08 February 2021

Michael Pappa
Competition Exemptions Branch
Australian Competition and Consumer Commission
Level 17, 2 Lonsdale Street
Melbourne VIC 3000

Dear Mr Pappa,

AA1000542 - Honeysuckle Health and nib - Interested party submission

We refer to the application (**Application**) made to the Australian Competition and Consumer Commission (**ACCC**) under section 88(1) of the *Competition & Consumer Act 2010* (Cth) by Honeysuckle Health Pty Ltd (**HH**) on behalf of itself and nib Health Funds Limited (**nib**) (**Applicants**) seeking authorisation to create a buying group for healthcare payers (**Proposed Conduct**).

The Australian Society of Anaesthetists (**ASA**) was established in 1934 and is the peak body representing the professional interests of specialist anaesthetists. Its mission is to support, represent and educate Australian anaesthetists, in order to assist them to provide best possible patient care.

The ASA is very concerned about the Application and believes an authorisation for HH to form and operate a buying group to collectively negotiate and administer contracts with healthcare providers (including medical specialists and specifically anaesthetists) will substantially lessen competition and may lead to other breaches of Part 4 of the *Competition and Consumer Act* 2010 (Cth) (**CCA**).

The ASA strongly believes that approval of the Application:

(a) would not enhance the welfare of Australians through the promotion of competition and fair trading, contrary to the object of the CCA (section 2: CCA);
(b) would not provide consumer protection;
(c) would result in a significant increase in market power for nib and the other major health insurers; and
(d) would result in public detriment, by way of lower quality healthcare, which will outweigh any possible benefits arising from purported transaction cost savings and efficiencies.

The ASA sets out its concerns below.

2. The Australian Healthcare System

2.1. Australian consumers have access through Medicare to a world class free public health system which provides high quality and safe healthcare. Those who choose to be treated as public patients incur no direct costs. Those who choose to be treated as private patients pay substantial premiums and out-of-pocket costs to obtain private health care. The question that arises therefore is: why do they do this?

2.2. The ASA submits that three factors account for the popularity of private health care in Australia:

(a) choice;
(b) access; and
(c) quality.

2.3. These factors are acknowledged by the private health insurance industry. The website of Private Healthcare Australia (https://www.privatehealthcareaustralia.org.au/consumers/find-a-health-fund/) lists the following reasons to have private health insurance:

(a) Access to timely care;
(b) Avoiding long public hospital wait lists;
(c) Choosing your doctor; and
(d) Continuity of care with a fully trained specialist".

Private Healthcare Australia represents health funds and their members.

2.4. A healthcare system that is controlled by healthcare payers who direct patients to preferred healthcare providers who are required to care for those patients in designated hospital facilities using procedures determined by the healthcare payers threatens each of these attributes of private care. This is the type of insurer controlled managed care system proposed in the Application.

2.5. Any representation by HH which espouses the virtues of a managed care system must be carefully examined. Managed health care is the predominant funding process in the United States, which represents the most expensive healthcare system, with the poorest health outcomes, when compared to similar high resource countries. We refer to the report prepared by The Commonwealth Fund titled Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health care

(https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and)

2.6. The ASA acknowledges the benefits to Australian consumers of a no gap scheme whereby Australian consumers clearly understand the costs involved with their medical treatment. Under the current system, it is already the case that close to 90% of medical services in the private healthcare sector involve no out-of-pocket (OOP) expense to patients. A further 4-5% are provided under a "known gap" arrangement, in which there are specific limitations placed on the level of OOP expense. Therefore, the argument that OOP expenses are a significant issue across the sector is false.

2.7. Where they do exist, OOP expenses are nearly always due to the inadequacy of medical rebates. The ASA believes it is essential that patients, whenever possible, know the cost of their medical care in advance, however it is inaccurate to infer that doctors are responsible for OOP expenses. The existence of OOP expenses is a result of inadequate medical rebates. Medicare and health fund rebates have failed to be indexed in line with the CPI for the last 40 years. In contrast the Australian Medical Association (AMA) List of Medical Services and Fees has been indexed in line with the CPI. Doctors whose charges are guided by the AMA have found their patients incurring OOP expenses. If health insurers and Medicare refuse to index their rebates in line with the CPI then OOP expenses become inevitable.

2.8. For this and other reasons, the Application is misleading when it asserts that the benefits of the Proposed Conduct to the Australian public outweigh the public detriments.

2.9. The Application sets out that the Proposed Conduct is to enable the streamlining of contract negotiation, procurement and management procedures which will improve efficiencies by virtue of reduced transactional and administrative costs, and increase information sharing and data analytical capabilities resulting in better health outcomes and reduced premiums for customers. This is disputed by the ASA. The ASA submits there is no evidence that any reduced transactional and administrative costs will reduce premiums or result in better health outcomes.

2.10. The ASA also submits that in addition to considering the impact of the Proposed Conduct on Australian consumers within the Australian healthcare system, the ACCC must also consider the position of medical professionals including medical specialists, general practitioners and allied health professionals (referred to as **Providers** in the Application). The Proposed Conduct as set out in the Application will make it

increasingly difficult for doctors to determine their own fees which is fundamental in a competitive and well-regulated market. The present system whereby doctors compete on quality and cost will be lost. In this regard, we note one of the ACCC's purposes is to protect the interests and safety of consumers, and support fair trade in markets affecting consumers and small business.

3. Market information and concentration

3.1. The Application submits that there are five relevant markets including a 'localised market for medical specialist services for each speciality practice'.

3.2. The ASA disputes the Proposed Conduct relates only to a localised market for medical specialist services. Experiences that the Proposed Conduct will also impact upon the national market for medical specialist services and this needs to be taken into account by the ACCC.

4. Public benefits

4.1. The ACCC must be satisfied that the benefit to the public from the Proposed Conduct outweighs any public detriment. The ASA submits that any public benefit would be no more than a 'negligible benefit' (see section 90(8) CCA), and that the benefit to the public will not outweigh the public detriment.

4.2. With regard to HH's submission that reduced transactional and administrative costs are a public benefit, the ASA submits this is a business benefit to HH and nib (and other health insurers). They are not a public benefit unless the reduced costs result in reduced insurance premiums and/or reduced gap payments by consumers. There is no evidence to suggest that these cost savings will be passed on to consumers.

5. Public detriment (including likely competitive effects)

5.1. The ASA understands that the ACCC gives a broad meaning to 'public detriment' to the extent that it includes:

> *...any impairment to the community generally, any harm or damage to the aims pursued by the society…*

5.2. We reiterate that Australian consumers expect:

(a) safe and good quality healthcare;

(b) ready availability of healthcare services;

(c) to be able to choose their own doctor; and
(d) that their chosen doctor can select the appropriate treatment for them, at the healthcare institution best suited to that treatment, in the opinion of their doctor

5.3. The ASA submits that contrary to the arguments set out in the Application there will not be an improvement in health outcomes. Instead, there is likely to be a reduction in choice of Provider and a limitation in availability of private health care. There will also be a substantial lessening of competition in the market for medical specialists.

Lack of Choice

5.4. Should a patient be insured by nib (or a member of the HH Buying Group) but their medical specialist has not entered into a contract with the HH Buying Group, then favourable rebates will not be available to that patient if they continue to attend their chosen Provider. The patient will effectively have no choice of Provider. The patient is disadvantaged by having to go outside of the preferred provider network of NIB. This is how the Cigna system operates in the United States (see paragraphs 4.12 to 4.14 of the Application).

5.5. Paying different rebates for the same service depending upon the network participation of a Provider is characteristic of the US system referred to in the Application. There is a clear disadvantage to patients who pay the same premium but may get lower rebates for the same service due to the doctor or hospital they choose.

Quality Healthcare / Improvement in Health outcomes

5.6. HH openly acknowledges in the Application that it intends to implement "value-based" contracting relationships which align with other health systems globally. HH claims this has led to improvements in health outcomes and reduced costs.

5.7. The ASA submits "value-based" contracting in fact reduces competition and choice by concentrating market power in the hands of insurers. The value-based payment systems rely upon large volumes of work to which collective pricing is applied. This treats patients as identical, not individual. It also obliges Providers to respond by working collectively. This makes it practically impossible to exist in the system as an individual Provider. Only fee-for service arrangements allow Providers to retain their independence and ability to operate at small scale.

5.8. The Application contains no evidence that "value-based" contracting improves health outcomes. There is no evidence in the Application of improvement in health outcomes in the US. In fact, the health system in the United States remains among the poorest performers compared to other developed nations as illustrated below:

Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	2	9	10	8	3	4	4	6	6	1	11
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

Source: Commonwealth Fund analysis.

The Commonwealth Fund

E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, *Mirror, Mirror: How the U.S. Health Care System Compares Internationally at a Time of Radical Change*, The Commonwealth Fund, July 2017.

5.9. The ASA is particularly concerned about the real impact of the "value based" contracting referred to in the Application. Simple data analytics of the sort described in paragraphs 2.25 and 2.33 of the Application will apparently be used to determine amounts to be paid to Providers (see paragraph 4.15). Such a process ignores the inherent conflict in health care that the most difficult to treat patients (i.e., those with comorbidities, the obese, multi-disease patients, and the terminally ill) are often treated by the most experienced and skilled doctors who, regardless of the exceptional care they provide, will not be able to prevent a disease from progressing and therefore cannot prevent a patient from needing further costly healthcare.

5.10. Providers treating such patients on a regular basis will never be able to achieve 'higher than standard quality outcomes' (to use the wording in paragraph 4.15 of the Application) and so those Providers would be paid less than other Providers who treat fewer challenging patients. If Providers are paid 'less for these services' because their 'standard quality outcomes were below average' (again, to use the wording from paragraph 4.15) then Providers would be discouraged from treating such patients as private patients and this would cause those patients to fall back into the public health system to obtain treatment from the Provider of their choice - notwithstanding their purchase of private health insurance. For a general discussion of the experience in the US see https://journalofethics.ama-assn.org/article/how-will-paying-performance-affect-patient-care/2006-03

5.11. Paragraphs 4.18 and 4.19 of the Application then deal with similar use of data analytics for the purpose of determining outcomes of particular procedures and the creation of 'a relative outcome scale established for each Provider at a procedure level'. The ASA is concerned that this will result in Providers being paid more for particular procedures deemed by insurers to be appropriate because of their apparent statistical efficiency rather than being based upon the needs of the individual patient as determined by their Provider of choice. A system which discourages Providers from using a treatment of their choice because they will be paid less for that treatment by an insurer cannot possibly benefit consumers.

5.12. It is also worth observing that experience in the US has shown if a patient has a procedure refused by a health fund the only option is for the patient to undertake legal proceedings against the health fund to gain approval for the procedure. Such legal action can cost a great deal and take a long time. Few patients have the time or money to undertake legal action.

Availability of Providers / Rural and Regional Australia

5.13. The ACCC also must consider the position of rural and regional doctors in Australia. There is already a desperate need for more medical specialists in rural and regional areas. Many regional towns have limited private health facilities and if a medical specialist is unable to enter into an arrangement with HH (or another major health insurer) it is likely they will not be able to work in the private healthcare facility in that regional town. This is likely to lead to unavailability of Providers in certain regional centres. We refer to our comments in 5.5 above.

5.14. In the alternative, the ACCC should be prepared to consider the ability for medical specialists (particularly in rural and regional Australia) to be able to collectively negotiate with healthcare payer groups such as the HH Buying Group.

Substantial lessening of competition / Significant increase in market power

5.15. HH intends to negotiate one set of terms and conditions including price schedules, business rules for payment of benefits and quality and performance targets for all providers (see paragraph 2.25: Application). It wishes to do this with a buying group which may involve the other large health insurers. The Proposed Conduct will therefore result in an enhanced ability for HH, nib and other health insurers to increase prices, profits and increase barriers to entry in the localised and national market for medical specialists.

5.16. The market power that will be held by HH will be significant and an individual Provider will be at a significant disadvantage and, realistically, be unable to negotiate on his or her own behalf. HH will instead be setting the terms and conditions of any medical purchaser provider agreement (**MPPA**).

5.17. If authorisation is granted, the reality is that there will be no ability for medical specialists in many locations to opt out of negotiations with HH. It is likely there will also be no ability to continue existing arrangements. HH would be in a position to exert considerable pressure on medical specialists to engage in the collective negotiations and if they do not the likelihood is that the medical specialist will not be able to practice at a specified healthcare facility or provide healthcare services to any HH and nib member.

5.18. Whilst the ASA acknowledges that the Proposed Conduct will not prevent Providers from offering healthcare services to other insurers, buying groups or healthcare payers that are not participating in the HH buying group, and will not restrict the terms and conditions on which the Provider is entitled to enter those agreements (see paragraph 2.9:Application), it is incorrect to state this means that Providers are not at any disadvantage or there is not a substantial lessening of competition in the market.

5.19. There will also be a significant impact upon Providers in relation to the proposed data analytic services which it is said will be part of contract negotiations (see paragraph 2.33: Application). HH intends to share information about Providers including, but not limited to cost information, adverse incident information, breach of contract information and discovery of fraudulent claims (see paragraph 2.34: Application). This information

will presumably be shared without the knowledge of the Provider - resulting in a lack of procedural fairness and, unless consent is provided, in breach of the Provider's privacy. The likelihood of any Provider willingly consenting to the sharing of such information is negligible but again, realistically, the Provider will be unable to negotiate and considerable pressure will be exerted to extract consent. Further, the proposed information sharing will increase information asymmetry as Providers will have less information about the price and quality of other Providers than HH. The Provider will not be fully informed.

5.20. Finally, the Applicants clearly state they intend to offer membership to the major health insurers to join the HH Buying Group either in full or by purchasing bespoke parts of the contracting services to supplement the major health insurers' internal contracting function. If this occurs then the share of the private health insurance market covered by members of the HH buying group would be over 70% (see paragraph 3.4: Application). The Application does not however reference any public benefit or detriments that would arise from their inclusion in the group. The Applicants should set out the public benefit and detriment they say would arise on the basis that all major health insurers joined the HH Buying Group.

6. Summary

6.1. The ASA submits the real purpose of the conduct described in the Application is to decrease payments to Providers and to seek to standardise the healthcare services given by Providers in order to minimise overall costs for health insurers and thereby increase profits. Consumers will not benefit from authorisation of this Proposed Conduct.

6.2. The ASA would be happy to provide further information if required by the ACCC and to participate in any Conference.

Yours sincerely,

Dr Suzi Nou
President
Australian Society of Anaesthetists