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11 March 2021

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Mr Darrell Channing
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Australian Competition & Consumers Commission
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Dear Mr Channing

RE: AA1000542 – Honeysuckle Health and nib – Submission

The Royal Australasian College of Surgeons (RACS) does not support the Application by Honeysuckle Healthcare Pty Ltd and other applicants for authorisation to form and operate a buying group for a period of ten years. The reason being, the Application is

- ultimately uncompetitive, detrimental to our patients, and
- goes against our blended healthcare system with the potential of creating a more litigious climate

In our submission RACS will focus on what we believe are the key elements of the Application which will dictate the business dealings of equal partners Honeysuckle Health and nib, and American based Cigna Corporation. “Managed agreements” in the Application under 2.32 is ‘managed care’ and it is a healthcare system which differs from Australia’s blended system designed for our demographic.

On behalf of RACS we appreciate the opportunity to provide feedback as it relates to the Application. RACS is the leading institution for the training of surgical practice for more than 7,000 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates in Australia and New Zealand.

Summary: Managed Care
The relevant provision for authorisation falls under section 88(1) of the *Competition and Consumer Act 2010* (Cth) (see link). RACS’s concerns are that this Application will introduce ‘managed care’ as “managed agreements” into the Australian healthcare sector. If this were to occur, patients will not be able to choose their own primary care regime. Instead a third-party or administration will end up deciding on their behalf. Reference to “managed agreements” in the Application under 2.32 goes to the very core of the parties’ intent.

Honeysuckle Health is also an ‘equal joint venture between nib health funds ltd and Cigna Corporation, a 'global health services company' according to the ACCC. This raises great concern for RACS as well with respect to a court matter concerning Cigna overseas. The United States Department of Justice (DOJ) has filed a 2020 lawsuit, which is publicly available, against Cigna alleging the company submitted fraudulent Medicare Advantage claims to the Centers for Medicare and Medicaid Services between 2012 and 2017 amounting to $1.4 billion in damages.[i] This matter appears to be ongoing.

This does raise the question if the ACCC has conducted due diligence on third parties. However, RACS respects the importance of natural justice for all. In the context of this Application, RACS’s primary concerns relate to the issue of ‘managed care.’

"Managed Agreements" is Managed Care (2.32)

The definition of managed care is effectively a health coverage arrangement which an entity contracts to provide third-party coverage and deliver covered services to members "through a network of providers selected and controlled by the entity."[ii] Its emergence in the United States have led critics to argue that it has

- restricted patient choices,
- reduced quality healthcare; and
- limited a medical practitioner's autonomy,

all in the interest of profit and shareholders of a corporation in the pursuit of revenue and the reduction of costs. It is quite clear that the Application is promoting 'managed care' as "managed agreements" under 2.32. It has all the hallmarks of 'managed care' with a third-party administration active in compliance, dispute resolution, customer complaints, data analytics, and performance and quality targets.

"Buying Group" (1.4)

The "buying group" criteria and scope under 1.4 of the Application is broad and open to outside market forces. The *Private Health Insurance (Prudential Supervision)* Act 2015 (Cth) sets out the guidelines under Part 2 with APRA being the legislative instrument under s174. As prescribed in the Application, the line between who can apply or is invited to the "buying group" is vague. Special emphasis was made to "international medical and travel insurance companies" under 1.4 of the Application. This raises concern as to external larger international companies accustomed to a 'managed care' environment and propelled by market forces attempting to influence our blended healthcare system in Australia. The clash in healthcare culture and expectations will be incompatible. There are no global limitations presented under 1.4 which defines our concept of a global health market and its impact on Australia.

"Value based contracting" (2.33, 4.15, 4.16)

"Value based contracting" under 4.15 to 4.16 of the Application is fundamentally incompatible with Australia, as this concept of healthcare delivery has germinated from a different healthcare system, namely that which exits in the United States. "Value based contracting" or VBC is about providing value-based care, which promises to "accelerate the shift from volume to value in health care". As Deloitte in the USA has recently articulated "The (American healthcare) industry is experimenting."[iii] But Australia does not need to adopt such a healthcare experimentation.

Healthcare in the United States is far more expensive for their citizenship by comparison to Australia. Let us examine private healthcare insurance premiums as an example. In December 2020 it was reported that the Australian federal government had allowed for an increase in premium to "for-profit health insurers Medibank (3.25%), NIB (4.36%) and Bupa (3.21%)" at a "higher rate than their biggest non-profit competitors HCF (2.95%) and HBF (0.95%), health department figures show." These five funds make up over 80% of the market here in Australia, but the overall average premium increases in Australia is 2.74%, the lowest since 2001.[iv] [v]

By comparison in the United States, the National Conference of State Legislatures (NCSL) reported in 2020 that "March estimated health insurance premiums could increase by anywhere from 4% to 40% for individuals and employers as a result of COVID-19."[vi] In 2018 it was recorded by the NCSL that "the average annual premium for employer-based family coverage rose 5% to $19,616 for single coverage, premiums rose 3% to $6,896."[vii] These numbers are significantly higher than in Australia.

As of 2020 the Worldwide Healthcare Rankings has Australia at 9th place compared with the United States at 30th.[viii] The Australian private health insurance industry has already adopted billing innovations like no gap and known gap schemes. In the interest of transparency RACS and other medical colleges and specialty societies have promoted informed financial consent as our national Golden Standard.

The other issue regarding “value-based contracting” is that it raises the question with respect to value care; who determines what is good value? If the Application is successful, the new entity is in a position of power to do so. This may promote easier procedures, with less inherent risk of complications, delivered cheaply. However, surgeons recognise that some cases are inherently riskier than others.

A system where surgeons and hospitals will not take on the challenge of a complex patient with greater risk of complications due to the possible funding implications under a value-based system does not support patient safety and quality care. In this system complex cases will all get forced into the public healthcare sector, leaving the private sector to conduct noncomplex procedures benefitting the insurers, but not the patients.

Litigation and Restriction of Trade

There is great potential for a cultural litigious change in Australian medical defence for specialities like surgery which we would not have otherwise experienced. These new parameters will challenge and most likely impact upon what a surgeon's responsibilities and fiduciary duties are within this new and combative context to the detriment of patient quality healthcare. This revolves around the critical distinction between an injury relating to the exercise of medical judgement by a medical practitioner and one which can be predicted on negligent benefits administration which does not involve a medical judgment.

For example, will the “managed agreements” under 2.32 ever partake in the practice of medicine or is its sole responsibility to make insurance decisions? If a medical practitioner’s request to refer their patient to a specialist on the basis of their expertise were to be rejected by the “managed agreements”, and the patient subsequently suffers a harm, where then will the liability fall? The Application creates the potential for a more adversarial relationship between a medical practitioner, the patient, the managed care provider, and the private health insurer. Hence, creating another layer for litigation to exist.

The restriction of trade practices may well be evoked if a specialist is denied service under Part IV of the *Competition and Consumer Act 2010* (Cth). There are several anti-competition provisions that the ACCC will need to consider. Testing these in court may well prove an expensive affair for all parties involved, including the ACCC. Do these “managed agreements” stipulated in the Application open the doors to cartel behaviour and collective boycotts in the midst of negotiations which may have broken down? The provisions that may be triggered under the *Competition and Consumer Act 2010* (Cth) are as follows:

- s45 Contracts, arrangements or understandings that restrict dealings or affect competition
- s46 Misuse of market power
- s47 Exclusive dealing

Conclusion

RACS respects that in our unique Australian blended healthcare service environment there is a need for doctors to:

- communicate with their patients as to their fees to diminish any ambiguity, and
- work with private health insurers where necessary to reduce any opaqueness in fee-for-service arrangements.

The key component here is transparency. However, RACS has significant concerns that if the Application is made successful, the Australian healthcare system would be a step closer to a United States-style ‘managed care’ model of healthcare in which patients rather than being

prescribed the type of treatment their doctor thinks is best, may receive care influenced by what is 'on tender' or 'under contract'. Because of this concern, RACS will not be supporting the Application.

Yours sincerely

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[i] USA VS CIGNA ET AL Filed 4 August 2020, p.2 https://www.documentcloud.org/documents/7014553-USA-vs-Cigna-08-04-20.html

[ii] Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, Law and the American Health Care System (Foundation Press, NY, NY, 1997; 2000-2001 supplement). Ch. 2J

[iii] Coppola J, David A, Morgan J & Imada M., Value-Based Contracting Services, Life science innovation and health care reimbursement models" *Deloitte* Last Accessed 10 February 2021 https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/solutions/value-based-contracting-services.html

[iv] Fernyhough, James., "Big health insurers ratchet up premiums", *Financial Review*, 21 December 2020 https://www.afr.com/companies/financial-services/big-health-insurers-ratchet-up-premiums-20201221-p56p9d

[v] Australian Government., "Average annual increases in private health insurance premiums", *Department of Health* Last accessed 12 February 2021 https://www.health.gov.au/resources/publications/average-annual-increases-in-private-health-insurance-premiums?utm_source=health.gov.au&utm_medium=callout-auto-custom&utm_campaign=digital_transformation

[vi] Pistor, Jack., "Are Health Insurers Panicked by the Pandemic? Not Yet", 29 July 2020, *National Conference of State Legislatures*, https://www.ncsl.org/research/health/are-health-insurers-panicked-by-the-pandemic-not-yet-magazine2020.aspx

[vii] "Health Insurance: Premiums and Increases", *National Conference of State Legislatures*, 4 December 2018, https://www.ncsl.org/research/health/health-insurance-premiums.aspx

[viii] "How Australian Healthcare Ranks Worldwide (2020)"., 5 June 2020, *Healthcare Channel* https://healthcarechannel.co/how-australian-healthcare-ranks-worldwide-2020/