

Private healthcare market investigation: consultant fees remedy

Provisional decision on possible material change of circumstances

The Competition and Markets Authority has excluded from this published version of the provisional decision information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. Some numbers have been replaced by a range. These are shown in square brackets.

Contents

	<i>Page</i>
Summary	1
Introduction	4
Market background in the Report	7
Key factors underlying the AEC decision in the Report	10
The MCCs put forward by FIPO	13
Views of other parties	18
Assessment	19
Decision on whether there has been an MCC	29

Summary

1. On 2 April 2014, the Competition and Markets Authority (CMA) published its findings regarding the market investigation reference on the supply of private healthcare services in the UK ([the Report](#)). In the Report, the CMA found that the lack of independent publicly available fee and performance information on consultants gave rise to an adverse effect on competition (AEC) in the provision of consultant services across the UK. In order to remedy the AEC, the CMA concluded that private hospitals should require that all consultants provide a range of fee and other information to patients, which we collectively refer to as the 'Consultant Fees Remedy'.

2. Following the conclusion of FIPO's appeals to the CMA's findings, in October 2016, the CMA published a Notice indicating its intention to bring Article 22 of the Order into force and invited submissions on whether there had been any material change of circumstances (MCC) since the preparation of our Report, such as to justify a departure from the remedy.
3. In its response to our consultation, FIPO submitted that there had been substantial material changes of circumstance, which made the Consultant Fees Remedy ineffective. FIPO made three broad points that it considered support the finding of an MCC.¹
4. First, FIPO submitted that restrictive practices of private medical insurers (PMIs) 'are now more extensively and rigidly applied than before, [...], which causes the consultant fees to converge around PMI fee schedules, and in turn, this prevents any meaningful comparison of price.'²
5. Second, FIPO submitted that the 'significant buyer power [of the insurers] has been sustained and entrenched'³ and concluded 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.'⁴
6. Third, FIPO expressed a concern that 'PMIs are increasingly interfering in clinical decisions'.⁵ It submitted that 'there is growing evidence of PMIs directing patients to consultants based on the fees ... with no or little regard to clinical need',⁶ and that 'PMIs dealings with consultants are increasingly unfair and non-transparent'.⁷ FIPO concluded that 'PMIs are also damaging consultants' practices, which has an indirect effect on patient welfare'.⁸
7. FIPO concluded that the above changes in the PMI sector mean that 'the CMA must reconsider its decision on the remedy'. FIPO proposed supplementary remedy measures including a prohibition on PMIs imposing restrictions on top-up fees.⁹ As alternatives, FIPO submitted that the CMA should consider abandoning the Consultant Fees Remedy, or should carry out a further investigation of the PMI market.¹⁰

¹ FIPO submission, Chapter 1, paragraph 2.5.

² FIPO submission, Chapter 1, paragraph 1.3.

³ FIPO submission, Chapter 4, paragraph 5.3

⁴ FIPO submission, Chapter 4, paragraph 6.1

⁵ FIPO submission, Chapter 4, paragraph 7.1

⁶ FIPO submission, Chapter 4, paragraphs 7.2–7.3

⁷ FIPO submission, Box 4, 37

⁸ FIPO submission, Chapter 4, paragraph 8.1.

⁹ FIPO submission, Chapter 5, paragraphs 2.2–2.3

¹⁰ FIPO submission, Chapter 5, Sections 3 and 4.

8. In our assessment, we have considered whether there has been an MCC relevant to the Consultant Fees Remedy and whether this justifies a departure from the remedy decided on in our Report. For the Consultant Fees Remedy to be effective and proportionate, we considered that the provision of additional information about consultants' fees must assist patients in making a more effective consultant choice.
9. We first assess FIPO's submissions regarding the increased buyer power of PMIs. We take the view that, irrespective of whether or not the PMIs have significant buyer power, the information remedy would still be relevant in enabling patients to 'shop around' for consultants and to avoid unexpected expenses. Moreover, there is no evidence to suggest that the buyer power of PMIs (if any) have caused a material number of consultants to leave private practice and reduced patient choice. Instead, the data we collected from PMIs indicate that the number of consultants has remained broadly stable since 2014.
10. Turning to FIPO's submission regarding PMIs' involvement in clinical decisions, FIPO did not explain how this would undermine patients' ability to 'shop around' for consultants and to avoid unexpected expenses.
11. Our assessment then focuses on FIPO's first argument regarding the expansion of 'restrictive' practices by PMIs. We gathered additional information from PMIs, including information on various elements of fees and excesses incurred by patients, in order to evaluate FIPO's arguments.
12. We have assessed self-pay and insured patients separately. For self-pay patients, we have not received evidence to suggest that there have been any material changes in the provision of consultant services to self-pay patients. For insured patients, the evidence suggests that the main change that has taken place since the publication of the Report has been an increase in the proportion of consultants that are covered by restrictive fee arrangements with PMIs. However, the incidence of shortfalls has not changed materially, at about [X] and about [X].
13. In addition to patients' exposure to consultant fees via shortfalls, the recent evidence that we have gathered on excesses (where [15–40]% of patients face an excess over £200) and outpatient benefit limits (where [X]% of patients under AXA PPP, [X]% under Vitality and [X]% under Aviva are not entitled to any outpatient benefits and a further [20–50]% of patients across all PMIs are subject to an outpatient benefit limit) demonstrates that a significant proportion of insured patients continue to be exposed to the costs of consultant fees and, as a result, are likely to benefit from the Consultant Fees Remedy.

14. On this basis, we conclude that the changes in restrictive fee practices identified by FIPO are not material to the effectiveness of the Consultant Fees Remedy. We expect that a significant proportion of patients will benefit from the remedy, including inpatients/day-case and outpatients.
15. In light of our assessment above, our view is that there have been no MCCs since the preparation of the Report that require us to consider a remedy that is different from that set out in the Report. In line with our duty under section 138 of the Act, we have provisionally decided to proceed to implement the Consultant Fees Remedy in line with the Report.

Introduction

The Competition and Markets Authority's investigation and subsequent developments

16. On 4 April 2012, the Office of Fair Trading (OFT) made a market investigation reference to the Competition Commission (CC) under sections 131 and 133 of the Enterprise Act 2002 (the Act) regarding the supply or acquisition of privately-funded healthcare services in the UK (the Reference). On 1 April 2014, the CC was replaced by the CMA and the remaining functions of the CC in relation to the Reference were transferred to the CMA. The CMA published its findings on 2 April 2014 ([the Report](#)).
17. In the Report, the CMA found that the lack of independent publicly available fee (and performance) information on consultants was a conduct feature that gave rise to an adverse effect on competition (AEC) in the provision of consultant services across the UK. The CMA found that this lack of information served to distort competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. As a result, this feature was reducing competition between consultants on the basis of quality and price.¹¹
18. In order to remedy, mitigate or prevent the AEC or any adverse effect arising from the AEC, the CMA concluded that private hospitals should require, as a condition of granting practising privileges, that all consultants provide a range of fee and other information to patients using standard letter templates prior to outpatient consultations and tests, and (again) prior to any further tests and/or treatments.¹² In addition, consultants practising privately should submit

¹¹ The [Report](#), paragraph 10.9.

¹² This other information includes details of any financial interests that the consultant holds in medical facilities or equipment, a list of all insurers which recognise the consultant, a note encouraging insured patients to check the terms of their policy with their insurer, with particular reference to the level of outpatient cover they have; and the address of the information organisation

information on their outpatient consultation fees and standard procedure fees to the information organisation for publication on its website alongside information on consultant performance. We refer to these requirements collectively as the 'Consultant Fees Remedy'.

19. On 2 June 2014, the Federation of Independent Practitioner Organisations (FIPO) filed an application to the Competition Appeal Tribunal (CAT) challenging the findings in the Report on various grounds, including on the basis that the Consultant Fees Remedy was ineffective and disproportionate.
20. On 1 October 2014, the CMA published the Private Healthcare Market Investigation Order 2014, which gave effect to a number of the remedies set out in the Report. Article 22 of the Order, which set out the consultant fees remedy, was not brought into force at this time, pending the outcome of FIPO's appeal.
21. In its judgment, handed down on 29 April 2015, the CAT dismissed FIPO's challenge on all grounds.¹³ FIPO appealed the CAT's judgment to the Court of Appeal and on 25 July 2016, the Court of Appeal dismissed FIPO's application in full.¹⁴
22. Following the conclusion of FIPO's appeal, the CMA published a Notice indicating its intention to bring Article 22 of the Order into force. In view of the time that had been taken up by FIPO's appeals, we also invited submissions on whether there had been any material change of circumstances (MCC) since the preparation of our Report, such as to justify a departure from the remedy decided on in the Report.
23. Section 138(4) requires our decision as to the remedial action to be taken to be consistent with the decision on remedial action included in our report, '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'. In view of the time that had been taken up by FIPO's appeals, we decided to invite submissions on whether there had been any material change of circumstances (MCC) since the preparation of our report in 2014, such as to justify a departure from the remedy decided on in our report. On 10 October 2016 we published a Notice inviting submissions on whether there had been an MCC. In this report we have considered, in the light of the submissions we have received, whether there has been an MCC relevant to

website, with a statement that this contains useful information on hospital and consultant quality information. For letters sent prior to follow-up treatment, the information should include details of the patients' diagnoses and a fee quote for the specific treatment (pathway) recommended for the patient. The design of the remedy is set out in detail in the Report, paragraphs 11.596–11.635.

¹³ Federation of Independent Practitioner Organisations V CMA [2015] CAT 8.

¹⁴ Federation of Independent Practitioner Organisations V CMA [2016] EWCA Civ 777.

the Consultants' Fee Information remedy; and if so, whether this justifies a departure from the remedy decided on in our report.

24. The CAT has summarised the approach to take in assessing whether there is an MCC as follows:

The first step is to consider whether a change is material in the sense that it *may* result in a different decision on remedy. 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. The second stage is to consider what the decision on remedy ought to be in the light of that material change in circumstances.¹⁵

25. In its response to our consultation, FIPO submitted that there have been 'substantial material changes of circumstance', which made the Consultant Fees Remedy in its current form ineffective in addressing the AEC arising from 'the lack of sufficient publicly available performance and fee information on consultants'.¹⁶ FIPO submitted that:

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 that [...] this AEC is caused by [...] the lack of sufficient publicly available information on fees. It is also caused by PMI practices which are now more extensively and rigidly applied.

It further stated that 'implementation of the consultant fees remedy would result only in publication of distorted fee information which cannot promote patients' ability to exercise effective choice in selecting consultants'. Consequently, FIPO submitted that the CMA must consider 'supplementing the [Consultant Fees Remedy] by measures to restore effective price competition'. Alternatively, were the CMA unable to impose on private medical insurers (PMIs) the remedies necessary to restore effective price competition, FIPO submitted that 'the [Consultant Fees Remedy] alone ceases to be reasonable, proportionate or practicable for achieving a comprehensive solution' and should not, therefore, be imposed.¹⁷

¹⁵ Ryanair Holdings plc v Competition and Markets Authority [2015] CAT 14, paragraph 110.

¹⁶ FIPO submission, Chapter 1, paragraph 1.4.

¹⁷ FIPO submission, Chapter 1, paragraph 2.1(c).

26. All responses to our consultation have been published on the [case page](#). The CMA has considered the submissions received in order to determine whether it should exercise its discretion and depart from the findings on remedial action set out in the Report.

Structure of this decision

27. This document sets out the possible MCCs put forward by FIPO, and the CMA's assessment of whether any of these amount to an MCC or special reason for the CMA to depart from its conclusions on remedies set out in the Report. It also refers, where appropriate, to the submissions advanced by other parties that responded to the CMA's notice.
28. The rest of this document is structured as follows:
- (a) In paragraphs 29 to 54, we summarise the background and the reasons given by the CMA in the Report for finding an AEC in relation to the availability of information on consultant fees.
 - (b) In paragraphs 55 to 75, we set out FIPO's submissions that there has been an MCC since the Report.
 - (c) In paragraphs 76 to 79, we summarise the views of other parties.
 - (d) Paragraphs 80 to 121 contain our provisional assessment of whether or not there has been any MCC and our provisional decision.

Market background in the Report

29. In this section we briefly review the background to the finding in the Report that there was an AEC in relation to the availability of information on consultant fees. Specifically we focus on the patients' choice of consultants and how consultant fees are set in the market.¹⁸
30. In the Report, the CMA recognised that there were different pathways by which a patient requiring further treatment could be referred to a consultant.¹⁹ In terms of the factors that are relevant from a patient's perspective to the choice of consultant, the Report cites evidence from its patient survey suggesting that the clinical expertise and reputation of a consultant is

¹⁸ For full details of the reasoning underlying the CMA's finding of an AEC, please refer to Section 9 of the [Report](#).

¹⁹ These include referral by a GP and 'open referral'. In an open referral, a GP specifies the type of consultant recommended but not a named individual. See the [Report](#), paragraphs 2.56–2.58.

important to patients as well as, for insured patients, that a PMI covers the consultant's fees when choosing a particular consultant.²⁰

31. Based on the above evidence the CMA considered that patients need information on both the quality and the fees of the consultant to make an effective choice between consultants.²¹ Moreover, the CMA stated that if 'the consumer lacks the necessary information to make these [consultant] choices, or if information asymmetries exist, it is possible that market distortions may arise.'²²
32. In the remainder of the section we review the mechanism for setting consultant fees. We consider this separately for self-pay patients who pay consultants directly, and for insured patients whose payments to consultants are determined by a combination of the fees consultants charge and the terms and conditions of their PMIs' policies.

Self-pay patients

33. For self-pay patients, the price of the treatment is a matter of agreement between the patient and the consultant.²³ Therefore, the information about the fee charged by the consultant is one of the factors in the decision of a self-pay patient, as evidenced by the patient survey.²⁴ Therefore, the lack of such information may distort competition between consultants for self-pay patients.

Insured patients

34. As regards insured patients, the fee-setting process is not just a matter between the patient and the consultant, but also depends on the reimbursement and recognition policies of the PMIs. Prior to 2008 the model was that, once recognised by a PMI, consultants set the fees for treatment offered by the consultant. PMIs either published fee schedules or guidance setting out the treatments and level of consultant fees they reimbursed under their policies, or agreed to pay fees which were deemed to be 'reasonable and customary'. If a consultant charged fees in excess of the PMIs' reimbursement schedule or the 'reasonable and customary' level, the PMI could either reimburse the consultants or it could refuse to pay fees. In this

²⁰ 38% and 36% of patients cite expertise and reputation respectively as a reason to choose a particular consultant. 29% of patients state the PMI covering the consultant's fees as important in choosing a particular consultant. See the [Report](#), paragraph 9.16.

²¹ Note that quality here is used in a broad sense and may therefore also include a patient's subjective view on a consultant's quality, such as 'friendliness'.

²² See the [Report](#), paragraph 9.1.

²³ Hospitals often offer a combined hospital and consultant fee as a 'package'. If a package price is offered, the consultant and the hospital agree on the split of the price.

²⁴ The CC's survey conducted in 2012 suggested that 15% of self-pay patients discussed fees about named private consultants.

latter case, a patient may have been asked to cover the difference between the fee and the PMIs' reimbursement.

35. The difference between the insurer's reimbursement rate and the consultants' fee was known as a 'top-up' fee if the patient was aware of it and agreed to pay the difference in advance of treatment, and a 'shortfall' if the patient was not aware in advance.
36. The Report set out that the larger PMIs were concerned to ensure that their policies covered consultant fees in full to avoid policyholders having to make additional payments. The PMIs also sought, where possible, to control claims costs by limiting consultants' fees, which comprised around 25% of insurers' claims' expenditure.²⁵ In order to achieve these aims, PMIs put in place a variety of measures, including introducing and/or changing the level of fee schedules, introducing contractual caps on the level of consultants' fees and offering customers 'open referral' policies.²⁶
37. Since around mid-2012, the PMIs' review of their fee schedules, based on changes in the complexity of procedures undertaken, has resulted in various changes to the level of reimbursement for certain procedures. The majority of changes made reduced the level of consultant fees paid by the insurers.²⁷
38. In addition, since mid-2008, some PMIs, such as Bupa and AXA PPP, have introduced recognition criteria for new consultants which required them to sign a contract under which they agreed to charge no more than either the fees set out in the insurers' fee schedules (we refer to such consultants as being 'fee-capped') or an otherwise contracted fee level. If a consultant does not agree to these terms, they would not be recognised by the insurer and therefore is not able to treat that insurer's policyholders.
39. As at 31 December 2013, AXA PPP told us that [X] recognised consultants were subject to this type of contract. In addition, approximately [X]% of AXA PPP's recognised consultants were 'fee assured' based on a 'usual and customary' approach. These 'fee-assured' consultants did not have a contract in place with AXA PPP but had historically charged within reimbursement levels deemed acceptable by AXA PPP. However, if these consultants were to routinely charge significantly higher fees than previously, they would be removed from AXA PPP's 'fee-assured' list and their fees would be capped and limited to the published schedule. Such consultants were attributed a lower preference by AXA PPP in the case of open referral and patients

²⁵ See the [Report](#), paragraph 7.55.

²⁶ See the [Report](#), paragraphs 7.55–7.92.

²⁷ See the [Report](#), paragraphs 7.61–7.67.

seeking pre-authorisation for treatment by such a consultant would be informed that they might be liable for additional fees.²⁸

40. As at 31 December 2013 Bupa had 25,883 recognised consultants. Approximately 7,500 consultants (ie 29% of all recognised consultants) were fee-capped, with a further 6,450 consultants (or 25%) covered by informal agreements that ensured consultants always, or habitually, billed within the Bupa fee reimbursement schedule.²⁹
41. During 2013, Aviva also made changes to its recognition criteria, requiring consultants seeking 'approved' status to agree to charge in accordance with its fee schedule and not to ask Aviva patients to pay top-up fees. However, consultants could still be recognised, without 'approved' status without agreeing to these terms. None of PruHealth, WPA or SimplyHealth had similar fee-capping contracts.³⁰
42. Finally, the four largest PMIs also introduced 'open referral' policies. Under an open referral policy, a policyholder requests a referral from their GP or other referring clinician that specifies the specialty or sub-specialty but does not name a consultant. The patient then contacts their PMI and is provided with a list of consultants available to the patient. The patient can choose from this list by which consultant to be treated. Open referrals enable the PMI to direct policyholders to consultants whose fees are capped or otherwise assured.³¹ As at December 2013, around [X]% of Bupa's total policyholder base held an open referral policy.³² As of January 2013, around [X]% of AXA PPP's policyholders were covered by policies that required open referrals.³³

Key factors underlying the AEC decision in the Report

43. In this section, we summarise the key factors underlying the CMA's finding in the Report that there was an AEC in relation to the availability of information on consultant fees.³⁴

²⁸ See the [Report](#), paragraphs 7.70–7.71.

²⁹ See the [Report](#), paragraph 7.76.

³⁰ See the [Report](#), paragraphs 7.80–7.81.

³¹ See the [Report](#), paragraph 7.82. It is within the PMI's discretion that the patient may choose a consultant not on the list presented to the patient.

³² See the [Report](#), paragraph 7.83.

³³ See the [Report](#), paragraph 7.86.

³⁴ For a full statement of the reasoning underlying the CMA's finding of an AEC, please refer to the Report. The summary included in this decision is in no way a substitute for reading the full Report.

The AEC assessment

44. In the CMA's assessment of choosing a consultant in the Report, the CMA stated that if 'the consumer lacks the necessary information to make these [consultant] choices, or if information asymmetries exist, it is possible that market distortions may arise.'³⁵
45. The CMA came to the view that the information available to patients 'did not address the full range of information needs of patients' and 'did not generally provide a reliable basis on which to distinguish between the large majority of consultants.'³⁶ The CMA found that the information available to patients on consultant fees was limited. In the Report the CMA therefore concluded that due to the lack of fee information available to patients, competition between consultants was reduced. The CMA concluded that this was a feature of the private healthcare market giving rise to an AEC.³⁷

The Consultant Fees Remedy

46. To remedy the AEC with respect to consultants' fee information, the CMA decided to impose an information remedy, ordering consultants to provide additional information on fees to self-pay and insured patients. This information would be provided in two ways. First, consultants should send letters to patients in advance of any appointment setting out the cost of the outpatient consultation and, if following the consultation further treatment were required, a fee quote for that treatment (or a package price for the treatment of self-pay patients). In addition, consultants should provide details to the information organisation (Private Healthcare Information Network (PHIN)) of their 'list prices' for standard procedures to facilitate shopping around by patients in advance of making an appointment with a consultant. Full details of the design of each element of the remedy are set out in Section 11 of the Report.³⁸ We set out below the reasoning in the Report on the effectiveness and proportionality of the Consultant Fees Remedy.

Effectiveness

47. The Report explained that the main aims of the Consultant Fees Remedy were (a) to ensure that patients are adequately informed regarding the costs of private healthcare thereby stimulating competition on price among consultants by facilitating shopping around by patients; and (b) to ensure

³⁵ See the [Report](#), paragraph 9.1.

³⁶ See the [Report](#), paragraphs 9.25–9.26.

³⁷ The [Report](#), paragraphs 9.79 & 10.9.

³⁸ See paragraphs 11.596–11.601.

greater transparency on the full costs of consultant services in order to avoid unexpected expenses for patients.³⁹

48. In its assessment of the effectiveness of the Consultant Fees Remedy, the CMA concluded that the remedy was effective in terms of helping patients to ‘shop around’ and preventing the occurrence of unexpected shortfalls. In coming to this view, it took into account several points raised by FIPO at the time of the investigation:⁴⁰
- (a) FIPO submitted that ‘restrictive’ fee practices inhibited effective competition, and consultants should be able to set their own fees without interference from PMIs for competition to function well in the market for consultants.
 - (b) FIPO put forward the view that patients should be able to freely choose a consultant for competition to work properly in the market for consultants.⁴¹
49. The CMA did not agree with either of those arguments for the following reasons:⁴²
- (a) There was no evidence to suggest that fee caps imposed by the PMIs were forcing consultants out of private practice at the aggregate level, which would have reduced the choices available to patients.
 - (b) Patients who were on an insurance policy that restricted their consultant choice were free to choose a different policy or a different insurer that allows for a free choice of consultant.
 - (c) Consultants were able to compete below the fee cap even in a context where insurers set an upper limit to the fees charged.
50. In addition the CMA explained that for this remedy to be effective, it was only necessary for a relatively small but significant proportion of private patients to shop around as switching on the part of these patient would provide consultants with an incentive to compete on fees. This conclusion was supported by evidence from the patient survey. Specifically, 10% of patients indicated that they were willing to travel further to a lower-cost consultant. Furthermore, 29% of patients cited PMIs covering consultant fees as an important reason for choosing a particular consultant. These survey results

³⁹ See the [Report](#), paragraph 11.618.

⁴⁰ AXA PPP also raised a concern regarding ‘the completeness of the information available to patients and the extent that it could be used to “shop around”.’ The [Report](#), paragraph 11.627.

⁴¹ See the [Report](#), paragraph 11.628.

⁴² See the [Report](#), paragraph 11.628.

provided evidence that a small but significant proportion of price-sensitive patients existed, which would make the remedy effective.

51. Finally, we noted that fee information would enable insured patients to be 'better placed to determine the extent of their policy coverage as early as possible in the process and make choices in terms of whether to claim on their policy and/or pay any additional fees not reimbursed by their insurer'.⁴³
52. Taking into account the above points raised by parties, the CMA concluded that the remedy was 'likely to be effective ensuring that patients had sufficient information on the prices charged by consultants'.⁴⁴

Proportionality

53. The CMA expected that the two main benefits from the remedy would be 'competition among consultants on the basis of price and the avoidance of unexpected costs for patients'.⁴⁵ The CMA concluded that the remedy was proportionate because it addressed the AEC finding and because the costs associated with introducing it were minimal and likely to be outweighed by benefits to patients, which the CMA expected to be large in the long run (the CMA estimated that a fall in fees by 1% results in a cost reduction of £15.9 million annually).⁴⁶ Moreover, the CMA considered the remedy as the least onerous remedy to achieve this aim. None of the parties at that time put forward any suggestions regarding a less onerous remedy.⁴⁷
54. Overall, the CMA concluded that the lack of fee information to patients prevented the proper functioning of the consultant market and therefore gave rise to an AEC in the provision of consultant services across the UK.⁴⁸ Furthermore, the CMA concluded that the remedy was effective and proportionate.

The MCCs put forward by FIPO

55. In this section we summarise the arguments and evidence provided by FIPO in response to our recent consultation.⁴⁹ FIPO made three broad points that it considered support the finding of an MCC:⁵⁰

⁴³ The [Report](#), paragraph 11.629.

⁴⁴ The [Report](#), paragraph 11.630.

⁴⁵ See the [Report](#), paragraph 11.631.

⁴⁶ See the [Report](#), paragraph 11.635.

⁴⁷ See the [Report](#), paragraph 11.634.

⁴⁸ See the [Report](#), paragraph 9.79.

⁴⁹ For FIPO's detailed submission please see the [case page](#).

⁵⁰ See [FIPO submission](#), Chapter 1, paragraph 2.5.

- (a) Expansion of restrictive practices by PMIs.
- (b) Increased buyer power of PMIs and reduction in patient benefits.
- (c) Expansion of PMIs in clinical decisions and impact on consultants' finances and patient welfare.

56. FIPO submitted that the Consultant Fees Remedy cannot work as intended as a result of these changes.⁵¹ Below we summarise the above three points in turn.

Expansion of restrictive practices by PMIs

57. FIPO submitted that the PMIs' 'restrictive practices are now more extensively and rigidly applied than before, [...], which causes the consultant fees to converge around PMI fee schedules, and in turn, this prevents any meaningful comparison of price.'⁵² FIPO stated that '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.' Moreover, FIPO submitted that these practices are 'more widely applied across the market.'⁵³

58. In its submission, FIPO pointed to the increased number of PMIs using fee practices that it considers as restrictive, including 'fee capping, ban on top-up fees, the use of e-billing to enforce such bans, and derecognition etc)'.⁵⁴

59. In addition, FIPO told us that 'there have been material changes in fee-capping practices'. It submits that these practices have spread to two other PMIs, Vitality and SimplyHealth, since the publication of the Report.⁵⁵

60. FIPO submitted that 'PMIs are increasingly channelling consultants to restrict fee practices'.⁵⁶ FIPO underlined this argument by results from its consultant survey showing that 280 of 338 (83%) new consultants 'reported that they have fixed fee schedules with at least one insurer', while the proportion of established consultants that have 'agreed to a fixed fee rate for both consultation and procedure fees' with Bupa, AXA PPP and Aviva are 32.2%, 31.3% and 9.9% respectively.⁵⁷ FIPO also states that 'all newly appointed

⁵¹ See [FIPO submission](#), paragraph 1.3.

⁵² [FIPO submission](#), Chapter 1, paragraph 1.3.

⁵³ [FIPO submission](#), paragraph 3.1.

⁵⁴ [FIPO submission](#), Chapter 1, paragraph 1.3.

⁵⁵ [FIPO submission](#), paragraphs 3.3–3.8.

⁵⁶ [FIPO submission](#), paragraph 3.35.

⁵⁷ See [FIPO submission](#), paragraph 3.10 and Box 1, P25.

consultants will be obliged to do [fixed fee schedules] with Bupa and AXA PPP and increasingly with others'.⁵⁸

61. Furthermore, FIPO states that PMIs are increasingly 'forcing more consultants to accept PMI fee schedules without the ability to charge a top-up fee'.⁵⁹ FIPO pointed to the 'de facto prohibition on top-up fees' by Bupa, AXA PPP and Aviva with a combined market share of 81.5% in 2014.⁶⁰ FIPO further submits that, since the Report, Vitality has adopted 'e-billing practices which indirectly achieve a ban on top-up fees'.⁶¹
62. Moreover, FIPO submitted that PMIs 'are increasingly steering patients to lower cost consultants' based on open referral policies.⁶² It states that '[p]reviously, Bupa led the market in [open referral] practices', and 'AXA PPP has adopted a similar practice, known as "fast tracking"'.⁶³ As a result, FIPO argues, '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'.⁶⁴
63. In addition, FIPO provides evidence from its survey that illustrates the 'threat of delisting for failure to abide by the PMIs fee schedule'.⁶⁵
64. FIPO concluded that the 'restrictive practices ... are now more extensively applied than before' on the basis that 'the degree of market coverage has increased', as set out in Table 1 below.⁶⁶ For example, based on FIPO's submission, in 2014 only BUPA and AXA PPP, with a combined market share of 65%, engaged in fee capping. According to FIPO, in 2016, Aviva and Vitality also introduced fee capping, increasing the total market share coverage to 91.5%.

⁵⁸ FIPO submission, Chapter 4, paragraph 3.10.

⁵⁹ FIPO submission, Chapter 4, paragraph 3.12.

⁶⁰ FIPO submission, Chapter 4, paragraph 3.12.

⁶¹ FIPO submission, Chapter 4, paragraphs 3.14–3.15.

⁶² FIPO submission, Chapter 4, paragraph 3.23.

⁶³ FIPO submission, paragraph 3.32. FIPO states that AXA PPP has introduced a fast-track/fee-approved scheme that allows it to nominate a consultant for a patient.

⁶⁴ FIPO submission, paragraph 3.33.

⁶⁵ FIPO submission, Chapter 4, paragraph 3.43.

⁶⁶ Based on Table 2 in FIPO's submission, Chapter 4, paragraph 4.1.

Table 1: Extension of ‘restrictive practices across PMIs as submitted by FIPO

<i>Restrictive practice submitted by FIPO</i>	<i>Market coverage April 2014 (based on shares as at 2012)</i>	<i>Combined market share 2014</i>	<i>Market coverage November 2016</i>	<i>Combined market share 2016</i>
Fee capping	Bupa and AXA PPP	65%	Bupa, AXA PPP, Aviva and Vitality	91.5%
Ban on top-up fees	Bupa, AXA PPP and Aviva	78%	Bupa, AXA PPP, Aviva and Vitality	91.5%
Restrictive fee arrangements	Bupa	39.5%	Bupa, AXA PPP and Vitality	78%
Open referral/ fast tracking	Bupa	39.5%	Bupa and AXA PPP	68%
Derecognition	Bupa and AXA PPP	65%	Bupa, AXA PPP, Aviva and Vitality	91.5%

Source: FIPO submission.

65. Finally, FIPO submitted that ‘the driving of consultant fees to fixed levels sets an expectation of fees being set at similar levels in the self-pay segment’. It states that ‘it cannot be said that the market distortion is confined only to the insured segment’, reasoning that ‘publication of fee information will only reinforce the tendency for all market fees (both insured and self-pay) to converge around the PMI schedules’.⁶⁷
66. Based on the above, FIPO concludes that ‘competition between consultants on price has effectively disappeared’, leading to ‘wider negative effects on consumer choice’.⁶⁸

Increased buyer power of PMIs and reduction in patient benefits

67. FIPO submitted that the ‘significant buyer power [of the insurers] has been sustained and entrenched’⁶⁹ and expressed a concern about ‘the implication for competition of further unchecked consolidation among PMIs’.⁷⁰ An example FIPO provided was the acquisition of SimplyHealth by AXA PPP.
68. Furthermore, FIPO told us that ‘the growing market power of the PMI ... allows the PMIs to reduce patient benefits’.⁷¹ In particular, FIPO told us that ‘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’.⁷² To illustrate

⁶⁷ FIPO submission, Chapter 4, paragraph 4.6.

⁶⁸ FIPO submission, Chapter 4, paragraphs 4.1–4.5.

⁶⁹ FIPO submission, Chapter 4, paragraph 5.3.

⁷⁰ For example, see FIPO submission, Chapter 4, paragraph 5.5.

⁷¹ FIPO submission, Chapter 4, paragraph 5.1.

⁷² FIPO submission, Chapter 4, paragraph 5.7–5.11.

this, FIPO pointed to a recent review by Which? suggesting variation in premiums between PMIs for a patient with the same characteristics.

69. Finally, FIPO stated that PMIs ‘have been progressively reducing policy benefits’, although it acknowledged that ‘because PMIs do not always publish a complete list of their reimbursement schedule ... it is not possible to discern the full extent of this trend’.⁷³ FIPO also states that ‘policy premiums have either increased or remained static’.⁷⁴ Further, pointing to the PMIs’ recent financial results, FIPO argues that ‘PMI economic performance has generally improved or been stable’.⁷⁵
70. In conclusion, FIPO stated that it is ‘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’.⁷⁶

Expansion of PMIs in clinical decisions and impact on consultants’ finances and patient welfare

71. FIPO expressed a concern that ‘PMIs are increasingly interfering in clinical decisions’.⁷⁷ It argued that ‘there is growing evidence of PMIs directing patients to consultants based on the fees ... with no or little regard to clinical need’.⁷⁸ Pointing to its survey, FIPO suggested that between 18% and 41% of respondents (depending on insurer concerned) were aware that a PMI ‘had redirected patients that had been referred to them, or had requested to see them, to other consultants’.⁷⁹ FIPO then concludes that PMIs interference has an ‘obvious and direct effect on patients’.⁸⁰
72. Furthermore, FIPO claimed that ‘PMIs’ dealings with consultants are increasingly unfair and non-transparent’, and that ‘consultant practice is increasingly financial challenging’.⁸¹ FIPO presents evidence from surveyed consultants, that respectively 48% of established consultants and 57% of new consultants reported that their private practices were ‘unlikely to be economically viable in the future or were uncertain’.⁸²

⁷³ [FIPO submission](#), Chapter 4, paragraph 5.10.

⁷⁴ [FIPO submission](#), Chapter 4, paragraph 5.12.

⁷⁵ [FIPO submission](#), Chapter 4, paragraph 5.12.

⁷⁶ [FIPO submission](#), Chapter 4, paragraph 6.1.

⁷⁷ [FIPO submission](#), Chapter 4, paragraph 7.1.

⁷⁸ [FIPO submission](#), paragraphs 7.2–7.3.

⁷⁹ [FIPO submission](#), Chapter 4, paragraph 7.5.

⁸⁰ [FIPO submission](#), paragraph 7.1.

⁸¹ [FIPO submission](#), Chapter 4, paragraphs 7.6–7.13.

⁸² [FIPO submission](#), Box 4, p37.

73. On this basis, FIPO concludes that ‘PMIs are also damaging consultants’ practices, which has an indirect effect on patient welfare’.⁸³

FIPO’s conclusions on MCC

74. FIPO concluded that the above changes in the PMI sector mean that ‘the CMA must reconsider its decision on the remedy’. In particular, FIPO submitted that there has been an MCC as ‘the PMIs increasingly determine the fees which consultants earn’, ‘these fees are increasingly undifferentiated’ and ‘patients are excluded from the financial “contract” between the consultant and the PMI’. As such, FIPO states that ‘the proposed [Consultant Fees Remedy] ... cannot, however, reasonably be expected to address an AEC caused by conduct which itself distorts the prices’.⁸⁴
75. Therefore, FIPO argued that ‘implementation of the remedy ... cannot promote patients’ ability to exercise effective choice in selecting consultants’.⁸⁵ It proposed supplementary remedy measures including the prohibitions on PMIs imposing restrictions on top-up fees.⁸⁶ As alternatives, FIPO submitted that the CMA should consider abandoning the Fee Information Remedy, or should carry out a further investigation of the PMI market.⁸⁷

Views of other parties

The British Medical Association

76. The BMA submitted that, since the publication of the Report, practices by PMIs which it considers restrictive, such as fee capping or ‘open referral’, have become more widespread. The BMA also pointed to the increase in concentration in the PMI market, including the merger between AXA PPP and SimplyHealth. In the BMA’s view, there has been a consequent reduction in consumer choice and an increase in patient detriment.
77. Furthermore, the BMA stated that the Consultant Fees Remedy is not effective because it operates against a fee structure that is already distorted by PMI behaviour. While the BMA was not against the imposition of the

⁸³ [FIPO submission](#), Chapter 4, paragraph 8.1.

⁸⁴ [FIPO submission](#), Chapter 4, paragraph 2.1(c).

⁸⁵ [FIPO submission](#), Chapter 4, paragraph 2.1(c).

⁸⁶ [FIPO submission](#), Chapter 5, paragraphs 2.2–2.3.

⁸⁷ [FIPO submission](#), Chapter 5, Sections 3 and 4.

Consultant Fees Remedy, in its view such a remedy would only be effective if consultants were able to set fees independently of PMI 'restrictive practices'.

AXA PPP

78. AXA PPP told us that FIPO's submission⁸⁸ lacks merit and is not relevant to the implementation of the Consultant Fees Remedy, which is aimed at addressing the AEC finding on the lack to transparency on consultant fees and performance and is not related to the issue of buyer power of PMIs. For the latter, the CMA did not find an AEC. AXA PPP argued that irrespective of the price levels in the market for consultants, patients should be provided with the additional information, both on fees and quality, to be able to compare consultants and exercise choice. Accordingly in AXA PPP's view, FIPO's arguments are irrelevant to the potential variation of the Order.
79. We also received submissions from other parties in response to our consultation. However, those submissions were primarily concerned with the implementation of the Order, rather than commenting on a possible material change of circumstance. We therefore do not provide a summary here.

Assessment

80. As noted above in paragraph 23, section 138(4) of the Act requires the CMA to take remedial action to remedy, mitigate or prevent an AEC and any adverse effects which have resulted from or may be expected to result from that AEC consistent with the decisions included in Report unless there has been an MCC or other special reason for deciding differently. In our assessment we have considered whether there has been an MCC relevant to the Consultant Fees Remedy; and if so, whether this justifies a departure from the remedy decided on in our report.
81. As summarised in paragraphs 43 to 45 above, the CMA found that the lack of fee and performance information on consultants resulted in an AEC. For the Consultant Fees Remedy to be effective, patients must be able to obtain additional information to make a more effective consultant choice. Specifically, we considered that the remedy is effective if it informs customers about costs they may face and allows them to make meaningful decisions between consultants and to avoid facing unexpected expenses.

⁸⁸ [FIPO submission](#).

82. We noted that in order for the remedy to be effective in allowing customers to shop around and avoid unexpected costs, 'it is only necessary for a relatively small but significant proportion of private patients to do so as switching on the part of these patients would provide consultants with an incentive to compete on fees'.⁸⁹

Assessment of PMIs' increased buyer power and expansion of PMIs in clinical decisions

83. We first assess FIPO's submissions regarding the increased buyer power of PMIs (paragraph 55(b)) and the expansion of PMIs involvement in clinical decisions (paragraph 55(c)).
84. First, the Report's conclusion on an AEC due to the lack of publicly available information on fees to patients did not depend on whether or not PMIs had buyer power. We consider that, irrespective of whether or not the PMIs have significant buyer power, the information remedy would still be relevant in enabling patients to 'shop around' for consultants, who retain the ability to charge less than the insurers' benefit limits and avoid unexpected expenses for patients. Moreover, in relation to FIPO's argument that consultants find the new fee structures uneconomical, while the evidence put forward by FIPO may suggest that some consultants are considering the financial viability of the fee structures, it does not point to consultants actually leaving private practice and not to such extent that this reduces patient choice materially.⁹⁰ Instead, the data we collected from PMIs indicates that the total number of consultants recognised by major insurers has remained broadly stable since 2014. Specifically, the number of active recognised consultants by each of Bupa, AXA PPP and Vitality were [redacted], [redacted] and [redacted] respectively in 2014. The corresponding numbers for 2016 were [redacted], [redacted] and [redacted].⁹¹
85. Similarly, we take the view that FIPO's argument regarding the expansion of PMIs' involvement in clinical decisions is not relevant to the effectiveness of the Consultant Fees Remedy. FIPO told us that PMIs' restrictive practices and increased interference in the clinical process resulted in the 'denial of patient choice and long-term consumer detriment'.⁹² However, FIPO did not explain why this claim is relevant to the Consultant Fees Remedy, or how PMIs' involvement in clinical decisions (if it were found to be material) would

⁸⁹ The [Report](#), paragraph 11.629.

⁹⁰ There is also the potential issue that FIPO's survey question may be biased. FIPO's communication with consultants made it explicit that the reason for the survey was to engage with the CMA on the fee remedy. This may lead to strategic response to this question. In any case, even if there is no bias, our above argument is not materially affected.

⁹¹ Aviva has not provided the corresponding data for 2014 and therefore a comparison between 2014 and 2016 is not possible.

⁹² [FIPO submission](#), Chapter 4, paragraph 7.15.

undermine patients' ability to 'shop around' for consultants and to avoid unexpected expenses.

Assessment of the impact of changes in restrictive practices

86. In the remainder of our assessment, we focus on FIPO's first argument regarding the expansion of restricted practices by PMIs (paragraph 55(a)). We have carefully considered submissions made by FIPO and other parties, as summarised in paragraphs 55 to 79 above. We have also gathered additional information from PMIs, including information on various elements of fees and excesses incurred by patients, in order to evaluate FIPO's arguments. We deal with self-pay patients first and then with insured patients.

Self-pay patients are expected to benefit from the remedy

87. We note that FIPO's submissions refer to PMI practices which apply to insured patients only. They do not apply to self-pay patients, who pay consultants directly and are not affected directly by the restrictions in the PMIs' policies. We have not received evidence to suggest that there have been material changes in the provision of consultant services to self-pay patients. Furthermore, FIPO did not provide evidence to substantiate its claim (see paragraph 65) that consultant fees for self-pay patients have converged towards the 'fixed levels' for insured patients. In any case, there is no theoretical reason why fees would converge given that consultants are free to set the fees they charge self-pay patients.

88. Therefore, we expect self-pay patients to benefit from the Consultant Fees Remedy by being able to make more effective consultant choices based on additional consultant fee information. This is the case irrespective of whether or not there has been any change in market circumstances for insured patients.

89. We also note that self-pay patients accounted for 14.5% of private healthcare funding in 2012,⁹³ and the proportion remains broadly the same in 2015.⁹⁴ We consider this to be a significant proportion.

90. In the remainder of the assessment, we focus on insured patients.

⁹³ Based on acute healthcare funding in 2012. See the [Report](#), Figure 2.5.

⁹⁴ LaingBuisson (2015), *Private Acute Medical Care in Central London market report*, p15 estimates that around 16% of independent hospitals' revenues in the UK come from self-pay patients. The figure for central London is higher at 19%.

Insured patients

Expansion of restrictive practices by PMIs

- *Assessment of FIPO's evidence on changes in PMI practices*

91. As noted in paragraph 47, we consider that the remedy is effective if it informs customers about costs they may face and allows them to make meaningful decisions between consultants and to avoid facing unexpected expenses. There are at least three ways in which insured patients can be exposed to consultant fees: the payment of shortfalls or top-up fees, excesses, and existence of outpatient benefit limits. Where patients are exposed to such costs, we expect them to benefit from being better able to 'shop around' for consultants using the additional fee information provided as a result of the Consultant Fees Remedy.
92. Therefore, in considering whether there has been an MCC that would undermine the effectiveness of the Consultant Fees Remedy, it is important to assess (i) the extent to which patients' exposure to consultant fees has changed since the Report, and (ii) the degree to which insured patients are currently exposed to consultant fees.
93. FIPO put forward two main pieces of evidence to illustrate the increasing use of the so-called 'restrictive' PMI practices. First, it submitted that more PMIs have adopted those practices since 2014, as shown by market shares. Second, it cites its survey of consultants to support the claim that consultants are not able to depart from the fee level set by the PMIs.
94. We consider that FIPO's market shares evidence provides a poor indicator of the extent of restrictive fee practices in the market. These market shares overstate the extent to which PMIs adopt restrictive practices across consultants and patients. It is the number of patients or consultants that are affected by PMI practices, not the market share of the PMI, that is informative about the effectiveness of the remedy. This is because not all consultants recognised by these PMIs are necessarily subject to 'restrictive' practices. Therefore, market share is not a good indicator of how widespread these PMI practices are. As set out in paragraphs 96 to 111 below, we have collected data from the PMIs which we consider to be more relevant in assessing the extent to which PMIs have extended their restrictive fee practices. We assess FIPO's survey of consultants when considering shortfalls.
95. Below, we assess shortfalls and top-up fees, excesses and outpatient benefit limits in turn, taking into account the additional information we gathered from

PMIs. Within each point, we distinguish between outpatient and admitted patient consultations/treatments where appropriate.

- *Shortfalls and top-up fees*

96. Shortfalls refer to unanticipated consultant fees above the insured amount. Top-up fees are similar to shortfalls except that the level of top-up fee is known to patients prior to a consultation or treatment. (In the following section, we will use 'shortfall' to cover both shortfalls and top-up fees unless otherwise specified.) In order to minimise the chance of incurring any shortfalls, patients have the incentive to shop around for consultants that charge lower fees and/or those who provide certainty on fees before any consultation or treatment. Shortfalls can apply to both outpatient consultations and inpatient/day-case treatments.
97. There would be no shortfalls if consultants' fees did not exceed PMIs' reimbursement rates. As a result, greater coverage of PMIs' practices such as fixed fees will reduce the impact of shortfalls. We look at the changes in the importance of shortfalls since the Report by considering the extent of shortfalls and also the coverage of PMIs' practices such as fixed fees.

- *Extent of shortfalls*

98. We requested additional information from PMIs regarding the extent to which patients have incurred shortfalls. Table 2 below shows that for AXA PPP and Bupa respectively around [X]% and [X]% of patient episodes were affected by shortfalls based on the latest available data. For AXA PPP, the proportions of patient episodes incurring shortfalls are similar for inpatients and outpatients.⁹⁵ Vitality told us that it had a policy of not shortfalling its members for any eligible care with consultants.⁹⁶ [X] a policy of no shortfalls for patients on open-referral policies.⁹⁷
99. Regarding how the position has changed since the Report, the data from Bupa shows very little change since 2012. For AXA PPP the proportion of shortfalls have not changed materially, but this is only based on two years (2015 and 2016). Furthermore, the position of Aviva and Vitality have not changed since the publication of the Report.

⁹⁵ The data provided by other PMIs is not split by inpatient and outpatient.

⁹⁶ Vitality stated that: 'Vitality are the only major full refund health insurer. We never shortfall our members for any eligible care with consultants. Therefore, not only do we fund higher rates than other insurers (samples below in appendix 1), we are more likely to conclude recognition for commercial reasons than other insurers who are happy for members to be shortfall.'

⁹⁷ Aviva stated that for its GuideWell policy 'no shortfalls on hospital charges, or specialist fees for treatment that is covered by the policy, where members follow the GuideWell claims process'.

Table 2: Proportion of patient episodes that have resulted in a shortfall

		%	
	<i>Bupa*</i>	<i>AXA PPP (Outpatient)†</i>	<i>AXA PPP (Inpatient)†</i>
2012	[X]	NA	NA
2013	[X]	NA	NA
2014	[X]	NA	NA
2015	[X]	[X]	[X]
2016	[X]	[X]	[X]

Source: Submissions of PMIs.

Note: While Vitality observes shortfalls from consultants, it has a policy to not pass the shortfall on to patients. Data for Aviva is not available.

* Defined by Bupa as 'Billed above limit and not covered by Bupa', which may include shortfall and top-up fees. The available data is not broken down by outpatient and inpatient.

† AXA PPP data is only available for 2015 and 2016. Data includes inpatients and day-cases.

100. In addition to those patients who incurred shortfalls in the past, we expect that the Consultant Fees Remedy will generally benefit all patients who are uncertain about the likelihood of incurring a shortfall. This is because the additional information will enable patients to better anticipate the overall costs prior to any consultation and treatment and to minimise the chances of incurring unexpected expenses due to shortfalls.

- *Coverage of PMIs' restrictive practices*

101. FIPO provided survey evidence which shows the proportion of consultants that are/are not on a fee-capped contract with the PMIs (see paragraph 60). It is not clear how representative FIPO's survey is of consultants active in private practice.⁹⁸ Moreover, we consider that the communications associated with the survey may give rise to biased responses, since consultants with a strong interest in the present consultation were more likely to respond.⁹⁹

102. To assess the extent to which the use of restrictive fee arrangements has evolved since the Report, we collected additional data from major PMIs (see Table 3).

⁹⁸ It is not clear how many and which groups of consultants received the survey questionnaire and had the opportunity to respond (the questionnaire was distributed through a variety of channels such as via consultants' organisations and medical directors of private hospitals, but it is not known which of these distributed the questionnaire to consultants).

⁹⁹ For example, the covering letter accompanying the questionnaire mentions the CMA's private healthcare market investigation and states that 'As a result of the investigation, the CMA implemented, among other remedies, a number of remedies aimed at ensuring greater transparency in information available on consultant fees and performance. FIPO has appealed certain aspects of the CMA's decision in the original private healthcare inquiry and the matter is currently going through the courts. The results of the current survey may serve as evidence in future submission to relevant bodies.'

Table 3: Proportion of consultants subject to fixed fees agreement or fee caps for major PMIs*

Year	Bupa (Contracted)†	Bupa (All fee assured)‡	AXA PPP (Contracted)§	AXA PPP (All fee assured)¶	Aviva#
2012	[X]	[X]	[X]	[X]	NA
2013	[X]	[X]	[X]	[X]	NA
2014	[X]	[X]	[X]	[X]	NA
2015	[X]	[X]	[X]	[X]	NA
2016	[X]	[X]	[X]	[X]	[X]

Source: CMA calculations on data provided by PMIs.

* We exclude Vitality in this table as it told us that it does not offer fixed consultant remuneration.

† Comprising Bupa consultants (consultant agrees to charge up to the Bupa Benefit limits for surgical procedures and agrees to charge up to Bupa's benchmarks for consultation fees) and Bupa premier consultant partners (consultant agrees to charge up to the Bupa Benefit limits for surgical procedures and agrees to charge up to individually agreed consultation fee limits, based on speciality and location). Denominator is number of recognised consultants.

‡ Including all contracted consultants that agree to charge up to the Bupa Benefit limits, as well as non-contracted 'fee assured' consultants (1) who have an informal agreement with Bupa to charge up to the Bupa Benefit Limits for a 10% bonus; or (2) who do not have an agreement with Bupa but tend to charge within the Bupa Benefit Limits. Denominator is number of recognised consultants.

§ Including consultants under 'Paid In Full Contracted', ie specialists who have a contracted fee agreement which may be at the levels in the AXA PPP Published Fee Schedule.

¶ Including consultants under 'Paid In Full Contracted' and those specialists who have not agreed fees with AXA PPP but nevertheless are paid in full.

Including Specialists and anaesthetists.

103. Bupa and AXA PPP provided data using two definitions (see notes to Table 3). We think the wider definitions ('fee assured') are more appropriate as these show the proportion of consultants who are likely to charge within the cap or at the level of their respective PMIs' fee schedule. In 2016, between [40]% and [95]% of consultants were likely to charge within the respective caps across the major PMIs. In terms of change since the Report, for AXA PPP, the proportions between 2012 and 2016 are very similar. Bupa's proportion of consultants that are fee assured has increased; the proportion in 2016 is [15–20] percentage points higher than in 2013.

104. Using the results in Tables 2 and 3, for Bupa, we are able to compare, in part,¹⁰⁰ the change in the occurrence of shortfalls with the change in the proportion of consultants who are likely to charge within Bupa's cap. These two tables show that proportion of patient episodes that incurred a shortfall remained stable over the period 2012 to 2015 (at about [X]%) while the proportion of consultants subject to fixed fees rose [X]. The incidence of shortfalls might be expected to decline over time if the proportion of consultants covered by BUPA's restrictive fee practices continues to increase. However, to date, there is not much evidence of this.

105. As noted above in paragraph 98, Vitality does not shortfall its members for any eligible care with consultants. Further, Vitality told us that it does not have fixed-fee arrangements with consultants.¹⁰¹

¹⁰⁰ Any findings on these two tables need to be interpreted with caution as we have not controlled for other factors.

¹⁰¹ In response to the CMA questionnaire, Vitality told us that 'we do not offer a fixed consultant remuneration and rather consider the technical competence, years of experience and market reputation to set individual consultants remuneration.'

- *Excesses*

106. Insured patients are liable for the cost of consultations or treatments up to a specified amount determined by an excess. A higher excess exposes patients to greater costs. Patients with a high excess therefore have an incentive to minimise cost by choosing a consultant with a lower fee (taking into account their quality and performance), as long as the total costs they have incurred remain to be smaller than the excess in a given year. Excesses on insurance policies are particularly relevant for patients when considering outpatient costs, as a patient normally has an outpatient consultation before receiving treatment (and may not progress to having treatment). Moreover, outpatient costs are more likely to fall below the excess amount than inpatient or day-case costs, given that the latter are typically much higher.

107. Table 4 below presents the distribution of excess amounts across patients for each of the major PMIs. It shows that [15–40]%¹⁰² of patients have an excess payment of £200 or more in their health insurance policies.

Table 4: Distribution of excess across insured patients of each PMIs

Excess amount	%			
	Bupa	AXA PPP	Vitality	Aviva*
No excess	[X]	[X]	[X]	[X]
£1–£199	[X]	[X]	[X]	[X]
£200–£499	[X]	[X]	[X]	[X]
£500–£999	[X]	[X]	[X]	[X]
£1,000 or above	[X]	[X]	[X]	[X]
Total	100	100	100	100

Source: CMA calculations on data provided by PMIs.

* Excluding patients with unknown excess.

Note: 2015 data for Aviva; October 2016 data for AXA PPP and Vitality, December 2016 data for Bupa.

108. To put these excess levels into perspective, we note that FIPO’s survey suggests that established consultants charge £207 on average for an initial outpatient consultation.¹⁰³ This implies that around [15–40]% of patients (ie those with excess above £200) will have to bear the full initial outpatient consultation fee; these patients therefore will have an incentive to shop around to try to reduce their exposure to fees. This will also apply to patients with an excess below £200 if they can reduce the fees to less than their excess. Therefore, with the additional fee information, these patients would be able to effectively ‘shop around’, potentially attending consultants of comparable quality, but with a lower fee.

¹⁰² The higher figure does not correspond to that in Table 4 due to rounding.

¹⁰³ Based on FIPO’s 2016 survey results (Q45), the average refers to the ‘initial consultant fee for those patients who are not fixed by an insurer’. The average fee was £135 for a follow-up outpatient consultation. Given the reservations we have with FIPO’s survey, we use these figures purely for illustration.

- *Outpatient benefit limits*

109. Some patients have chosen policies that only reimburse outpatient costs up to a specified amount set by the outpatient benefit limits. The lower the outpatient benefit limit, the more likely it is that a patient will incur outpatient expenses that exceed the limit, and therefore the more exposed the patient will be to additional payments. As such, we expect patients with low outpatient benefit limits to be more conscious of fees and, by implication, to benefit from additional fee information.
110. The data we gathered from PMIs in Table 5 shows that [X] % of patients under AXA PPP, [X] % under Vitality and [X] % under Aviva are not entitled to outpatient benefits at all. Additional information on consultant fees will be particularly useful to these patients. In addition, we note that [20–50] % of patients across the major PMIs are subject to an outpatient limit (see categories ‘£1–£999’ and ‘£1000 or above’ combined in Table 5), and they may have incentive to shop around for consultants in order to limit the risk of incurring fees exceeding these limits.

Table 5: Distribution of outpatient benefit limit across insured patients of each PMI*

Outpatient benefit limit	%			
	Bupa†	AXA PPP	Vitality	Aviva‡
No outpatient benefits	[X]	[X]	[X]	[X]
£1–£999	[X]	[X]	[X]	[X]
£1,000 or above (excluding full refund)	[X]	[X]	[X]	[X]
Full refund	[X]	[X]	[X]	[X]
Total	100	100	100	100

Source: CMA calculations on data provided by PMIs.

* 2015 data for Aviva; October 2016 data for AXA PPP and Vitality, December 2016 data for Bupa.

† Excluding members with multiple benefit limits, which account for [X] % of all Bupa’s members.

‡ Excluding patients with unknown outpatient benefits.

111. PMIs typically do not impose a benefit limit on inpatient treatment costs. Therefore the benefit limit analysis above is not applicable to patients requiring inpatient treatment.
112. In summary, the data provided by PMIs shows that a significant proportion of patients will continue to be exposed to cost of consultant fees in the form of shortfalls (which accounted for [X] % and [X] % for AXA PPP’s and Bupa’s patients respectively), excesses (where [15–40] % of patients face an excess over £200) and outpatient benefit limits (whereby [X] % of patients under AXA PPP, [X] % under Vitality and [X] % under Aviva are not entitled to outpatient benefits at all and a further [20–50] % of patients across all PMIs are subject to an outpatient benefit limit). These patients will therefore directly benefit from the Consultant Fees Remedy.

- *Open referrals*

113. Turning to FIPO's claim that open referral policies are restrictive (see paragraph 62), the CMA does not consider this to be a material concern for the MCC assessment. Notably, the additional information we gathered from PMIs indicates that the majority of the patients are in fact not under open referral policies ([redacted]% for Bupa, [redacted]% for AXA PPP, [redacted]% for Aviva and [redacted]% for Vitality in 2016).¹⁰⁴

Conclusions on effectiveness of information remedy and any change in circumstances

114. In our assessment we have covered self-pay and insured patients separately. For self-pay patients, we have not received evidence to suggest that there have been any material changes in the provision of consultant services to self-pay patients. Therefore, we continue to expect self-pay patients to benefit from the remedy by being able to make more effective consultant choices based on additional consultant fee information.

115. For insured patients, the evidence suggests that the main change that took place since the publication of the Report was an increase in the proportion of consultants that are covered by restrictive fee arrangements with the PMIs. This is largely driven by an increased proportion of Bupa's consultants that are 'fee assured', from [redacted]% to [redacted]% over the period 2012 to 2015. However, while the proportion of fee-capped or fee-assured consultants has increased since 2012, the incidence of shortfalls has not changed materially, at about [redacted]%.

116. As set out in paragraph 47, we consider that the Consultant Fees Remedy will be effective if it informs customers about costs they may face and allows them to make meaningful decisions between consultants and to avoid facing unexpected expenses. Inpatients will be mainly affected by shortfalls. In our view the evidence does not support an MCC – for Bupa the extent of shortfall ([redacted]%) has been broadly consistent over the period, and for AXA PPP the proportion of consultants subject to a cap has been broadly consistent ([redacted]%). In this context, we consider that the lack of change in the incidence of shortfalls indicates that the extension of restrictive fee practices by the PMIs does not amount to a material change in circumstance with respect to this remedy.

¹⁰⁴ PMIs' responses to CMA Questionnaire.

117. In addition to patients' exposure to consultant fees via shortfalls, the evidence that we have gathered on excesses (where [15–40]% of patients face an excess over £200) and outpatient benefit limits (where [X]% of patients under AXA PPP, [X]% under Vitality and [X]% under Aviva are not entitled to any outpatient benefits and a further [20–50]% of patients across all PMIs are subject to an outpatient benefit limit) demonstrates that a significant proportion of insured patients continue to be exposed to the costs of consultant fees and, as a result, are likely to benefit from the Consultant Fees Remedy.
118. Finally, in addition to the direct benefits described above, the CMA concluded in the Report that we would expect that the Consultant Fees Remedy will benefit all insured patients at the time when they choose insurance policies, ie before they require consultations or treatments. With the remedy, patients 'would be better placed to determine the extent of their policy coverage as early as possible in the process and make choices in terms of whether to claim on their policy and/or pay any additional fees not reimbursed by their insurer'.¹⁰⁵
119. On this basis, we conclude that the changes in restrictive fee practices identified by FIPO are not material to the effectiveness of the information remedy. In particular, having taken into account recent data on the costs patients will be exposed to, we expect that a sufficient proportion of patients will benefit from the remedy, including inpatients/day-case and outpatients.

Decision on whether there has been an MCC

120. As no party suggested to us that there is any special reason for the CMA to depart from its conclusions on remedies in the Report, nor has the CMA found one to exist, this decision refers only to whether there is an MCC that would cause the CMA to reach a different conclusion on remedies from that set out in the Report.
121. In light of our assessment in paragraphs 80 to 119 above, our view is that there have been no MCCs since the preparation of the CC's Report that require us to consider a remedy that is different from that set out in the Report.
122. As no party has suggested that there is any other special reason for the CMA to depart from its conclusions on remedies in the Report and, in line with our duty under section 138 of the Act, we have provisionally decided to proceed to implement the Consultant Fees Remedy in line with the Report.

¹⁰⁵ The [Report](#), paragraph 11.629.