COPS Response to ACCC Draft Determination (DD) Regarding Honeysuckle Health[1]

Executive Summary

The Council of Procedural Specialists' (COPS) position is that the proposed conduct should not be authorised. COPS is concerned that the assessment of net public benefit is speculative. Inadequate consideration has been given to the public detriments likely to be incurred by patients and the adverse impact on Australia's successful healthcare delivery system.

Health funds' consumers' major concerns

1. According to the ACCC, in its most recent Senate Report, the "key issues of concern" regarding private health insurance as reflected in consumer complaints are ***"…hospital policies with unexpected exclusions and restrictions, and complaints about extras treatment."***[2][Bolding added]

2. COPS is concerned that if the application is approved, these "key issues of concern" are likely to worsen as "health fund determined concepts of value" are imposed by confidential contractual arrangements between third party payers and those who deliver healthcare.

No regulatory oversight of proposed unsighted contracts

3. At 1.41 of the Draft Determination (DD), the ACCC has disclosed that ***"…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."*** [Bolding added]

4. This admission by the ACCC is reason alone for the application to be dismissed until proper consideration of this issue has been determined by responsible regulators and legislators, after appropriate public debate.

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[1] Draft Determination - 21.05.21 - PR - AA1000542 - Honeysuckle Health and nib.pdf (accc.gov.au)

[2] ACCC Report to the Australian Senate on Anti-Competitive and Other Practices by Health Insurers and Other Providers in Relation to Private Health Insurance 1/7/2019-30/6/2020 pg. 2

Potential health detriments not assessed and proposed contracting model "not clear"

5. 1.42 of the DD states "***At this stage, the ACCC notes that the Applicants propose to introduce a different model of contracting with Providers but it is not clear how different this is likely to be.*** *Even if the Applicants' model does prove to be significantly different, the ACCC considers it is only likely to be implemented broadly if the Applicants can gain the agreement of Providers and there is also support from consumers.* ***That is, if 'value-based contracting' leads to reduced practitioner or procedure choice or worse health outcomes, consumers have the ability to move and HH participants will lose members to other insurers****."* [Bolding added]

6. In reality, in many instances **"worse health outcomes"** may not be able to be rectified. The whole-body system cannot be compared to a standardised product or defective consumer good. For this reason alone, the application should not proceed.

7. **COPS maintains that it is inconceivable that Australians should be subjects of an experiment potentially involving "worse health outcomes" arising from the ACCC approval of unregulated and unseen value-based contracts.** Denial of medical treatment has real implications for vulnerable Australians. The market should not be used as an experiment to road-test unseen and unapproved value-based contracts.

Value-Based Contracts

8. In researching US and European application of value-based contracts, COPS finds no compelling case for the approval of value-based contracts as proposed by the applicant, designed to establish a "clinical partnership" between a doctor and a third-party payer in order to deliver value ***"from the third-party payer's perspective"*** [1.30 of the DD].

9. COPS notes a recent analysis of a Canadian P4P (Pay for Performance) programs, finds *"There is a variety of nuanced P4P initiatives, which provide financial incentive according to differing criteria, based on quality measures, incentives, and/or benchmark structures. However, there is no conclusive evidence demonstrating that P4P programs provide better value for money than traditional pay schemes, regardless of particular structural choices.* ***Some evidence has even shown that P4P may be detrimental, especially in disadvantaged and high-risk populations. Additionally, there are a number of ethical and practical concerns that arise with the use of P4P, such as the risk of financial incentives being misused or misinterpreted and patients being refused or referred during treatment. P4P initiatives require careful examination and the creation of solid, evidence-based criteria for evaluation and implementation in Canadian medical systems.***" [3]

10. In 2019 in the US, Ferris Taylor, Executive Director of the Healthcare Executive Group (HCEG), [previously The Managed Care Executive Group (MCEG)], states as follows concerning value-based contracts in the US **"Is it concerning that the transition from**

[3] An Analysis of Pay-for-Performance Schemes and Their Potential Impacts on Health Systems and Outcomes for Patients - PubMed (nih.gov)

volume to value has been on the HCEG list for ten years and still looks to be five-plus years off?" [4]

11. COPS concludes from its own research that claims of the benefits of value-based contracts have been over-stated and not subject to sufficient rigorous research. Furthermore, there is every indication that the concept represents the imposition of a top-down closed system solution being imposed by third party payers whilst disregarding the complexities and dynamics of the safe and effective delivery of healthcare by those who have clinical and legal responsibility to deliver it.

Greater opportunity for conflicts of interest impacting on patient care

12. Since the applicants have stated that the formula for the contract will determine value **"from a health care payer's perspective"** [5], COPS considers that this opens up strong possibilities of a conflict of interest between the health fund's determination of value v. the patient's determination of value v. the doctor's determination of clinical need. These complexities are likely to be compounded in emergency situations where fast approval is required, and should be added to the public detriment arising from this application.

Established medical colleges sidelined in favour of commercial concepts of value

13. COPS draws the ACCC's attention to the role of medical colleges in determining the efficacy and safety of clinical practice and the measurement thereof. Health funds have never had this role. It would result in a shift of clinical decision making from those who have clinical and legal responsibility for the outcomes to those who do not. It is therefore critical that treatment considered to be effective and clinically indicated is determined by those who are specialists in medical treatment. This treatment should be funded by insurers in order to deliver and maintain standards of care that Australians consider acceptable. Eroding the role of medical colleges is a public detriment, as yet not considered in the DD.

ACCC determines that health funds, not patients, 'acquire medical services'

14. COPS notes that the ACCC has determined that it is the health fund (not the patient or consumer with private health insurance) that is "acquiring health services" of medical specialists, GPs and allied health professionals. ***"The ACCC notes that private health insurers compete to acquire health services from hospitals, medical specialists, general practitioners and allied health professionals."*** [4.83 of the DD]

15. The implications of this assertion appear to be that under the proposed contractual arrangements, the health fund member (consumer) has forfeited their individual right to

[4] https://revcycleintelligence.com/news/value-based-contracts-with-risk-3-to-5-years-away-for-providers
[5] "The Proposed Conduct involves a value-based contracting model, which HH describes as comparing health outcomes with the costs of providing services to determine the value of the service from the healthcare payer's perspective." (1.30)

acquire the health services that they determine/prefer, despite this principle of choice of practitioner being a foundational element of Medicare. COPS maintains that the implications of this reinterpretation of the principles currently governing Medicare and the doctor-patient relationship is at the centre of COPS concerns about Australian healthcare system moving to a US styled Managed Care model. The end result will be a displacement of the established and successful Australian healthcare model where patients make decisions in conjunction with their treating doctor. According to the US Commonwealth Fund, our unique Australian model has resulted in world's best health care outcomes and efficiency of healthcare delivery. [6]

Impact on General Practice

16. Furthermore, it is unclear how the acquisition of GP and specialists' services, by the applicant will impact on the established GP/specialist referral model which underpins the payment of Medicare rebates to the patient and imposes strict requirements for referral to a particular specialist under Medicare rules. [7]

17. COPS considers there is real potential under these proposed arrangements to disrupt the established pathways between patients, their preferred GPs and their preferred specialists. It is accepted that having a strong primary healthcare sector is critical to the efficient and effective operation of the overall healthcare delivery system. Anything that undermines this principle, COPS believes should be considered a significant public detriment. For this reason, policy changes to Australian healthcare should seek to strengthen not undermine Australia's primary healthcare system.

Who determines value?

18. The DD provides no explanation of what happens to patients who have purchased private health insurance but whose treatment options are declared by the health insurer (applicant) to be of low-value under a value-based contract. What rights do these patients have to challenge these often clinically controversial decisions and who will fund any objections process? Under this DD, there is a strong possibility that patients which nib describes as "frequent flyers" [8] will find themselves being transferred to the public hospital system or health fund approved modalities of care whose primary goal is to contain health costs. COPS asserts that this will result in a significant unstated public detriment and loss of public confidence in private health insurance.

[6] Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, Pg 2

[7] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=GN.6.16&qt=noteID

[8] "PHI, States and Commonwealth payers together contract with GPs (healthcare home) for the purposes of better managing 'frequent flyers' and reducing unnecessary volume." Presentation to UBS Australasia Conference – November 2016 pg. 5

De-facto substitution of risk rated private health insurance to the detriment of community rating

19. COPS considers that an unassessed public detriment arising from the draft approval of value-based contracts specifically purposed to eliminate health fund determined low-value care, is the undermining of a key equity principle of Australian healthcare: namely community rating (equal sharing of burdens). Australian healthcare has always held that all patients' health care needs are worthy of clinical diagnosis, and where clinically indicated, medical treatment, underpinned by our Medicare rebate system. Dividing patients into those with high or low value needs will disadvantage those patients whose treatment options are limited but may improve their condition. In practice, this is likely to be implemented by the health fund insisting on "pre-assessment" of patients by a health-fund-contracted specialist to determine if their clinical needs warrant specialist consultation. From the patient's perspective, they will simply be told that the medical specialist they are seeking to consult on referral does not provide that form of treatment or that their condition does not qualify. Hence, the patient may never know the reasoning behind their inability to see a particular specialist. The mechanism of value-based contracts allows the third-party payer (according to the DD the acquirer of health services) to remove insurance costs (risks) without raising public controversy, resulting in a move to full risk rated private health insurance, which policy makers up till now have considered to be contrary to the public interest. This detriment has not been addressed in the DD.

Incentive Payments to doctors – no definition or limits

20. The DD also fails to clarify the legality of paying or providing contracted doctors or other health professionals "incentives" to treat patients according to health fund protocols. Such "incentives" are legislated against in other areas of health care. However, as the ACCC has noted, value-based contracts are not regulated, leaving open the prospect of future use of incentives and disincentives by the applicant and other third-party funders leading to potential conflicts of interest, ethical concerns and related loss of public confidence in the quality of Australia's medical treatment.

Patient Disempowerment

21. COPS draws attention to the fact that the determination will permit and create an asymmetrical power imbalance delivered by a contractual business/clinical partnership between doctor and health fund payer in comparison to the individual patient. The ACCC has not considered this aspect of public detriment in its determination.

Denial of Managed Care not plausible

22. COPS notes that the applicants give assurances that value-based contracting of medical specialists will not give rise to managed healthcare. The ACCC is aware that the application is supported by Private Healthcare Australia, which is the peak organisation for private health funds. This organisation was previously known as the Australian Health Insurance

Association (AHIA). Its published platform includes the following: "The AHIA supports the development of managed care initiatives". (*Working with Medicare*, April 1993, p22.) Therefore, COPS is not reassured that the blights of Managed Care, which have been avoided by the Australian healthcare system thus far, will no longer be avoided should the ACCC grant final approval. This potential public detriment cannot be eliminated by assurances from the applicants which include a US health corporation, experienced in the implementation of Managed Care practices. Furthermore, the ambitions of nib in regard to its future direction may be interpreted from its own presentations as predicting that by 2025 'DVA is outsourced and operated by PHI' and that by 2040 'Private sector operates entire public hospital system under contract'.[9]

Commercial Coercion to sign Value-based Contracts

23. The applicants maintain that medical practitioners who do not sign contracts will not be adversely impacted. ***"The Applicants have not sought authorisation for the HH Buying Group to engage in the collective boycott of any services of a Provider. This means that no Provider would be obliged to deal with the HH Buying Group, and the HH Buying Group is not permitted to boycott any Providers that refuse to deal with the group."*** [1.16 of the DD] [Bolding added]

24. The above conveniently ignores the fact that there is no prohibition on the applicants using significant financial resources and advertising budgets to 'position' doctors who have not signed value-based contracts as being 'not preferred' as providers of medical specialist services. The Australian medical profession is more than aware of the tactics used by corporate health funds to coerce patients and health fund members to use their preferred provider network, including reimbursing patients with lower "differential rebates" for choosing out-of-network doctors and advising health fund members who have agreed to a procedure with a medical specialist of their choice of their health fund approved alternatives. The independent medical practitioner has no ability to respond to such behaviour, which has previously been raised with the ACCC. The playing field is not level.

25. There is no guarantee that existing no-gap and known-gap arrangements will not be altered to provide significant disincentives designed to drive doctors towards value-based contracts as being the only option for their survival. **These factors are likely to lead to a loss of confidence amongst the medical profession in private health insurance.** This potential detriment has not been adequately assessed.

26. COPS considers that the approval will significantly reduce the opportunity for medical specialists and other health professionals to practice independently without value-based contracts, and hence deprive patients of the services of a significant number of independent non-contracted medical practitioners and health professionals. This is a public detriment.

[9] Presentation to UBS Australasia Conference 8 Nov 2016, Pg 7-8

Arbitrary 40% 'market share' cap

27. The draft determination imposes a 40% 'market share' cap on the buying group. The ACCC states that 40% is at the 'upper end' of what it was prepared to authorise - however it is still at a level which gives the buying group 'market power' and should be rejected so that the possibility of more than two health funds collectively bargaining together in any state is not possible.

28. The ACCC has offered no explanation as to why the 40% 'market share' cap has been chosen, as opposed to 20% or 30%. COPS submits that the 40% 'market share' cap does not provide sufficient protection from the detriments outlined in our submission.

Competition between buying groups

29. The emergence of buying group competition is questionable as, if a member of an existing buying group joins nib/Honeysuckle buying group, in practice its membership of other buying groups is likely to cease.

30. COPS is concerned that the result will be a large buying group led by one of the private health funds without any real or qualified benefit in terms of improved contracting or patient outcomes. COPS expects that (at least some) members of other buying groups will join the nib/Honeysuckle buying group, and that the strength of competition from existing buying groups will be diminished. The DD apparently recognises this at 4.11, 4.93.

No protections against reduced service quality

31. The conduct proposed to be authorised provides no protections against reduced quality in terms of what is and is not included for a particular surgical procedure. In practice it is likely to be difficult for doctors to resist participating if the applicant is successful signing up doctors in the same hospital, and more experienced doctors will be prevented from independently valuing their own services commensurate to their experience. COPS is concerned that this will result in doctors being forced to accept take-it-or-leave-it terms, and there will be a real risk of boycott activity as a practical matter, e.g. removal of doctors from operating lists, downgrading of doctors from current or preferred operating slots if they don't participate. See 4.98 of the DD.

Term

32. While the term of authorisation has been scaled back from 10 to 5 years, COPS submits that it is still too long given that no known "value-based contract" is currently in use and therefore, the purported benefits and detriments of a value-based model to the Australian health system and patients is unknown. COPS opposes authorisation, given the potential public detriments.

Cybersecurity and Health Data

33. According to the DD at 1.37 ***"The existence of the HH Buying Group provides the scale required to engage with Providers – both in terms of data collection and wide participation to ensure a standardised approach to value-based contracting***" and at 4.138 ***"they recognise the importance of data sharing parameters, both commercially and legally, and they will continue to adopt a best practice approach to both privacy and data governance through HH's Risk Management Framework and Information Security Management System"*** and at 4.139 ***"the personal information of each Participant's members will not be shared between Participants and it will not be shared with international organisations."***

34. **It is not clear in the DD whether the applicants will have access to the My Health Record (MHR) system and what contractual obligations will be placed on doctors to provide patient information under the value-based contract yet to be seen**, and what third party use the applicants intend to apply to the data collected. According to Deakin University Law Professor, Danuta Mendelson, *"The MHR system potentially facilitates access to patients' health information by individuals and entities beyond the practitioners who are directly providing them with healthcare and, in some circumstances, without the patients' consent."*[10]

35. COPS draws the ACCC's attention to previous data breaches by major health funds. In 2017, Bupa's Global Managing Director Mr Sheldon Kenton advised that 'an employee in its Global Division had inappropriately copied and removed some customer information'. The magnitude of the breach was acknowledged by Bupa Australia's Management, as involving 547,000 customers of which 19,595 were believed to be Australians.[11] Mr Kenton also advised 'the data was made available to other parties'.[12] In 2015, Medibank Private, trading as Medibank Health Solutions, dismissed a contractor, Luxottica Retail Australia, following revelations that personal medical data belonging to the Australian Defence Force had been sent offshore.[13]

36. US health industry analyst CB Insights is reporting that healthcare data breaches are at an all-time high in the US, with 172 data breaches already reported by healthcare providers in the US in 2021 (514 in 2020), stating 'patient data is among the most profitable information hackers can get their hands on, plus healthcare organisations' critical operations making them attractive ransomware targets… we don't expect the barrage of attacks to subside anytime soon.'[14]

37. COPS maintains that the potential public detriments of the inappropriate use of patient information following the introduction of new layers of health data analytics have not been addressed or assessed in the DD. For this reason alone, the DD should not be approved.

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[10] 'The My Health Record System: Potential to Undermine the paradigm of patient confidentiality?' (2019), Wolf & Mendelson, *UNSW Law Journal* Vol 2 (2)
[11] 'Nearly 20,000 Australians caught up in massive Bupa Global data breach', SMH 17 July 2017
[12] 'Nearly 20,000 Australians caught up in massive Bupa Global data breach', SMH 17 July 2017
[13] 'Defence medical records sent to China in security breach', SMH, 7 July 2015
[14] 'In defence of Healthcare', CB Insights

Condition to authorisation

38. COPS notes the reasoning behind the imposition of the condition to authorisation (the 40% cap). However, there are major concerns and uncertainties about how it will be observed and enforced in practice. A particular concern is whether the APRA data which will be used to assess the cap will be current. The APRA data cited in the draft determination is two years old, from 2019. COPS submits that the 40% cap is not a valid safeguard on the public detriments.

Other conditions

39. 4.79 of the DD states that nib/Honeysuckle submitted that it would be reasonable for the ACCC to impose a condition requiring the buying group to notify the ACCC of new Participants to provide the ACCC with an opportunity to raise any concerns it may have. The draft determination does not impose this requirement. COPS questions why not?

Conclusion

40. **The Council of Procedural Specialists (COPS) cannot support any scheme that potentially compromises the relationship between doctors and their patients. COPS maintains that the Draft Determination introduces significant risks to the stability of Australia's internationally recognised, world class health care system, which is under-pinned by patient choice of doctor, referral to medical specialists on the basis of clinical need not health fund membership, the protection of patient confidentiality in healthcare data, community rated private health insurance, and the rejection of third party intervention into clinical decision making as exemplified in the anti-conscription provisions of the Australian Constitution**.

41. **COPS requests that the ACCC review its position as stated in the Draft Determination and not proceed to authorise the application in the public interest**.

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