AHSS Submission

Honeysuckle Health ACCC Application

Application to Form and Operate a Buying Group HH. Honey Suckle Health is jointly owned by Cigna (large American company employing over 70,000 people) and NIB (Australian owned insurance company).

The outcome of this Application may have a significant impact on the Australian Medical Industry in the long-term and should be considered carefully, after very thorough investigation and careful consideration by industry experts representing ALL stakeholders.

We believe the HH Application is fundamentally flawed. The benefits identified by the ACCC are marginal at best. The detriments are very significant. The requested exemption should not be granted by the ACCC.

Fundamental Objections

A. Misplaced Use of Exemption Power

1) The genesis of the exemption power for buying groups was to enable groups of small businesses to enter into effective negotiations with larger parties that have significantly greater bargaining power. There are already a combination of large health insurers and buying groups representing the smaller insurers. No exemption should sanction a buying group with more than 20% of any state or territory markets. It certainly should be not used to permit an entity to exercise dominance over a market (which in most jurisdictions is taken to occur at around a 40% share).

2) In the applicants' response to the Draft Determination: "*The Applicants consider that the increased market share cap* [to 60%] *is required to be able to extend the Broad CPP (clinical partner program in the further amended application by Minter Allison on behalf of HH) to at least one major insurer which would allow the realisation of the following public benefits:"*

   In their original application, the applicants stated: "*Some Providers have much stronger bargaining power in the negotiation of agreements with healthcare payers which can impede the parties from achieving efficient pricing outcomes for health services. This is particularly the case in the private hospital market where the 5 largest hospital provider groups account for 50% of the market.*"

   These are contradictory and self-serving statements by the applicants.

   If the applicants object to such a condition (5 independent hospital provider groups accounting for 50% of the market), imagine our concern with 1 buying group (not independents) representing in excess of 30% of the buyers, never mind 40% - 80%. Based on the above comments from the applicant, we believe, like us, they would heavily object to such application if they were sitting on the other side of the fence.

3) To further clarify this unjustifiable application, a comparison of the relative bargaining positions of the various stakeholders.

Insurer Market Share of Hospital Policies compared to Market Share of Hospital Providers

(Below 2019 figures quoted from the Original Application)

Hospital Provider	Market Share		Insurer	Market Share	
			(Buyer of Health Services)		
Ramsay	21.60%		Medibank	26%	
Healthscope	13.70%	2 Groups 35.3%	Bupa	25.1	2 Groups 51.1%
Healthe Care	9.30%		AHSA	20%	
St John of God	5.50%		HCF	11.70%	
St Vincents Health	3.40%	5 Groups 54%	Honeysuckle Health	9.50%	5 Groups 93%
Mater Misercordiae Ltd	3.10%		HBF		
Little Company of Mary	3.10%		ARHG		

The diagram indicates that Insurers already have greater concentration of market share than Private Hospital Providers.
The largest 2 Independent Insurers represent 51.1% of the market as compared to the 35.3% represented by the largest 2 Private Hospital Groups
The largest 4 Independent Insurers represent 72.3% of the market as compared to the 50.1% represented by the largest 4 Private Hospital Groups
The largest 5 Insurer Buying Groups represent 92.3% of the market as compared to the 53.5% represented by the largest 5 Private Hospital Groups.

It is quite apparent that Insurers are not marginalised by their relative bargaining power, in fact, the balance of power already leans towards the Insurers.

Medical Service Providers

There are approximately 100 000 employed medical practitioners in Australia, of which around 29 000 are specialists.

There are approximately 200 000 Registered Allied Health Professionals in Australia.

Service providers are infinitely smaller than the insurers, independent, not organised in bargaining groups and not allowed to withhold services.

A stronger negotiation base, as requested by HH for negotiations with Medical Service Providers is clearly unjustifiable and should be excluded from any such ACCC determination.

Should the Determination allow the applicants to negotiate with service providers as a buying group, the ACCC should allow service providers a Class Exemption allowing them the right to collective bargaining.

4) The limited public benefits identified by ACCC do not come close to outweighing the reduction in competition in both the health insurer and buying group markets, and the potential detriments to healthcare standards identified in the various interested party responses already submitted to the ACCC.

Learnings from the US Antitrust Agency

1) One potential anticompetitive harm that the Antitrust Agencies evaluate with respect to joint purchasing agreements is whether the agreement will give the participants **monopsony** power over suppliers (i.e., buyer market power to drive down the price of the purchased product, thereby depressing prices below what would exist in a competitive market).

2) In terms of the competitor collaboration Guidelines, the Antitrust Agencies "identify a general "safety zone" in which they will not challenge a competitor collaboration absent extraordinary circumstances, as long as:

> "…all participants collectively account for no more than 20% of each relevant market. …as well as downstream markets,…"

As an alternative, the agencies also established "an antitrust safety zone" for joint purchasing arrangements among healthcare providers, providing the following 2 conditions are met:

> "*The purchases must account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and*
>
> *The cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant…"*

B. Unacceptable Lack of Clarity

1) We are unclear / struggling to understand the scope of services specifically included and excluded from this buying group application, referring to clauses 2.8 and 2.9 of the application and paragraphs 2 & 3 of "Consultation and amendments to the application for authorisation" of the ACCC Draft Determination.

2) Our understanding of the scope of the Application is as follows:

   a. To create a buying group providing a range of services to participating health insurers, including contract negotiation, data analytics and performance and compliance assessment of service providers;

   b. The application does NOT seek to extend to the provision of such services to Medibank, BUPA and HBF (in WA), except:

      i. In relation to the Broad Clinical Partners Program ("**BCPP**"). BCPP is defined somewhat vaguely as "*HH's program under which HH enters into agreements with medical specialists to ensure that customers are not charged out-of-pocket costs for medical services provided during an episode of hospital treatment (for joint replacement surgery or otherwise).*"

      ii. There is no definition of "medical specialists" in the Amended Application. In paragraph 2.16 they are referred to as persons "*such as radiologists, pathologists and surgeons*". Clarification of exactly to whom this term applies should be provided.

      iii. It is not clear whether the exemptions are intended to apply to MPPAs with medical specialists in relation to defined gaps/out of pocket expenses. The wording suggests it applies only to no-gap arrangements but appears to be (intentionally) drafted to provide some latitude to the applicants to interpret it flexibly. Again, this is unacceptable and should be clarified.

3) There appears to be a typo in paragraph 2.10 referring to the market share threshold. This refers to the "*a condition on the exception in paragraph 2.8*". However, the "exception" is contained in paragraph 2.9. This point should be clarified.

C. Disingenuous Application

1) In their original submission the applicants state that "*The major health insurers are unlikely to join the HH Buying Group…*" However, in response to the Draft Determination, the applicant requests that the cap be lifted to 60% "*to enable at least one major health fund to join the Broad CPP on a national basis.", allowing "HH to represent one third of the AHSA funds (by market share), nib and one major insurer.*"

This is a significant contradiction by the applicant based on their original submission.

We also note that opposition from the AHSA in their submission to the ACCC.

2) Calculation of the 40% - We believe the ACCC Determination was based on their presumption that the applicant would represent the minorities, by giving them collective buying privileges, in the interest of their members. We believe this Determination already overstepping the boundaries of a fair determination.

Calculation of the 40% Market Cap Basis as proposed is assumed to be based on the following logic:

nib	10%
AHSA	20%
ARHG	1.5%
Business Growth	8.5%
Total Cap	**40%**

With reference the numbers provided by the applicants in their original submission – This was obviously not the real intent, and not a good faith statement. In its Draft Determination, the ACCC have authorised a cap of 40%, which covers every State requirement as listed below by the Applicant, but now seems to be unacceptable to the Applicant.

We believe the Applicant not to be forthright in its statements.

Other Objections and Submissions Relevant to the Application

A. Scope of Exemption Requested – Current and Future

The condition in paragraph 2.10 provides that the applicants will not enter into a BCPP arrangement with any of the four entities if it would result in Honeysuckle providing services to more than "[60% - Response to Draft Determination/40% - Draft Determination/20% - International Threshold]*%* [1] *of the national private health insurer market measured as a share of total hospital policies*". This raises a number of required clarifications:

i. What happens if the total market share becomes greater than 60%/40%/20%?

ii. The condition refers to the "national" market. However, in the Applicant's Response, it states at paragraph 1.2 that the "*cap applies at a State and Territory level*". This appears to be in response to the Draft Determination. It is important the references to the "national" market do not slip back into any exemption granted.

B. Conflicts of Interest

[1] Draft Determination 40%, Further Amended Application 60%, 20% International Threshold

1) The management of Honeysuckle owe a duty of care to act in the best interest of their shareholders (nib and Cigna). The fact that the press release states it will be operationally independent is irrelevant to this duty. The chief executive of Honeysuckle is a longstanding executive of NIB. The court have long been understandably sceptical of the efficacy of any purported information barriers between related parties, such as nib and Honeysuckle. The ACCC should reject any attempt to rely upon such purported arrangements.

2) In addition, the joint venture agreement for Honeysuckle has not been disclosed. This may contain additional conflicts of interest for Honeysuckle and nib.

3) Honeysuckle is proposing to adopt nib's existing contracts with providers which creates an immediate advantage for nib in the health insurer market.

4) Honeysuckle has the ability to negotiate contracts in a manner that is known to be amenable to nib's position.

5) Honeysuckle has through its performance and compliance assessment function, a quasi-disciplinary power with regard to providers. This provides additional powerful influence and control to nib over the providers.

C. Additional Anti-Competitive Implications – Data Housing, Data Aggregation and Access to Data

1) It is not stated that nib does not have any (formal or informal) additional or preferential access to data analytics or other information over and above any other participant in the buying group. An express representation from nib and Honeysuckle should be sought on this.

2) The aggregation of up to 60% of state and territory markets in relation to BCCP would provide Honeysuckle with a decisive information and data advantage in comparison to other buying groups. It is difficult to see how this advantage would not ultimately lead to a reduction in choice of buying groups. The market power that this would provide to Honeysuckle would enable it to raise costs to health insurers to the detriment of those insurers and, ultimately, consumers.

3) The ongoing sharing of data within the buying group (in addition to the sharing for the purpose of negotiations) is anti-competitive as this would tend to encourage health insurers to act in concert, thereby limiting competition in the market. There is absolutely no justification to permit such sharing of data to take place with any of the participating entities (including nib).

D. Government Spend on Medical Treatment per Capita has remained constant in Real Terms since 2001.

1) Consider this fact against the expansion of medical services in response to greater sophistication, increased life expectancy and greater focus on / empathy towards mental health care.

2) We believe AMA rates are fair.

3) The gap between AMA Rates and Schedule Rates exist because government have not indexed medical rates annually in line with the official annual CPI figures published by Government.

4) Government is an active competitor in this market

E. Other

Quotes from the application that are of significant concern and point to the manner in which such unbalanced position of negotiation will manifest to compromise service providers not contracted by the Buying Group:

1) "…will see improved volume provided to the Providers of these services who have been selected…"
2) "The establishment of MPPAs with these Providers will drive more volume to them…"

Our Proposal

We need to address and balance the misplaced use of the exemption power for large and powerful market participants. No exemption should sanction the formation/establishment of a buying group between independent parties with combined market share in any state or territory of more than 20%.

We have submitted evidence that the Insurers are already in a stronger bargaining position than both the private hospital groups, and the thousands of independent medical service providers (incl Allied Health) in Australia.

We believe this application to be an ungrounded, opportunistic attempt at quickly gaining market share, building a business of significant scale and profit by gaining ACCC exemption / slack, thereby gaining access to undue negotiating power to bully / unduly influence much smaller Medical Service Providers.

1) Based on the evidence presented, the application should not be approved on any basis.

2) **However, should the ACCC believe that the application has some merit**,

   i. Based on the evidence presented, **the application should not be approved for negotiations with Medical Service Providers**, and

   ii. Based on the evidence presented, **such approval should be done in line with international norms, limiting the size of the buying group (20%**), and by **limiting their right to participate in the supply of downstream services** due to their ability to impact on existing downstream providers.

   iii. Prior to any final decision being made by the ACCC, seek disclosure of:

      a. The Honeysuckle Health Joint Venture Agreement
      b. Honeysuckle Health, NIB and Cigna board papers relating to commercial and economic benefits of the proposed conduct.

3) The Medical Industry has very clear guidelines around patient disclosure. We suggest that the industry associations establish a joint task force to evaluate the level of adherence and improve existing strategies to ensure proper financial compliance and disclosure as well as provider fee structure comparisons.

4) If the applicant feels that strongly about the opportunity in hospitals and provision of medical services, let them focus their energy and investment on organic growth and further roll-out of their downstream operations.

Jeff Ecker

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