5 February 2021

Mr Michael Pappa
Competition Exemptions Branch
Australian Competition and Consumer Commission
exemptions@accc.gov.au
Reference No: AA1000542-1

Dear Mr Pappa,

AA1000542 - Honeysuckle Health and nib – Submission

Catholic Health Australia (CHA) appreciates the opportunity to comment on Application AA1000542-1 lodged on 24 December 2020 (the Application).

By way of background, CHA is the peak body for Australia's largest non-government grouping of health, community, and aged care services. CHA not-for-profit (NFP) Catholic hospital and aged care providers promote the ministry of health care as an integral element of the mission and work to fully provide health care to the sick, the aged and the dying.

CHA members share a range of concerns about the application, principally in relation to:

- Understanding the public detriments that may arise, for example, how the bargaining power of the proposed buying group may impact providers, particularly smaller health care providers, in contract negotiations;
- Privacy protections and how information sharing will be managed;
- How government agencies will manage potential conflicts of interest when aligning their negotiations with commercial entities;
- Conflicts of interest for the involved parties, particularly nib who holds a 50% stake in HH;
- What protections will be in place to prevent the buying group from engaging in cartel behaviour or collective boycott when negotiations have broken down and funds refuse to deal with the health care provider;
- Testing the public benefits identified in the Application and whether these have been overstated.

Assessing Participants Collective Negotiating Impact on Health Care Providers

In considering this Application, we would suggest the Australian Competition and Consumer Commission (the Commission) pay particular attention to the impact the buying group will have on providers. Smaller NFP private hospitals play an important role in the Australian

health care sector but are typically 'price takers' in negotiations with private health funds. The ability for smaller NFP private hospital operators, and indeed all providers, to invest in medical equipment, attract doctors, and to improve service quality and health care is directly correlated with the ability to negotiate reasonable rates from health funds.

Pursuant to the Application, Honeysuckle Health (HH) seeks authorisation to negotiate collectively on behalf of an insurer buying group. CHA is concerned the Application lacks clarity around key aspects that CHA believes would be necessary for the Commission to assess the public benefits and detriments that are likely to arise from the proposed conduct.

Further, CHA is also concerned the Authorisation does not clarify which health funds will form the buying group. The open-ended nature of the application means it is possible, and cannot be ruled out, that larger health funds will form part of the buying group (for example, Medibank, Bupa, HCF and HBF). The potential membership of larger health funds will distort the analysis of public benefits and detriments.

The Application sets out the view that the proposed buying group might result in conduct to which the cartel (Division 1, Part IV), general substantial lessening of competition (s.45(1)), concerted practices (s.45(1)), misuse of market power (s.46(1) and exclusive dealing (s.47(1)) provisions are of the *Competition and Consumer Act 2010* would apply. CHA urges the Commission to seek clarification as to how and why the proposed conduct might result in the application of the aforementioned provisions and whether the conduct could be engaged in without the terms of the authorisation sought.

CHA is concerned that statements made within the Application are, on occasion, inaccurate or unclear. For example, HH indicates it intends to use the current nib contract as a base for negotiations. CHA notes that these contracts are generally based on per-diems (as opposed to Diagnostic Related Groups) but the Application articulates an intention to move contractual benchmarks to a Diagnosis Related Grouping (para 4.18). CHA would urge the Commission to seek clarification on these contradictory assertions.

Potential for Public Detriment

CHA has also considered some of the potential public detriments that were not raised in the Application. The Application proposes to aggregate health fund bargaining power as against all private hospital operators – both small and large. This increase in bargaining power as against smaller hospitals has the real potential for significant public detriment. It is likely to put additional pressure on smaller hospitals' ability to negotiate reasonable revenue which it relies on in order to improve and invest in quality of service, advanced treatments and up to date equipment, while being able to attract doctors and adequately staff hospitals. The establishment of the proposed buying group is unlikely to materially change the ability to negotiate better terms as against large private hospital operators. Accordingly, it will asymmetrically reduce the competitiveness of smaller private hospital operators as against larger private hospital operators.

CHA believes the authorisation of this buying group has the potential to increase inefficiencies and costs in the market. This has been demonstrated by an existing buying group where the

outsourcing of the contracting negotiation function often creates additional disputes over contract interpretation because funds are removed from direct discussion and development of the contract. A lack of clarity around the business rules also results in delayed payments from funders that create cash flow issues for health care providers. This subsequently results in increased administration and governance costs after signing. CHA is concerned that where HH conducts negotiations for multiple funds, administrative costs arising out of contractual interpretation disputes is likely to increase.

Implications for Conflicts of Interest

The Application proposes no mechanisms to deal with the inherent conflict of interest or proliferation of confidential commercial information inherent in the authorisation of the proposed buying group. Nib maintains 50% ownership of HH and may find itself in a position to obtain information and data from HH that would give it a competitive advantage vis-à-vis the smaller health fund members of the buying group. Apart from access, nib may also find itself in a position to benefit from the asymmetric use of data. HH purports to act as an agent for negotiations for all health funds while presenting a common contract to all members of the buying group. However, not all health funds will have the same interests. In particular, there is a real risk that a competitor's substantial ownership of HH is likely to mean: nib's interests are prioritised over other members; and/or that there is some additional strategic ability of nib to advantage itself. An example might include the establishment of benchmarks that are comparatively beneficial to nib's membership base when compared to other buying group members. We would recommend the Commission seek clarification from the Applicants on what protections (if any) will be put in place to ameliorate the risk that nib become privy to information on their competitors.

The Application does declare the Department of Veteran Affairs (DVA) and other government agencies as potential participants in the HH Buying Group who currently negotiate directly with health care providers. This raises concerns about the privacy and security of information and how this might be used as a competitive advantage for participants that have a greater stake in the buying group. CHA is wary of arrangements that align government agencies with the commercial interests of one group of market participants over and above the interests of other market participants. CHA urges the Commission to take a closer look at the range of potential consequences this sort of arrangement might have for private hospitals.

Data Analytics and the Transition to Value-Based Contracting

CHA is also concerned that data collected, aggregated and analysed by the buying group is likely to disadvantage smaller health care providers. Smaller hospitals often have less capability or sophistication to do data analysis, and funds use their data analysis capability to negotiate terms against smaller hospitals without the hospitals having a clear sense about what this means. Terms negotiated under these conditions will typically result in funds paying hospitals less money for activities undertaken than would otherwise be fair and reasonable.

CHA believes the Commission should also seek clarification on the Applicants' understanding of value-based contracting. The Commission would be aware that much of the benefits or detriments of this type of contracting depend on the detail of the terms and conditions.

Value-based contracting in some circumstances is a means of imposing undue penalties on private hospitals, and is typically the result of an imbalance in bargaining power rather than any desire to move to better quality outcomes for patients. CHA urges the Commission to seek clarity on the terms of the proposed value-based contract and an explanation as to why it should be satisfied that any authorisation would not incentivise the buying group to impose undue penalties on hospitals.

CHA believes the assertion that the ability to negotiate more contracts on 'value-based contracting' basis will lead to better health outcomes at lower costs is overstated. There is no basis for concluding that value-based contracting will lead to better health outcomes – in many ways, these terms can be arbitrary and impose penalties on hospitals without a corresponding health outcome. Health funds are profit maximising entities that obtain fees from members – in exchange for negotiation of the provision of services by hospitals to those members. Health funds benefit from increasing the fees charged to members while reducing the benefits paid to hospitals for members (that is, their margin). The Commission should not accept without evidence that HH's assertions about value-based contacting will result in lower healthcare costs and premiums for members.

Supporting Quality and Patient Outcomes

CHA believes that improvements in patient outcomes are best supported by initiatives that provide immediate feedback to clinicians and are informed by industry wide consensus and evidence-based best practice. CHA health care providers work closely with the Australian Commission on Safety and Quality in Health Care and other such organisations to improve safety and quality. CHA contends this should not be dictated by negotiations around financing and hospital contracting.

The Commission should also exercise caution when considering the timeframe for authorisation. Contracting rounds usually range from one to three years. It is CHA's view that five years is sufficient time for HH to experience several rounds of contracting and for the Commission to be in a position to assess if the Authorisation should stand with the benefit of several years' experience.

CHA urges the Commission to only consider authorisation where it has been able to establish conditions or clarity on the matters raised in this submission, including but not limited to how information sharing will be managed, how conflicts of interest will be managed, and whether there is some form of restraint on the buying group intended to be in place during negotiations.

Should you wish to discuss our submission in more detail, please contact James Kemp, Health Policy Director at [redacted] or on [redacted]

Yours sincerely,

Pat Garcia

Chief Executive Officer
Catholic Health Australia