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Dear Sir,

AA1000542 Honeysuckle Health (HH) and nib application for authorization – Draft determination

Thank you for forwarding on 21 May 2021, your draft determination regarding this matter. Adventist HealthCare Limited (AHCL) has further considered this matter including your draft determination and wishes to make the following additional submission:

1. **HPPA contracting**

We note in the draft determination that HH would not be open to contract HPPA's for Medibank, Bupa, HCF or HBF in WA. AHCL is supportive of this direction however the draft determination does allow HH to contract for the Australian Health Service Alliance, ARHG buying groups as well as some small funds, HBF (other than in WA) and DVA. AHCL believes this would give a potential dominant market power to HH if they were successful in enlisting these other groups. AHCL submits that HBF and DVA should be excluded from the authorisation on the following basis:

- HBF is the dominant market player in WA and may gain significant market presence in other states because of these arrangements for no known benefits to the consumers or industry.
- DVA should be excluded:
  - As they represent the Federal government in contracting health services;
  - Because their case mix is significantly different to the case mix of the rest of the insured population. As an example, the DVA case mix tends to be an older generation with more comorbidities, greater mental health issues and longer length of stays than the general insured population. AHCL fears that nib and HH in the negotiations will adopt a standard approach for care of veterans with consequential negative impacts on the quality of care delivered to the veteran community; and
  - Because it is unclear how the existing contractual arrangements between DVA and providers (open-ended tender with standard contract conditions and price escalation) can be varied to accommodate the HH proposal.

2. **Broad Clinical Partner Program**

The draft determination allows HH to contract on behalf of nearly all funds under their broad clinical partner program. This includes Medibank, Bupa, HCF and HBF. In the ACCC's summary, it suggests that this is for "no out of pocket costs (medical gaps)" whereas in the detail of the draft determination, it covers both known and no out of pockets. AHCL believes there is little public benefit in having another party with a "known out of pocket for medical gaps" cover. Consumers generally believe that they should be fully covered for services and thus pay a higher health insurance premium or pay a lower premium for a known excess or co-payment. AHCL believes any authorisation from the ACCC should have a real public benefit and be limited to no out of pockets and should cover all medical services, i.e. surgeons, assistant surgeon, anaesthetists, radiology, pathology etc.

ACCC is proposing to authorise HH to engage participants that would not exceed the 40% of that state or territory. AHCL believes the 40% market share is far too high and believes it should be limited to 30%.

3. Public Benefit, Transparency and Known KPI's

AHCL believes that any authorisation that is being given for public benefit should at the outset (prior to authorisation being granted) have publicly known and agreed KPI's established which can be measured and reported against and used in monitoring the authorisation and assessing any extension of authorisation. AHCL believes that it is far too easy for applicants to seek authorisation without having to demonstrate the public benefits. Furthermore, we believe it puts the ACCC in a much stronger position to monitor and assess if there is agreed minimum KPI's for assessment.

It is also unclear how broad the clinical program could be and what additional burden it may place on hospitals or clinicians in submitting data to the program.

AHCL believes that:

- No additional data sets for items should be imposed on hospitals or clinicians unless mutually agreed through industry bodies; and
- Quality indicators could be inappropriately used with a detrimental impact on the quality of care. For example, the inappropriate use of the HAC data set. AHCL believes that the authorisation should require approval by the Australian Safety and Quality Commission of any quality indicators used and the appropriateness of their use.

4. Length of Authorisation

HH has requested a 10-year period of authorisation but the ACCC is proposing a 5-year authorisation period. AHCL is concerned that there may be a negative public benefit associated with the proposed authorisation in terms of the quality of care and the appropriate length of stay provided to patients. Certainly, this has been the experience in the United States where one of the HH joint venture partners operates. Also, most current HPPA's are negotiated for a period of 2-3 years and hence a full cycle of negotiations of all providers should be able to take place within a 3-year period.

Consequently, we believe that there should be a monitoring process throughout the authorisation period and the authorisation should be limited to no more than 4 years. This would allow all contracts to be negotiated under these arrangements and to have at least 1 year in operation prior to the ACCC considering whether the determination is to be continued or renewed.

5. Further Elaboration at the Optional pre-decision conference

AHCL is willing to elaborate further on the above by participating in the optional pre-decision conference.

Yours faithfully

Brett Goods
Chief Executive Officer