

PRIVATE HEALTHCARE MARKET REMITTAL

Scope of remittal

1. INTRODUCTION

- 1.1 HCA International Limited ("HCA") submits its preliminary comments concerning the remittal of the CMA's decisions in the private healthcare market investigation. In particular, these comments address: the scope of the remittal; the issues which the CMA will need to reconsider in its investigation; and the process and procedures which the CMA is obliged to follow to ensure transparency and fairness.
- 1.2 HCA has been granted permission to appeal to the Court of Appeal with regard to its application that the remittal investigation should be carried out by a newly-constituted inquiry group and case team, and with regard to its application as to costs. Although the Court has declined to grant a formal stay of the remittal investigation, HCA considers that the CMA should refrain from taking any further steps pending the outcome of HCA's appeal. HCA submits its preliminary comments without prejudice to this position.
- 1.3 The Competition Appeal Tribunal (the "Tribunal") has quashed the CMA's AEC finding in respect of insured patients in central London, and its divestiture remedy. The CMA is now required as a matter of law to reconsider its findings without any preconceptions. It must reconsider whether there are any features of the healthcare market (or markets) in central London which result in an AEC. It cannot confine itself to the flaws in its economic model and will need to reconsider its analytical framework as a whole.
- 1.4 The Tribunal's decision, overturning the CMA's central adverse findings and remedy in a market investigation, is unprecedented. It reflects serious failures by the CMA, throughout the original investigation, to undertake a fair and impartial investigation, consider the evidence, and engage properly and fairly with HCA and its advisers. It is precisely for these reasons that HCA is seeking a new inquiry group and case team, to restore its confidence in the CMA's decision-making process. It is essential that the CMA recognises and acknowledges these failures, and demonstrates its willingness and capability to carry out a fresh and impartial reconsideration of its findings.
- 1.5 HCA is focusing these preliminary comments on the CMA's reconsideration of the AEC finding in relation to insured patients. It would be unlawful for the CMA to begin with any assumption, either that there is an AEC, or that a divestment (or indeed any other) remedy should be imposed. If, and only if, the CMA identifies an AEC, it would then need to fully reconsider the question of remedies, including what remedies may be effective and

proportionate to address the AEC. HCA does not propose to comment at this stage on the scope of any consideration of remedies.

1.6 The key points set out in the submission are as follows:

- (i) The CMA has made serious errors in its insured price analysis ("IPA"), which is the central piece of evidence against HCA relied on in its Final Report. These errors have vitiated both its AEC finding and its divestiture remedy. The IPA has been comprehensively undermined and the CMA must undertake a full reconsideration of its analytical framework, methodology and findings.
- (ii) The flaws which HCA has identified do not simply relate to the computer coding and statistical errors which the CMA has conceded in the proceedings before the Tribunal. It would therefore be wrong and unlawful for the CMA to approach this remittal with the mind set of seeking to "fix" its previous economic model with a view to reinstating its previous decision. HCA's advisory team has identified a number of substantial analytical and methodological problems in the CMA's approach and its reliance on the IPA to support an AEC finding and divestiture remedy. It is essential that the CMA carries out a fresh and critical review of the IPA as a whole and of the conclusions which may properly be drawn from it.
- (iii) Furthermore, since the AEC finding in relation to insured patients and the divestiture remedy have now been quashed, it is incumbent on the CMA to look again at its structural findings concerning high concentration and barriers to entry in central London. The IPA cannot be viewed in isolation from other factors which, the CMA (wrongly) alleges, have led to higher prices to insured patients in central London. As the Tribunal has noted, a reconsideration of the IPA may well affect the reasoning behind the CMA's other findings in the Final Report. The IPA is closely interwoven with the CMA's reasoning as a whole.
- (iv) There have also been material developments in central London since the CMA published its Report, which cast serious doubt on its findings, for example on barriers to entry in central London.

1.7 As to the IPA, HCA briefly summarises in this submission the major methodological, conceptual and other flaws that comprehensively undermine the conclusions reached by the CMA on the alleged relationship between any observed price differences and concentration levels in central London.

1.8 The IPA does not show that there is a measurable price difference between HCA and TLC and actually directly contradicts the view that concentration drives higher prices.

1.9 In relation to measuring price differences, one key flaw is that prices are not being directly measured and instead the IPA uses price indices derived from aggregate charges for a given

patient. This means that the IPA is not able to compare prices on a like for like basis and instead different patient types and clinical approaches will drive price differences. Another key flaw is that even ignoring that prices are not correctly measured, there is no consistent finding of HCA charging higher prices as a significant number of price differences are not statistically significant.

- 1.10 As to a relationship between local concentration and prices, the IPA flaws are even more severe. First, the IPA shows that prices vary widely across insurers and (for the same insurers) over time, while according to the CMA, concentration does not change. This means prices changes are not driven by concentration. Second, the IPA provides no evidence of a causal relationship between concentration and price. The IPA does not test for alternative drivers of price differences. It does not assess differentials in quality or costs, nor does it account for differences in episode complexity. Instead it simply plots HCA's and TLC's concentration and "prices" on a chart. This provides no basis for the CMA's conclusion.
- 1.11 More generally, the IPA is entirely divorced from the assessment of relative bargaining power in negotiations between hospital operators and PMIs, even though it is attempting to understand the outcome and drivers of precisely those negotiations.
- 1.12 This submission also summarises the other substantive issues that the CMA will need to consider in the course of the remittal, including PMI bargaining power, the role of clinical quality, market definition, barriers to entry and profitability.
- 1.13 The CMA has a duty to ensure that it consults fully and fairly with HCA throughout the investigation. This remittal is taking place against a background of three prior Tribunal Rulings which have found the CMA's procedures to be unfair. The Tribunal has stated that the onus is on the CMA to undertake "*a genuine and effective reconsideration*", which affords HCA a proper opportunity to review and comment on the CMA's evidence to support any AEC findings and any resulting remedies.
- 1.14 HCA trusts that the CMA will consider carefully all of these points when determining the scope, process and procedures for the remittal investigation. HCA is committed to working closely with the CMA throughout this investigation and is confident that a fresh review of the available evidence will cause the CMA to reach a different conclusion.

2. BACKGROUND

- 2.1 In its Final Report, the CMA concluded that the market for the provision of private healthcare services in the UK was characterised by: (i) high barriers to entry and expansion for private hospitals, and (ii) weak competitive constraints on private hospitals in many local markets including central London.¹
- 2.2 The CMA found that these features in combination led to adverse effects on competition (“AEC”), which in turn led to higher prices being charged to both self-pay patients and PMIs.²
- 2.3 In relation to PMIs, the CMA attempted to carry out an empirical analysis of insured price outcomes (“insured price analysis” or “IPA”), on which the CMA based its conclusion that HCA is able to charge higher prices by virtue of the weak competitive constraints it faces in central London.³ The IPA was central to the CMA’s AEC finding in relation to insured patients. Outside of central London, where the CMA was able to consider more data points and compare results across different local areas, the CMA concluded that the results of the IPA were mixed and did not provide a sound evidential basis to support its theory of harm or proposed remedy. Some of the results were broadly consistent with its hypothesis that local substitutability plays a role in determining insured prices, while other results were not.⁴ By contrast, in central London the IPA sought to rely on a comparison of HCA’s prices with those of just one other hospital.
- 2.4 Despite this lack of evidence, the CMA used the results from its IPA to conclude that divestment by HCA was required in order to address the AECs in central London. It decided not to pursue any divestitures outside of central London.
- 2.5 The IPA, and the CMA’s interpretation of the results, therefore played a key role in the CMA’s decision to order HCA to divest some of its key assets. However, before and during HCA’s appeal of the CMA’s decision to the Tribunal, HCA’s economic advisors identified a number of substantial errors with the IPA calling into question its results. These were set out in particular in KPMG’s Data Room Report and in Professor Michael Waterson’s Expert Report.⁵
- 2.6 The CMA has accepted during the proceedings that there were a number of serious errors in the IPA which “*merit a remittal*” and that it will reconsider the IPA “*with an open mind*”⁶. It has conceded that there were two substantial computer coding errors, relating to the R-squared

¹ CMA’s Final Report, paragraph 6

² *Ibid.*, paragraph 7

³ *Ibid.*, paragraph 27

⁴ *Ibid.*, paragraph 6.382

⁵ See Nabarro’s letter of 8 October 2014 to TSol with the accompanying Reports

⁶ CMA’s Amended Defence, paragraph 94

statistic and the statistical significance testing. The CMA has also accepted that "*the precise extent, impact and effect*" of all the errors which HCA has identified "*are properly matters which are to be considered afresh upon remittal.*"⁷ Taken together, these errors are indicative of serious methodological and analytical shortcomings that raise fundamental questions about the probative value of the IPA.

2.7 In its Ruling of 23 December 2014 (the "Ruling"), and its Order of 12 January 2015, the Tribunal has:

- quashed the CMA's AEC finding in respect of insured patients in central London;
- quashed the CMA's divestiture remedy requiring HCA to divest two of its facilities in central London;
- remitted the AEC finding in respect of insured patients and the divestiture decision for reconsideration by the CMA.

⁷ Ibid

3. REMITTAL

- 3.1 HCA welcomes the CMA's assurances that it will consider afresh the IPA and that it will reconsider "*with an open mind*" not merely the particular computer coding errors which it has expressly conceded in these proceedings, but also all of the flaws which HCA's advisory team has identified. The specific errors which the CMA accepted during the litigation are only part of the picture and HCA's advisers have identified a number of substantial flaws. These include the numerous methodological errors which were set out in KPMG's Data Room Report and in Professor Michael Waterson's Expert Report, and in HCA's various earlier submissions during the course of the inquiry.
- 3.2 The CMA has relied on the IPA as the foundation for an AEC finding in respect of insured patients and its divestiture remedy. The Tribunal has noted that the IPA is central to the CMA's insured AEC finding and remedy: "*It will be important in the context of the present case to be able to examine carefully the basis for the CMA's conclusion that the relationship between market share and prices is causal, and that issues regarding whether – in constructing the IPA – prices have been correctly measured and comparisons have been performed on a suitable like-for-like basis (even allowing for a significant margin of evaluative judgement on the part of the CMA at each stage in the process of investigation and analysis) are capable of being illuminated by HCA ...*"⁸
- 3.3 The Tribunal has also found that if the specific computer coding errors (and setting aside all the other methodological flaws which HCA has identified) are found to undermine the validity of the IPA: "*that would mean that a key part of the statistical reassurance one may have that it is safe to rely on the parameter estimates could be removed and the IPA could not properly be relied upon as a basis for any insured AEC decision as the basis for any divestment decision*" and that in consequence there is a prospect "***that no insured AEC decision or finding could be made and also a real prospect, therefore, that no new divestment decision should be made.***"⁹
- 3.4 It is therefore incumbent on the CMA to carry out a fresh review of the IPA which is the cornerstone of the AEC finding underlying the divestiture remedy. The CMA must be prepared to undertake a full, genuine and critical reconsideration of this analysis. It would be wholly wrong for the CMA to seek to "reverse engineer" the same findings by manipulating the results of the IPA. The CMA has a statutory responsibility to reconsider carefully its analytical framework as a whole. If, on reconsideration, the CMA's empirical analysis does not provide clear evidence of the existence of higher prices in central London that can be explained only by levels of market concentration, the CMA simply cannot reach an AEC finding.

⁸ Tribunal's Ruling (Application for disclosure) of 25 July 2014, paragraph 37

⁹ Tribunal's Ruling of 23 December 2014, paragraph 12

- 3.5 It is not the purpose of this submission to explain the methodological flaws and errors in the IPA: these have been set out in some detail in the KPMG Data Room Report and Professor Waterson's Expert Report. However, HCA briefly summarises below (section 4) major errors in the IPA which will in particular need careful reconsideration in the remittal.
- 3.6 However, the remittal cannot properly reconsider the IPA in isolation from the CMA's broader findings, in particular its findings that there are structural features in the form of weak competitive constraints and high barriers to entry in central London which, it alleges, give rise to higher prices to insured patients. There are three reasons for this.
- 3.7 First, the consequence of the Tribunal's Ruling and Order is that the AEC decision in respect of insured patients and the divestiture decision have been quashed in their entirety. The Tribunal has not simply quashed the IPA findings or aspects of these findings. The CMA cannot therefore re-adopt these decisions without carefully reconsidering whether there are structural features which "*in combination*" give rise to an AEC leading to higher prices being charged to insure patients in central London. The Tribunal has stated that the CMA must "*re-determine the question whether any new insured AEC decision should be made and whether any new divestment decision should be made*"¹⁰. These are matters on which HCA will wish to make detailed representations in response to the CMA's findings in the Final Report, and the CMA has a duty to consider its submissions and take these into account in any new decisions.
- 3.8 Secondly, the Tribunal has pointed out that it is not possible or practicable for the CMA to reconsider the IPA in isolation from the CMA's broader findings which led to the AEC decision and divestment remedy:
- (i) The CMA is obliged to consider the extent to which any further work in relation to the IPA impacts on other aspects of the Final Report: "*The CMA will have to consider what impact the new information and representations it received in relation to the IPA has upon the existing statements of reasoning contained in the Final Report with respect to those decisions.*"¹¹
 - (ii) The Tribunal has specifically pointed out that the CMA must also direct its mind to whether revisions to the IPA "*have an indirect knock-on effect on the reasoning in relation to the self-pay AEC decision ... and the implications it may have for the overall reasoning in the Final Report.*"¹²
 - (iii) The Tribunal has also noted that there is considerable integration and inter-linkage between the IPA and other aspects of the Final Report and that the CMA will need

¹⁰ Ibid, paragraph 56

¹¹ Ibid

¹² Ibid, paragraph 60

to "integrate new findings in respect of the IPA into the existing reasoning in the Final Report, and to understand how that reasoning should be adjusted in the light of the further consideration."¹³

- (iv) Furthermore, the CMA has itself accepted that there were some limitations to the robustness of the IPA, which "highlight the need to consider this evidence in the context of the other evidence", i.e. noting that the IPA could not be viewed in isolation.¹⁴

3.9 Thirdly, the Tribunal has also confirmed that the CMA must "understand and take account of the impact of any material changes in circumstances upon the decisions that have been made ... or future decisions which may be made (in part by reference to existing reasoning in the Final Report)."¹⁵ The Final Report was adopted on 2 April 2014, based on the CMA's fact-finding during the investigation period, which included an analysis of data (including pricing) going back several years. There have been significant developments in central London, not least in terms of market growth, new entry and expansion and quality initiatives. In many cases, a significant amount of time has elapsed since the CMA originally considered the evidence which informed its findings. The CMA has a duty to consider the extent to which material changes in circumstances ("MCCs") have affected its findings of structural features in central London.

3.10 It would therefore be misconceived to characterise the remittal in terms of a "narrow" versus a "broad" remittal, as the CMA appeared to be contending in the proceedings before the Tribunal¹⁶. The CMA is required to consider the statutory question whether there are features of the market that result in an AEC. The IPA is at the heart of the insured AEC finding and divestment remedy, and therefore a review of the IPA will be centre stage in the remittal. However, that review needs to take account more generally of the CMA's reasoning and findings which either impact on the IPA, or which are themselves affected by any reconsideration of the CMA's analysis of pricing. The CMA would not fulfil its statutory duties if it adopted a "narrow" approach which merely reconsiders the IPA without also considering the broader context of the CMA's findings.

3.11 HCA has therefore also highlighted below (section 5) the various findings which will need to be reconsidered by the CMA, the inter-linkage with the IPA, and their relevance to the remittal.

3.12 Finally, HCA also raises an issue with regard to the geographic scope of the remittal investigation. The Tribunal has ordered a remittal of the insured AEC finding and divestiture

¹³ Ibid, paragraph 88(a)

¹⁴ Final Report, paragraph 6.344

¹⁵ Ibid, paragraph 88(b)

¹⁶ See e.g. the CMA's skeleton argument for the hearing on 15 December 2014

remedy, both of which relate to HCA's position in central London. The CMA is therefore required to re-examine its findings concerning central London. There has been no insured AEC finding in relation to hospital operators outside central London. However, the CMA has a duty to ensure that HCA is treated on a fair and non-discriminatory basis alongside other hospital operators. The CMA cannot therefore make adverse findings against HCA on the basis of a revised analysis (including, for example, a revised IPA) which treats HCA differently to other hospital operators such as BMI, Spire, Ramsay or Nuffield. HCA would have grounds for challenge against any revised AEC finding or remedy which failed to treat HCA comparably or which applied a methodology or analytical framework to HCA in central London which is different to that which the CMA has applied to other operators outside central London.

4. KEY ISSUES IDENTIFIED DURING THE DATA ROOM IN RELATION TO THE IPA

4.1 In the Data Room,¹⁷ HCA's economic advisors identified a number of major errors with the IPA. While there were a large number of errors identified,¹⁸ HCA summarises those which are particularly relevant to determining the scope of issues that the CMA will have to consider during the remittal process:

- The fit of the regressions (the "R² statistic") was overestimated. This means that a large part of observed variability in episode charges cannot be explained by the patient characteristics that the CMA included in its model. The CMA, therefore, cannot be confident that it is conducting a meaningful "like-for-like" comparison of episodes and thus of episode charges. This calls into question the ability of the analysis to properly estimate any potential price difference.
- This is further highlighted by the fact that in some cases the prices predicted for some treatments in the IPA were irrational. In a number of cases, the CMA's analysis predicted prices that were negative, missing, or not consistent with the data used to predict them. Additionally, HCA's economic advisors identified a substantial number of treatments where the estimated price difference between the two operators was potentially irrational, with some price differentials being over 100%. The CMA, therefore, is not accurately measuring "prices" for fairly homogenous services. On the contrary a large proportion of the price difference is left unexplained, and many price differences are erroneously calculated, calling into question the ability of the analysis to properly estimate any meaningful price differential.
- The statistical significance of estimated price differences was overestimated. Once this error is corrected, the IPA does not identify a price difference for certain PMIs across a number of years.
- Related to the previous point, the CMA's analysis shows large variability of price differences between HCA and TLC, across PMIs and across years, while the CMA was not aware of factors that would have substantially affected the shares of

¹⁷ During the appeal, HCA's advisors were granted access to the raw data and computer code used by the CMA to perform its IPA analysis. This access was granted between 18 August 2014 and 18 September 2014 at the CMA's office in a Data Room.

¹⁸ HCA's economic advisors identified a number of errors in the CMA's processing of the raw data. These included the incorrect measurement of patient age, errors in the removal of consultant fees from the episode "price", failure to exclude non-central London HCA hospital episodes and "price", errors in the identification of the representative patient for central London, and failure to exclude ancillary fees.

supply during the time period of the IPA.¹⁹ This is inconsistent with the CMA's hypothesis that local market concentration drives the observed price differences.

4.2 These errors are all the more significant as they are compounded by a number of serious shortcomings which further undermine the reliability of the IPA.

- In relying on episode charges, as recorded by Healthcode, the CMA fails to take into account discounts provided to PMIs, or the shortfalls that the PMIs do not pay to HCA. Healthcode data reports the charges that operators request from the PMI for specific invoices, it does not represent the final amount paid by the insurer to the operator for the service.
- Given the wide differences in the range services offered by HCA and TLC, a small basket of overlapping treatments is not representative of either operator, rendering the CMA's results uninformative. This effect is particularly relevant given the way in which hospital operators negotiate prices with PMIs. They do not focus on each treatment type in detail – which would be impracticable – but the range as a whole. Against this background, the tiny sample of treatments analysed by the IPA does not give a fair reflection of the overall picture.
- Furthermore, the IPA does not take into account patient acuity and the complexity of the treatment offered. Patients with more acute or complex conditions are necessarily more difficult (and therefore potentially more expensive) to treat. It is likely that HCA receives more difficult or more acute patients due in part to the breadth of services it offers. To provide one example, a patient with a pre-existing heart condition which may cause a complication during another procedure will likely not be treated at TLC as it does not offer cardio-vascular care. The reason why the IPA cannot account for these differences is that it relies on CCSD procedure codes as the basis for comparing prices. These codes can be misleading. A patient admitted for one treatment may receive treatment for a number of conditions in addition to the primary procedure received. To give a real example, one HCA patient who was classified as receiving a colonoscopy was in the hospital for over a month and received multiple rounds of chemotherapy treatment. Owing to the way Healthcode data is presented, this patient episode is listed as an extremely expensive colonoscopy, when it was obviously far more. The IPA, therefore, does not recognise that the CCSD procedure codes do not necessarily fully reflect the treatment provided and that differences in how operators code their procedures could lead to systematic differences in episode charges. Simply controlling for length of stay and patient age is not sufficient to

¹⁹ CMA's Final Report, paragraph 6.349, footnote 463

differentiate complex patients and therefore to correctly account for episode cost drivers. This was further emphasised by the CMA having overestimated the R² statistic in its regressions.

- The IPA compares HCA's "prices" with only one competitor, *i.e.* TLC (which the CMA considers to be HCA's closest competitor despite material differences between the two operators). It is wholly inadequate to compare HCA with only one other operator when other information is available.
- The IPA does not take into account the significant cost differences faced by HCA and TLC. In particular, TLC enjoys charitable status. This gives it a significant tax advantage. Also, TLC owns its current premises and has done so for many years. This gives it a further cost advantage over HCA. The CMA's argument that the costs differences not factored into its model were "*likely to be small and/or not affect pricing decisions*" is no answer to these unavoidable realities.²⁰

4.3 Professor Waterson's independent Expert Report concluded as follows: "*Based upon the identified and clear errors in the CMA's analysis of the data, their formerly clear conclusion that HCA set its prices significantly higher in the central London market than does TLC is cast into serious doubt and in my view needs re-examination taking into account the key points, including obviously errors, that the KPMG team have uncovered and been able to pursue in the Data Room.*"²¹

4.4 The CMA itself acknowledged that "*as a result of certain errors identified by HCA's advisers, it made a procedural error by not re-consulting with HCA on its [IPA], which the CMA had revised following an earlier consultation during the investigation. The CMA submitted to the CAT that the most appropriate course of action would be for the matter to be remitted to it to consider further representations on the [IPA].*"²²

4.5 A consideration of the IPA in isolation, following the correction of the errors identified, clearly shows the complete lack of support for an AEC finding or a divestment remedy. The errors identified show that the CMA cannot rely on the IPA as a meaningful way of measuring insured prices. The IPA does not identify a reliable price difference that could form the basis of any benefit calculation. However, even if the CMA thought that the results of the corrected IPA were informative of price differences, the corrected results demonstrate that local market concentration cannot possibly drive prices in the way hypothesised by the CMA and thus there is no support for a divestment remedy.

²⁰ The Final Report, paragraph 6.368.

²¹ Expert Report, paragraph 59

²² See <https://www.gov.uk/government/news/cat-ruling-on-private-healthcare-remittal>

4.6 The CMA recognised, albeit in the last stages of its inquiry, that the IPA results outside central London could not support an AEC finding. The CMA acknowledged that the "*insured price results were mixed across insurers and by insurer and, together with the remaining evidence, were insufficient to make a findings that local concentration ... was leading to higher insured prices*".²³ The Chairman of the CMA inquiry group, Roger Witcomb, conceded in a press interview that the variability in prices across different operators and across different regions meant that the CMA was "*not able to be confident that local monopolies were charging higher prices*" and that "*getting a robust result in the insurer patient market was more problematic*".²⁴ The errors in the IPA in relation to central London demonstrate in similar vein the difficulties in placing reliance on a price comparison in order to make findings that local concentration gives rise to higher prices. Even correcting for the factual errors, the IPA does not provide a sufficiently robust basis on which to found an AEC or divestment remedy.

4.7 If the CMA, despite the errors identified in the IPA, persists with its theory of harm that there is a causal relationship between insured prices and local concentration, the CMA would necessarily need to take into account a number of additional issues. These areas have been set out by HCA's economic advisors in KPMG's Data Room Report and can be broadly grouped into four areas:

- First, the CMA will have to take into account patient-specific clinical information when comparing insured prices. In its regression analysis, it only used information on patients' age, gender and length of stay, noting that these were the only patient-specific characteristics available in the raw data and that these characteristics were enough to explain almost all observed price variability. However, the errors identified show that these variables alone cannot explain price differences and therefore the CMA will need to explore alternative ways of conducting a like-for-like comparison. This will include exploring to what extent any differences between HCA's episode prices and those charged by its competitors are driven by the different mix of services (line items) provided during an episode. This may also include using additional variables already included in the Healthcode data, such as the primary diagnosis code assigned to the patient, which may be informative of the severity of the condition the patient was being treated for. Additionally, the identity of the specialist who first saw the patient may give some insight into the medical speciality the patient had been admitted through.
- Second, the data room analysis emphasised that the common basket is not representative. The CMA will need to consider the entire sets of treatments

²³ Final Report, paragraph 6.494

²⁴ Health Investor, May 2014, p.31.

provided by HCA and the hospital operators it is compared with to ensure that any price difference estimated is not simply an artefact of the incomplete picture the common baskets afford.

- Third, similar to its analysis of insured prices outside of central London, the CMA would need to consider a number of other competitors to HCA to ensure that any link between estimated price differential and local market concentration is robust to changes in the hospitals HCA is being compared with. In the Final Report, the CMA argued that TLC is HCA's closest competitor in central London. However, during the remittal it will need to reassess whether there are other hospital operators that compete closely with HCA, perhaps in a subset of specialties. No finding of causality can be supported by an analysis of just two data points on price and quantity, and any finding of causality for central London would necessarily need to be reconciled with the finding on the same issue outside of central London from both a theoretical and empirical perspective.
- Professor Waterson's independent Expert Report has emphasised this fundamental difficulty with the CMA's analysis: "*In my view, **there is nothing specifically in the econometric/statistical analysis of the central London market that enables one to say that the higher market share of HCA than TLC leads to higher prices for HCA than TLC.** By the same token, there is nothing in the econometric/statistical evidence that enables one to assert that reducing the market share of HCA will lead to a reduction in its prices.*"²⁵
- Finally, given the variability of price differentials that the CMA estimates across years, the CMA would need to test whether factors other than local market concentration (which does not change from year to year) were driving any estimated price differentials. The main candidate to explain price differences is the quality of services provided and the CMA will not be able to support a finding of causality without a full and rigorous assessment of competition in quality including product and service innovation, operational quality, clinical pathways etc. Additional factors will also need to be explained, including cost differences. The identification of appropriate competitive constraints will also need to be reviewed.

4.8 In the next section, HCA provides some details on the further analysis required and the areas of inquiry that the CMA would need to assess during the remittal inquiry, and how each of these is linked to the CMA's (flawed) IPA.

²⁵ Expert Report, paragraph 60

5. OTHER KEY AREAS THAT THE CMA WILL NEED TO CONSIDER DURING THE REMITTAL

Bargaining

- 5.1 In its Final Report the CMA found that hospital operators and PMIs were dependent on each other and therefore concluded that both sets of parties had some degree of bargaining power.²⁶
- 5.2 The errors in the IPA highlight significant variability in prices across time and insurers that cannot be captured by different levels of concentration. The lack of precision in identifying prices, together with the obvious inconsistency between price variability and concentration level, mean that if the CMA aims to test whether there is any link between concentration and insured prices it needs to fully explain how this emerges out of the bargaining process.
- 5.3 Additionally, market developments suggest that the PMIs' bargaining power may have increased in recent years. Continued development of managed care pathways, open referral products, the increased ability for PMIs to control the recognition of new hospital facilities, the use of policy networks, and ability for PMIs to steer patients (including to the NHS through the use of cash-backs), changes to the competitive landscape, and the growing prevalence of PPU's in central London (providing additional outside options to PMIs) have all contributed to a stronger bargaining position of PMIs in relation to HCA.
- 5.4 Without quantitatively assessing the impact of these developments, and assessing drivers of bargaining strength in the context of a proper bargaining framework, the CMA cannot be confident that any estimated price differential is in fact due to any difference in local concentration.

Quality

- 5.5 In its Final Report, the CMA concluded that it would have been extremely difficult to assess quality in relation to the provision of private hospital services, as there was a lack of objectively comparable quality measures.²⁷
- 5.6 The results of the corrected IPA, however, show that to the extent that any meaningful price difference can be described on a like-for-like basis (which does not appear to be the case in the corrected IPA) this is inconsistent with concentration being its key driver. As stated above this implies that alternative drivers, including quality, need to be explored fully.
- 5.7 In order to do so, the CMA needs to examine measures of hospital quality, the cost of providing quality health care, and differences in patient mix. There have been significant

²⁶ Ibid., paragraph 6.317

²⁷ Ibid., paragraphs 6.437

developments, for example in relation to the introduction of ICD-10, which allow for the tracking of differences between patients in co-morbidities.

5.8 Specifically, in relation to quality, the CMA needs to consider, and incorporate into its analysis of insured prices, both:

- direct measures of quality, including patient outcomes and the benefits arising from offering integrated pathways; and
- indirect measures, including investments and the type of information gathered by different hospital operators.

Market definition

5.9 The CMA interpreted the evidence from the IPA as consistent with local substitutability (proxied by local market shares) being a key determinant of insured prices.²⁸ As such, the way in which the CMA defined the product and geographic scope of the markets played a key role in the conclusion drawn by the CMA on the IPA. The CMA also considered concentration levels and HCA's market shares in particular to evaluate alternative divestment remedies.²⁹

5.10 The inconsistent relationship between estimated price differentials and local market shares that is highlighted in the corrected IPA means that the CMA needs to reconsider its conclusions on both the product and geographic boundaries of the relevant markets, and undermines any confidence that the CMA may place on its findings. In addition, the CMA will also need to take into account developments that may have occurred since the original market inquiry. In order to do this, the CMA needs to re-assess a number of issues.

5.11 First, the CMA needs to review the competitive constraint posed by the NHS on the privately-funded healthcare sector, especially in London. This constraint is particularly relevant when it comes to assess the factors that influence a private hospital operator's decision to invest in higher quality of care and new treatments to keep up with, or stay ahead of, the NHS. Throughout the inquiry HCA put forward detailed evidence of the competitive constraint posed by the NHS,³⁰ including the multiple ways in which this interacts with the privately-funded healthcare sector.³¹ Despite stating that this constraint was considered in the Final Report, the CMA did not provide any evidence showing how this assessment was conducted and the results it yielded. As mentioned above, the CMA will also need to assess any MCCs

²⁸ CMA's Final Report, paragraph 6.381

²⁹ Ibid., paragraphs 11.77-11.85 and 11.112-11.132

³⁰ See, for example, HCA's Response to PFs, paragraphs 5.19-5.28

³¹ Ibid., paragraphs 5.19-5.28

in relation to schemes offered by PMIs to their policyholders which encourage the use of NHS providers.

- 5.12 Second, in order to appropriately identify the geographic and product dimensions of the market, the CMA will need to carry out a proper assessment of the outside options that each PMI has when it comes to negotiate their contractual terms with HCA. This would provide the CMA with a clear indication of which hospital operators each PMI sees as alternatives to HCA.
- 5.13 Third, the CMA will need to investigate the MCC which is represented by the increasing use of open referrals by Bupa (and potentially other insurers). Open referrals give PMIs the ability to steer their patients to different operators and their increasing use has the potential to change the relevant geographic market (if PMIs steer patients to hospitals outside of central London). It also has the potential to change the mix of patients treated at each operator, increasing the difficulty of making an appropriate like-for-like comparison of insured prices.
- 5.14 Fourth, the CMA will need to investigate the extent to which HCA's evolving competitive landscape, both domestic and international, will have impacted on its findings as to the geographic scope of the market.

Barriers to entry

- 5.15 In its Final Report, the CMA concluded that a combination of high sunk costs, the lack of availability of suitable sites, the difficulty in obtaining planning permission, and long lead times associated with developing a private hospital constituted barriers to entry and expansion in central London.³²
- 5.16 Having reassessed the boundaries of the relevant markets based on the competitive constraints set out above, the CMA would need to reassess the existence and the extent to which the factors above still constitute significant barriers to entry and expansion.
- 5.17 In doing so, the CMA also needs to take into consideration any MCCs that may have occurred, including, for example, the development of any new sites for private healthcare facilities. As stated above, the private healthcare market is growing, there are new PPU developments, more sites are becoming available from the NHS, and there are a growing number of new entrants. All of these are matters on which HCA will submit further evidence.

³² CMA's Final Report, paragraph 22

Competition for self-pay patients

- 5.18 In its Final Report, the CMA concluded that prices for self-pay patients were generally set locally and, vary across a hospital group's portfolio of hospitals depending on the degree of local concentration.
- 5.19 Some of the problems affecting the IPA also apply to the PCA, including not fully taking into account the impact of quality and complexity on prices. Many of the MCCs that are relevant to the CMA's assessment of the various areas set out above will need to be factored into its analysis of self-pay prices. As stated above, the Tribunal has specifically stated that the CMA will need to consider the extent to which any flaws in the IPA impact upon the reasoning supporting the AEC finding in respect of self-pay patients.
- 5.20 Furthermore, HCA notes that the CMA seeks to "read across" findings relating to self-pay patients into the IPA: in paragraph 6.378 of the Report, the CMA asserts that the self-pay PCA *"also provides some support for the existence of an analogous relationship between local concentration and prices in the PMI segment."* It is therefore difficult to see how the CMA can avoid re-examining its findings relating to self-pay patients when reviewing the IPA.

Impact of other remedies

- 5.21 The CMA will need to consider to what extent the other remedies ordered during the market investigation have had a material impact on the market for private health care. These include the increased transparency of data on quality, and the new PPU remedy. The CMA will need to assess the impact that these other remedies are having, and will have in future, and whether these mitigate or remove any structural features of the market.
- 5.22 The CMA adopted the Private Healthcare Market Investigation Order 2014, which implements inter alia the information remedy in relation to hospital operators. This remedy, on the CMA's own analysis, *"should serve to stimulate competition between hospitals and between consultants over areas of performance that matter to patients."*³³ It follows from the CMA's analysis that this remedy is likely to have a particularly marked effect in London, and the impact of this new measure will therefore need to be taken into account in the CMA's assessment of competition in central London.

Profitability

- 5.23 The CMA stated in the Final Report³⁴: *"our finding of excess profitability suggests that the price of private healthcare services may be high in relation to costs incurred by private*

³³ Final Report, paragraph 11.576

hospital operators in providing those services, and thus higher than we would expect to find in a competitive market."

- 5.24 Plainly, in the light of the flaws in the IPA, which do not disclose any evidence that there are significantly higher prices in central London than would be the case in a more competitive market, the CMA will need to reconsider its findings on profitability and their relevance to the AEC finding.
- 5.25 HCA will also wish to provide the CMA with submissions on the flaws in the CMA's methodology in assessing profitability.

³⁴ Final Report, paragraph 6.476

6. PROPORTIONALITY

- 6.1 As stated above, HCA's initial comments relate to the reconsideration of the AEC finding for insured patients. Clearly, if the CMA were to re-adopt the AEC finding in relation to insured patients and consider that remedies are appropriate, it would have to consider afresh what (if any) remedies were appropriate, and it would need to fully consult on any remedy proposals.
- 6.2 The flaws in the IPA have a direct impact on the CMA's case that divestment is a proportionate remedy. The CMA's failure to establish that there are any significant price differences between HCA and TLC means that its proportionality assessment is no longer applicable.
- 6.3 Further, the CMA has conceded that it has made significant arithmetical errors in calculating the likely price impact of divestiture.³⁵ The CMA has therefore seriously over-estimated the alleged price benefits of its previous divestiture remedy, and this will also require reconsideration.
- 6.4 The CMA would also need to give proper consideration to the question of what remedies are effective and proportionate, including non-divestiture options. The CMA's original remedy, involving the divestiture of approximately one-third of HCA's business with a potential value [REDACTED], was grossly disproportionate. Even if the CMA believes that divestiture remains appropriate and proportionate (which HCA vigorously refutes), it must give HCA a full and fair opportunity (which it did not have in the original investigation) to comment on the CMA's proposals and to put forward alternative proposals for consideration. The CMA failed, for example, to hear HCA's views on the configuration of any divestiture package, or on the need to include specialist services e.g. neurorehabilitation or fertility services.
- 6.5 HCA will submit further comments at the appropriate time if there is a "remedies" phase in the remittal investigation.

³⁵ Letter from TSol to Nabarro dated 29 October 2014

7. PROCESS

7.1 There have been serious procedural failings throughout the course of the CMA's private healthcare market investigation, and the CMA has persistently failed in its duty to consult fairly with HCA:

- (i) The Tribunal initially found that the CMA's approach to disclosure following its Provisional Findings in 2013 "*was a breach of the rules of natural justice in comprehensively failing to give the Applicant a fair opportunity to correct or contradict the Commission's Provisional Findings ... or to make worthwhile representations*" and "*were fundamentally flawed*".³⁶
- (ii) Further, the CMA wrongly rejected HCA's application for disclosure of the IPA following the Final Report. The Tribunal ruled that "*HCA would be hampered in presenting its case with proper force and effect in these proceedings without having access to the underlying data and the modelling, and that this would be unfair to it in the context of this litigation.*"³⁷
- (iii) The CMA has conceded HCA's appeal on ground 1, that it failed to consult HCA on the revised IPA.

7.2 The Tribunal has recognised the highly unsatisfactory way in which the CMA has handled this investigation, and has directed the CMA to: "*give very careful consideration to the requirement of fairness to HCA and other affected parties in working through the practical steps to **undertake a genuine and effective reconsideration.***"³⁸

7.3 On the two previous occasions on which HCA has been granted disclosure by the Tribunal, HCA's advisers have been able to identify serious shortcomings in the CMA's methodology. Against this background, there is a heavy burden on the CMA to be fully transparent during the remittal investigation and to allow full access to any new pricing model it proposes to rely on.

7.4 It is therefore essential that the CMA respects the principles of fairness and natural justice and consults fully and fairly with HCA in the course of this remittal.

7.5 The CMA must at a minimum ensure as follows:

- (i) HCA is given full and timely access to any revisions to the IPA, including the underlying raw pricing data, if necessary in a data room. It must be given adequate time for its advisers to analyse and comment on the data, without unjustified

³⁶ *BMI v. CMA* [2013] CAT 24, paragraph 74

³⁷ Tribunal's Ruling (Application for disclosure) of 25 July 2014, paragraph 35

³⁸ Tribunal's Ruling of 23 December 2014, paragraph 89

restrictions. The Tribunal ordered the CMA to open the data room during the proceedings for a month, and HCA would expect at least a similar duration for the review of pricing data in any further data rooms which the CMA creates during the remittal. Furthermore, in accordance with the Tribunal's judgement in *BMI v CMA*, the data room must be accessible throughout the consultation period to allow HCA's advisers to make successive visits at different stages of the investigation.³⁹

- (ii) HCA must also be provided with sufficient opportunity to respond to any new findings, together with reasonable timescales.
- (iii) There must be full disclosure of submissions made by third parties. HCA has previously expressed concern about the CMA's lack of impartiality in dealing with evidence from PMIs, for example by failing to disclose third party evidence in time for HCA to respond. It is essential that the CMA upholds the principle of transparency so that HCA can see, and address, the case which is being presented by insurers and competitors.

7.6 During the recent litigation, the CMA repeatedly placed emphasis on the constraints of the statutory timetable, and this appears to have affected many of its procedural decisions e.g. its decision not to disclose the revised IPA to HCA following the Provisional Decision on Remedies. This is plainly unacceptable. The CMA must ensure that it handles its procedures efficiently and affords HCA a proper opportunity to review the CMA's findings and respond. It cannot use lack of time as an excuse for failing to provide full disclosure and carry out a proper consultation. In any event, these statutory constraints no longer apply. There can therefore be no excuse for failing to offer HCA sufficient opportunity to examine the evidence and make submissions.

7.7 The CMA has briefly referred in its letter of 23 February 2015 to a two-stage consultation process. HCA has a number of preliminary comments:

- (i) The CMA should ensure from the outset that HCA's advisory team has full access to the IPA which was the subject-matter of the recent proceedings. HCA rejects the CMA's argument that it is unnecessary to provide HCA with renewed access "*at this stage in the remittal process*" to allow HCA to make representations. Although HCA's advisers have previously seen the IPA, this was for the limited purposes of a judicial review of the CMA's decisions, based on the judicial review standard of irrationality. Unless the CMA abandons the IPA model, HCA should be granted renewed access to make further representations in the context of a full re-investigation of the merits of the IPA. Furthermore, the CMA itself has requested responses to questions concerning the KPMG Data Room Report. HCA's advisers

³⁹ *BMI v CMA* [2013] CAT 24, paragraph 73

cannot fully respond to these questions without having an opportunity to re-access the original data.

- (ii) If the CMA wishes to avoid the cost of a further data room, it can simply make available the "raw" and "clean" data sets forming the IPA on disc for HCA's external economists to review. The restrictions in the CMA's confidentiality undertakings are sufficient to protect the confidentiality of the data outside a data room environment.
- (iii) HCA also invites the CMA to hold an early meeting between HCA's economic advisers and the CMA's economics team. The fundamental flaws which HCA has identified in the IPA might well have been averted by a better level of engagement and dialogue between HCA and the CMA, and in particular their respective economics teams. HCA therefore strongly suggests that there is an early meeting between economists to discuss the CMA's proposed methodology for a re-examination of the IPA.
- (iv) Unless the CMA abandons the IPA model altogether, the CMA must ensure that there is adequate time for HCA and its advisers to prepare submissions relating to the IPA and to the range of related areas which are discussed above, well before the CMA presents its initial views following its reconsideration of the IPA.
- (v) Finally, we note the CMA's comment in the letter that "*the CMA has not made any decision on whether it may be appropriate to grant access to a data room in due course.*" This CMA is referred to the comments above. If the CMA intends to rely on an economic model as part of the evidential base for findings against HCA, it must disclose it. The CMA's obligations have now been fully and clearly set out in three prior Tribunal decisions. The Tribunal's judgment in *BMI v. CMA* make it clear that a data room must be accessible throughout the whole consultation period to allow HCA's advisors to make successive visits at different stages of the investigation. If the CMA makes adverse findings, HCA has a right of access to any revised analysis at the earliest opportunity, and certainly in good time for HCA to make appropriate submissions, and well before the CMA proceeds to any Provisional Findings. HCA notes and welcomes the recent comments by the CMA's Director of Mergers and Markets⁴⁰ that the CMA has learned "*some very important lessons*" on how to handle data disclosure as a result of the Tribunal's decisions in the private healthcare market inquiry, and trusts that the CMA will comply with its disclosure obligations.

⁴⁰ Reported in MLex: "*UK authority "learned lessons" from data disclosure in healthcare review*", 26 February 2015

7.8 HCA will comment in more detail on the investigation process once the CMA has published its proposed administrative timetable and procedures for the remittal investigation.