Adventist HealthCare
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11 Feb 2021

By Email: exemptions@accc.gov.au

Mr Darrell Channing
Director - Competition Exemptions Branch
Australian Competition & Consumer Commission (ACCC)
Level 17 | 2 Lonsdale St Melbourne VIC 3000

Attn: Mr Michael Pappa,

RE: Honeysuckle Health and nib application for Authorisation AA1000542 — interested party consultation

I refer to your letter of 12 Jan 2021 inviting comments of interested parties on the Honeysuckle application and granting to Adventist HealthCare Limited (AHCL) of an extension for submission until 15 Feb 2021.

It is noted that:

1. Honeysuckle Pty Ltd (HH) is a 50/50% joint venture between nib health fund limited and Cigna Corporation (a US Health Service Operation).
2. The authorisation sought is for 10 years that HH may form and operate a buying group to collectively negotiate and administer contracts with Health Care providers on behalf of participants (Health Insurers and other purchasers of health services).

Adventist HealthCare Limited (AHCL), ABN 76 096 452 925 was established in one of its earlier forms in 1903 and operates the largest private hospital in NSW at Wahroonga - comprising of 524 overnight beds, 19 theatres and the largest private emergency departments (ED) in NSW (only 3 private EDs in NSW). We also operate a day facility at Hornsby called San Day Surgery Hornsby (SDSH). AHCL currently has HPPAs with all health funds and has MPPA's in place covering radiology and Ultrasound with 29 health funds covering over 50% of all our admissions. The onsite pathology is provided by a 3rd party who also have no gap arrangements in place with most health funds.

Unfortunately, nib has chosen not to have such arrangements in place to cover medical gaps with AHCL.

AHCL also has in place a total no gap arrangement for Obstetric services with a major health insurer; a similar arrangement was offered to nib who declined to participate.

From AHCL's perspective, the current tension between hospital providers and insurers has become more aggressive and extreme in recent times than the industry has previously witnessed. Many insurers are introducing into the HPPA contract, conditions which:

1. Change referral patterns and direct work to providers that they prefer and / or own.
2. Reduce access to services for members e.g. limiting access to overnight rehabilitation services. Such constraints are inconsistent with the health fund rules. This means members are not receiving the product benefits that they have signed up for.
3. Misleading advertising that market services widely but are generally limited in scope and often with poorer outcomes than alternative services. E.g. chemotherapy in home and Rehab at Home. Often contracts require referral to these services in the first instance, on many occasions the services are not available and result in a delay in the timely treatment of the patient.
4. Utilising processes / systems such as Hospital Acquired Complications (HAC) to decrease benefits payable to hospital operators when the authors of HAC and the Australian Safety and Quality Commission have indicated to insurers and the health industry generally that HAC was not designed for this purpose and is not fit for this purpose and should not be used.

5. Utilising audit and other contract conditions to deny total payment of benefits imposing a penalty inconsistent with the breach. An example of this is the extension of the re-admission timeline to such an extent that those readmissions are unlikely to be caused by the previous hospital admission.
6. Negotiating rate increases that are far less than health inflation and sometimes proposing negative increases.

While AHLC has renewed the HPPA with nib in 2020, AHCL expressed to nib serious reservations about many of the conditions which nib was endeavouring to include in its HPPA. Under our confidential provisions in the HPPA, we are prevented from disclosing the specific issues in the contract.

As mentioned earlier, AHCL has successfully negotiated either directly or indirectly with other insurers (other than nib) for medical services including radiology, pathology, ultrasound and obstetrics to be provided at no gap to the consumer. AHCL offered to introduce such initiatives for consumer benefit with nib. Regrettably, nib would not entertain entering such arrangements. Nib's actual position in the authorisation application seems inconsistent with their current approach and the suggested public benefit that is being proposed in its application.

In regards to the proposed authorisation, AHCL is opposed to the application for the following reasons:

1. AHCL believes the public detriment significantly outweighs any public benefit. Regarding consumers, they will have less product choice (as a result of standardised HPPA terms and conditions) and consumers may be misled because product disclosure statements may offer more extensive benefits which in practice have been limited through contracting conditions.
2. It is most likely that the proposed authorisation will facilitate a US styled Managed Care being introduced into Australia negatively impacting on referral patterns and the primacy of the doctor patient relationship. It is likely that the proposed arrangement will deliver less access and choice for consumers while increasing overall healthcare costs.
3. There is a lack of evidence and transparency in the application to support the proposition being put forward by Honeysuckle. In this regard, at the applicant's request annexure B, C and D have been excluded from the public register. Consequently, the commercial information that could support the proposition has not been subject to scrutiny.
4. Honeysuckle has proposed that using an US style negotiation approach that there is real savings to consumers. However, the US health system is far more costly than the Australian healthcare systems. (USA 18% of GDP, Australia 10% of GDP), the US health outcomes are poorer than Australia, the life expectancy is lower in USA than Australia and access is poorer in USA (even after Obama Care 30 Million Americans do not have access to proper health care coverage.)
5. There are numerous internal inconsistencies in the HH submission. (Refer to later comments).
6. There are already existing buying groups such as AHSA and ARHG in place and these are not dominated by 1 fund as proposed by this authorisation. These buying groups already have cost structures in place to negotiate with all hospital providers. HH would only be able to realise savings if one of these other buying groups cease to exist otherwise there will be little if any transactional savings.
7. The authorisation does not adequately assess the market. HH proposes that the applicant's main target are funds that use AHSA or ARHG but in different sections of its submission is that it could provide services to other major funders like Medibank or Bupa or even government agencies.
8. The applicant indicates that it could achieve market share of 34% in NSW, 29.6% in QLD and 34.7% in Vic. This is significant market dominance and greater than any other existing fund including Bupa and Medibank. These market share numbers excludes if HH were to work with the other funds e.g. Medibank or Bupa which this application would allow. The application significantly understates the market dominance that it would have in certain regions particularly if it were to gain as participants funds such as Latrobe, St Luke's, Westfund, Mildura and GMHBA which have significant market share in certain regional locations.
9. There is little justification in proposing an authorisation for a 10-year period.

10. Cigna Corporation, the JV partner is subject to US Justice Department concerns regarding unethical and fraudulent behaviour. It would be prudent for the ACCC to explore this further including a survey of several US providers who have been subject to Cigna's operations.
11. The proposal runs counter to universality of the Australian Healthcare system.

Comments of specific paragraphs are as follows:

a. Para1.5 suggests that the payers that belong to AHSA and ARHG are most likely to join the HH buying group. No evidence has been provided that these buying groups are buying at inferior levels to other major purchasers such as Medibank and Bupa. Also, the submission indicates that other major health insurers e.g. Medibank and Bupa may be interested in purchasing bespoke parts of these services. This means the authorisation could deliver market dominance which could lead to cartel situations which would be detrimental and anticompetitive to consumers and providers.
b. Para 2.15/16 suggest that nib is entering MPPA's with radiology and pathology and surgeons to provide no-gap medical services to 'customer during a visit to a private hospital that is part of the nib network'. AHCL's experience and that of other providers is that this assertion is inaccurate and in no way reflects existing arrangements. AHCL believes nib has one of the poorest coverages on no-gap arrangements of any fund and is an extremely poor payer. AHCL believes that it would be worthwhile for the ACCC to survey pathology and radiology providers, anaesthetists and surgeons to ascertain their view of nib's medical no gap arrangements.
c. Para 2.25 b. proposes that HH will negotiate one set of terms and conditions including price schedules and business rules and performance targets for all participants for all HPPA and MPPA's with a provider. This may reduce product differentiation between different health funds stifling product design thus reducing consumer choice and competition.
d. Para 2.32 (a) proposes that the HH group will facilitate compliance with the terms and conditions of the Managed Agreement. HPPA's have been used to restrict access to services, influence and direct referral patterns often these being inconsistent with product disclosure statements. Such agreements have also used audit processes to deny payment of benefit and impose penalties inconsistent with the breach that has been incurred. This Managed Agreement would enable HH to act this way.
e. Para 2.33 (a) proposes the use of HAC for a purpose that Hospital Acquired Complications (HAC) for which it was not designed to be used (according to its authors) and inconsistent with the advice given to the industry by the Australian Safety and Quality Commission.
f. Para 2.34 provides for sharing of information on issues such as a breach of contract with a provider to all participants in the HH buying group. There is no justification provided for this. It is seen as a punitive, inappropriate step and a denial of natural justice.
g. Para 2.36 AHCL believes that the proposed authorisation would give effect to cartel operations.
h. Para 2.38 suggests that the proposed arrangement would result in better health outcomes and reduce premiums for health customers. No evidence has been provided to demonstrate how this would occur and how it could be solely attributed to HH nor has the submission proposed any timeframe for this to occur or how significant premium reductions may be. AHCL believes it is highly unlikely for this outcome to be achieved and to be attributable to the actions of HH. Should an authorisation be contemplated, there needs to be strict criteria for these outcomes to be delivered in a short timeframe otherwise this authorisation should cease.
i. Para 2.40 seeks a 10-year authorisation however there is little justification for this particularly given that the existing nib contract is to be rolled into the new HH contract.

j. Section 3 The market assessment has been poorly undertaken and does not consider the market shares of insurers and providers in different geographies. E.g. some smaller health insurers can have significant market share in the local region – E.g. Mildura, Latrobe, St Luke's and Westfund. Also, certain health providers may have significant market presence in their immediate market e.g. AHCL in Wahroonga, Epworth in Melbourne and Geelong and Cabrini in Melbourne. The market assessment needs to be more thoroughly examined for a proper assessment to occur.

k. Pare 3.27 suggests that HH will keep premium increases low. This is inconsistent with para 2.38 which suggests that there will be a reduction in premiums to members. What is the public benefit and how does this relate to other insurer premiums?

l. Para 4.15 proposes that: if a provider achieves higher than standard quality outcomes then the insurers would pay more to the provider and if the quality outcomes were below average, then the insurer would pay less for these services. There is no evidence that nib or Cigna have achieved this in their current operation. Also, there is no accountability for this being achieved under the proposed authorisation.

m. Para 4.18 proposes the use of HAC and the excessive use of Medicare item numbers as part of the risk adjusted outcome database to be used in assessing relative outcomes. As mentioned earlier this is an inappropriate use of HAC and potentially an inappropriate use of MBS.

n. Para 4.27 suggest that the HH buying group would "broaden access to nib's clinical partners program' in engaging surgeons, assistant surgeons and anaesthetists to bring a no gap experience for customers for knee and hip procedures". No information is provided as to the extent and availability of access to this program.

o. Section 4 and 5 AHCL believes that the public benefit is grossly overstated, and the public detriment is grossly understated.

p. Para 5.4 suggests that product insurers offer will not be influenced by this proposal. There is no detail provided to support this proposition. Given the standard contract conditions and terms, one does wonder how the product offering will not be reduced.

q. Para 5.9 refers to existing health insurance arrangements and second tier defaults. The statements are misleading as its intention is to suggest that consumers and providers will find that average rate of 85% of benefits paid for treatment as acceptable. It needs to be understood that the second tier default rate is not a weighted rate of comparable hospitals (volume x price) but a simple average and that health funds have "gamed" a simple average by having contract with providers for very low rates for certain items for which the provider has low or no volume. This artificially lowers the second-tier default rate and increases the potential for out of pocket costs that consumers pay when a provider is out of contract with a health fund.

For all the above reasons, AHCL believes the public detriment significantly outweighs the public benefit and AHCL opposes the authorisation.

AHCL is happy to further elaborate on this submission.

Yours sincerely

Brett Goods
Chief Executive Officer

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