8 June 2021

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

Mr Darrell Channing
Director
Competition Exemptions Branch
Australian Competition and Consumer Commission
By email: exemptions@accc.gov.au

Dear Mr Channing

Re AA1000542 Honeysuckle Health and nib - submission

We refer to the draft determination issued by the ACCC in relation to the above application for authorisation. We remain opposed to the proposed authorisation as it is likely to result in less choice for patients, in terms of both doctor and health fund, no premium relief and a less competitive market.

While we recognise that the ACCC has responded positively to a number of issues raised by the AMA in our earlier submission, we remain firmly of the view that the proposed authorisation should be rejected. The applicants ('the HH buying group') have made a number of amendments to their original application and the ACCC has gone even further in proposing additional conditions. Despite this, the authorisation remains fatally flawed and will operate to the detriment of patients. In the longer term it will undermine competition within the private health sector and support greater insurer control of patients' health care choices.

In particular, the ACCC has given insufficient weight to stakeholder concerns about the potential for this application to further embed the trend towards the costly and inefficient US style system of managed health care in Australia. While the applicants, and indeed the major private health insurers, consistently say they are committed to clinical autonomy, we know that in the real world they are increasingly seeking to intrude on decisions that ordinarily lie with doctors and their patients. In this regard, the ACCC draft determination is notable for its acknowledgement of the lack of regulation that could prevent this from becoming a feature of contracting arrangements, but then chooses to ignore this concern.

In practical terms, for most contracted services the draft authorisation will potentially allow the HH buying group to comprise insurers representing in excess of 30% of the private health insurance market. In relation to the Clinical Partners Program, the ACCC has capped participation at no more than 40% of health insurance policies in each state or territory.

On any measure, the achievement of these levels of market penetration would provide the HH buying group with substantial market power that would ordinarily be seen as detrimental to competition and would also empower the HH buying group to pursue the managed care agenda that stakeholders raised concerns about. The potential public benefits nominated by the ACCC in its draft decision are illusory and would not outweigh the significant detrimental impact on competition and the delivery of health care.

The decision also fails to consider the extent to which this application is a Trojan Horse through which nib can significantly improve its position in the private health insurance market. Not only does nib stand to benefit from the increased purchasing power the proposed HH buying group might bring, but it may also be the beneficiary of the market disruption that will result from the establishment of the HH buying group, including the potential exit of smaller funds.

In attempting to curb the worst excesses of the original application by the HH buying group, the ACCC has also effectively created a situation where the HH buying group will now largely compete for membership with the two existing buying groups. The latter represent smaller funds that operate on a not for profit basis, or are part of a member owned group, or are regional or community based. These funds would be particularly vulnerable if they were caught up in aggressive competition for membership between buying groups that would have little regard for the needs of these funds.

The inevitable consequence of the environment that the ACCC draft authorisation creates would fall into one of three categories as follows:

1. *The HH buying group fails to recruit members*

This scenario is considered highly unlikely given the clear intent of the HH buying group and the fact that it is backed by nib and the Cigna Corporation. Indeed, the latter is likely to give the HH buying group significant scope to engage in predatory pricing and undercut its rivals in order to secure market share.

2. *The HH buying group recruits some members, largely splitting the existing market between three buying groups*

This is a plausible scenario that would prove to be a zero sum game in relation to any public benefit. While the HH buying group may achieve some economies of scale and potential transaction savings (particularly for nib), there would be a corresponding loss of these incurred by members of other buying groups.

3. *The HH buying group achieves monopoly status*

This scenario is considered highly likely. With an established market share, the option to offer its Clinical Partners Program to major insurers and the backing of nib and the Cigna Corporation, the AMA believes that the HH buying group will have the desire and capacity to engage in sustained

predatory pricing in order secure market share and inevitably drive competing buying groups out of the market.

This would result in the HH buying group effectively becoming a monopoly provider of buying services to smaller health funds, accompanied by the potential exit of some smaller funds from the market as collateral damage from the competitive battle between buying groups. There would be no net public benefit in this circumstance and, given commercial imperatives, it is likely that the HH buying group would then exercise its market power so that members faced higher costs and inferior services in the longer term.

The ACCC has assessed the main potential public benefits of this authorisation as being choice of buying group and increased competition between buying groups. While in other markets these may deliver the types of public benefits the ACCC envisages, the reality is that the private health insurance market is far more complex and does not operate like a normal market. It is characterised by the existence of a small number of dominant insurers, significant Government subsidies, high barriers to entry and the significant regulation of the funding and delivery of clinical services.

It finds some other more limited public benefits with respect to transaction savings, greater input into contracts and improved information for HH buying group participants. Given the reality that existing buying groups already provide these public benefits, little or no weight should be attached to these. Indeed, it is likely that these public benefits would be significantly diluted in scenarios 2 and 3 outlined above.

In its conclusion on the public benefits of the application, the ACCC does not include reduced private health insurance premiums, reduced out of pocket costs for patients or improved contracting arrangements with hospitals as being among the public benefits. This is despite the significant emphasis that was placed on these by the applicants. This means that patients may ultimately end up with less choice and less control of their healthcare, while having no premium relief.

The AMA believes, for the reasons outlined above, that it is impossible for the ACCC to strike the right balance in seeking to approve this application. The original materials submitted by the applicant took a laissez faire approach that the ACCC was right to seek to constrain. However, in doing so, the ACCC has simply set up an environment where it will become the survival of the fittest with three buying groups largely fighting over a limited membership base. For reasons outlined earlier, the HH buying group will come to this fight with a significant and unfair advantage and will simply split the market or, in the more likely scenario, achieve monopoly status.

The consequences of this would prove to be bad for patients and the private health sector, with no regulatory framework in place to guard against the imposition of unfair and intrusive contracting arrangements that could interfere with clinical autonomy and the delivery of patient care. These far outweigh any perceived public benefit and, on that basis, the application should be rejected.

Yours sincerely

Dr Omar Khorshid
President