Margaret Faux
PhD Candidate | Solicitor | RN | Founder and CEO

12 February 2021

Mr Michael Pappa
Competition Exemptions Branch
Australian Competition & Consumer Commission
exemptions@accc.gov.au

Dear Mr Pappa

RE: HONEYSUCKLE HEALTH (HH) AND NIB, AUTHORISATION AA1000542-1

Thank you for giving me the opportunity to comment on the above application and for providing your written approval that I may avail a one-week extension of time in which to respond.

Introduction and Background

By way of background, I am a Solicitor admitted to practice in the Supreme Court of NSW and the High Court of Australia, and have practiced law for over two decades. I am also an academic scholar of Medicare and health insurance law. My work has been published in peer reviewed journals and my PhD on the topic of Medicare claiming and compliance is currently being examined. I have been administering medical billing since Medicare began (across every medical specialty), am a Registered Nurse, and the founder and CEO of global MedTech company, Synapse Medical Services, which operates a medical billing service and has developed Australia's only medical billing rules engine outside of Medicare. Specifically, I have been administering Medicare and Private Health Insurance Gapcover scheme claims since they were introduced in 2000. I contribute widely to the national health reform debate and my publications (both peer reviewed and popular media) are available here.

My doctoral thesis is the first to examine the phenomenon of Medicare non-compliance from a legal, administrative and system perspective, which necessitated an examination of Private Health Insurance (PHI) in areas where Medicare and PHI money is blended through Medicare Benefits Schedule (MBS) billing arrangements. The evidence collected during the research suggests that no-one, including the Federal Government and the PHI's, has any detailed understanding of what is or is not a compliant Medicare bill. No national curriculum on the topic of Medicare and PHI financing law and practice has ever existed, levels of knowledge are therefore extremely variable and, in most cases, demonstrably low. The Medicare billing and health financing system has become largely incomprehensible and unable to be complied with, and without responsible reform, already intolerable consumer OOPs will continue to rise.

Accordingly, I offer the following responses in my personal capacity as a concerned individual with deep knowledge of the operation of Australia's health financing arrangements and the likely impact of this application both in grass roots medical practice and on consumers. While I can see the potential benefits of centralised hospital contracting (for accommodation, operating theatre fees and prosthetics), I have significant concerns about this application, principally in relation to the impact on consumers via the applicant's proposed changes to Gapcover schemes.

The underlying legal structure of the Australian health system has not been well considered or understood in my opinion, likely resulting in higher out-of-pocket costs (OOP) for consumers, *not* cost control.

Margaret Faux

PhD Candidate | Solicitor | RN | Founder and CEO

I have referenced sparsely throughout this document but am happy to provide full references and further details upon request.

Constitutional Issues

Section 51(xxiiiA) of the Australian Constitution grants the Commonwealth Government power to make laws for medical, dental and other social services in the following terms:

> *"The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances;"*

Section 51(xxiiiA) is the foundation upon which fee-for-service reimbursements for private services rendered by medical practitioners under the Medicare scheme rest, enabled by the *Health Insurance Act 1973 (Cwth),* which links to the *Private Health Insurance Act 2007 (Cwth)*.

The practical effect of the bracketed text in s 51(xxiiiA) which is known as the 'civil conscription caveat' is that it prevents the Commonwealth Government from socialising medicine and controlling medical practitioner fees. Numerous High Court decisions have settled certain points of law in relation to this clause, including that the relationship between a privately practising doctor and a patient is governed by general principles of contract law, and that both legal and practical compulsion may offend the caveat (see e.g. *British Medical Association v Commonwealth* (1949); *General Practitioners Society in Australia v Commonwealth* (1980); *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987); *Health Insurance Commission v Peverill* (1994); *Wong v Commonwealth* (2009)).

Since Medicare was introduced, Australian doctors have always been free to set their fees as they wish, and the ongoing failure by both the Federal Government, the PHIs, and other payers to understand this, has been a significant contributing factor to Australian consumers now paying some of the highest OOPs in the world. All attempts to force medical practitioners to enter contracts that control fees have failed, and will continue to fail, due to the constitutional provision. A recent example of the disastrous impact on consumers when the government missteps in this area is noteworthy. The government attempted to force medical practitioners to bulk bill Covid services. Some medical practitioners refused, preferring to exercise their constitutional right to charge as they wished, causing Medicare eligible taxpayers to be denied their Medicare rebates. An article explaining this is available at this link https://auspublaw.org/2020/04/frenetic-law-making-during-the-covid-19-pandemic-the-impact-on-doctors-patients-and-the-medicare-system/

Gapcover Schemes

Gapcover Schemes were introduced on the back of the failure of MPPAs, which are also mentioned by the applicant.

The applicant has correctly stated that the majority of MPPAs relate to pathology and radiology services. This is likely to continue, despite the applicant reporting that a modest number of additional MPPAs having been entered with orthopaedic surgeons, for hip and knee replacements. If the applicant is able to entice medical practitioners to voluntarily enter MPPAs, that would certainly represent an historic achievement, though seems unlikely given that when MPPAs were introduced, less than 100 medical practitioners across Australia had signed up to MPPAs after two years of operation.

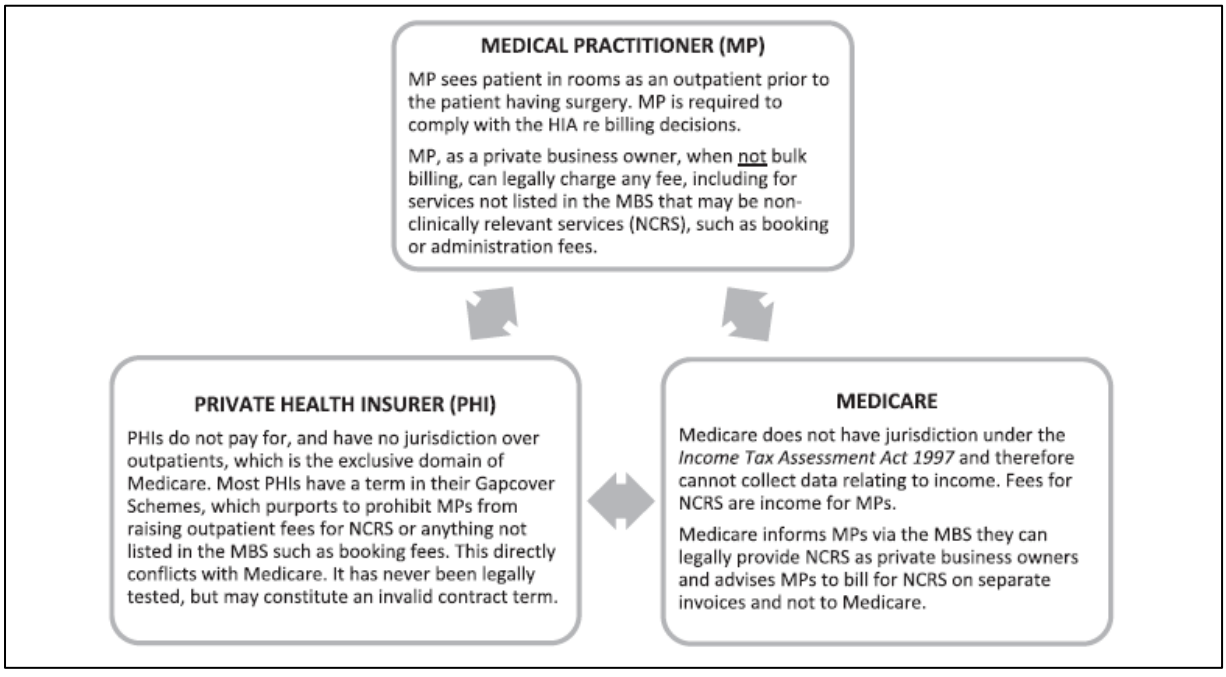
Margaret Faux
PhD Candidate | Solicitor | RN | Founder and CEO

After MPPAs had failed, the central objective of the new Gapcover Schemes was to provide an alternative that would be agreeable to the medical profession and would simplify billing processes and limit out of pocket costs for hospitalised patients without the need for contracts. Then Federal Health Minister Michael Wooldridge said:

> *'This Bill amends the National Health Act 1953 (NHA) and the Health Insurance Act 1973 (HIA) to provide for gap cover schemes. The purpose of these schemes is to enable registered health benefits organisations to provide no gap and/or known gap private health insurance without the need for contracts.'*

Whilst often referred to as 'simplified' billing arrangements (and in NIB's case, the Medigap Scheme), a new medical billing industry quickly emerged to deal with the complexities of the new schemes. These schemes have now become so complex and convoluted that a single Medicare service can be the subject of more than 30 different rates and rules, and the public money at the core of the transaction has become hidden in a regulatory maze of labyrinthine proportions.

One area of this legal complexity that is central to this application is that the terms and conditions of some PHI gapcover schemes, including NIB's, accessible here https://www.nib.com.au/docs/medigap-terms-and-conditions have the effect of making medical practitioner participation in their schemes contingent upon agreement to terms which may place the medical practitioner in breach of the Medicare scheme, in circumstances where the PHIs have questionable jurisdiction to purport to exercise such control. As small business owners, medical practitioners are permitted to charge for non-Medicare services (a common example being cosmetic Botox injections) and it is a Medicare requirement that such invoices *not* be invoiced to Medicare but be billed separately to the patient. Another example is booking fees, which the PHIs have always believed are illegal, though this has never been legally tested. This phenomenon is presented in the table below copied from this article from my PhD https://pubmed.ncbi.nlm.nih.gov/31682343/



Irrespective of arguments concerning the legality of 'booking fees', the reality is that medical specialists can easily pass costs to consumers in other ways, such as by raising the price of the consultation fees they charge in their rooms, where the PHIs exercise no jurisdiction. For example, the most common Medicare item number for an initial consultation by a surgeon is item 104. Instead of charging say $500 for the item 104 consultation plus a $500 booking fee, a surgeon can simply instead charge $1000 for item 104 and there is absolutely nothing the PHI can do about it. Further, many such transactions are recorded off books, on local accounting systems, and so will never be seen by the government or the PHI.

In addition to the applicant failing to appreciate that it cannot achieve the stated aim of controlling OOPs, and if it were to intrude too far into the private contractual relationship between medical practitioners and patients, a High Court challenge based on a 'practical compulsion' argument would likely result, in the public hospital context, many PHIs have already adopted legally questionable practices in relation to the operation of their Gapcover schemes.

Gapcover schemes involve the passage of public money. All PHIs receive 75% of the Medicare schedule fee for each inpatient professional service billed. Unfortunately, lax regulation has meant that once the Medicare payment is in the hands of the PHI the government has little practical control over it. The most common practical example occurs when PHIs, including NIB, use delaying tactics such as making payment to the medical practitioner contingent upon the happening of another event over which the medical practitioner has no control, such as proof of a corresponding hospital bill for the same service. While relevant contracts between the PHIs, medical practitioners and hospitals may lawfully enable delayed transfer of the PHI component of each payment, the Medicare component should either be immediately released to the medical practitioner or returned to consolidated revenue, which would better serve the national interest. This is currently not happening.

In addition, most PHI (including NIB) now impose questionable restrictions in relation to the operation of their Gapcover schemes for patients who elect to be treated privately in public hospitals. NIB's Medigap Terms and Conditions state that Gapcover rates will *not* be paid if:

> *"…you are a salaried practitioner at a Public Hospital and are treating Private Patients covered by the registered participating health fund at a Public Hospital;"*

Section 73BDDA of the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (the Act) expresses its purpose as enabling a registered organisation [a PHI] to

> "*offer insurance coverage for the cost of particular hospital treatment and associated professional attention for the person or persons insured…greater than the Schedule fee (within the meaning of Part II of the Health Insurance Act)…for the person or persons insured…*[where] *there is not a medical purchaser-provider agreement…and the person insured pays a specified amount or percentage under a known gap policy or the full cost of the treatment or attention is covered under a no gap policy*."

Central features of Section 73BDDA are:

- That both hospital *and* 'associated professional attention' or medical practitioner services are covered;

- That the benefits of gapcover schemes are intended to be afforded to policy holders (or patients) who enter insurance contracts with the PHI and pay relevant monthly premiums, and who also subsidise the PHI industry via their taxes;
- That no formal contract, such as a 'medical purchaser-provider agreement' is required as between the PHI and the medical practitioner, and
- The amount payable under gapcover schemes must be 'greater than the Schedule fee'.

The terms and conditions of many PHI, including NIB's appear to be inconsistent not only with the spirit of the Act, but also with key requirements of Section 73BDDA. For example, if a privately insured patient is admitted to a public hospital (usually having been delivered there by ambulance or having self-presented with an acute illness after hours) and wishes to avail their NIB policy, the legal basis for NIB to deny Gapcover benefits to the treating medical practitioners purely on the basis they are salaried employees of the public hospital, is nowhere apparent. And the policy holder patient will have no knowledge that their treating medical practitioner/s have been denied Gapcover benefits.

Given it appears HH (who administers NIB's MediGap scheme) may already be adopting what might be described as a questionable approach to strict compliance with Gapcover law, I am concerned about its role as an appropriate administrator of Gapcover schemes going forward. Further, the absence of any mention of the impact in the application on privately insured consumers who find themselves admitted to public hospitals is of concern.

I would urge the ACCC to request comprehensive details of the comments skimmed over in points 2.10, 2.27 and 2.28 of the application; namely, what does HH and NIB mean by use of the words; 'extension' and 'replacement' of its Gapcover schemes.

Managing Provider Compliance

Having just completed a PhD on medical provider compliance I am concerned about the applicant's comments around managing compliance in 2.33(b) and the impact on providers. With the exception of a relatively small number of internal business rules, neither NIB nor any other PHI has any role in, or ability to manage billing compliance, which they have never been formally taught (there is no national curriculum) and which is centrally controlled by Medicare. I have further concern around the suggestion in clause 4.9(a) that the proposal may reduce the administrative burden on medical providers. In my experience, the opposite is a more likely outcome.

Medicare determines billing rules not the PHI and as such the PHI have little or no ability to create simplicity. The PHI marketed the exact same concept – simplicity – when Gapcover schemes were introduced in 2000. But, instead of simplicity, what transpired was complexity and administrative burdens imposed on medical providers of such magnitude that a new medical billing industry (of which I was a part) quickly appeared. There is no evidence to suggest it will be different this time, and comments around this area in the application are vague. What is most likely to eventuate is an increased burden on medical providers as HH and NIB seek to further contain and control medical fees (such as by delaying legitimate payments), and medical practitioners will have no option other to increase their engagement with medical billing companies, who will charge for their time advocating to ensure legitimate claims are correctly paid. These administrative costs are inevitably passed to consumers as OOPs.

Further, given HH has no statutory authority to determine what constitutes 'excessive use of MBS item numbers' (clause 4.18), I would urge the ACCC to enquire further on this point to determine exactly what is meant by this. Under what statutory authority can HH determine what is excessive and what action does it intend to take in circumstances where it makes a finding of 'excessive' services.

The impact on eligible veterans under the DVA scheme

The applicant has incorrectly stated that eligible veterans avail a DVA no-gap scheme (clause 3.13) under which veterans are never charged OOPs.

DVA does not, and has never, operated a Gapcover scheme and in fact, there is no legal barrier to DVA patients being charged OOPs due to the constitutional provision already mentioned. The fact that most veterans are not charged gaps has nothing to do with a DVA Gapcover scheme (it primarily relates to ignorance by the medical community about compliant billing) and as the veteran treatment population diminishes in size, if DVA were to participate in the proposed buying group, the most likely scenario is that medical practitioners will shift costs to eligible veterans in the form of OOPs. This would be very damaging to the veteran community.

Value based care

I am concerned that the applicant has been unclear in relation to its comments around 'value based care' versus 'value based contracting'. Medicare is predominantly a fee-for-service (FFS) scheme, and whilst FFS is often criticised as being the least effective payment type in health systems, research has suggested other payment types have led to more worrying outcomes such as risks to human health. For example, the introduction of capitated managed care did not alleviate fraud and non-compliance in the US health system, but made it worse. Not only did non-compliance become more difficult to detect, it became more dangerous to patients when overservicing was replaced with underservicing.

> *"…the trend…is to replace fee-for-service structures with some kind of standardized fee structure – Diagnosis Related Groups, Prospective Payment Systems, or even fully capitated managed care…it suggests there is no hope of ever managing a fee-for-service system properly; the only 'fix' available is to scrap it and replace it with something else…the introduction of capitated or prospective payment systems carries with it an entirely new set of problems and new fraud types…" (Malcolm Sparrow, License to Steal)*

More recently, a study of alternative payment models reported in the New England Journal of Medicine (NEJM), described potential negative impacts of value-based care (VBC) on vulnerable populations, who are unlikely to achieve the measurable outcomes VBC depends upon. The research suggested these new payment models may hurt rather than help, particularly for medical practitioners serving poor and disadvantaged communities (Joynt Maddox 2018). Another commentator, also in the NEJM, expressed similar concerns around measurement of the nebulous concept of value under VBC.

> *"…perhaps the most problematic is its [VBC's] reinforcement of illusions about value: that we know what it means and can measure it, that the same things matter to all patients, and that the effect of any intervention can be understood in isolation from countless others." (Rosenbaum 2017)*

The way we choose to pay for health in the future will continue to evolve, but it is important not to overstate the benefits of any one payment model over another, as the applicant has sought to do. Further, the applicant's use of a US experience is not a valid comparator in the Australian setting, given our very different health systems

I would urge the ACCC to require that the applicant provides comprehensive details of what it means by 'value based contracting' to ensure the term is not being used as a proxy for managed care, which would not be in the best interests of consumers or the Australian health system.

Conclusion

The Nimmo report in 1969 described health insurance in Australia as "unnecessarily complex and beyond the comprehension of many," and the report became the catalyst for the introduction of Australia's first universal health coverage scheme, Medibank (later Medicare). My PhD research has found that Australia's current health insurance arrangements have again become so complex and incomprehensible that compliance is nigh impossible, and the system is beginning to unravel.

My concerns in relation to this application relate to the direct consumer impact, which involves medical practitioner fees. The applicant's proposal will almost certainly increase complexity in this area. When changes of this type are made, it is consumers who feel the impact the most because health spending happens (whether directly or indirectly) at the point of service based on an encounter between a medical practitioner and a patient. When medical practitioners become exhausted by constantly increasing regulatory burdens, payment controls and delays, they quickly shift costs to consumers as OOPs.

It cannot be denied that the need for both the government and the PHI to control escalating health expenditure sits at odds with the unique position of power and privilege held by Australian medical practitioners who have constitutional protection against excessive intrusion into the private contractual arrangements they negotiate with their patients. In addition, there is a compelling argument to suggest that the medical profession itself has been derelict in its duty to provide some form of education to medical practitioners around responsible fee setting and the ways in which their own poor billing behaviour contributes to the overall failure of the health system in which they work. However, this application will not solve these problems.

Further, while the applicant's statement that the PHIs are tightly regulated is correct, absent is the fact that they are extremely poorly policed. There is in fact very little effective oversight or governance around the conduct of PHIs, as evidenced by lax compliance around the delayed passage of public money to the entitled end beneficiary under Gapcover schemes and denying policy holders the benefit of these schemes in public hospitals.

There is also no evidence to suggest that any cost savings resulting from this proposal will be passed to consumers via lower PHI premiums (clause 4.2). During the COVID pandemic when all elective surgery was cancelled, thus dramatically reducing PHI claims payouts, there was little or no evidence that the PHIs were offering discounts to their policy holders who could not (and in some cases still cannot) utilise their PHI due to government imposed restrictions. In most cases the PHIs appear to have continued to charge their policy holders the same significant monthly or quarterly premiums, despite their own Covid induced windfalls.

Margaret Faux
PhD Candidate | Solicitor | RN | Founder and CEO

Gapcover schemes are one of the most complex areas of Australian medical billing, involving public money and up to five parties, with various contracts and legal relationships that collectively determine the fate of the Medicare rebate at the heart of the transaction. Practically, patients are not involved in gapcover transactions, though the legal basis for this is somewhat labyrinthine and porous, rendering such schemes vulnerable to various abuses some of which have been described in this letter.

Gapcover schemes have also failed to achieve their core objective which was to eliminate OOPs for hospitalised patients. This is in large part due to the failure by the government and PHIs to understand and accept the impact and power of the constitutional caveat. The present application also appears to have failed to understand this fundamental tenet of the Medicare scheme, and while its intentions to exert downward pressure on expenditure and OOPs may be sound, the reality is that the opposite will likely occur, and consumer OOPs will rise. As they have always done, medical practitioners will simply sidestep every barrier imposed and will likely also redirect patients to the public hospital system, the negative downstream impacts of which are beyond the scope of this letter.

Accordingly, I suggest this application be rejected certainly insofar as it relates to Gapcover schemes.

Thank you for considering my submissions which I would be happy to expand upon if required.

Yours sincerely

Margaret Faux