they wish to see a particular consultant for a particular procedure. If the parties' obligations are not clear, the arrangements will oblige the consultant to defer to the interpretation that is likely to meet with least resistance by the PMI. Such ambiguous contractual arrangements restricts competition equivalent to a complete ban. Bupa has said the member will be informed about shortfalls but it is unclear whether these relate only to excesses or exclusions on their policy, or consultant fees. AXA PPP stipulates "[y]ou will agree to charge fees in accordance with the AXA PPP Contracted fee Schedule and not to make any additional charges to us or the patient".<sup>51</sup> See further **Annex 5**.
- 3.42** Finally, the PMIs (for example, Bupa) will sometimes not explain to the patient why a consultant has been derecognised. The problem is that silence may indicate to the consumer that the reason is not price-related, but could be disciplinary. Any suggestion the reason is disciplinary would likely damage the consultant's professional standing, which pressures consultants to accept the PMI's lower fees.
- 3.43** The Consultant Survey confirms the ever present threat of delisting for failure to abide by the PMIS' fee schedules: see **Box 2** below.

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<sup>49</sup> FIPO is not opposed to e-billing itself, but objects to the use of e-billing as a tool to prevent top-up fees and thus, price differentiation.

<sup>50</sup> <http://www.aviva.co.uk/health-insurance/practitioner-zone/frequently-asked-questions.html> (retrieved on 2 November 2016).

<sup>51</sup> This comment is made in the context of the Fast Track programme, which AXA PPP uses as an incentive to fix consultants' fees.

## Box 2: Consultant Survey results on threats of delisting and actual delisting

### Established consultants

- 213 out of 798 respondents (27%) reported to have been threatened to be delisted due to fee levels by Bupa and 192 by AXA PPP (24%). Some have also been threatened for the same reason by other insurers.
- These patterns were broadly similar across London-based and non-London-based consultants as well as across specialties.

### New consultants

- 182 out of 338 respondents (54%) reported to have been told they would not be recognised (or their recognition would be removed) if they failed to comply with a fixed fee schedule by Bupa and 147 by AXA PPP (43%).
- These patterns were broadly similar across London-based and non-London-based consultants, and across different specialties.

## 4 CONCLUSIONS ON MCC

### *Practices more extensively applied*

- 4.1** The restrictive practices described and exemplified above – which originally gave the CMA cause for concern – are now more extensively applied than before: in each case, the degree of market coverage has increased, in some cases, very substantially; however, this does not capture the whole effect since each practice reinforces every other. **Table 2** summarises the degree of change in market coverage of these practices:

**Table 2: Extension of restrictive practices across the PMI market**

Restrictive practice	Market coverage April 2014	Market coverage November 2016	Comments
Fee capping	Bupa and AXA PPP (65%)	Bupa, AXA PPP, Aviva and Vitality (91.5%)	Large increase in market coverage.
Ban on top-up fees	Bupa, AXA PPP and Aviva (78%)	Bupa, AXA, Aviva and Vitality (91.5%)	Large increase in market coverage, also reinforcing other practices in particular fee capping.
Restrictive fee arrangements	Bupa (39.5%)	Bupa, AXA PPP and Vitality (78%)	Large increase in market coverage.

Restrictive practice	Market coverage April 2014	Market coverage November 2016	Comments
Open Referral/Fast tracking	Bupa (39.5%)	Bupa and AXA (68%)	Large increase in market coverage.
Derecognition	Bupa and AXA (65%)	Bupa, AXA, Aviva and Vitality (91.5%)	Now, more than three quarters of the market is characterised by derecognition, or the threat of it.

*NB: the 2014 report based on market shares as at 2012; since the market has consolidated since then, the figures represent a baseline against which the current position is compared. See Annex 10 for consultant T&Cs.*

#### *Practices more rigidly applied*

- 4.2** The practices above are implemented inflexibly, on their strict terms, and FIPO has not seen evidence of discretion being applied to attenuate these effects materially, although this could be the subject of further CMA investigation.

#### *Erosion of competition between consultants*

- 4.3** The practices above have the collective effect of reducing to the margins any degree of consultant discretion to set fees according to qualitative non-price factors.
- 4.4** In short, competition between consultants on price has effectively disappeared.

#### *Erosion of consumer choice*

- 4.5** It follows from the erosion of competition between consultants that consumers cannot choose between consultants based on the consultants' ability to price according to their skill, expertise, locality etc. The wider negative effects on consumer choice – leading in some cases to actual incidences of serious consumer harm – are discussed in greater detail in section 7 below.

#### *Leakage from insured to self-pay market*

- 4.6** The driving of consultant fees to fixed levels sets an expectation of fees being set at similar levels in the self-pay segment. Therefore, it cannot be said that the market distortion is confined only to the insured segment. As the market currently stands, publication of fee information will only reinforce the tendency for all market fees (both insured and self-pay) to converge around the PMI schedules.

## **5 MARKET STRUCTURE**

- 5.1** In the previous section, we showed how various restrictive fee practices are now extensively and rigidly applied, with consequent loss of competition between consultants on fees and erosion of consumer choice. In this section, we explain how the growing market power of the PMIs allows this to happen, and allows the PMIs to reduce patient benefits without suffering material damage to their businesses' profitability.

*The market power of the largest insurers has increased*

- 5.2** In the Final Report the CMA "found that at least the two largest insurers, Bupa and AXA PPP, have significant buyer power".<sup>52</sup>
- 5.3** Significant buyer power has been sustained and entrenched.
- 5.4** The Final Report found that the ranking of the largest PMIs has been relatively stable for the past 20 years and the PMI industry is concentrated, where the top four PMIs accounted for 87.5 per cent of the private health cover market in 2012 (see Figure 3.15 of the Final Report).<sup>53</sup> The Final Report found AXA PPP itself accounted for just over a quarter of the market and with a share practically double that of the next provider, Aviva, with about 13 per cent.<sup>54</sup> Citing Laing & Buisson, Health Cover 2013 (page 25), the CMA found the remainder of the market (12.5 per cent) was accounted for by 12 smaller providers.<sup>55</sup>
- 5.5** At this level of concentration, the CMA should be concerned about the implications for competition of further unchecked consolidation among PMIs.
- (a) The acquisition of Simplyhealth by AXA PPP (completed on 3 August 2015) removed the largest player outside the four major PMIs at that time. Indeed, before the deal, Simplyhealth described itself as "*currently the UK's 5th biggest provider of private medical insurance*".<sup>56</sup> The CMA cleared the merger on 21 July 2015<sup>57</sup> despite third party objections, including a submission from FIPO (reinforcing its previous submissions) noting the damage to patient choice resulting from further consolidation in an already oligopolistic market.
- (b) AXA PPP has continued to acquire or manage small groups. In July 2016 it announced it will manage all aspects of The Exeter's PMI claims processing – for both new and existing business – from 1 November 2016.<sup>58</sup> These transactions often fall below the CMA's radar owing to their size, but in a concentrated market they help the bigger players ossify their market power with creeping extensions of control over their smaller rivals.
- (c) FIPO believes – following the Simplyhealth takeover – there are now only four major PMIs with a combined market share of 91.5% and the remainder being fringe players. As a result, consultants who are not recognised by any one of these PMIs (and Bupa, AXA PPP, Vitality and Aviva) are placed at a competitive disadvantage (at its lowest) or face threats to their practice viability.
- 5.6** The CMA may want to examine closely the pace of structural change since the Final Report and will need to satisfy itself whether smaller players are able to challenge the major players and offer diverse (i.e. less restrictive) arrangements. FIPO has serious doubts this is the case; witness how following AXA PPP's takeover Simplyhealth has altered its fee practices. WPA has also reduced its benefits.

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<sup>52</sup> Final Report, Summary, § 48.

<sup>53</sup> Final Report, § 3.80.

<sup>54</sup> Final Report, Figure 3.15.

<sup>55</sup> Final Report, § 3.80.

<sup>56</sup> Simplyhealth, "Simplyhealth sells its private medical insurance business to AXA PPP healthcare", 13 May 2015. Available at: <http://newsroom.simplyhealth.co.uk/simplyhealth-sells-its-private-medical-insurance-business--to-axa-ppp-healthcare> accessed 30 July 2016.

<sup>57</sup> Competition and Markets Authority, Anticipated acquisition by AXA PPP healthcare Limited of the private medical insurance business of Simplyhealth Limited, 21 July 2015.

<sup>58</sup> Health Insurance and Protection daily, "AXA PPP to manage The Exeter's PMI claims processing", 13 July 2016, available at: [https://www.healthinsurancedaily.com/health-insurance/product-area/pmi/article480690.ece?utm\\_medium=email&utm\\_term=&utm\\_source=GB179%20Health%20Insurance\\_Daily%20News%20Alert&utm\\_content=&utm\\_campaign=0%20DNA%20XML%20Edition](https://www.healthinsurancedaily.com/health-insurance/product-area/pmi/article480690.ece?utm_medium=email&utm_term=&utm_source=GB179%20Health%20Insurance_Daily%20News%20Alert&utm_content=&utm_campaign=0%20DNA%20XML%20Edition), accessed 30 July 2016.



*Patients' policy benefits are variable, lacking in transparency and are being further reduced*

- 5.7** There are three recurrent trends which are relevant to the benefits and value enjoyed by patients under their insurance policies. First, there is a significant *variation* in policy benefits across the PMIs. They do not always publish a complete list of their reimbursement schedules which makes it difficult for purchasers of PMI policies to compare benefits.
- 5.8** The variation in PMI benefits has been documented by a recent review by *Which?* reporting in October 2016 (see further **Annex 11**). For a couple of non-smokers aged 55, annual premiums ranged from £1,663 with VitalityHealth to £2,850 with AXA PPP. At 70 the AXA PPP policy would cost £5,383 each year compared with £2,446 for WPA. It is not apparent that benefits will clearly correlate to prices, or that consumers are adequately informed to make a meaningful comparison. Further, it is not clear how far any PMIs' cost savings are being passed on to consumers in the form of benefits.
- 5.9** Second, the *lack of transparency* and *vagaries* of insurance can leave patients short changed. For example, spinal cord stimulation (SCS) is a NICE approved treatment for painful neuropathic problems, such as persistent back and leg pain in patients who have had spinal surgery. It is the standard treatment for this condition and there are thousands of patients in this country with these implants and on NHS waiting lists. While Bupa and AXA PPP cover this treatment, Aviva and Vitality do not. It is an expensive treatment but raises two concerns. First, they are denying patients NICE approved treatment that is best practice within the NHS. Secondly, intermediaries (who sell group policies) are likely unaware of this restricted cover and therefore are not in a position to advise their clients. If intermediaries are not aware, how can consumers be expected to be aware?
- 5.10** Third, the PMIs have been progressively reducing policy benefits. As noted above, they do not always publish a complete list of their reimbursement schedules such that it is not possible to discern the full extent of this trend. However, the direction of travel is incontrovertible: the subscriber now gets less value for their money. As far as FIPO is aware, there has been no cessation in year-on-year increases in premiums. The CMA could ask the PMIs to provide their benefits schedules and the effect on their profitability, taking into account volume effects.
- 5.11** The restrictions or progressive cuts in benefits by both the large and moderate players include:
- (a) Bupa's standard policy document (2015): the current version (**Annex 12**) contains 7 pages of general exclusions.
  - (b) As noted in FIPO's 3 March 2015 letter to the CMA (**Annex 1**) AXA PPP's new process from 2015 reimburses benefits at (on average) 20% less across nearly all their procedures.
- 5.12** In a competitive market where the market power of suppliers<sup>59</sup> (here, the PMIs as suppliers of benefits to policyholders) is effectively constrained one might expect a commensurate reduction in returns to the PMIs, which has not happened. First, while patient benefits have been reduced, policy premiums have either increased or remained static. Second, PMI economic performance has generally improved or been stable. This is illustrated by the following announcements of financial results by the major PMIs:<sup>60</sup>

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<sup>59</sup> Please see paragraphs 2.14 to 2.17 of Chapter 6 below.

<sup>60</sup> The figures reported here are obtained from PMIs own public statements which the CMA may want to interrogate. For example, FIPO has not been able to obtain the details of the PMIs' exact loss ratios.

- (a) Bupa reported £9.8 billion in revenues for the year ended 31 December 2015, an increase of 6% over the previous year. Bupa delivered profit growth across most of its operations including the UK.<sup>61</sup>
- (b) AXA UK and Ireland's 2015 revenues amounted to £4.1 billion, representing a 5% increase over the previous year (2014: £3.8 billion). Underwriting profitability improved.<sup>62</sup>
- (c) Vitality showed a 16% increase in pre-tax operating profit to £42.8 million across VitalityHealth and VitalityLife in the first year of its operations since its rebrand in November 2015. Its overall premiums revenue increased by 11% to £553 million.<sup>63</sup>

**5.13** Against this background, the claim by PMIs that their reimbursement practices are consistent with delivering best value to consumers is hollow.

**5.14** The CMA may want to analyse whether PMIs' costs are being efficiently incurred. It is questionable whether the observable decline in consumer benefits must necessarily follow from efficient choices of organising a PMI business and administration.

## **6 CONCLUSION ON MARKET STRUCTURE**

**6.1** It is therefore clear that the growing market power of PMIs not only allows them to distort competition among consultants and erode consumer choice; it also allows them to reduce patient benefits without suffering material harm to their businesses.

**6.2** In the next section, we turn in greater detail to the market outcomes.

## **7 MARKET OUTCOMES**

### *PMIs interference in clinical decisions and effect on consultant practice*

**7.1** PMIs are increasingly interfering in clinical decisions. This has an obvious and direct effect on patients. PMIs are also damaging consultants' practices, which has an indirect effect on patient welfare.

### *PMIs are increasingly interfering with clinical decisions*

**7.2** The Final Report made plain the role of the PMIs in directing patients to consultants. The CMA "considered that insurers, and in particular Bupa, as they increase their role in directing patients to consultants, needed to ensure that their policyholders were provided with clear and accurate information about the terms of their policies."<sup>64</sup>

**7.3** There is growing evidence of PMIs directing patients to consultants based on the fees that they have agreed to charge. This evidence illustrates that decisions are being taken by the PMIs which are driven by costs and inflexible policy guidelines and exclusions, with no or little regard to clinical need. There may be circumstances in which professionals might - acting reasonably - legitimately differ in their clinical assessment of a patient's condition and the

<sup>61</sup> Bupa: full year statement for the year ended 31 December 2015 available at <https://www.bupa.com/~media/files/site-specific-files/our%20performance/pdfs/financial%20results%20-%202014%20and%202015/bupa-15-full-year-report.ashx>, accessed 13 August 2016.

<sup>62</sup> AXA: AXA UK and Ireland earnings rise by 25 per cent, 25 February 2016, available at: <http://www.axa.co.uk/newsroom/media-releases/2016/AXA-UK-and-Ireland-earnings-rise-by-25-percent/>, accessed 13 August 2016.

<sup>63</sup> Vitality: Vitality announces 16% rise in profit, 18 September 2015, available at: <http://www.vitality.co.uk/mediaonline/PDF/Presales/About/Press%20Centre/Vitality-announces-16pc-rise-in-profit.pdf?pdf=Vitality-announces-16pc-rise-in-profit>, accessed 13 August 2016.

<sup>64</sup> Final Report, Summary, § 50.

most appropriate treatment for them. However, the cases that have been brought to FIPO's attention as reported in this Submission cannot be described thus.

- 7.4** Whether a patient gets a particular treatment often depends on the PMI's own advisors.<sup>65</sup> Each refused treatment will tell its own story and the case histories that have been brought to FIPO's attention show how differences between the views of expert clinicians and the PMIs' advisors can result in arbitrary decisions unrelated to the underlying medical issues. The cases illustrate that PMI involvement in clinical decisions is not confined to the major PMIs. The following examples will illustrate the arbitrariness of the position and which led the clinicians and their peers involved to conclude that the PMIs' decisions in these cases were motivated by the PMI's own financial modelling:
- (a) In 2015 AXA PPP chose not to fund Chondrotissue articular grafting. This treatment was funded in full by other PMIs including Bupa and the treatment was available on the NHS. The particular surgeon had been performing the operation for 5 years. AXA PPP's position was intransigent. The surgeon in question offered to present to AXA PPP's advisors on the subject but they declined.
  - (b) In 2015 WPA refused authorisation for a patient to have an arthroscopy of the knee. The patient in question was a fit 55 year old and the treatment was recommended by his consultant orthopaedic surgeon. The surgeon reported to FIPO that WPA misquoted guidelines from specialist orthopaedic associations as a reason not to fund the treatment. The surgeon considered that this was a "very clear-cut case" for the recommended treatment and that WPA's approach was based on a flawed analysis.
  - (c) In 2014 a woman presented with a mass in her breast. The consultant offered her Oncotype DX genomic profiling for her cancer as it met the criteria for testing as set out in the relevant literature. Bupa refused to fund the treatment despite having previously sanctioned tests for other patients with positive lymph nodes (as presented by the patient). The patient declined to fund the £2,700 cost personally and had another treatment. Two years later in 2016 she decided to have her follow-up care with another provider due to financial restrictions imposed by Bupa.
  - (d) In October 2016 Bupa tried to redirect a patient from one neurophysiologist (Consultant A) to another neurophysiologist (Consultant B) far away from the patient's home. The patient found this unacceptable and inconvenient. Consultant B was a different specialist to the one which the patient's referring clinician recommended on the basis of ability. The patient had some past experience of Consultant A, who dealt with another member of the patient's family and he had the "utmost confidence in his abilities". The patient asked for Bupa to review the situation - regardless of outcome, further delaying treatment to the patient. His predicament is not atypical and summed up in his comment that "*as matters stand, I seem to be paying for health cover which I am unable to utilise in an acceptable manner. Moreover, I find myself in the unenviable position of being in the middle of a dispute between Bupa and [the specialist and recommending consultant].*"
  - (e) Bupa states it has involved specialist professional associations in the development of its pre-authorisation policies, implying that it has the support of such bodies. However, in practice there does not appear to have been specialist input or consultation with the body in question. Bupa is thus able to claim (spurious) clinical legitimacy for its authorisation criteria when in fact there has been no specialist input. One such body, The British Association of Dermatologists, has raised concerns with Bupa that statements made by Bupa create a misleading impression about the involvement of the Association in the development of the authorisation process for minor skin procedures. In fact the Association considered that a number of areas presented significant difficulties. The British Cardiovascular Society has raised similar concerns.

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<sup>65</sup> For example, nurse practitioners.

- (f) Bupa has effectively assumed the role of a clinical regulator by purporting to "accredit" hospitals for particular specialities. An example is the case of spinal surgery accreditation. The main professional body representing spinal surgeons in the British Association of Spine Surgeons ("**BASS**"). The General Medical Council ("**GMC**") and the Royal Colleges are responsible for professional training and the GMC for the regulation of all doctors. In June 2015 it came to FIPO's attention that Bupa asked individual surgeons and hospital groups to provide detailed information about all aspects of a surgeon's practice. The initiative apparently sought to form spinal networks throughout the UK but BASS was not consulted. This is an example of Bupa taking on an ostensibly clinical regulatory role when it is not a professional or regulatory body. Bupa extending its role in this way risks interference with clinical decisions outside its competence, with potential consequences for patient treatment.

**7.5** The Consultant Survey provides evidence of substantial interference by PMIs in patient choice as shown in **Box 3**.

**Box 3: Consultant Survey results on disruption from insurer practices**

- 335 consultants out of 811 respondents (41%) reported being aware that Bupa had redirected patients that had been referred to them, or had requested to see them, to other consultants. 271 (33%) consultants reported the same for AXA PPP, 146 (18%) for Aviva and over 20 to each of four other insurers. 157 (19%) respondents were not aware of insurers having redirected patients and 247 (30%) were uncertain if insurers had redirected patients. Redirections were reported as occurring predominantly away from HCA, Spire and BMI.
- 66% of respondents whose primary place of practice is HCA were aware of patient diversions away from HCA.
- 140 consultants out of 818 respondents (17%) reported being aware that Bupa had suggested that patients already under their care see another consultant. 102 (12%) consultants reported the same for AXA PPP and 46 (6%) for Aviva. 307 (38%) consultants responded they were not aware of any such redirection, while 337 (41%) were uncertain.
- 234 consultants out of 798 respondents (29%) reported being aware that Bupa had required their patients to attend a hospital other than the consultant's or the patient's first choice. 240 (30%) consultants reported the same for AXA PPP and 141 (18%) for Aviva. 170 (21%) respondents were not aware of any insurer having redirected patients in this fashion, while 249 (31%) respondents were uncertain. This insurer practice appears to be more common in London<sup>66</sup> than outside.
- Over 34% of respondents reported that insurer pre-authorization for treatment has affected the GP-to-consultant pathway.
- New consultants receive "open referral" patients more commonly than established consultants.
- It is unclear whether some of the redirection may be due to contractual (cover) issues, e.g. if a policyholder was redirected from a hospital (or a consultant) to another hospital (or another consultant) because his/her insurance policy did not cover the former hospital (or consultant).

<sup>66</sup> In London, the HCA is predominantly affected by patient diversions to other hospitals.

*PMIs' dealings with consultants are increasingly unfair and non-transparent*

- 7.6 In the Final Report the CMA warned that insurers "needed to ensure that their interaction with consultants was fair and transparent to enable consultants to manage their practices and treat their patients effectively."<sup>67</sup>
- 7.7 As noted above, in section 4 above, the market power of PMIs allows them to perpetuate restrictive fee practices without damage to their business.
- 7.8 Experience has shown that the interactions between PMIs and consultants are lacking in candour and are unfair. This means that consultants cannot manage their practices and treat their patients effectively, a risk that the CMA properly highlighted and which is now borne out in new evidence.
- 7.9 The following are case examples including copies of the underlying correspondence between PMIs and consultants which illustrate the types of experiences that have been brought to FIPO's attention. These cases highlight the imbalance in the relationship between PMIs and consultants where, effectively, PMIs are able to impose their terms unilaterally. In FIPO's experience these are not isolated examples but are symptomatic of the experience of many consultants in their dealings with PMIs.
- (a) An ENT surgeon from the West Midlands has been subject to aggressive and threatening tactics from an insurer where they have attempted to secure a reduction in his fees. This case highlights a number of recurrent themes. First, the fees proposed were unviable. The surgeon was presented with a reduced fee from the insurer against a background of static surgical fees for over 20 years. It was suggested that he reduce his fees by over 25% against rising costs and indemnity fees. Second, the insurer used threats of sanctions including derecognition and withdrawal of an annual Practice Award payment. The insurer said that if it was unable to reach agreement with the surgeon over a reduced fee "*we do need to consider if we're able to continue working together moving forward*" (i.e. the threat of derecognition is very real and is used as a negotiating lever). Third, there is a lack of transparency in that the insurer claims to have benchmarked the surgeon's fees but is unable to give details that would allow him to determine the validity of the comparative data. Fourth, consumer choice is restricted. The surgeon is warned that he cannot charge a top up fee ("*we wouldn't expect any shortfalls to be passed on to your patients*").
- (b) A senior orthopaedic consultant was asked by Vitality to reduce his fees by 40%. His fees had not increased for 8 years despite rising costs. This communication was sent by email on 10 August. The consultant was notified on 12 August (by a letter dated 5 August) that he had been delisted stating:

*"Your recognition as a VitalityHealth recognised consultant will regrettably conclude with immediate effect. This means that any members contacting us for authorisation for new claims for care you provide will not receive pre-authorisation numbers and will not receive funding. Members currently under your care will be contacted within the next 14 days to inform them that we will continue to fund their ongoing care for a maximum of 3 months to allow conclusion of treatment or appropriate handover of their care."*

The procedure that Vitality adopted in this case is lacking in transparency and fairness. First, while the Vitality claimed that its "decision ha[d] not been taken lightly" the consultant had no reasonable opportunity to be heard on the matter having received the initial communication only two days before Vitality's final decision was communicated. Second, the terms of delisting were unclear and inconsistent. While the delisting was stated to take effect "with immediate effect" it was not clear whether this date referred to the date of receipt of

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<sup>67</sup> Final Report, Summary, § 50.

the letter or the date the letter was sent. If the latter, this raised a procedural irregularity as the letter was dated prior to Vitality's 10 August email containing the fee reduction proposal. Finally, no appeal from Vitality's decision was allowed.

- 7.10** The interactions between PMIs and individual consultants show how PMIs are able to impose their will on consultants and to the detriment of consumer choice. As the CMA accepted in the Final Report,<sup>68</sup> the major PMIs have market power. Demand withholding (through open referrals or other steering practices) could lead to a reduction in the supply of consultants, and ultimately to the lessening of consumer choice on quality and potentially higher prices for medical care.

*Consultant practice is increasingly financially challenging*

- 7.11** In the Final Report the CMA did not accept that the PMIs' practices were having a detrimental effect on the numbers of consultants in practice.<sup>69</sup> However, the current and evolving market reality presents indications of increasing threats to consultant profitability.

- 7.12** Although the CMA accepted in the Final Report that the large insurers have significant buyer power it "*did not find sufficient evidence that it was currently being exercised in such a way as to harm competition by suppressing fees to uneconomic levels resulting in a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services.*"<sup>70</sup>

- 7.13** It would of course be a concern if younger consultants chose not to enter private practice, or more consultants expressed concern about the future sustainability of private practice, particularly because this could impede innovation and starve particular specialties of new talent, to consumers' detriment. Yet, FIPO sees ever more consultants reporting that consultant practice is becoming increasingly unsustainable as a result of the increasing intensity of the PMIs' practices. The following examples are noteworthy:

- (a) In January 2015 a hip surgeon in the Southwest of England was derecognised by Bupa and AXA PPP (in the case of AXA PPP only 24 hours' notice was given). The surgeon was "undecided" about whether he would continue in practice but he could not see how continuing without recognition by the two largest insurers (commanding over 65% of the market) could be viable.
- (b) In May 2014 a consultant obstetrician and gynaecologist was informed by Bupa that if she did not reduce her charges they would not recognise her. Bupa said that she was in the top 10% of charges but was unable to justify this. The consultant reduced her charges to £150 for a new patient consultation but has not had any patients referred to her since. The problem appears to have been that she worked at a hospital which Bupa did not accredit. The impact on patient choice and viability of consultant practice is made clear by the consultant's comment that "*I have even had patients who have seen me for years requesting to see me again and they are refusing and saying they need to see other practitioners [...] I fear I will have to give up altogether as I am now seeing 1-2 patients in a session when I used to see 7. Sadly, outgoings are greater than the income at this point*".
- (c) A distinguished expert on cataract surgery and president of a leading professional society had to accept fees with AXA PPP in July 2015 that he regarded to be "financially unviable". The fees included pre- and post-operative consultations, diagnostic tests and the anaesthetist for

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<sup>68</sup> Final Report, Summary, § 48.

<sup>69</sup> The CMA stated that "*we have not received evidence that Bupa's and AXA PPP's contracts with new consultants are leading to the number of new consultants being recognized reducing annually since their introduction. We also do not have evidence that the number of consultants in private practice as a whole is being adversely affected by the actions of the insurers*" (Final Report, § 7.107).

<sup>70</sup> Final Report, Summary, § 48.

£900. Of this £900, after paying £200 for the anaesthetist, £350 for consultations and £220 for investigations, the surgery was left with £130.

7.14 The Consultant Survey confirms the increasing financial pressures on consultants' practices.

#### Box 4: Consultant Survey economic trends

##### Future costs of private practice expected to rise

- Over 67% of respondents expected their medical malpractice indemnification insurance costs to increase in the following three years.
- Over 67% of respondents also expected admin costs from private practice to increase in the following three years.

##### Future income from private practice expected to be static or to decline

- Over 73% of respondents expected their income from private practice to remain static or to decrease in the following three years.

##### Concerns over viability more acute for younger consultants

- About 48% of *established* consultants who responded, reported that their private practice was unlikely to be economically viable in the future or were uncertain.
- About 57% of *new* consultants who responded, reported that their private practice was unlikely to be economically viable in the future or were uncertain.

*The result: denial of patient choice and long-term consumer detriment*

7.15 The damaging effect of the PMIs' practices on patient choice is made plain in the volume of complaints that FIPO has received from consultants reporting their experiences and the effect on their patients, some of which are discussed above.

7.16 As regards the specific effect of fee-capping, the Final Report did not accept that "*consultant fees are being constrained to such a level that this is adversely impacting on consumer choice or quality, discouraging innovation or otherwise causing long-term consumer detriment.*"<sup>71</sup>

7.17 It will be recalled that the Court accepted FIPO's submission that "*in principle competition may be prevented, restricted or distorted within section 134 without any detrimental effects having yet become apparent*" (emphasis added).<sup>72</sup> Since, according to the Court the "*existence or absence of such detrimental effects*" is "*plainly a material indication of whether or not competition has in fact been prevented, restricted or distorted*", it is pertinent that the current market position shows adverse effects on consumer choice, quality and innovation are happening now.

7.18 The limitation in consumer choice may operate in different ways and more than one restriction may be present in the same facts. These limitations may be categorised as:

- (a) denial of treatment where the PMI does not fund the treatment at all and the patient uses the NHS or pays for it themselves (*denial of preferred treatment*);

<sup>71</sup> Final Report, § 7.107.

<sup>72</sup> *Ibid.*

- (b) reduction in the specific level of treatment such as where the PMI is willing to fund another treatment but this is not the choice recommended by the consultant (*reduction in level of treatment*);
- (c) denial of preferred consultant where the PMI will not cover all the costs of the patient's preferred consultant usually because that consultant has not agreed to limit their fees in which case the patient may seek another consultant whose fees will be paid in full by the PMI. In some cases there will be no option for the patient to pay a top-up fee and be treated by their preferred consultant. In extreme cases a patient may have to cancel a pre-booked consultation where their consultant is derecognised with minimal notice (*denial of preferred consultant*);
- (d) transfer to a non-preferred facility for all or part of the procedure where the preferred treatment facility (as chosen by consultant or patient or both) is not accepted by the PMI (at all or for the relevant treatment) (*denial of preferred facility*).

**7.19** The following selection of case stories will illustrate these effects. The CMA will see that many of the restrictive effects and consumer detriments involve multiple and overlapping restrictions, they are mutually reinforcing albeit they may defy easy categorisation within one single theory of harm.

- (a) A consultant orthopaedic and hand surgeon wrote to FIPO because he was concerned about communications from Bupa offering him the "privilege" of becoming a Premier Consultant. What concerned the consultant most was an obligation to refer patients to other Bupa recognised consultants. The consultant expressed his concern that that condition "would presumably be against GMC guidance to what is best for patients". Medical professionals are bound by a strict code of ethics and are guided by the principle to act in the best interests of patients. The increasing intrusion by PMIs in the consultant-patient relationship presents a serious risk that referrals will not be made in the best interests of patients or based on clinical reasons.
- (b) AXA PPP refused to cover all of a consultant's fees. AXA PPP recommended another consultant who they would cover fully as he was "signed up" to their terms. This was despite a specific GP referral and the consultant being the subscriber's preferred choice. The subscriber even agreed to pay the shortfall but treatment by the preferred consultant was refused (denial of preferred consultant).
- (c) Bupa authorised a consultation with a consultant who advised an endoscopy, colonoscopy and pH bravo box for a child. The patient's mother was informed by Bupa that the insurance covered these procedures but that they would not pay all of the consultant's charges (only a little over £300). They gave a list of 4 other consultants that they would cover in full. After telephoning the secretary of the first on the list the patient's mother discovered that the Bupa nominated consultant did not actually perform colonoscopies. Eventually, the patient's mother found one on the Bupa list who was able to do the procedure. Bupa said that they would not pay for the anaesthetist that he was using but they could not say which anaesthetists they would pay for. As the patient's mother stated "[t]he whole situation caused a great deal of stress and I was left feeling very let down by Bupa". In the end the consultant agreed to do the procedures at no additional cost.

**7.20** In individual cases where the consumer is disappointed with the PMI's decision on cover they have very few realistic options to obtain a satisfactory outcome or redress. In some cases the patient will make a complaint to the PMI or to the Financial Ombudsman who may award compensation if the complaint is upheld.<sup>73</sup> However, the financial compensation that the Ombudsman awards will typically not cover the wasted premiums that the subscriber has paid

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<sup>73</sup> FIPO is not a regulatory body and has no jurisdiction to rule on the merits of complaints by patients or consultants on behalf of their patients in cases where decisions of PMIs have led to poor outcomes for consumers. It cannot provide redress to individual patients.



for private medical insurance where an insurer elects not to cover the treatment (at all or in full). Any financial award made by the Ombudsman though it can cover pain and suffering may not be a true reflection of the suffering that the patient has incurred in waiting for and in some cases having to accept alternative and what they and their physician consider to be sub-optimal treatment.

- 7.21** For example, private healthcare patients can be denied operations that are free on the NHS owing to restrictions that are being imposed by PMIs. In one case that has been widely reported in the national press, AXA PPP refused to pay for the surgeon's first-choice treatment, a frozen autograft. This is a £10,000 procedure which has been performed on the NHS for 20 years. The surgeon then recommended a second choice procedure (£6,000) which had been available for around 12 years and this was also refused. The insurer did tell the patient that it would pay £10,000 for a partial knee replacement but this was considered "inappropriate" by the patient's surgeon and it was a more invasive procedure with a longer recovery time. The patient had no alternative but to seek treatment on the NHS. The patient complained to the Financial Ombudsman who awarded £2000<sup>74</sup> compensation to compensate them for their pain and suffering while on the NHS waiting list.
- 7.22** Furthermore, in the year ended 31 March 2016, the Financial Ombudsman received 873 new complaints against PMIs; an 11% increase on year-on-year figures. For the period between 1 January 2016 and 30 June 2016, the Financial Ombudsman received: 148 new complaints against Bupa; 135 new complaints against AXA PPP; 65 new complaints against Aviva; and 55 new complaints against Vitality. This clearly shows that patients are increasingly encountering difficulties with the PMIs.
- 7.23** However, even though a consumer may be able to obtain some form of redress following raising their case before the Ombudsman, the procedure does not provide an adequate remedy for the wider and more endemic concerns documented here which arise from PMIs controlling and distorting the process of fee setting in a manner that is inimical to a competitive market. First, the ombudsman can deal with individual consumer issues only as they arise and his decision is limited to the facts of the individual case. Second, any compensation awarded by the (financial) ombudsman is capped at £150,000 which may not adequately address the non-financial consequences and patient detriment arising from being denied their choice.
- 7.24** The evidence presented in sections 3 to 4 above shows that the practices of concern that the CMA identified in its Final Report are in fact "extensively and rigidly applied". The detrimental impacts on innovation manifest themselves in the following ways:
- (a) First, adherence by consultants to PMI-imposed restricted fee levels confines their practice to a set of procedures which the PMI accepts as reimbursable. As a result there is limited incentive for consultants to innovate at the margins where they cannot obtain full payment for a procedure that is not covered by the PMIs' benefit schedules. In some cases where the PMI does not agree to fund a particular treatment purportedly because they consider that there does not yet exist a body of medical opinion in support of it, a patient may have to accept an alternative and inferior treatment for their condition in circumstances where there is wide professional support for the treatment. Rather than the medical professionals defining the frontiers of innovation as would be expected in a competitive market, the current practices of the PMIs means that they are allowed to constrain and dictate when innovations may be practised based on their own business agenda and not on advancing the practice of medicine and patient care.

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<sup>74</sup> "Victory over the health insurers that reject claims for routine operations after watchdog rules against giant firm", *Daily Mail*, 28 May 2016 available at <http://www.dailymail.co.uk/news/article-3613610/Victory-health-insurers-reject-claims-routine-operations-watchdog-rules-against-giant-firm.html>, accessed 2 August 2016. See also <http://www.ombudsman-decisions.org.uk/viewPDF.aspx?FileID=112505>

- (b) Second, the prevalence of actual delisting does not need to be widespread for it to have disproportionate effects on innovation. The mere threat of delisting for not adhering to fee restrictions operates as a disincentive to consultants to step outside the PMIs' stipulations. When delisting is implemented, the effect on the practice of a single practitioner can be disproportionate, in terms of the qualitative loss of diversity in the profession where that practitioner operates at the frontier.

## **8 CONCLUSION ON ISSUE 1: MCC**

- 8.1** We conclude from the evidence presented above that there has been MCC since the Final Report causing significant consumer detriment. In the alternative, it will be open to the CMA to conclude on the evidence presented here that it has special reason for deciding differently. Such a special reason may consist in the need for consideration of wider practices in the PMI market.

## CHAPTER 5

### CONSEQUENCES OF A MATERIAL CHANGE OF CIRCUMSTANCES

#### 1 ISSUE 2: EFFECT OF MCC ON REMEDY

*CMA cannot leave Fee Information Remedy untouched*

- 1.1 Given the MCC, the second stage of the analysis is to consider what the decision on remedy ought to be in light of that MCC. As stated above, taken in isolation, section 138(3) means that the CMA may decide to keep the existing remedy, supplement it, replace it or abandon it.
- 1.2 To keep the existing remedy unchanged, the CMA would have to conclude – despite the MCC – the proposed remedy was still reasonable and practicable for preventing remedying or mitigating the AEC and the resulting adverse effect on consumers, having regard to the need for a comprehensive solution. The CMA must actively consider this; it may not impose a remedy if it does not consider it reasonable and practicable. Whilst the statutory wording allows the CMA discretion in considering remedies, it would be an unreasonable exercise of that discretion to adopt a decision on remedies which no reasonable regulator could consider reasonable or practicable for addressing the AEC.
- 1.3 FIPO's interpretation of the changes in the PMI market and in PMI practices is that the Fee Information Remedy alone can have no prospect of remedying the AEC, even if it could have done so on the basis of the facts available to the CMA at the time of the Final Report. Consequently, it would not be a reasonable exercise of the CMA's discretion to leave the Fee Information Remedy untouched by implementing it in its current form. The CMA must instead replace it, supplement it or abandon it.
- 1.4 The CMA saw the Consultant AEC stemming from a lack of both performance and fee information.<sup>75</sup> Thus, the Fee and the Performance Information Remedies must support each other if they are to remedy – effectively and comprehensively – the Consultant AEC. In short, even if accurate and competitively determined fee information could be derived, untainted by PMI interference, it would still need to connect to accurate measures of quality to be competitively meaningful in differentiating between consultants. To conclude otherwise assumes healthcare provision is an undifferentiated commodity, differentiated by price alone.
- 1.5 Where MCC undermines the effectiveness of one remedy, it may also call into question of the effectiveness of the other. In its own terms – regardless of the Fee Information Remedy – the Performance Information Remedy may present practical implementation challenges. FIPO is working with PHIN through FIPO-COAG<sup>76</sup> to try to make the data collected by PHIN relevant and meaningful for patients, and on this, FIPO provides further evidence below. But where considered together with the MCC and the Fee Information Remedy, no one can be confident that the composite information that will emerge is reliable and informative and the result of effective competition in the market. The CMA's task is therefore to consider both information remedies and to decide – in light of the MCC – what to do about them. Furthermore the CMA will wish to consider the implications for the existing part of The Private Healthcare Market Investigation Order 2014, including the Performance Information Remedy under section 162 of the Enterprise Act 2002.

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<sup>75</sup> “We found that the lack of sufficient publicly available performance and fee information on consultants was a feature in the provision of privately-funded healthcare services by consultants. This feature gives rise to AECs in the provision of private consultant services across the UK by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.” Final Report, Summary § 10.

<sup>76</sup> FIPO Clinical Outcome Advisory Group – a widely representative body of consultant experts.

## 2 ISSUE 3: RESOLVING THE AEC BY RESTORING EFFECTIVE PRICE COMPETITION

*The Fee Information Remedy cannot work on its own*

- 2.1** Sections 138(2) and (4) of the Act require the CMA to resolve the AEC as comprehensively as reasonable and practicable. The MCC has resulted in the destruction of effective price competition on consultants' fees such that publication of those fees alone cannot resolve the AEC. Must the CMA consider supplementing the Fee Information Remedy by measures to restore effective price competition?
- 2.2** FIPO does not oppose a fee information remedy in principle or in all or most circumstances (i.e. it cannot work in an emergency medical situation which demands immediate referral to a consultant or hospital). Its position is that such a remedy must be likely to be effective as an aid to consumers in exercising choice. FIPO's starting point is not that no remedy is needed at all: rather, if information on fees is to be meaningful to promote competition between consultants, price competition and the patient's ability to choose their consultant must be fully restored. If it is not possible – on the basis of the Final Report when viewed in light of the MCC – to restore and protect price competition and the patient's ability to choose their consultant, the CMA should consider abandoning the remedy altogether.
- 2.3** The type of remedies which the CMA could reasonably consider include:
- (a) a prohibition on PMIs banning top-up fees;
  - (b) a prohibition on PMIs banning consultants from invoicing patients directly for top-up fees;
  - (c) a prohibition on de-recognition or non-admission for reasons relating to (i) and (ii);
  - (d) a prohibition on PMIs from discriminating against subscribers in terms of the benefits or terms of cover offered for reasons relating to their choice of consultant;
  - (e) a requirement on PMIs to publish clearly for the major procedures (i.e. the top most commonly performed procedures) and in plain English the benefits they provide for both surgeons and anaesthetists and also for diagnostic and out-patient procedures so that subscribers can be clear both about their competitive status and also what benefits they may expect. For example, there would be benefit in publication of a comparative list of common procedure so that a potential subscriber can cross-reference the various benefits offered by **all** PMIs. The PMIs would also be required to show how benefits levels will vary for different categories of subscribers, such as age, family and existing conditions noting that there may be exclusions for pre-existing conditions and certain health factors; all benefits under private medical insurance policies should be 'portable' to a consultant or hospital of the patient's choosing so that true choice of both consultant and hospital is allowed and accepting there may be shortfall for either;
  - (f) a requirement on PMIs to:
    - (i) enact requirements relating to admission, suspension and withdrawal of recognition for consultants that are objective, based on medical/professional issues, and which can be applied in a uniform and non-discriminatory manner and which take appropriate account of a consultant's competitive situation including in terms of seniority, expertise, experience and locality ("Recognition Requirements");
    - (ii) put in place procedures, such as an independent appeal/review mechanism, which would ensure that the Recognition Requirements are applied, and have been applied, in an appropriate, reasonable and non-discriminatory way;

- (iii) provide an adequate system (for example, independent dispute resolution or appeals mechanisms) for ensuring that any refusal by the PMI to fund certain treatment in full or in part is taken with due regard to current best practice that commands support of a wide body of professional opinion,

in each case at the cost of the PMIs.

- 2.4 These remedies would do no more than create the conditions needed to ensure the practices of concern that the CMA identified in its Final Report were less likely to be extensively and rigidly applied in the future. Alongside the Fee Information Remedy, these measures may address the lack of meaningful publicly available information on fees. Moreover, the current practice whereby fee estimates are given by consultants in all but emergency situations may be expected to continue.<sup>77</sup>
- 2.5 It is open to the CMA to conclude from its review of MCC evidence that the basis of its Consultant AEC finding has been displaced as it fails to identify the precise nature of the impediment to consumer choice. At the very least, that AEC finding is now rendered more complex because the MCC show an intractable problem – rooted in the PMIs’ practices – that needs to be remedied before fee information can be competitively useful to consumers. The MCC contradicts the original reasoning: instead of the AEC being caused by a lack of sufficient, publicly-available information on fees, this is but a secondary phenomenon. An AEC is caused by a prior market distortion or interference whereby the PMIs set the conditions under which consultants may practice, and at what price. Reaching this conclusion implies that the Fee Information Remedy cannot be considered proportionate or reasonable because it will reinforce rather than remove the feature of the market that produces the AEC.
- 2.6 The Fee Information Remedy could be relevant only for those consumers who can genuinely influence or be affected by the resultant fees. This excludes NHS-funded private healthcare patients since the NHS procurement arm mandates the fees that consultants will be paid for such work. Moreover, the business arrangements for consultants conducting NHS overflow work are managed by the NHS (i.e. professional indemnity and administrative costs are covered by the NHS) relieving consultants of those costs. Outside the NHS channel, the Fee Information Remedy can reasonably be expected to aid consumers in exercising effective competitive choices only where those choices are unhindered by distortive PMI practices. What is required is a market where both self-pay patients and subscribers of private medical insurance are free to pay a top-up fee, and not artificially steered towards the lowest cost consultant, without regard to their personal choices or their clinical needs. Given the ubiquity of low fixed fees in the PMI segment, it may be expected that the publication of those fees alongside existing fees for self-pay, will rapidly result in a convergence of fees across both the PMI and self-pay segments with PMIs determining the level of fees overall.

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<sup>77</sup> See: <http://www.fipo.org/resources/index.htm>.

### **3 ISSUE 4: NOT IMPOSING THE FEE INFORMATION REMEDY**

#### *Basis for taking no remedial action*

- 3.1** Where a proposed remedy is not reasonable, proportionate or practicable for achieving a comprehensive solution, the CMA may choose not to pursue an effective remedy option or to take no remedial action.<sup>78</sup> If the CMA considers that it is unable following its Final Report to restore effective price competition by measures directed at the PMIs, can the CMA instead not impose the Fee Information Remedy now pending an investigation of the PMI market?
- 3.2** As stated above, FIPO does not object to the principle of a fee information remedy provided that it is indeed reasonable, proportionate and practicable. FIPO has suggested how the Fee Information Remedy might be supplemented through proportionate obligations imposed on PMIs and consultants (not only to publicise their fees but to also give estimates of potential costs to patients whenever possible).
- 3.3** The CMA should be cautious in implementing the Fee Information Remedy in isolation where the MCC show that there is no confidence that it will make any difference to the effective choices available to consumers. To do so would be wasteful and risk unintended consequences in entrenching an already distorted marketplace by giving the resulting fees spurious regulatory legitimacy. It would increase transaction costs for consumers in seeking out relevant information in the first place with no guarantee of welfare gains. Currently, for example, a consumer may find a quoted fee for their desired consultant only to discover a number of possible scenarios as the consultant may be restricted by some PMIs but not others for the required procedure or may be excluded entirely by one but not another PMI or may be able to see the patient but at an even greater shortfall cost to the patient if the AXA PPP rule applies in that case.
- 3.4** With these evident flaws noted, the CMA may choose instead to investigate the PMI market in full detail, given the evidence of MCC since the Final Report. Rather than implement a flawed remedy without guarantee of success, we would respectfully suggest that a better approach would be to suspend implementation until the outcome of that investigation - so that the risk of unintended consequences can be mitigated - or not impose it at all. Further, implementing the Fee Information Remedy now without a fuller investigation of the PMI market and consideration of the need for supporting remedies might jeopardise its effectiveness at a later date once the right conditions had been created for its success. This would be because consumers would be less inclined to engage with the remedy over time if they had bad experiences of premature adoption based on distorted fees and PMI practices which rendered their choices based on those published fees practically meaningless.
- 3.5** In the CMA's own Guidelines for market investigations, §354 foresees the possibility that an effective remedy option should not be pursued, for example because it would not be proportionate. FIPO suggests this may be one such case. Equally, this case may – if the CMA is unwilling to impose reasonable measures on PMIs now – be one where there is no practicable remedy option available, or that the cost of the remedy is disproportionate compared with how far the option addresses the AEC, in both cases such that the CMA should impose no remedy.

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<sup>78</sup> §354 of CC3 (Revised) Guidelines for Market Investigations.

## **4 ISSUE 5: FURTHER INVESTIGATION OF PMI MARKET**

### *Investigating the PMI market*

- 4.1** The CMA's power to investigate markets may be exercised where the market is of sufficient priority, in terms, among other things, of likely direct effect on consumer welfare from intervention. The OFT plainly considered the private healthcare market to be of sufficient priority but failed to appreciate the significance of the tripartite nature of the market which involves consultants, hospitals and the PMIs. As the PMIs' fundamental role in this market has changed rapidly, even since the Final Report on 2 April 2014, undermining the CMA's reasoning and conclusions on the consultant AEC, should the CMA refer the PMI market for its own investigation, to ensure the consumer benefits of its private healthcare intervention are not lost?
- 4.2** Plainly there are time and cost implications of undertaking a new Market Investigation in an area already closely bordering on a recent market investigation. However, this is not an unprecedented situation and the CMA has shown agility and responsiveness in addressing related issues across sequential investigations. For example, the CMA investigated certain insurance aspects of store cards<sup>79</sup> which was followed shortly by a full investigation into the payment protection insurance market across a wider range of financial products.<sup>80</sup>
- 4.3** The fact of the recent investigation into the private healthcare sector should not determine whether the PMI market is of sufficient priority for investigation, for a number of reasons. First, because the original investigation was broad in scope whereas the issues here are specific to the PMI market. Secondly, because there has been MCC since then and the negative trend is clear. Thirdly, because the very same adverse effects on competition that the CMA anticipated have in fact materialised. Finally, because the CMA has already done much valuable work in understanding the wider market dynamics and it would not be starting from scratch: it has unfinished business. Instead, the positive choice would be to ensure that developments in the PMI market are taken fully into account, to reinforce and preserve the benefit of the CMA's original investigation and the Final Report. Today, the problem is getting worse and may become irreversible if not corrected. Without investigating the PMIs, the CMA risks regulating for yesterday's problem while failing to regulate today's.

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<sup>79</sup> Competition Commission. Store Cards Market Investigation, 7 March 2006.

<sup>80</sup> Competition Commission. Payment Protection Insurance Market Investigation, 29 January 2009.

## CHAPTER 6

### CONCLUSIONS

#### 1 WHAT SHOULD THE CMA DO NOW?

*Imposing the Fee Information Remedy alone will not resolve the relevant AEC*

- 1.1** In the Final Report, the CMA considered that "with greater availability of information on consultant performance and fees, this will increase competition between consultants and lead to patients being able to make more effective choices."<sup>81</sup> The CMA further considered that availability of such information "may address some of the issues that have led to insurers adopting the type of strategies considered in this section and may ensure that these strategies are not rigidly and extensively applied with the consequent risks to, in particular, quality or innovation."<sup>82</sup>
- 1.2** Since the Final Report, clear evidence of MCC has emerged. The MCC requires the CMA to ask: can the Fee Information Remedy now be imposed unchanged? The answer is no. The MCC undermines both the likely effectiveness of the remedy and the reasoning on which the AEC was based. The MCC consists of (i) changes to PMI practices which tend ever more towards fee-capping, banning of top-up fees, the threat and reality of de-recognition; and the spread of restrictive fee arrangements and open referral; (ii) changes to PMI market structure, including consolidation and increasing concentration, leading in turn to weaker competition (iii) lower patient benefits.
- 1.3** Of course, PMIs engaged in such practices before. The MCC is that these practices have become yet more prevalent and all pervasive and increasingly ingenious practices have been adopted to reinforce their restrictive effects. The likely negative effects that the CMA anticipated have materialised and are not confined to the major PMIs. FIPO drew these to the CMA's attention on 3 March 2015, less than one year following the Final Report (see **Annex 1**), and providing evidence of reduction of benefits, open referral, e-billing and de-recognition. The subsequent 18 months have vastly increased the evidence and the worsening trends show no sign of relenting.

*The CMA's choice (1): add remedies to restore price competition or not impose the Fee Information Remedy*

- 1.4** The Fee Information Remedy is within the universe of possible remedies the CMA may impose, and FIPO's objection is not to such a remedy in principle; rather, the MCC itself makes the remedy at best redundant and fundamentally ineffective since the consultant fees result from market-distorting practices of the PMIs.
- 1.5** Since by definition the Fee Information Remedy is a behavioural remedy and is aimed at consumer behaviour the CMA must be satisfied that introducing it in its current form will not be counterproductive by adding to transaction costs yet producing perverse results that deliver no or negative welfare benefits.
- 1.6** The CMA may conclude that simple conduct remedies relating to PMI practices, designed to create the conditions that the CMA expected to continue at the time of its Final Report could be achieved without the need to find a PMI AEC at the current time. Without it, the CMA must consider whether the Fee Information Remedy can be imposed at all, given the likelihood of its failure or the risk of unintended consequences

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<sup>81</sup> Final Report, § 7.135.

<sup>82</sup> Final Report, § 7.135.



*The CMA's choice (2): investigate PMI market in depth.*

- 1.7** In the Final Report, the CMA noted, "the evidence [the CMA] received did not demonstrate that, at present, Bupa (or indeed any other insurer) was distorting competition between consultants by imposing fee-capping, in particular on newly-recognized consultants, as a condition for recognition."<sup>83</sup>
- 1.8** But the CMA also pointed out "the risk that without transparent and fair review mechanisms and flexibility in application, uniform fees could lead to a distortion of competition between consultants and an adverse effect on quality and innovation."<sup>84</sup>
- 1.9** Yet it is the practices of PMIs that remove competition between consultants, resulting in uniform fees, and prevent patients from exercising effective choice in selecting consultants. All newly appointed consultants in the last 5 to 6 years are subject to exactly the same fixed fees limits (imposed by the two major insurers PPP and Bupa) and clearly with the passage of time the proportion of these consultants will increase. Of course many established consultants are similarly affected at this time. The fast diminishing transparency and increasingly unfair negotiating procedures in PMIs' dealings with consultants bears testimony to their market power (which power was accepted by the CMA in its Final Report). This also renders remote the prospect that consultants acting individually will be able to resist the PMIs' terms so as to achieve a more competitive equilibrium in the foreseeable future. If this was not true at the time of the Final Report, it is now.
- 1.10** The evidence shows that providing more information (on fees or performance) cannot be expected to stimulate competition amongst consultants and improve consumer choices where those choices are precluded by PMI restrictive practices. Instead, the Fee Information Remedy is likely to distort patient choice still further, by presenting information which purports to be reliable when it is actually determined by PMI practices.
- 1.11** Yet, if the CMA considers that it cannot impose simple conduct remedies on PMIs without further investigation of PMI practices, then we welcome such investigation. It would be a pity to waste the valuable work of the Private Healthcare market investigation over several years through a failure to deal at an appropriate time with rapid and fundamental changes that cannot be left unchecked.

*Procedure for implementation of the Fee Information Remedy*

- 1.12** It will be apparent from FIPO's comments above that fundamental questions as to the legal and factual basis for the implementation of the Fee Information Remedy and the conditions that would need to exist for it to be effective are logically prior to the question of *how* such a remedy is to be implemented should the CMA conclude that it is an appropriate solution to any AEC identified.
- 1.13** The Notice invites submissions on a draft of the instrument varying the Order. At this stage, FIPO is not commenting in detail on the modalities of the Order pending the CMA's review of the options on a way forward presented here and which will dictate the nature and timing of any order that the CMA may want to make. In whatever way the Fee Information Remedy is implemented, at this stage we foresee a number of practical implementation challenges. The proposed procedure is complex, and likely to be costly and very time consuming to implement and monitor, imposing burdens on both consultants and hospitals.
- 1.14** In order to assist the CMA in its ongoing consideration of these matters FIPO makes the following points at the level of methodology based on the draft Order in the Notice:

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<sup>83</sup> Final Report, Summary, § 49.

<sup>84</sup> Final Report, Summary, § 49.

- (a) Paragraph 2.1 of the Order (information to be provided to information organisation): Paragraph 11.621 of the Final Report states that the fee information is to be consultants' 'list prices', leaving them free to charge more or less than this level, as they considered appropriate, in particular cases. The concept of a 'list' price is not readily translatable to the provision of private healthcare by consultants. FIPO notes the two month period for commencing the use of fee letters to patients; however, the practicality of issuing such letters in all circumstances needs to be addressed. While consultants will provide fee estimates in all but emergency situations, resulting fees may be differentiated depending on individual circumstances.
- (b) Paragraph 2.2 of the Order (role of private healthcare facility): The operator of a private healthcare facility is to be required "to ask every privately-funded patient undergoing any inpatient, day-case or outpatient procedure, including diagnostic tests and scans at that facility, to sign a form confirming that the relevant consultant provided the information required by Article 22.4, and shall take appropriate action if there is evidence that a consultant has failed to do so". There are situations where it may not be possible for such information to be provided (e.g. emergency situations). It is not clear what is meant by the operator of a private healthcare facility taking "appropriate action". Will a patient's admission to hospital be deferred? If so what are the medical and legal consequences of such an action?
- 1.15** If the CMA is minded to implement the Order substantially in the terms set out in the draft annexed to the Notice, FIPO requests an opportunity to meet with the CMA to discuss the matter before that action is taken. In any event, FIPO expects that the CMA would want to consult on any supplementary remedial measures (within option 1 above) and reserves its position to comment on those should the CMA take that course.
- 1.16** Finally, on timing, FIPO notes that the CMA proposes to allow only up to 30 months for PHIN to prepare for publication of fee information. This is highly ambitious: is it achievable?

#### *The Performance Information Remedy*

- 1.17** The Final Report mandated "a combination of measures to improve the public availability of information on consultant fees and of information on the performance of consultants and private hospitals."<sup>85</sup> Evidently, the CMA viewed the package of information remedies (on both fees and performance) as working together to inform and improve patient choice.
- 1.18** The facts outlined in this Submission are relevant to the operation of the Performance Information Remedy. Given the growing interference by PMIs in the selection of consultants and where clinical considerations are not determinative of patient treatments there can be no confidence that the allocation of consultants across specialities could genuinely be the product of a competitive process. Even if robust and reliable performance data could be collated on actual clinical performance in specific cases, this would be tainted by the ex ante manipulation of consultant selection by PMIs or by intrusions in to clinical care. For example, PMIs sometimes deny certain treatments, or refer patients to other practitioners such as physiotherapists without obtaining a consultant opinion. In a competitive process it might be expected that patients would be matched with consultants based on such non-price elements as expertise, experience and specialty. Where, however, such non-price elements are not key drivers of the selection process the allocation of consultants to specific cases is likely to be sub-optimal in terms of performance outcomes. In these circumstances "performance" data (however presented) is unlikely to provide a meaningful tool for patients to determine absolute or relative competence between consultants.
- 1.19** Private Healthcare Hospital Network ("**PHIN**") has been appointed by the CMA as the "Information Organisation" for the private sector for the purposes of the Order. FIPO works closely with PHIN but FIPO is not responsible for the publication or provision of data which is

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<sup>85</sup> Final Report, Summary, § 72(a).

the responsibility of PHIN and the hospital providers. Its role is to provide professional guidance regarding the interpretation and presentation of data and clinical outcomes in order to fulfil the requirements of Part 4 of the Order.

- 1.20** PHIN is attempting to mirror NHS Hospital Episode Statistics for the independent sector with the ambition to link both data sets to provide a complete picture of individual consultant activity and, by implication, outcomes and performance. FIPO is supportive of transparency as it has made clear in giving evidence to the CMA throughout the *Private Healthcare Market Investigation*. However, experience with the data collection exercise has shown that there are challenges with the practical implementation of the Performance Information Remedy including data governance issues.
- 1.21** As a result, it is likely to take some time (perhaps 2-3 years) before the published data are sufficiently accurate or statistically reliable to be useful to patients. FIPO is dedicated to help PHIN to achieve its task but is concerned to ensure the published information can effectively inform patient choice. Because of the current flaws in methodology and data presentation and capture, this goal is some way from being achieved. In these circumstances, to proceed or continue with the implementation of these measures without addressing the implications of the MCC would not ultimately address the CMA's identified AEC based on lack of immediately available and meaningful information on performance.

## **2 ACTION BY THE CMA USING ITS COMPETITION LAW POWERS**

- 2.1** The practices described above prevent, restrict or distort competition, to the detriment of consumers. It is for the CMA to consider whether it should now open separate investigations under the Competition Act 1998, and if it did so, it would not act inconsistently with those cases where market investigations have uncovered possible breaches of competition law.<sup>86</sup> It would assist the CMA achieve a comprehensive solution to the AEC. Here we provide only our outline observations on possible breaches of competition law to assist the CMA.

### *Chapter 1 / Article 101 considerations*

- 2.2** There are several possible relevant agreements or arrangements that may prevent, restrict or distort competition:
- (a) as between insurers;
  - (b) as between insurers and subscriber undertakings (e.g. employers purchasing private healthcare insurance benefits for their employees);
  - (c) as between hospitals and insurers; and
  - (d) as between insurers and consultants.
- 2.3** It is plain that the object or effect of the PMIs' strategy documented here is to control the conditions under which consultants provide their services to patients by stipulating who, where and at what price those services are provided.
- 2.4** It is plain that at least Bupa and AXA PPP are pursuing equivalent policies and that they collectively account for close to 70% of all the PMI policies in the UK.
- 2.5** Bupa, AXA PPP and Aviva have individual market shares above the level that would suggest that agreements and arrangements to which they are a party do not appreciably affect competition (see further paragraph 3.8 of Chapter 4 above on market shares). Moreover,

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<sup>86</sup> E.g. the 2008 Groceries Market Investigation prompted or coincided with competition law interest by the OFT in certain related markets including tobacco and dairy products.

agreements that directly or indirectly fix prices or share markets are capable of having an appreciable effect on competition even where the market shares fall below the *de minimis* thresholds.<sup>87</sup>

- 2.6** Assuming there is an appreciable effect on competition, the next question is whether the test for exemption under section 9 of the Competition Act 1998/ Article 101(3) TFEU is satisfied. The PMIs argue that they must act as they do to control the costs of private medical insurance to the benefit of their subscribers in the form of lower premiums or increased benefits.
- 2.7** This assertion is unsupported. Such a strategy should not deny a subscriber his choice of consultant, facility or treatment or freedom to pay an additional (top-up) fee outside the arrangements with their PMI and should not harm the overall quality of care. Equally, such strategy would have to be applied in a proportionate and non-discriminatory manner, which it is not: the PMIs' control over whether to admit consultants to private practice is highly restrictive.
- 2.8** As almost 80% of PMI expenditure is on hospital benefits there should also be clarity about arrangements between hospitals and insurers.
- 2.9** The vertical relationship of PMIs and consultants and subscriber organisations combined with enforced fee levels implicitly create resale price maintenance, to which the EU and UK authorities have been consistently hostile.
- 2.10** In addition, since the fees imposed are identical across the sector because of the underlying fee arrangements (here between PMIs and consultants) the effect is equivalent to a horizontal price fixing agreement facilitated by an intermediary, equally of great concern where this is liable to result in price alignment between those competing undertakings even without direct contact between those competing undertakings. The PMIs' practices in setting what amounts to a fixed fee for consultant services backed by actual or threatened sanctions (e.g. delisting) ensures adherence analogous to 'hub and spoke' practices previously found to infringe the Chapter I prohibition.<sup>88</sup> A common supplier (here the PMI) can and does facilitate or maintain common fees across the sector for particular types of services.<sup>89</sup>

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<sup>87</sup> *Communication from the Commission — Notice on agreements of minor importance which do not appreciably restrict competition under Article 101(1) of the Treaty on the Functioning of the European Union (De Minimis Notice)*, para 13.

<sup>88</sup> This reasoning has parallels with the approach developed by the UK OFT to address the indirect flow of information between competitors via a common trading partner. The phenomenon has been described variously as 'A-B-C information exchange' or 'hub and spoke collusion'. According to this principle when information on price is exchanged between two or more undertakings operating at the same level of supply/ distribution (A and C) via a common trading contractual party (B) operating at a different level in the supply chain, there can be said to exist horizontal price fixing agreements between the retailers (A and C) themselves. The UK Court of Appeal has been satisfied that A, B and C can be seen as parties to a single infringement as opposed to independent vertical agreements:

"if (i) retailer A discloses to supplier B its future pricing intentions in circumstances where A may be taken to intend that B will make use of that information to influence market conditions by passing that information to other retailers (of whom C is or may be one), (ii) B does, in fact, pass that information to C in circumstances where C may be taken to know the circumstances in which the information was disclosed by A to B and (iii) C does, in fact, use the information in determining its own future pricing intentions". Cases 102/1/1/03 and 1022/1/1/03, *JJB Sports plc v Office of Fair Trading; Allsports Limited v Office of Fair Trading* [2004] CAT 17, para 141.

<sup>89</sup> Similar concerns about the Article 101 implications of a third party setting a fixed fee for professional services have been raised on a reference to the Court of Justice where Bulgaria has asked whether Article 101(1) of the TFEU precludes a provision of the Bulgarian Law on the Legal Profession under which the Supreme Council of the Legal Profession has discretion, by virtue of a power conferred on it by the State, to lay down in advance the minimum level of legal fees (Case C-427/16 - *Chez Elektro Balgaria' AD v Yordan Kotsev* and Case C-428/16 - *Frontex International' EAD v Emil Yanakiev*).

## Chapter II / Article 102 considerations

- 2.11** Major PMIs enjoy a position of market power, whether individually or collectively.
- (a) Bupa market share at dominance levels (i.e. at or close to 40%).
  - (b) Major PMIs account for over 90% of all PMI policies, with equivalent business practices, backed by strong consumer brand awareness which give them significant advantages in the promotion of PMI policies.
  - (c) Barriers to entry and expansion in the PMI market are high.
- 2.12** The PMI market operates in a way increasingly conducive to tacit collusion.
- 2.13** With increasing concentration, it is reasonable to expect coordination among the major PMIs will increase, spreading restrictive fee arrangements and other PMI practices more widely. The loss of Simplyhealth (whose subscribers must now follow the AXA PPP fee strategy) and other smaller players as an actual or potential disruptive force and alternative service proposition is worrying. Indeed, the CMA's own *Merger Assessment Guidelines* emphasise the importance of direct evidence of competitive harm such as elimination of a maverick as a relevant consideration when determining whether coordination in the market is more likely:
- "Coordination will be harder to sustain where there is a firm with substantially different incentives to coordinate than its rivals, and with the capacity to take significant share from any group of firms that tried to coordinate without its participation. Such a firm is sometimes termed a 'maverick'. For example, a firm might value having a reputation for offering the lowest price in the market, and might consider itself likely to sacrifice profits in the long term if it were to lose that reputation by coordination. Whatever the cause of its behaviour, a maverick may be particularly disruptive to coordination."*<sup>90</sup>
- 2.14** In fact, FIPs previous warnings to the CMA about converging restrictive business models are more manifest now; see further below.

### Monopsony power

- 2.15** Given the fragmented nature of the consultant market, where consultant services are typically provided by individuals, the CMA should consider the possibility that the exercise of buyer power by PMIs could lead to adverse effects because of "demand withholding" where powerful buyers reduce the amount they purchase in order to reduce the purchase price, ultimately resulting in reduced supply and higher prices (or reduced benefits) to final consumers (patients).
- 2.16** Typically a single buyer, a "monopsonist"<sup>91</sup> (or a dominant buyer) purchases an input from competitive sellers. Just as in a typical 'market framework' a supplier with market power (e.g. a monopolist) will have an incentive to reduce supply in order to increase prices, a monopsonist may withhold demand to reduce input prices. This withholding of demand results in less input being purchased and hence reduced production, which ultimately will lead to less supply and higher prices for consumers.
- 2.17** The conditions that need to be satisfied for this framework are:

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<sup>90</sup> Competition and Markets Authority. *Merger Assessment Guidelines*, § 5.5.18.

<sup>91</sup> For a detailed exposition of this monopsony power, see Blair, R.D. and Harrison, J.L., 'Monopsony—Antitrust Law and Economics', Princeton University Press, 1993 or Dobson, Waterson and Chu, 'The Welfare consequence of the exercise of buyer power', 1998, pp11-16.

- (a) First, the supply of consultant services needs to be "upward sloping", so that the level of fees paid to consultants is directly related to the number of consultants that may enter private practice.
- (b) Secondly, there needs to be a single "market price" for consultant services (or services of a certain type). There should be limited scope for individually negotiated prices between consultants and insurers and to some degree the prices set by the larger insurers would also be charged by other (perhaps less powerful) insurers.
- (c) Thirdly, the buyer must have market power downstream, so that there would be scope for restricting supply in the final market and ultimately harming consumers.

**2.18** These conditions may be seen as plausible in relation to consultants. A fragmented supply seems consistent with the market for consultants, where there is a large pool of suppliers, each with limited individual market power.

- (a) We would expect the supply of consultants for private practice to be upward-sloping. Consultants choosing whether to practice privately or not, are likely to have a successful NHS day-job, and would only contemplate supplying this additional labour, if the fees were worthwhile. A reduction in fee rates could be expected to lead to a more significant withdrawal of supply than for a 'primary' day-job.<sup>92</sup> The steeper the supply curve is, the greater the welfare loss resulting from buyer power.
- (b) The existence of a single market price, with limited scope for obtaining individual prices, is also a feature of the relationship between insurers and consultants. Bupa clearly sets out its "benefit maxima" for what it will pay a consultant, which clearly acts as the 'market' price for consultants within a specialty. It appears therefore that the second assumption of this framework is met in these circumstances.
- (c) Finally, the market power of the larger insurers, and Bupa in particular, in their final market (particularly in relation to corporate clients) should at least be presumed given their market share. Therefore they should be considered in a position to restrict the supply of health services.

#### *Risks of abuse*

**2.19** Insofar as the PMI's practices result from unilateral action by the PMIs such as delisting or diversion of patients (amounting to a de-facto refusal to deal with a consultant or hospital), the CMA should consider whether PMIs have abused an individual or collective dominant position.

**2.20** The PMIs' practices are directed at a consultant's ability to operate sustainably. This is indicated by the wide-ranging practices discussed above, some of which may overlap and all of which together, or in combination, constitute behaviour designed to or in fact limiting consultants' ability to compete on the basis of their offering. As a result competition between consultants (in quality, expertise, experience, location or other factors) is blunted because the PMIs steer patients to lower cost consultations.

**2.21** Examples of exclusionary tactics which may form separate heads of abuse include:

- (a) Failure to negotiate promptly in good faith.<sup>93</sup> PMIs have consistently 'stonewalled', procrastinated or failed to negotiate promptly, casting doubts on their *bona fides* (see paragraphs 7.6 to 7.10 of chapter 4 above for examples).

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<sup>92</sup> Dobson, Waterson and Chu, *The Welfare consequence of the exercise of buyer power*, 1998, § 4.5.

<sup>93</sup> Case C-53/92P, *Hilti AG v Commission*, [1994] 4 CMLR 614.

- (b) The creation of legal uncertainty. Dominant companies should not refuse to negotiate where to do so would jeopardise the economic position of a rival.<sup>94</sup> In *De Post-La-Poste*<sup>95</sup> the Commission criticised the giving of a notice of termination of a preferential pricing agreement where the notice was to be understood as a warning to the other party to enter a collateral agreement. Similarly, the refusal to negotiate in good faith on fees or choice of consultant is not an isolated act but may be seen as a measure that, through the threatened withdrawal of a significant benefit (i.e. PMI recognition) provides the PMIs with a powerful negotiating lever to compel consultants to agree to their terms or reductions in fee levels which are clearly unacceptable to the consultants or the patient seeking access to their preferred consultant.
- 2.22** The fact that the anti-competitive effects of the abusive behaviour are felt not on the market where the insurer(s) is/are dominant (private medical insurance provision) but on the neighbouring market for private healthcare provision by consultants does not preclude a finding of abuse.<sup>96</sup>

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<sup>94</sup> *Software Cellular Networks v T-Mobile (UK) Ltd*, [2007] EWHC 1790.

<sup>95</sup> *De Post-La Poste*, OJ 2002 L61, page 32.

<sup>96</sup> Case 333/94P, *Tetra Pak International SA v Commission* [1996] ECR I-5951.

## LIST OF ANNEXES

Annex no.	Annex Title/Reference in Submission
<b>1</b>	FIPO Letter to CMA - 03 March 2015 <b>CONFIDENTIAL</b>
<b>2</b>	PMI Benefits and Income <b>CONFIDENTIAL</b>
<b>3</b>	FIPO Consultant Survey 2016 Representative Responses <b>CONFIDENTIAL</b>
<b>4</b>	AXA PPP Letter to providers on Fee Arrangements – 26 April 2016 <b>CONFIDENTIAL</b>
<b>5</b>	AXA PPP Letter to consultants on Fast Trak Scheme – 05 October 2015 <b>CONFIDENTIAL</b>
<b>6</b>	BUPA Email correspondence on becoming Premier Consultant – 29 January 2015 <b>CONFIDENTIAL</b>
<b>7</b>	BMI Healthcare Letter on e-referral – 21 September 2016
<b>8</b>	AXA PPP Advert in Daily Telegraph
<b>9</b>	AXA PPP Email on E-Billing – 10 February 2016
<b>10</b>	Consultant T&Cs (AXA, BUPA, Vitality, Aviva)
<b>11</b>	Review by Which? - October 2016
<b>12</b>	BUPA Standard T&Cs for members