**FEDERATION OF INDEPENDENT PRACTITIONER ORGANISATIONS**

# CMA PROVISIONAL DECISION ON POSSIBLE MATERIAL CHANGE OF CIRCUMSTANCES

**RESPONSE**

**20 MARCH 2017**

## 1 INTRODUCTION

1.1 There is much common ground between FIPO and the CMA and we are keen to work with the CMA to put in place the conditions to allow the Consultant Fees Remedy to achieve the CMA's objectives.

1.2 Patients are best served when consultants compete with each other on the quality of their services and the fees they charge. Patients need to choose meaningfully in three senses: first, being *able* to choose, second, having *different options* to choose from, and third, being *willing to switch*. If a patient can meaningfully choose and is willing to exercise that choice, the market may respond to each patient's needs. Since the CMA finds the market today does not respond effectively, the CMA is right to act. Here, we stand on common ground.

1.3 We are debating with the CMA *how* to develop effective competition based on consultants' fees. With information about different prices, the consumer can compare; without that information, the consumer cannot. In principle, it follows the lack of sufficient publicly available information about consultant fees must - at least in part - explain why the consumer cannot meaningfully choose between consultants based on price. Publishing good quality information about consultant fees must be at least part of the solution. As the CMA knows, FIPO supports the Consultant Fees/Quality Remedy and is working with PHIN to bring it about.[1] So, here too, we stand on common ground.

1.4 Where we disagree is whether the CMA can stop there. The CMA believes it can; FIPO believes it cannot - the CMA has unfinished business to ensure its remedy actually works. The CMA believes there have been no material changes of circumstance ("MCCs") since its Final Report that require the CMA to consider a remedy different from that set out in that Final Report.[2] We understand "a remedy different from that set out in the [Report]" to refer not only to a remedy that is actually *different*, but also one which keeps the Consultant Fees Remedy entirely, *but with additional and supporting elements* to ensure its effectiveness.

[1] FIPO provides the professional input to PHIN on the Quality remedy with a specialty group of advisers and with contacts and meetings with specialist associations, the main national clinical registries, HQIP and the Medical Directors of private hospitals. FIPO is now developing a separate advisory group to assist PHIN in the development of the Fee remedy, this group to have representation from the BMA, HCSA and other leading specialist associations.
[2] Provisional Decision, paragraph 15.

Our difference of views with the CMA – regardless of MCCs – is whether the Consultant Fees Remedy can alone bear the burden the CMA places on it:[3] we say it cannot.

1.5 If the CMA stands in the shoes of a patient deciding to buy private health insurance, it will not as readily see the value of consultant fee information to that choice. If, however, the consultant fee information corresponded clearly to information the PMIs provide to the patient about the benefits on offer, then the CMA will see how both sources of information can help the patient make a meaningful choice. A patient cannot make a meaningful decision about the costs they may face and avoid an unexpected shortfall unless they have quality information on the main determinants of those costs, namely benefits and consultant fees. PMIs currently provide only basic information on what they will pay for. The patient has no idea at the time of buying private health insurance exactly what they will get when they need to claim. Providing consultant fee information without correspondingly detailed benefits information does not help the patients when they buy private health insurance.

1.6 Let us now suppose the patient has bought private health insurance from a PMI, and some time later needs to claim on that insurance to undergo treatment. The patient checks the policy for what is covered and either assumes – rightly or wrongly - the treatment is covered by the broad terms used to describe benefits, or does not find the policy gives sufficient, or sufficiently precise, information. The patient calls the PMI for authorisation and finds out only then what the PMI will actually pay for – which hospitals, which treatments, which consultants. If the patient has information about different consultants' fees we must ask: what value will that information give the patient when they need treatment? We say: consultant fee information is meaningful **only in the context of the benefits information which PMIs provide** – both pre-contract and during the contract.

1.7 To this the CMA may say the remedy still works for self-pay patients - who represent about 15 per cent of the private healthcare market - because they can now choose between consultants based on price, so the Consultant Fees Remedy at least improves their position (assuming the potential hospital charges are included, the patient is not inert and – regardless of their health condition - is willing to shop around). It would be rash to assume – without more – that consumers are more active and engaged in the private healthcare market than in

[3] "[f]or 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 unexpected expenses", Provisional Decision, paragraph 81.

any other consumer market, but that is a question for the CMA when it considers appropriate.

1.8 Even if the Consultant Fees Remedy does benefit the 15 per cent, it is a separate question whether any such improvement justifies the CMA stopping there. Again, this is doubtful, because the self-pay patient is in a fundamental respect already in a better position to choose than the insured patient: the self-pay patient may also interrogate the healthcare provider about what they will actually get for their money. Pre-contract, the insured patient will not be able to match benefits with fees. The insured patient pays a premium without knowing how much the PMI will actually pay on their behalf. Thus a remedy that works only for the 15 per cent in effect discriminates against the 85 per cent. To level that playing field, the remedy must address the prevailing information asymmetries and provide disclosure of commensurate benefit information to the insured market.

1.9 The rest of this paper illustrates this problem and our proposed solution.

## 2 WHAT DOES THE PATIENT NEED PRE-CONTRACT TO MAKE A MEANINGFUL CHOICE OF PMI?

2.1 A patient who chooses to buy private health insurance (or their employer where insurance is provided as an employment benefit) may consider what – in broad terms – a PMI will offer: the comprehensiveness of treatments, the levels of excess, whether pre-existing conditions are covered, and of course, the price. From general information, including perhaps comparing these elements across the market, the patient will choose. The PMI issues the policy and sets out the cover, but only in general terms. The Annex to this note contains an extract from an actual insurance certificate from Vitality to illustrate the level of detail of the information provided.

2.2 It is apparent pre-contract and after entering a contract the patient has received only cursory information about benefits. Where can the patient find out whether a PMI will pay for a particular procedure, a particular hospital, or a particular consultant and to what level? In the certificate of insurance (an extracted example of which is included in the table in the Annex), where does it confirm hip replacements or gall bladder removal are covered, and if so, to what extent? If you know where to look and know how to extract the information, you can find out – but only with great difficulty. The patient may be directed to a further source of information on the PMIs' website once they have signed up to a policy but in FIPO's experience this is not easily navigable even by professionals in the industry.

2.3 If the patient has good quality information on (meaningful) consultant fees as the Consultant Fees Remedy proposes (and let us suppose it has this information pre-contract), what exactly is the patient supposed to do with this information to make a meaningful choice between PMIs? It may say – for example – that BUPA authorises a certain number of orthopaedic consultants at specified rates. But if it does not say which procedures are included in a patient's benefits and at which hospital, the patient is none the wiser.[4] How much more difficult is this for the patient with no pre-existing conditions buying private medical insurance in the abstract without having a particular treatment need in mind?

2.4 Moreover – and this is the critical point for the CMA – where the patient has consultant fee information but not PMI benefit information at a congruent level of detail, not only can it not compare like-for-like in the market, it is vulnerable to patient benefits being eroded without knowing it, leading to unexpected shortfalls.

2.5 Where consultant fees exceed patient benefits, a shortfall arises. The Consultant Fees Remedy is designed to address the first part of the equation, but so far, nothing addresses the second. Without specific pre-contract/pre-treatment information about precisely what is covered, consultant fees information is being provided in a vacuum. How can the patient be sure the benefits will not be eroded, even post-contract, creating a shortfall where previously one might not have arisen? It is not enough to say PMIs compete with one another and it is not in their interests to erode patient benefits: the reality is somewhat different in two senses:[5] first, patient benefits are being eroded,[6] and second, the consumer is unaware of it, and cannot then make a meaningful decision as a result.

## 3 CONCLUSION: RECOMMENDATIONS

3.1 It should now be clear FIPO supports the CMA's objective of helping patients take meaningful decisions about their choice of consultants based on the consultants' prices (and quality). Consequently, FIPO supports the aim of the Consultant Fee/Quality Remedy.

3.2 The question is simply whether the Consultant Fees Remedy does all that is asked of it. As we have shown, the patient is ill-informed about PMI benefits, and cannot easily find quality

[4] Almost certainly the common procedures will be covered but as new techniques evolve there is variation and confusion. An example is Chondrotissue treatment for knees which is accepted by most but not one of the leading PMIs.

[5] See, further, Annex 11 of our 8 November submission, *Which?* report.

[6] See FIPO's 8 November 2017 Submission, section 7. Furthermore, the CMA finds that while the proportion of fee-capped or fee-assured consultants has increased since 2012, the incidence of shortfalls has not changed materially (Provisional Decision, paragraph 115). One reason why such shortfalls persist in the face of more consultants being subject to fixed fees must be that benefit levels are being reduced.

information. Without quality information on benefits, the information on fees is only part of the picture, and the question of shortfalls/unexpected expenses remains unanswered.

3.3 Where the patient is presented – either pre-contract or during the term of the contract – with consultant fee information, what precisely can the patient do with it? Especially the patient with no pre-existing conditions being shown the prices charged by different specialists without any inkling of why they might require treatment from any of them?

3.4 The level of benefits information must be meaningful, and here FIPO suggests it should correspond to the level and category of consultant fee information required: detailed fee information[7] detailed benefits information; less detailed fee information, less detailed benefits information. Without congruence between the level of detail of information available for fees and benefits consumers will not be comparing like-for-like, so they will have no way to determine the costs they may face to avoid a shortfall. The principle is to help the consumer see – pre-contract – what they will get. To give an example:

(a) PMI P offers benefit B corresponding to a specific procedure;

(b) PMI P permits policy holders to claim benefit B through this specific list of authorised consultants X, Y or Z, at hospital L, M or N whose prices are shown.

(c) Thus it can be seen the benefit B corresponds to the fee information and the patient can know exactly what is given in return for the policy premium.

3.5 We have in previous submissions listed other safeguards to this remedy: in summary, preserving the patient's right to choose a different consultant, from a differentiated panel, which presupposes the ability to pay a top-up fee[8] – itself reinforced by allowing the doctor in those cases to bill the patient directly; and allowing consultants to set fees based on their experience, expertise and location. These safeguards reinforce the effect of providing benefit information: first, the patient can see how the benefit levels correspond to fees, and second, they preserve real price competition between the consultants.

[7] It being understood that detailed fee information must be on a disaggregated basis to allow the consumer to see the options available and the extent to which fees are differentiated.

[8] We note the CMA's finding that the major change since the Final Report has been the increase in consultants covered by contractual fee-capping arrangements, which the CMA states to be in the range of [50-70] per cent for 2016, up from [20-30] per cent for 2013; this means the patients are increasingly receiving no bill from the consultant (therefore no visibility on consultant fees) and increasingly these fees are converging (no differentiation).

3.6 It may be the CMA believes at this stage the market does not need detailed requirements on the modalities of the remedy to function effectively. FIPO would not agree; yet we are open to the possibility that with publication of benefits information at a correspondingly detailed level to meaningful consultant fee information, the market may resolve these other safeguard issues in due time. If the CMA adopts this approach, it will nonetheless need to remain vigilant.

3.7 If, however, the publication of benefits information alongside consultant fee information does help the market function more effectively, we might expect a different patient journey. In contrast to the patient journey outlined above at paragraph 1.5, with a remedy amended as FIPO proposes, the patient – pre-contract – can see what specific benefits (treatment, hospital, consultant) are being provided and – using the consultant fee information – whether that PMI allows the patient sufficient choice. Moreover, at the time of electing to be treated privately, the patient can choose from a variety of consultants, knowing in advance whether the benefit levels match the fees of various consultants and can then elect – **in the patient's own discretion** – to be treated by a consultant within the fee range or indeed outside it. This is a vision of a future where patients are given better tools than they currently have to make effective choices and where the Consultant Fees Remedy is given the safeguards it needs to achieve its aim.

3.8 To reach this conclusion does not require a new AEC, a new market investigation or even a finding there have been MCCs or special reasons (without prejudice to FIPO's views on all these points). It simply requires the CMA to design its remedy to ensure the highest likelihood of effectiveness. We look forward to working with the CMA to achieve this aim.