

FEDERATION OF INDEPENDENT PRACTITIONER ORGANISATIONS

CMA PROVISIONAL DECISION ON POSSIBLE MATERIAL CHANGE OF CIRCUMSTANCES

SUBMISSION

11 APRIL 2017

1 INTRODUCTION

1.1 This submission addresses three key issues that were raised at the hearing with the CMA Panel Members on Friday, 31 March 2017 (the “Hearing”) and which have a bearing on the extent to which and how the CMA implements the Consultant Fee Remedy:

- (a) Whether or not the provision of private medical insurance (“PMI Market”) is a separate market from the provision of private healthcare through consultants (“Consultant Market”);
- (b) Whether or not the supplementary remedy proposal (“Supplementary Remedy Proposal”) proposed by FIPO in its 20 March submission (“FIPO’s Submission”) (including the requirement on Private Medical Insurers (“PMIs”) to publish the level of benefits corresponding with the level and category of consultant fee information) is lawful; and
- (c) The practicability and feasibility of the CMA implementing the Supplementary Remedy Proposal within the CMA’s current procedure and without a separate market investigation reference.

1.2 We address these issues in turn.

2 PMI MARKET IS NOT A SEPARATE MARKET FROM CONSULTANTS

2.1 During the Hearing, the CMA suggested that since the Consultant Fee Remedy is based on the Consultant AEC as found by the CMA in its Final Report, and which did not identify any AEC in relation to the provision of private medical insurance by PMIs, the PMI Market was not within the scope of the CMA’s findings on Consultant AEC and resulting remedies in the Final Report. The CMA noted in this context that the terms of reference of the private healthcare market investigation were restricted to the provision of privately funded healthcare services to patients via private facilities/clinics (including private patient units), through the services of consultants, and medical and clinical professionals who work within such facilities. Consequently, the CMA questioned whether it had the power to impose remedies that might concern a putative (economic) market (the PMI Market for private insurance provision) that was distinct from the one where it had identified an AEC (the Consultant Market for private healthcare provision).

2.2 FIPO submits that private healthcare provision, as far as insured patients are concerned, is a two-sided market. Two-sided markets have a number of features including in particular:

- (a) *Interdependence*: Two-sided markets are markets characterised by two distinct end user groups, where one user group's participation is in some way dependent on the other user group's participation, and vice versa.
- (b) *Single v multi-homing*: Some two-sided markets are characterised by two phases of decision-making: a membership decision, i.e. whether to join the platform/ scheme, or not; and a usage decision, i.e. whether to use the platform/ scheme once you have joined.
- (c) *Network effects*: Network effects arise where the participation of an additional user in a network changes the value of that network to existing users. The presence of these network effects tends to lead to relatively concentrated markets.

2.3 It is beyond the scope of this submission to provide a detailed economic analysis of the nature of the relevant market engaged by the Consultant Fee Remedy. We note in this context that private healthcare provision, as far as insured patients are concerned, exhibits many of the features of two-sided markets.

- (a) When a patient purchases private healthcare insurance from the PMIs and undergoes a treatment from a private consultant as the need arises, he enters into a contract with the consultant who in turn owes a duty of care to the patient. However, the insured patient has an economic relationship with the PMIs in that patients will pay premia to insurers in return for benefits under their private healthcare policy that defray the cost of consultant charges in whole or in part. The PMIs pay the consultants for the services offered to the patients (except where the patient pays any top-up fees to meet any differential between the amount that the PMI is prepared to reimburse and the amount that the consultant charges).
- (b) An insured patient will face two stages of decision-making. They will first decide to take up a policy with a particular insurer and before they have an immediate treatment need (i.e., a membership decision). They will then have a need for specific treatment where they will need to take decisions regarding their choice of consultant or hospital. These usage choices may be determined for them by the PMI.

(c) The presence of network effects in private medical insurance provision coincides with highly concentrated markets where the four largest PMIs account for over 90 per cent of private medical insurance provision. This situation can be explained in part by positive feedback effects where the value of the network increases as the network grows thereby encouraging more users to the network which enhances the value of the network and so on. This is the position with the major PMIs which individually and collectively have become ‘must haves’ in the sense that a consultant will need to be recognised by all the major PMIs including Bupa, AXA, Vitality, Aviva and WPA if they are to build and sustain a viable practice. This tendency of network effects to create or reinforce market dominance or monopsony power in private medical insurance provision means that the PMIs are able to and do exert market power over consultants through the threat of and actual delisting as strategies to enforce adherence to their fee schedules. They are also able to and do dictate the patient-consultant pathway in ways that may not be socially optimal (e.g. by denying a patient their choice of consultant or hospital).

2.4 The two-sided nature of the private healthcare market is similar to the newspaper and magazine market as examined by the then Office of Fair Trading in the newspaper distribution investigation. In that case the CMA found that ‘[n]ewspapers and magazines carry advertising as well as editorial content. As a result, publishers, unlike retailers or wholesalers, receive income from the sale of advertising space as well as from copy sales – in other words they face two-sided markets’.¹

2.5 We have reached the following conclusions applying the theory of two-sided markets in the context of private healthcare provision and the Consultant Fee Remedy:

(a) Private healthcare provision cannot be examined in isolation from private medical insurance since the patient’s decision to take treatment cannot be viewed in a silo that is divorced from their decision to join a PMI network and claim benefits under their policy should they need treatment. Far from corresponding to different economic

¹ Paragraph 3.3, Newspaper and magazine distribution in the United Kingdom, Decision not to make a market investigation reference to the Competition Commission (September 2009).

markets, private healthcare provision and private medical insurance may be viewed as part of an overall system for the delivery of private healthcare to patients.²

- (b) Where, as here, the CMA has found an AEC in relation to the lack of publicly available consultant fee information for private healthcare provision and devised a remedy (the Consultant Fee Remedy) to correct for that situation, it will fall short of achieving its objectives based on making *meaningful decisions* if it does not satisfy itself that there is simple like-for-like transparency of information in relation to private healthcare insurance benefits.

3 HOW CAN THE CMA LEGALLY ADDRESS FIPO'S CONCERNS?

- 3.1 The Final Report concluded that “a lack of sufficient independent, publicly available performance and fee information on consultants prevents the proper functioning of competition between consultants and is a conduct feature in the provision of privately funded healthcare services by consultants”.³
- 3.2 FIPO submits that the CMA has available to it the legal powers and margin of discretion to implement a form of Consultant Fee Remedy that addresses its concerns and within the confines of the existing consultation and procedure on the draft Order.
- 3.3 First, section 134(6) of the Enterprise Act 2002 (“EA02”) (as amended by the Enterprise and Regulatory Reform Act 2013) imposes a duty on the CMA to, while deciding what actions to take or recommend to remedy, mitigate or prevent the adverse effect on competition identified by it on a market investigation reference, have regard to the need to achieve as **comprehensive** a solution as is reasonable and practicable to the adverse effect on competition and any detrimental effects on customers resulting from the identified adverse effect on competition. The CMA’s guidance also confirms this.⁴
- 3.4 The Consultant Fee Remedy, as it stands, would help only self-pay patients, who represent about 15 per cent of the private healthcare market. The majority of the private healthcare market, namely that represented by insured patients would not benefit from the Consultant

² See, further, on the nature of systems markets, Nalebuff, B., Bundling, Tying, and Portfolio Effects, DTI Economics Paper No 1, February 2003.

³ Paragraph 9.79 of the Final Report.

⁴ See paragraph 354, Guidelines for market investigations: Their role, procedures, assessment and remedies, CC3 (April 2013) (the “CMA Guidance”).

Fee Remedy. Therefore, FIPO questions how the Consultant Fee Remedy as currently formulated can satisfy the CMA's duty under Section 134(6) to achieve as *comprehensive* a solution as reasonable and practicable? FIPO maintains that the supplementary measures set out in the FIPO Submission in whole or in part go some way to achieving as comprehensive a solution to the AEC identified (subject to the CMA being satisfied that the measures are reasonable and practicable as discussed in paragraph 4.2 below).

- 3.5 Second, section 138(3) of the EA02 relieves the CMA of the duty to ensure that its decision to remedy, mitigate or prevent the adverse effect on competition and resultant or expected detrimental effects on customers must be consistent with the remedies identified in the CMA's market investigation reference report, in the event there is a ***material change of circumstances***, or there is a ***special reason***.
- 3.6 As FIPO noted at the Hearing, it maintains its position that the circumstances brought to the CMA's attention in its submission of 8 November 2016 amount to an MCC which would justify the supplementary measures. Events since that submission confirm the progressive and worsening trend. This is not the place for FIPO to repeat its submissions on MCC again as it believes that the CMA has grounds to adopt the Supplementary Remedy Proposal without concluding that there has been an MCC (see paragraph 3.7 below). However, given the CMA's expressed desire to keep a watching brief over the market in the coming months and years, FIPO is continually seeing new evidence of further changes in the market.⁵
- 3.7 FIPO notes that in rare circumstances, such as where there are no practicable remedy options available, the CMA may choose not to take a remedial action in spite of its finding of an AEC. FIPO submits that this need not be one of those rare cases where the CMA takes no action at all: the private healthcare market is a two-sided market, which includes PMIs, consultants, hospitals and patients; and the AEC identified by the CMA can be effectively addressed only if the PMIs at the very least make available the corresponding information on benefits levels. It would be open to the CMA to conclude, therefore, that the evolving nature of the two-sided private healthcare market – whether or not amounting to MCC – constituted a 'special reason' for the CMA to implement a modified Consultant Fee Remedy containing supplementary measures of the type proposed by FIPO.

⁵ These changes fall into two categories: first, evidence from consultants regarding actual or threatened de-listing by PMIs for failure to adhere to PMI-stipulated fees; second, evidence showing the increasing margins for PMIs.

- 3.8 FIPO also accepts, however, that the CMA may consider that its remedial powers in the current situation extend only to consultants based on a narrow construction of the Final Report. FIPO submits that such a conclusion would be an unnecessarily narrow and incorrect interpretation of the CMA's jurisdictional powers given the nature of the market under consideration. FIPO notes in this context that if the CMA considered that it was not open to it to mandate supplementary measures requiring implementation by the PMIs it would nonetheless be open to the CMA to make *recommendations* to the PMIs on how they could achieve commensurate transparency of information in their benefit/premia levels and adopt supplementary measures of the type proposed by FIPO that would support the remedy in achieving its aim.⁶
- 3.9 As FIPO has demonstrated, without the PMIs publishing their benefits levels in a comparative and understandable manner, combined with the PMIs' increasing restriction of patients' choice of consultant and hospital, the Consultant Fee Remedy cannot achieve the CMA's objective as it stands.

4 OPTIONS AVAILABLE TO THE CMA

- 4.1 FIPO reiterates its support for the CMA's Consultant Fee Remedy whose objective is to help patients make meaningful decisions about their choice of consultants based on consultants' prices and quality. The remedy as proposed by the CMA, however, does not achieve this objective. As noted above, it would address only the self-pay segment of the market, and would not benefit the majority, namely, the insured segment of the market.
- 4.2 FIPO submits that it is well within the CMA's powers to order a comprehensive remedy that at the very least requires the PMIs to publish benefit information alongside consultant fee information so that the patients can compare between PMIs before entering into a contract. FIPO does however accept that the CMA has some margin of appreciation in devising as comprehensive a solution as is reasonable and practicable to the AEC. Consequently, FIPO

⁶ An analogous dilemma arose for the Competition Commission ("CC") in relation to the proposed acquisition by Dräger Medical AG & Co KGaA of the Air-Shields neonatal warming therapy products business from Hillenbrand Industries Inc. Here the CC was unable to impose remedies that would apply to the contracting practices of overseas suppliers (being outside the jurisdiction). Instead it concluded that the most comprehensive and appropriate remedies to the SLC in these markets in the short and the long term could be achieved by a package of actions comprising a number of measures including recommendations to UK health departments and their procurement agencies designed to encourage market entry from overseas and the increased exercise of buyer power by trusts. See, further, *Dräger Medical AG / Air-Shields from Hillenbrand Industries Inc merger inquiry* (CC), 19 May 2004.

recommends an options-based approach across the spectrum of potential practicability and feasibility for the CMA depending on the CMA’s level of acceptance of FIPO’s Submission and its confidence that it has a sound legal and evidential basis for the supplementary measures (green representing the least modification to the existing remedy proposal, and red representing the greatest modification).

Option	Recommendation	Acceptability Indicator
Option 1: - Watching brief	The CMA acknowledges that there is possibility of the market changing materially, and the CMA is keeping a close eye on the PMI market but takes no action at this stage while noting that it will keep a watching brief over market developments.	No change
Option 2 – Voluntary measures: The CMA agrees with FIPO’s Submission that supporting measures are needed but believes that these should be PMI-led at this stage.	Recommend a voluntary code mechanism similar to those implemented in the Grocery Market Investigation and in relation to indirect access in payment systems. See Annex 1 for a summary of the Grocery Market Investigation where a supplier code was introduced progressively. See Annex 2 for a summary of how a code of conduct for indirect access was introduced in the payments sector	Least change
Option 3: The CMA accepts there are special reasons for supplementing the remedy within the meaning of Section 138(3) of EA02.	Supplement the Fee Consultation Remedy as per FIPO’s Submission to require <i>inter alia</i> the PMIs to publish benefits information and allow top-up fees/ direct billing.	Medium change

Option	Recommendation	Acceptability Indicator
<p>Option 4 – Market Investigation: The CMA accepts there has been material change of circumstances and/or the CMA believes the PMIs’ conduct, increased market concentration and profitability is reason for making a market investigation reference.</p>	<p>The CMA makes a market investigation reference relating to the private medical insurance market in the UK (whether immediately or if it is not satisfied that the implementation of a voluntary code of conduct achieves – or has achieved - the benefits that it envisages).</p>	<p>Most change</p>

Annex 1

Grocery Market Investigation Code of Practice summary

The Competition Commission (“CC”) published a report (under the monopolies provisions of the Fair Trading Act 1973) in October 2000, which came to two conclusions:

1. There was a complex monopoly situation relating to the pricing practices of a number of grocery retailers which operated against the public interest.
2. There was a complex monopoly situation in relation to the way in which the largest supermarkets treated their suppliers.

Between 2004 and 2005, the Office of Fair Trading (“OFT”) carried out a public consultation, which followed an earlier proposal by the OFT to refer the grocery market to the CC. Having evaluated the views of respondents to the consultation, the OFT concluded that there were a number of competition concerns that warranted a full investigation by the CC.

The OFT made the referral to the CC on 9 May 2006, with evidence compiled by the OFT suggesting that:

- The planning regime acts as a costly barrier to entry, making it difficult for new stores to open and compete with those already in the market.
- Big supermarkets have significant land holdings which could aggravate barriers to entry or otherwise harm consumers.
- In some instances, supermarkets have attached restrictive covenants when selling sites.
- There is also evidence to suggest that the big supermarkets’ buyer power has increased and that some aspects of their pricing behaviour – such as below-cost selling and price-fixing – could distort competition.

The CC was required to consider whether any feature, or combination of features, of the market (or markets) for the supply of groceries by retailers in the UK prevented, restricted or distorted competition in connection with the supply or acquisition of any goods or services in the UK or part of the UK.

In its final report, published on 30 April 2008, the CC recommended to the Government that a competition test be applied to grocery retail planning applications as part of a package of remedies to remedy the adverse effect of competition that it had found.

Remedies to address adverse effects in the supply chain

The CC required the establishment of a Groceries Supply Code of Practice (“GSCOP”), which amended the existing Code of Practice. This was the existing Supermarkets Code of Practice (“SCOP”), developed following an examination by the CC in 2000 into the buyer power of large supermarkets. This investigation found that five of the largest supermarkets had sufficient buyer power, whose practices adversely affected the competitiveness of some of their suppliers and distorted competition in the supplier market for the supply of groceries

In particular:

- It covered all grocery retailers with groceries turnover in excess of £1 billion a year.
- It included an overarching “fair-dealing” provision.
- It prohibited grocery retailers from making retrospective adjustments to terms and conditions of supply.
- It prohibited grocery retailers from entering into arrangements with suppliers that result in suppliers being held liable for losses due to shrinkage.
- It required grocery retailers to enter into binding arbitration to resolve any dispute with suppliers arising under the GSCOP.
- It required grocery retailers to keep written records of all agreements with suppliers on terms and conditions of supply.
- It required the grocery retailers to provide the body monitoring and enforcing the GSCOP any information that it requires to perform its functions.

It was felt that a *statutory* Code of Practice was needed for a number of reasons. These include the lack of prescriptiveness of the standards in the Code, and the apparent reluctance of suppliers to raise complaints under the Code, perhaps out of fear of commercial reprisals. This clearly demonstrates the unravelling of the voluntary code and the CC’s subsequent move towards a broader Code of Practice. The CC’s decision also led to the appointment of a Grocery Code Adjudicator (under the Groceries Code Adjudicator Act 2013) to arbitrate disputes between retailers and suppliers in relation to the GSCOP and to investigate complaints that the GSCOP had been breached.

Annex 2

Code of Conduct for Indirect Access to UK Payment Systems Summary

The principal aim of the voluntary Code is to improve the experience of Indirect Payment Service Providers (“Indirect PSPs”) by clearly setting out the responsibilities of Indirect Access Providers (IAPS) that subscribe to the Code. The original Code (published in September 2015) was developed by Payments UK (the Code Administrator) on behalf of the industry, working with the four current subscribing IAPs - Barclays, HSBC, Lloyds and RBS - and in consultation with the Payment Systems Regulator (“PSR”).

An enhanced version of the Code followed a formal consultation process with stakeholders including IAPs and Indirect PSPs. Consultation responses were shared with the PSR so it could consider industry views alongside its market review into indirect access. The PSR’s final report on indirect access was published in July 2016.

Since the Code’s launch in 2016, subscribing IAPs have taken steps to demonstrate alignment with the Code commitments. The Code Administrator declares that it will continue to monitor the effectiveness of the Code through compliance monitoring, and engaging with stakeholders and the PSR. This monitoring will include seeking feedback from interested stakeholders via a new Code Consultative Group.

Source: <https://www.paymentsuk.org.uk/news-events/news/code-conduct-indirect-access-uk-payment-systems-updated>