11 June 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 - Response to draft Determination

We refer to the draft Determination dated 21 May 2021 proposing to grant authorisation to enable Honeysuckle Health (**HH**) and NIB to form and operate a buying group to collectively negotiate and manage contracts with healthcare providers (**Providers**) on behalf of health and medical insurance providers and other payers of health care services (**Participants)**.

We also refer to the amended application for authorisation under section 88(1) of the *Competition and Consumer Act 2010* (Cth) (**CCA**) dated 6 May 2021 submitted by HH on behalf of itself and NIB.

For the avoidance of doubt, the amended application does not address or impact the submissions made by the Australian Society of Anaesthetists (**ASA**) as set out in my letter dated 8 February 2020 (**ASA First Submission**). The ASA maintains the position set out in that Submission.

The ASA remains strongly opposed to the HH / NIB application for authorisation which would set a precedent in Australia, allowing health funds to collectively negotiate and administer contracts with healthcare providers.

The ASA maintains that approval of the amended application:

(a) would not enhance the welfare of Australians through the promotion of competition and fair trading, contrary to the object of the 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, most importantly;

(d) would result in public detriment, by way of lower quality health care, which will outweigh any possible benefits arising from purported transaction cost savings and efficiencies.

The ASA sets out its specific responses to the Draft Determination below.

1. The Amended Application

1.1 The Applicants state HH operates independently of NIB and Cigna. HH was established as a joint venture between NIB and Cigna (with each owning 50% of HH). HH is clearly not independent of Cigna and such a statement that it operates independently must be treated with caution.

1.2 The amended application asserts that independent doctors would encourage the creation of a powerful managed care provider [see para 1.3]. Having regard to its membership which represents a majority of all anaesthetists working in private healthcare in Australia who contract with health payers, the ASA does not accept this assertion and says that the ASA membership would not support this assertion. A survey of ASA members conducted in April and May this year revealed that 72% of responding anaesthetists believed that contractual arrangements between health insurance funds and anaesthetists would have a significantly detrimental effect on practice. Only 1.2% believed that there would be a positive effect on practice.

1.3 The Applicants do not say which doctors they spoke to; the specialities of those doctors; or the percentage of time those doctors commit to the private sector. These are all important factors.

1.4 Further, the Applicants suggest administrative efficiencies will flow to doctors from participation in the provision of contracted services. The ASA submits this statement is incorrect. If the authorisation is granted, there will need to be separate administrative requirements for a doctor for each health fund. Doctors will have to negotiate as many payment schedules as there are health insurers. They will continue to do this even if there is a HH Buying Group. The present situation where a doctor sets his or her own fee, using a tool such as the Relative Value Guide or AMA schedule of fees, is both simpler to administer for doctors and more transparent than entering into a MPPA.

1.5 The ASA submits that the only reason the Applicants intend to create a buying group is to gain coercive market power. Doctors will not willingly sign up to MPPAs. The Applicants know this and need to be able to apply pressure for doctors to participate.

2. Nature of the Proposed Conduct

2.1 The Draft Determination concludes that the Proposed Conduct will not restrict the terms and conditions upon which Providers are entitled to enter MPPAs [see para 1.24]. It is said this is because Providers will be able to contract with Participants individually or with a different set of Participants than those proposed by the HH Buying Group.

2.2 The practical reality is that the Proposed Conduct will restrict the terms and conditions upon which Providers are entitled to enter agreements.

2.3 As set out in the ASA First Submission, the Proposed Conduct will make it increasingly difficult for doctors to determine their own fees - which is a fundamental aspect of a competitive and well-regulated market. The present system whereby doctors compete on quality and cost will be lost. If Participants have agreed to join the HH Buying Group then they will not agree to contract with Providers individually for the exact reasons set out in the amended application as to why they would want to join the HH Buying Group in the first place.

3. **Value-based contracting**

3.1 The ASA supports the Australian Medical Association's submission that the Proposed Conduct will create a vertically integrated managed care arrangement which will result in poor health outcomes and increased costs.

3.2 The ASA also supports the AHSA's submission that the Applicants have provided insufficient detail on how value-based contracting would assist patient outcomes and the Applicants have not substantiated the claim that value-based arrangements have been a key component of Cigna's 'success'. We refer to comments made above in this regard and note there is no evidence that value-based contracting provides any benefits for patients or Providers.

3.3 The Applicants' submission in the amended application that their conception of value-based contracting aligns the amount of funding for the healthcare services to the quality of care delivered and the outcomes for the patient has no basis in fact. The ASA has no doubt that the Proposed Conduct would lead to the implementation of a US-style 'managed care' model of service which will inevitably reduce patient choice and patient outcomes while increasing patient costs - thereby increasing the overall cost of healthcare in Australia and, thereby, the overall cost to be borne by taxpayers in funding the healthcare system.

3.4 The ASA disputes the ACCC's conclusion that if value-based contracting leads to reduced practitioner or procedure choice or worse health outcomes, then consumers will have the ability to move and HH participants will lose members to other insurers. The ASA submits this conclusion is naïve having regard to the Australian health market and

the fact that consumers are limited in their ability to move between the dwindling number of health insurers.

3.5 Finally, the ASA notes the comment in the Draft Determination [see para 1.41] that:

> *The ACCC understands there is no specific regulatory oversight or limitation on how parties contract with each other in the medical supply chain, and any such limitation (for example, to prevent value-based contracting) would be a matter for Government, through the Commonwealth Department of Health, to determine.*

3.6 The ASA queries why this is not a matter for the ACCC? Noting the role of the ACCC is to promote competition and fair trade in markets to benefit consumers, businesses and the community, is it not the ACCC that through this authorisation process must provide the specific regulatory oversight and limitation on parties contracting with each other in the medical supply chain that would lead to a decrease in competition, decrease in quality and an increase in consumer costs?

3.7 The ASA presses the ACCC to play its proper role in this process.

4. **No gap experience for customers**

4.1 The Draft Determination acknowledges the comment in the ASA First Submission that:

> *Under the current system, close to 90% of medical services in the private healthcare sector already involve no out-of-pocket 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 out-of-pocket expenses. Therefore, the argument that out-of-pocket expenses are a significant issue across the sector is false.[1]*

4.2 Yet, notwithstanding the submission by the ASA, the ACCC considers that uncertainty about the extent of gaps that patients face in the private healthcare system is one of the major concerns or causes of dissatisfaction for consumers.

4.3 The ASA notes that the ACCC provides no evidence for the basis of this statement and maintains that the statement that out-of-pocket expenses are a significant issue across the sector is false.

4.4 Patients / consumers have limited ability to change health funds. Many use comparator websites which the ACCC has reported helpful in 'overcoming choice paralysis' for

[1] The figure of 4-5% of medical services provided in the private healthcare sector under a 'known gap' arrangement was incorrectly stated in the ASA First Submission. We submit the correct known figure is closer to 7-8%.

consumers.[2] On April 1 2019, the Australian Government introduced a tiered (bronze, silver, gold)[3] nomenclature to standardise health insurance products to 'help make private health insurance simpler, and make it easier for people to choose the cover that best suits them'[4]. Despite these tools which would make it easier to change, historic data further indicates most policy holders rarely change health fund providers.

4.5 The ACCC also states that comparators are helpful in 'overcoming barriers to entry for small-to-medium enterprises (SMEs)' but that one of the 'hidden dangers is in undisclosed commercial relationships'.[5] CHOICE Australia found that comparator sites can earn substantial fees per sale from insurers (which then becomes money not spent on providing healthcare), that some sites compare only a fraction of the market and that some sites are actually owned by insurance companies they are supposedly comparing. The ASA asserts that a buying group such as Honeysuckle Health managing these SMEs attempting to enter the market and could reduce transparency for consumers and cause considerable consumer and market detriment by distorting results.

5. **Reduced healthcare costs and premiums for members**

5.1 The ASA maintains that any benefits that may arise for the Applicants will not be passed on to consumers [as noted in para 4.67]. The US experience does not support the ACCC's conclusion [see para 4.70] that:

> *competition between health insurers would provide an incentive for members of the buying group to pass on part of the savings to them (arising from their participation in the buying group) in the form of lower premiums (or lower increases in premiums) and/or better services to members, although the overall effect is unlikely to be large*.

5.2 The ASA notes that health administration costs in the US are the highest in the world. We refer to Appendix A which is located at: **https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/**.

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[2] Australian Competition and Consumer Commission, *The comparator website industry in Australia: An Australian Competition and Consumer Commission report* (Nov 2014).<https://www.accc.gov.au/system/files/926_Comparator%20website%20industry%20in%20Australia%20report_FA.pdf>.

[3] PrivateHealth.gov.au, *Product tiers* (Undated) <https://www.privatehealth.gov.au/health_insurance/howitworks/product-tiers.htm>.

[4] PrivateHealth.gov.au, *Private Health Insurance Changes 2019* (Undated) <https://www.privatehealth.gov.au/health_insurance/phichanges/index.htm>.

[5] CHOICE, *Insurance comparison sites* (Jun 2017) <https://www.choice.com.au/money/insurance/insurance-advice/articles/insurance-comparison-sites>.

5.3 Despite approximately 55% of Americans having private insurance, an estimated 25% are underinsured due to additional insurance-imposed excesses or “deductibles” ranging from $500 - $10000 per year.[6] In the US, more than 1 in 50 Americans who interact with the health system have an out-of-pocket excess of $5000 per year and 1 in 200 have costs over $10,000.[7] Whilst the ASA maintains that benefits which arise will not be passed on as lower premiums, we also note that consideration of premiums in isolation is not sufficient as it does not take into account excesses that may be imposed prior to the receipt of any benefits.

5.4 During the COVID-19 pandemic in Australia, health funds allocated $1.8b as deferred claims liability for a predicted increase in activity due to the pandemic. Rather than an increase in activity, there was a lower demand for healthcare. So far only the not-for-profit HBF and insurer AIA have moved to rebate cash to members.[8] Rather than redistribute some of the deferred claims liability, the larger for-profit funds, including nib, have increased premiums (nib by an average of 4.36%). This is further evidence that savings are not “passed on in the form of lower premiums” as claimed in the proposal.

6. Public benefits

6.1 The ACCC has determined the main public benefits likely to result from the Proposed Conduct are for 'the achievement of the economic goals of efficiency and progress' being:

(a) Greater choice of buying group for healthcare payers;

(b) Increased competition between buying groups;

(c) Increased input into contracts and improvements in information for participants in the HH Buying Group; and

(d) Some transaction cost savings.

6.2 The ASA submits that none of these stated public benefits are of value to the community generally notwithstanding the benefits of efficiency and progress for HH and NIB. It appears the ACCC has only looked at one side when considering public benefit and not looked at whether there will be any efficiency or benefits for Providers.

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[6] Advisory Board, *Who's underinsured in America, in 4 charts* (Feb 2019) <https://www.advisory.com/en/daily-briefing/2019/02/08/underinsured>.

[7] Ryan Nunn, Jana Parsons, and Jay Shambaugh, *A dozen facts about the economics of the US health-care system* (Mar 2020) <https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/>.

[8] Natasha Robinson, 'Health insurers ‘sit on pot of gold’, say private hospitals' *The Australian* (online), 21 May 2021 <https://www.theaustralian.com.au/nation/health-insurers-sit-on-pot-of-gold-say-private-hospitals/news-story/a71e7363126ffaf14ac55b03fa5af7fe#:~:text=Private%20hospitals%20say%20health%20insurers,cash%20pile%20of%20member%20contributions.>.

6.3 More importantly however, the ACCC has not set out any public benefits likely to result to the patient / consumer. The ASA submits this is because there is no public benefit that is likely to result for patients / consumers.

6.4 The ASA submits the biggest losers if the amended application is authorised will be patients / consumers. They will lose choice of doctor, and instead be required to seek healthcare services instead from large, profit-oriented companies.

6.5 The Australian healthcare system currently connects individual patients with individual doctors. There are no distortions or distractions from the provision of individualised care. Decisions on treatment and the setting in which it is provided are made for each individual patient. The Applicants wish to make these decisions on patients' behalf for the benefit of their shareholders.

6.6 The ASA notes the ACCC's primary role is to promote competition to benefit consumers.

7. Public detriments

7.1 The amended application did not seek to make any changes to the composition of the HH Buying Group in relation to medical specialist contracting. The HH Buying Group could still end up including all health care payers in Australia. This is the issue of most concern to the ASA and the amended Application does not therefore impact the comments made by in the ASA First Submission [see para 4.82].

7.2 The ASA agrees with, and reiterates, the ACCC's comments in the Draft Determination [see para 4.84] that:

> *The ACCC agrees that if the HH Buying Group comprised 100% of private health insurers, this would be likely to result in significant public detriment through its effect on competition between insurer healthcare acquirers and the bargaining position of small healthcare providers, and the potential reduction in the quantity and quality of health services. More specifically, it is likely that small healthcare providers would face strong incentives to accept the terms and conditions offered by the group. The risk of losing customers because they are not part of the Participants' schemes would also be significant if the HH buying group were very large.*

7.3 The ASA disputes the Applicants' submission that the impact of the HH Buying Group would be minimal in the market for medical specialist services because MPPAs are not critical to medical specialists but are an optional arrangement [see para 4.96]. It is correct that MPPAs are currently an optional arrangement however if the HH Buying Group is authorised and builds a significant market share it will become coercive and,

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as the ACCC has set out above, medical specialists would face strong incentives to accept the terms and conditions offered.

7.4 It is also misleading to state that consumers will retain the ability to choose their medical specialist and those specialists will still be able to treat members of the HH Buying Group's Participants [see para 4.98]. The reality is that consumers undergoing the same procedure with different medical specialists could receive different rebates for the same service. Consumers are likely therefore to choose (or be required to choose) the greater rebate and not their preferred medical specialist

7.5 The ASA acknowledges the ACCC has considered these issues and proposed a condition that HH must not supply services to any Major PHI as part of the Broad Clinical Partners Program if that would mean it collectively accounts for more than 40% of private health insurance policies in a State or Territory. The ASA does not believe this is enough and notes it only applies to the Broad Clinical Partners Program.

7.6 The ASA submits any contracting that includes major insurers *and* other healthcare payers will result in public detriment by reducing competition between acquirers of medical specialist services, not only the Broad Clinical Partners Program including major insurers.

8. Summary

8.1 The ASA believes the amended application and Draft Determination represents a turning point for Australian healthcare. Our members believe we must preserve the right of all Australians to have a choice of doctor and protect the freedom of all doctors to make treatment decisions unhindered by commercial pressures. The payer of health services must not be given the power to decide what treatments are on offer, where the treatment will be delivered, and who the treating doctor will be.

8.2 The ACCC has accepted that the Proposed Conduct is likely to result in public detriment by reducing competition in the acquisition of medical specialist contracting services [see para 4.143]. The ASA completely agrees.

8.3 The ASA disputes however that the public detriment is averted by the proposed condition of authorisation and that, due to the imposition of the condition, the Proposed Conduct will result in public benefit that will outweigh any likely public detriment.

8.4 The ASA requests the ACCC reconsider its position and final determination.

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8.5 In conclusion, the ASA urges the ACCC to refuse to grant the authorisation in order to prevent irreparable harm being done to the Australian healthcare system.

Yours sincerely,

Dr Suzi Nou
President
Australian Society of Anaesthetists