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**AUSTRALIAN COMPETITION TRIBUNAL**

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**Lodgment and Details**

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| Document Lodged: | Statement |
| File Number: | ACT 5 of 2021 |
| File Title: | RMSANZ APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021 |
| Registry: | VICTORIA – AUSTRALIAN COMPETITION TRIBUNAL |


REGISTRAR

Dated: 16/05/2022 3:04 PM

**Important information**

This Notice has been inserted as the first page of the document which has been accepted for electronic filing. It is now taken to be part of that document for the purposes of the proceeding in the Tribunal and contains important information for all parties to that proceeding. It must be included in the document served on each of those parties.

**STATEMENT**

**IN THE AUSTRALIAN COMPETITION TRIBUNAL** **File No: ACT 5 of 2021**

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| **RE:** | **APPLICATION FOR REVIEW OF AUTHORISATION DETERMINATION MADE ON 21 SEPTEMBER 2021** |
| **APPLICANT:** | **REHABILITATION MEDICINE SOCIETY OF AUSTRALIA AND NEW ZEALAND LTD** |

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| Statement of | **Margaret Annette Faux** |
| Address | 1 Spring St, Bondi Junction, 2022 in the state of New South Wales |
| Occupation | Solicitor, Health Insurance Law Academic, and Chief Executive Officer of Synapse Medical Services Pty Limited |
| Date | 15 May 2022 |

I, Margaret Annette Faux of 2/1 Spring St, Bondi Junction, 2022 in the state of New South Wales, say as follows:

1. I am a solicitor, health insurance law academic, and the founder and chief executive officer of Synapse Medical Services Pty Limited.

2. I am authorised to make this statement on behalf of Synapse Medical Services Pty Limited, and otherwise in my own capacity.

3. I make this statement from my own knowledge and experience.

## A. BACKGROUND

4. I am a solicitor admitted to practice in the Supreme Court of NSW and the High Court of Australia, and have practiced law for over two decades.

5. Prior to studying law, I qualified and practised as a registered nurse for 13 years. I now maintain non-practising registered nurse status with the Australian Health Practitioner Regulation Agency.

6. I am also an academic scholar of Medicare and health insurance law and have recently published my PhD on Medicare claiming and compliance.[1] **Annexed hereto and marked with the letter A is a copy of my PhD**.

[1] Available online in the UTS thesis collection at this link: https://opus.lib.uts.edu.au/handle/10453/155387

7. Synapse Medical Services **(SMS)** is a MedTech company that operates one of the largest medical billing services in Australia.

8. I have been administering medical bills since Medicare began in 1984, and in May 2004 I established, in partnership, one of the first companies offering medical billing services for gapcover schemes in Australia. This company was called Pulse Medical Management Pty Limited, which was later deregistered after I commenced SMS.

9. SMS administers all types of medical bills, including gapcover schemes and medical purchaser provider agreements **(MPPA)** for individual medical practitioners across every medical speciality, as well as providing medical billing services and consulting to public and private hospitals and large corporate organisations.

10. The educational arm of SMS offers education and training for medical practitioners, specialist medical colleges and health administrators on medical billing and the operation of the Australian health system.[2]

11. I am the principal and sole practitioner of my law firm, Margaret Faux, Solicitor, which operates exclusively as an online service, providing pro-bono answers to complex medical billing questions submitted by medical practitioners and other health professionals.[3]

12. I have published over 100 articles, both peer reviewed and popular media, on the topic of Medicare and private health insurance law and billing, and contribute widely to Australia's health reform debate.[4]

13. I made three submissions to the Australian Competition and Consumer Commission **(ACCC)** in relation to the Honeysuckle Health and NIB buying group authorisation application **(HHBG)**, which is the subject of this review. I annex each of those submissions in chronological order as **Annexures B, C and D**, and adopt them, in full, as forming part of this, my witness statement.

## B. RELEVANT FINDINGS FROM MY PHD RESEARCH

14. I refer the tribunal to pages 270 and 271 of my PhD, which is a short section titled **"Honeysuckle Health Buying Group"**. In addition to expanding on the concerns expressed by me in my three submission to the ACCC, that section describes three further potentially serious impacts of the HHBG application on the proper functioning of the Australian health system as follows:

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[2] This is a separate legal entity known as Synapse Medical Training Pty Limited, which trades as The Australian Institute of Medical Administration and Compliance. The website of this entity is available at this link: https://aimactraining.com

[3] The website to my law firm can be accessed at this link: https://mbsanswers.com.au/

[4] My consolidated articles and media appearances are available at this link: https://synapsemedical.com.au/news/category/publications/

i) The HHBG proposal is likely to further confound the already compromised ability of the Australian National Audit Office to accurately quantify public money that should not have been disbursed, noting that 75% of the Medicare schedule fee will remain a component of every medical claim under the HHBG;

ii) The HHBG application is littered with vague and imprecise terms such as a "hospital or health experience" which has no legal meaning in the Australian, or any health system, and is therefore likely to be inconsistent with Medicare's fee-for-service structure in which each service is complete and finite. For example, a service provided in an outpatient setting is completely separate from a service provided to an admitted patient, however the evidence suggests the HHBG application may be attempting to blur this boundary. This will worsen compliance challenges for medical practitioners, and

iii) The HHBG application exposes medical practitioners to being investigated twice in relation to a single service, once by HHBG and once by Medicare.

15. I refer the tribunal to pages 254 to 259 of my PhD, which is a section titled **"The conduct of the private health insurers in relation to gapcover schemes."** This section also expands on issues mentioned by me in my previous submissions to the ACCC, but went further, drawing from the available evidence, finding that gapcover schemes had *"effectively become junk in the context of public hospital medical service delivery, through deliberate abuse of untested legal provisions, not by medical practitioners, but by the Private Health Insurers."* This section also describes why tiered private health insurance (gold, silver, and bronze policies) are fundamentally unworkable, and in the recommendations chapter, I recommend they be abolished, and the existing gapcover legislation be tightened.

16. I refer the tribunal to pages 260 and 261 of my PhD, which is a section titled **"How was a U.S standard slipped into Australia's Medicare?"** This section explains the operation of managed care creep in Australia, which will be worsened by the HHBG application.

17. I refer the tribunal to pages 262 to 269 of my PhD, commencing from the penultimate paragraph on page 262, which commences with "One of the strengths…" In this section I have examined regulatory gaps in the area of hospital substitute treatment and hospital in the home, which form part of the HHBG application. I draw the tribunal's attention to the following content of those pages:

i) The increased medico-legal risks around who has overarching responsibility for a patient being treated at home, there being no protection under a hospital's accreditation under the private health insurance pathway;

ii) The increased Medicare compliance risks for medical practitioners;

iii) The complete lack of visibility caused by home treatment not being coded in Australia, so no public health data will be collected on these patients, and

iv) The concern that private health insurers may permit or even encourage non-compliant Medicare billing by the medical practitioner if it achieves an overall reduced benefit outlay for the private health insurer.

18. I refer the tribunal to page 348 of my PhD, which is the section titled **"8.1 Overview"** This is the first section in the "Recommendations for Reform" chapter, and the first paragraph states that the evidence suggests that the HHBG application is likely to worsen medical practitioner compliance challenges, because it adds another layer to an already chaotic regulatory environment.

## C. THE IMPACT ON THE MEDICAL BILLING INDUSTRY

19. I refer the tribunal to Annexure D under the heading **"The administrative burden will increase not decrease"** and make the following additional statements:

i) As previously stated, I have been processing medical bills for over 30 years. I therefore have deep knowledge of the costs involved in processing the various types of medical bills across the Australian medical billing landscape.

ii) The most expensive medical bills to process are private claims either direct to patients, or to payers like HHBG, where there are interpretive contracts involved and/or the payer has an inflated view of their expertise around Medicare and Australian medical billing law. The evidence makes clear that because there has never been a national medical billing curriculum in this country, there are no medical billing experts. This problem permeates the medical payment environment, and adds unnecessary time and cost to the administrative process.

iii) In my first medical billing company, the fees we charged to medical practitioners for managing this complex administration was 7% of monthly receipts. Over time, as more competition has entered the market, the rate has reduced to, on average, 3-5%.

iv) SMS will need to increase its fees to our medical practitioner clients if the HHBG application is granted. This has already been decided by me as the CEO. More than 30 years of experience informs me that the administrative work my team will be required to do will be similar to the work they do now for workers compensation and third-party claims. It largely involves spending wasted hours on the phone chasing legitimate claims that remain unpaid, with the payer continually using various obstructive techniques that are designed to wear the provider down and avoid or delay making payment.

V) I anticipate we will initially raise our fees by 1% for any client with an HHBG contract, and may increase them back up to 7% for any clients having HHBG contracts that they require us to administer. I anticipate our competitors will follow suit. These additional administration costs will typically be passed to patients by medical practitioners. Some claims may also be referred to formal debt recovery

which will add further cost to the process and which medical practitioners will usually also pass to their patients.

## D. WHY THIS APPLICATION WILL ULTIMATELY FAIL TO REDUCE OUT-OF-POCKET COSTS

20. I refer the tribunal to the draft MPPA which was provided to me in the confidential materials. Specifically, I refer to page 17 of that document, which contains the schedule of specified services. This is where the fatal flaw in the HHBG application is found insofar at the application relates to medical fees and out-of-pocket costs.

21. I also refer to Annexure D in which I explained how medical practitioners will simply manipulate services in the outpatient setting to maintain their incomes.

22. The MBS item numbers that HHBG needs to be able to include in the specified services schedule, to ensure their policy holders will not be charged out-of-pocket costs, can never be included in that schedule for the following reasons:

    i) MBS item 104 (initial consultation) and 105 (subsequent consultation) are the main MBS items used by surgeons for consultations, both inpatients and outpatients, that are separate to the surgical items.

    ii) MBS item 110 (initial consultation) and 116 (subsequent consultation) are the main equivalent MBS items used by physicians for consultations, both inpatients and outpatients.

    iii) The specified services schedule can never include the above MBS items (and other similar items) that are used for outpatient consulting because adding those items would cause medical practitioners to be effectively unable to continue to operate their outpatient practices. This is because if a medical practitioner who has signed an HHBG MPPA sees a patient for a condition that does not require surgery or will never require hospitalisation, the medical practitioners need to be able to bill the above items to enable patients to receive their Medicare benefits. But if they charge a private fee, which they are legally entitled to do, they will breach their HHBG contract even though the service may have nothing to do with HHBG. An example might be a patient seeking a second opinion or attending for a condition that will never require surgery.

    iv) As a result of HHBG being unable to ever add MBS outpatient consultation items to the specified services schedule, medical practitioners will (and must) remain free to bill those items in accordance with Medicare requirements in the outpatient setting. As I explained in Annexure D, medical practitioners will therefore simply increase their fees for these services in the outpatient setting (such as by charging $1000 for item 104) and/or by prolonging outpatient treatment. This will shift the cost burden to consumers and cause out-of-pocket costs to rise.

## E. THE STATUS QUO VERSUS THE HHBG PROPOSAL

23. The evidence presented in my PhD indicates that regulation of the health sector has become a morass of incoherent legal instruments in need of urgent reform. While the status quo does not adequately protect consumers from rising out-of-pocket medical expenses, the newly designed MPPAs proposed by the HHBG are unlikely to solve that problem, and may worsen it.

24. The original MPPA's were designed to bring out-of-pocket medical expenses for hospitalised patients under control. They failed.

25. Then, the introduction of gapcover schemes, which had the same stated purpose of controlling out-of-pocket medical expenses for hospitalised patient, also failed. The HHBG application for new MPPA's would not be before the tribunal if either of these former initiatives had succeeded.

26. The HHBG MPPA proposal will also almost certainly fail for the same reason, which is that the underlying legislation has not changed. Further, to achieve absolute control over medical practitioner fees, a referendum will be required to change section 51(xxiiiA) of the Australian Constitution. Australia has had 44 referendums since federation and only eight have passed, so the prospects of this being achieved are low.

27. I note that HHBG is now seeking to increase its market share as part of the review application that is currently before the tribunal. I am concerned that if successful, the public detriment will be significant. I refer the tribunal to page 396 of my PhD, where I describe the impact already being felt across the medical payments landscape, which is that medical practitioners are increasingly refusing to bulk bill or use gapcover schemes because the benefits of immediate payments have been overtaken by the corresponding threat of prosecution. This is already causing out-of-pocket costs to rise. Under further pressure, caused my market consolidation, this problem is likely to worsen.

## F. CONCLUSION

28. The evidence does not support the introduction of the HHBG MPPAs, or any new products introduced into the Australian medical payments landscape, until such time as urgent regulatory reform is undertaken by the government of the day.

Dated 15th May 2022

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Dr Margaret Faux (PhD)

Annexure A – in a separate document

Annexure B

ANNEXURE B

**Margaret Faux**
**PhD Candidate | Solicitor | RN | Founder and CEO**

12 February 2021

Mr Michael Pappa
Competition Exemptions Branch
Australian Competition & Consumer Commission
exemptions@accc.gov.au

Dear Mr Pappa

**RE: HONEYSUCKLE HEALTH (HH) AND NIB, AUTHORISATION AA1000542-1**

Thank you for giving me the opportunity to comment on the above application and for providing your written approval that I may avail a one-week extension of time in which to respond.

**Introduction and Background**

By way of background, I am a Solicitor admitted to practice in the Supreme Court of NSW and the High Court of Australia, and have practiced law for over two decades. I am also an academic scholar of Medicare and health insurance law. My work has been published in peer reviewed journals and my PhD on the topic of Medicare claiming and compliance is currently being examined. I have been administering medical billing since Medicare began (across every medical specialty), am a Registered Nurse, and the founder and CEO of global MedTech company, Synapse Medical Services, which operates a medical billing service and has developed Australia's only medical billing rules engine outside of Medicare. Specifically, I have been administering Medicare and Private Health Insurance Gapcover scheme claims since they were introduced in 2000. I contribute widely to the national health reform debate and my publications (both peer reviewed and popular media) are available here.

My doctoral thesis is the first to examine the phenomenon of Medicare non-compliance from a legal, administrative and system perspective, which necessitated an examination of Private Health Insurance (PHI) in areas where Medicare and PHI money is blended through Medicare Benefits Schedule (MBS) billing arrangements. The evidence collected during the research suggests that no-one, including the Federal Government and the PHI's, has any detailed understanding of what is or is not a compliant Medicare bill. No national curriculum on the topic of Medicare and PHI financing law and practice has ever existed, levels of knowledge are therefore extremely variable and, in most cases, demonstrably low. The Medicare billing and health financing system has become largely incomprehensible and unable to be complied with, and without responsible reform, already intolerable consumer OOPs will continue to rise.

Accordingly, I offer the following responses in my personal capacity as a concerned individual with deep knowledge of the operation of Australia's health financing arrangements and the likely impact of this application both in grass roots medical practice and on consumers. While I can see the potential benefits of centralised hospital contracting (for accommodation, operating theatre fees and prosthetics), I have significant concerns about this application, principally in relation to the impact on consumers via the applicant's proposed changes to Gapcover schemes.

The underlying legal structure of the Australian health system has not been well considered or understood in my opinion, likely resulting in higher out-of-pocket costs (OOP) for consumers, *not* cost control.

# Margaret Faux

## PhD Candidate | Solicitor | RN | Founder and CEO


I have referenced sparsely throughout this document but am happy to provide full references and further details upon request.

**Constitutional Issues**

Section 51(xxiiiA) of the Australian Constitution grants the Commonwealth Government power to make laws for medical, dental and other social services in the following terms:

> *"The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances;"*

Section 51(xxiiiA) is the foundation upon which fee-for-service reimbursements for private services rendered by medical practitioners under the Medicare scheme rest, enabled by the *Health Insurance Act 1973 (Cwth),* which links to the *Private Health Insurance Act 2007 (Cwth)*.

The practical effect of the bracketed text in s 51(xxiiiA) which is known as the 'civil conscription caveat' is that it prevents the Commonwealth Government from socialising medicine and controlling medical practitioner fees. Numerous High Court decisions have settled certain points of law in relation to this clause, including that the relationship between a privately practising doctor and a patient is governed by general principles of contract law, and that both legal and practical compulsion may offend the caveat (see e.g. *British Medical Association v Commonwealth* (1949); *General Practitioners Society in Australia v Commonwealth* (1980); *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987); *Health Insurance Commission v Peverill* (1994); *Wong v Commonwealth* (2009)).

Since Medicare was introduced, Australian doctors have always been free to set their fees as they wish, and the ongoing failure by both the Federal Government, the PHIs, and other payers to understand this, has been a significant contributing factor to Australian consumers now paying some of the highest OOPs in the world. All attempts to force medical practitioners to enter contracts that control fees have failed, and will continue to fail, due to the constitutional provision. A recent example of the disastrous impact on consumers when the government missteps in this area is noteworthy. The government attempted to force medical practitioners to bulk bill Covid services. Some medical practitioners refused, preferring to exercise their constitutional right to charge as they wished, causing Medicare eligible taxpayers to be denied their Medicare rebates. An article explaining this is available at this link https://auspublaw.org/2020/04/frenetic-law-making-during-the-covid-19-pandemic-the-impact-on-doctors-patients-and-the-medicare-system/

**Gapcover Schemes**

Gapcover Schemes were introduced on the back of the failure of MPPAs, which are also mentioned by the applicant.

The applicant has correctly stated that the majority of MPPAs relate to pathology and radiology services. This is likely to continue, despite the applicant reporting that a modest number of additional MPPAs having been entered with orthopaedic surgeons, for hip and knee replacements. If the applicant is able to entice medical practitioners to voluntarily enter MPPAs, that would certainly represent an historic achievement, though seems unlikely given that when MPPAs were introduced, less than 100 medical practitioners across Australia had signed up to MPPAs after two years of operation.

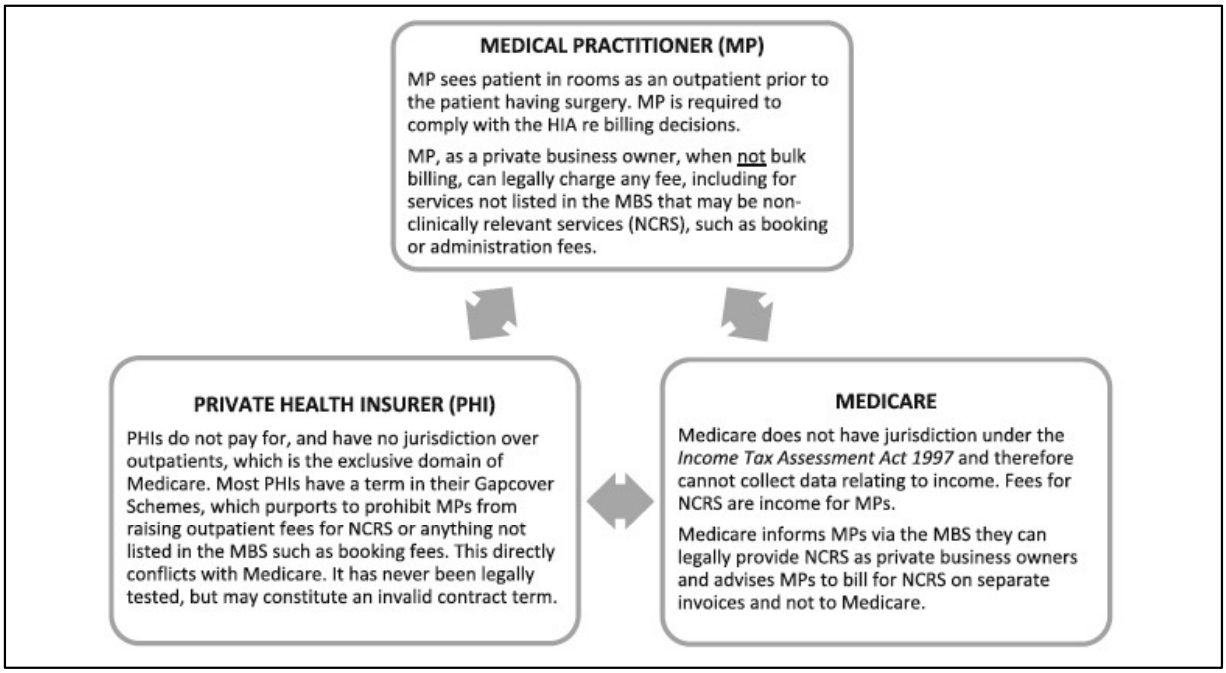
**Margaret Faux**
**PhD Candidate | Solicitor | RN | Founder and CEO**

After MPPAs had failed, the central objective of the new Gapcover Schemes was to provide an alternative that would be agreeable to the medical profession and would simplify billing processes and limit out of pocket costs for hospitalised patients without the need for contracts. Then Federal Health Minister Michael Wooldridge said:

> *'This Bill amends the National Health Act 1953 (NHA) and the Health Insurance Act 1973 (HIA) to provide for gap cover schemes. The purpose of these schemes is to enable registered health benefits organisations to provide no gap and/or known gap private health insurance without the need for contracts.'*

Whilst often referred to as 'simplified' billing arrangements (and in NIB's case, the Medigap Scheme), a new medical billing industry quickly emerged to deal with the complexities of the new schemes. These schemes have now become so complex and convoluted that a single Medicare service can be the subject of more than 30 different rates and rules, and the public money at the core of the transaction has become hidden in a regulatory maze of labyrinthine proportions.

One area of this legal complexity that is central to this application is that the terms and conditions of some PHI gapcover schemes, including NIB's, accessible here https://www.nib.com.au/docs/medigap-terms-and-conditions have the effect of making medical practitioner participation in their schemes contingent upon agreement to terms which may place the medical practitioner in breach of the Medicare scheme, in circumstances where the PHIs have questionable jurisdiction to purport to exercise such control. As small business owners, medical practitioners are permitted to charge for non-Medicare services (a common example being cosmetic Botox injections) and it is a Medicare requirement that such invoices *not* be invoiced to Medicare but be billed separately to the patient. Another example is booking fees, which the PHIs have always believed are illegal, though this has never been legally tested. This phenomenon is presented in the table below copied from this article from my PhD https://pubmed.ncbi.nlm.nih.gov/31682343/



Irrespective of arguments concerning the legality of 'booking fees', the reality is that medical specialists can easily pass costs to consumers in other ways, such as by raising the price of the consultation fees they charge in their rooms, where the PHIs exercise no jurisdiction. For example, the most common Medicare item number for an initial consultation by a surgeon is item 104. Instead of charging say $500 for the item 104 consultation plus a $500 booking fee, a surgeon can simply instead charge $1000 for item 104 and there is absolutely nothing the PHI can do about it. Further, many such transactions are recorded off books, on local accounting systems, and so will never be seen by the government or the PHI.

In addition to the applicant failing to appreciate that it cannot achieve the stated aim of controlling OOPs, and if it were to intrude too far into the private contractual relationship between medical practitioners and patients, a High Court challenge based on a 'practical compulsion' argument would likely result, in the public hospital context, many PHIs have already adopted legally questionable practices in relation to the operation of their Gapcover schemes.

Gapcover schemes involve the passage of public money. All PHIs receive 75% of the Medicare schedule fee for each inpatient professional service billed. Unfortunately, lax regulation has meant that once the Medicare payment is in the hands of the PHI the government has little practical control over it. The most common practical example occurs when PHIs, including NIB, use delaying tactics such as making payment to the medical practitioner contingent upon the happening of another event over which the medical practitioner has no control, such as proof of a corresponding hospital bill for the same service. While relevant contracts between the PHIs, medical practitioners and hospitals may lawfully enable delayed transfer of the PHI component of each payment, the Medicare component should either be immediately released to the medical practitioner or returned to consolidated revenue, which would better serve the national interest. This is currently not happening.

In addition, most PHI (including NIB) now impose questionable restrictions in relation to the operation of their Gapcover schemes for patients who elect to be treated privately in public hospitals. NIB's Medigap Terms and Conditions state that Gapcover rates will *not* be paid if:

> *"…you are a salaried practitioner at a Public Hospital and are treating Private Patients covered by the registered participating health fund at a Public Hospital;"*

Section 73BDDA of the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (the Act) expresses its purpose as enabling a registered organisation [a PHI] to

> "*offer insurance coverage for the cost of particular hospital treatment and associated professional attention for the person or persons insured…greater than the Schedule fee (within the meaning of Part II of the Health Insurance Act)…for the person or persons insured…*[where] *there is not a medical purchaser-provider agreement…and the person insured pays a specified amount or percentage under a known gap policy or the full cost of the treatment or attention is covered under a no gap policy*."

Central features of Section 73BDDA are:

- That both hospital *and* 'associated professional attention' or medical practitioner services are covered;

- That the benefits of gapcover schemes are intended to be afforded to policy holders (or patients) who enter insurance contracts with the PHI and pay relevant monthly premiums, and who also subsidise the PHI industry via their taxes;
- That no formal contract, such as a 'medical purchaser-provider agreement' is required as between the PHI and the medical practitioner, and
- The amount payable under gapcover schemes must be 'greater than the Schedule fee'.

The terms and conditions of many PHI, including NIB's appear to be inconsistent not only with the spirit of the Act, but also with key requirements of Section 73BDDA. For example, if a privately insured patient is admitted to a public hospital (usually having been delivered there by ambulance or having self-presented with an acute illness after hours) and wishes to avail their NIB policy, the legal basis for NIB to deny Gapcover benefits to the treating medical practitioners purely on the basis they are salaried employees of the public hospital, is nowhere apparent. And the policy holder patient will have no knowledge that their treating medical practitioner/s have been denied Gapcover benefits.

Given it appears HH (who administers NIB's MediGap scheme) may already be adopting what might be described as a questionable approach to strict compliance with Gapcover law, I am concerned about its role as an appropriate administrator of Gapcover schemes going forward. Further, the absence of any mention of the impact in the application on privately insured consumers who find themselves admitted to public hospitals is of concern.

I would urge the ACCC to request comprehensive details of the comments skimmed over in points 2.10, 2.27 and 2.28 of the application; namely, what does HH and NIB mean by use of the words; 'extension' and 'replacement' of its Gapcover schemes.

**Managing Provider Compliance**

Having just completed a PhD on medical provider compliance I am concerned about the applicant's comments around managing compliance in 2.33(b) and the impact on providers. With the exception of a relatively small number of internal business rules, neither NIB nor any other PHI has any role in, or ability to manage billing compliance, which they have never been formally taught (there is no national curriculum) and which is centrally controlled by Medicare. I have further concern around the suggestion in clause 4.9(a) that the proposal may reduce the administrative burden on medical providers. In my experience, the opposite is a more likely outcome.

Medicare determines billing rules not the PHI and as such the PHI have little or no ability to create simplicity. The PHI marketed the exact same concept – simplicity – when Gapcover schemes were introduced in 2000. But, instead of simplicity, what transpired was complexity and administrative burdens imposed on medical providers of such magnitude that a new medical billing industry (of which I was a part) quickly appeared. There is no evidence to suggest it will be different this time, and comments around this area in the application are vague. What is most likely to eventuate is an increased burden on medical providers as HH and NIB seek to further contain and control medical fees (such as by delaying legitimate payments), and medical practitioners will have no option other to increase their engagement with medical billing companies, who will charge for their time advocating to ensure legitimate claims are correctly paid. These administrative costs are inevitably passed to consumers as OOPs.

Further, given HH has no statutory authority to determine what constitutes 'excessive use of MBS item numbers' (clause 4.18), I would urge the ACCC to enquire further on this point to determine exactly what is meant by this. Under what statutory authority can HH determine what is excessive and what action does it intend to take in circumstances where it makes a finding of 'excessive' services.

**The impact on eligible veterans under the DVA scheme**

The applicant has incorrectly stated that eligible veterans avail a DVA no-gap scheme (clause 3.13) under which veterans are never charged OOPs.

DVA does not, and has never, operated a Gapcover scheme and in fact, there is no legal barrier to DVA patients being charged OOPs due to the constitutional provision already mentioned. The fact that most veterans are not charged gaps has nothing to do with a DVA Gapcover scheme (it primarily relates to ignorance by the medical community about compliant billing) and as the veteran treatment population diminishes in size, if DVA were to participate in the proposed buying group, the most likely scenario is that medical practitioners will shift costs to eligible veterans in the form of OOPs. This would be very damaging to the veteran community.

**Value based care**

I am concerned that the applicant has been unclear in relation to its comments around 'value based care' versus 'value based contracting'. Medicare is predominantly a fee-for-service (FFS) scheme, and whilst FFS is often criticised as being the least effective payment type in health systems, research has suggested other payment types have led to more worrying outcomes such as risks to human health. For example, the introduction of capitated managed care did not alleviate fraud and non-compliance in the US health system, but made it worse. Not only did non-compliance become more difficult to detect, it became more dangerous to patients when overservicing was replaced with underservicing.

> *"…the trend…is to replace fee-for-service structures with some kind of standardized fee structure – Diagnosis Related Groups, Prospective Payment Systems, or even fully capitated managed care…it suggests there is no hope of ever managing a fee-for-service system properly; the only 'fix' available is to scrap it and replace it with something else…the introduction of capitated or prospective payment systems carries with it an entirely new set of problems and new fraud types…" (Malcolm Sparrow, License to Steal)*

More recently, a study of alternative payment models reported in the New England Journal of Medicine (NEJM), described potential negative impacts of value-based care (VBC) on vulnerable populations, who are unlikely to achieve the measurable outcomes VBC depends upon. The research suggested these new payment models may hurt rather than help, particularly for medical practitioners serving poor and disadvantaged communities (Joynt Maddox 2018). Another commentator, also in the NEJM, expressed similar concerns around measurement of the nebulous concept of value under VBC.

> *"…perhaps the most problematic is its [VBC's] reinforcement of illusions about value: that we know what it means and can measure it, that the same things matter to all patients, and that the effect of any intervention can be understood in isolation from countless others." (Rosenbaum 2017)*

The way we choose to pay for health in the future will continue to evolve, but it is important not to overstate the benefits of any one payment model over another, as the applicant has sought to do. Further, the applicant's use of a US experience is not a valid comparator in the Australian setting, given our very different health systems

I would urge the ACCC to require that the applicant provides comprehensive details of what it means by 'value based contracting' to ensure the term is not being used as a proxy for managed care, which would not be in the best interests of consumers or the Australian health system.

**Conclusion**

The Nimmo report in 1969 described health insurance in Australia as "unnecessarily complex and beyond the comprehension of many," and the report became the catalyst for the introduction of Australia's first universal health coverage scheme, Medibank (later Medicare). My PhD research has found that Australia's current health insurance arrangements have again become so complex and incomprehensible that compliance is nigh impossible, and the system is beginning to unravel.

My concerns in relation to this application relate to the direct consumer impact, which involves medical practitioner fees. The applicant's proposal will almost certainly increase complexity in this area. When changes of this type are made, it is consumers who feel the impact the most because health spending happens (whether directly or indirectly) at the point of service based on an encounter between a medical practitioner and a patient. When medical practitioners become exhausted by constantly increasing regulatory burdens, payment controls and delays, they quickly shift costs to consumers as OOPs.

It cannot be denied that the need for both the government and the PHI to control escalating health expenditure sits at odds with the unique position of power and privilege held by Australian medical practitioners who have constitutional protection against excessive intrusion into the private contractual arrangements they negotiate with their patients. In addition, there is a compelling argument to suggest that the medical profession itself has been derelict in its duty to provide some form of education to medical practitioners around responsible fee setting and the ways in which their own poor billing behaviour contributes to the overall failure of the health system in which they work. However, this application will not solve these problems.

Further, while the applicant's statement that the PHIs are tightly regulated is correct, absent is the fact that they are extremely poorly policed. There is in fact very little effective oversight or governance around the conduct of PHIs, as evidenced by lax compliance around the delayed passage of public money to the entitled end beneficiary under Gapcover schemes and denying policy holders the benefit of these schemes in public hospitals.

There is also no evidence to suggest that any cost savings resulting from this proposal will be passed to consumers via lower PHI premiums (clause 4.2). During the COVID pandemic when all elective surgery was cancelled, thus dramatically reducing PHI claims payouts, there was little or no evidence that the PHIs were offering discounts to their policy holders who could not (and in some cases still cannot) utilise their PHI due to government imposed restrictions. In most cases the PHIs appear to have continued to charge their policy holders the same significant monthly or quarterly premiums, despite their own Covid induced windfalls.

**Margaret Faux**
**PhD Candidate | Solicitor | RN | Founder and CEO**

Gapcover schemes are one of the most complex areas of Australian medical billing, involving public money and up to five parties, with various contracts and legal relationships that collectively determine the fate of the Medicare rebate at the heart of the transaction. Practically, patients are not involved in gapcover transactions, though the legal basis for this is somewhat labyrinthine and porous, rendering such schemes vulnerable to various abuses some of which have been described in this letter.

Gapcover schemes have also failed to achieve their core objective which was to eliminate OOPs for hospitalised patients. This is in large part due to the failure by the government and PHIs to understand and accept the impact and power of the constitutional caveat. The present application also appears to have failed to understand this fundamental tenet of the Medicare scheme, and while its intentions to exert downward pressure on expenditure and OOPs may be sound, the reality is that the opposite will likely occur, and consumer OOPs will rise. As they have always done, medical practitioners will simply sidestep every barrier imposed and will likely also redirect patients to the public hospital system, the negative downstream impacts of which are beyond the scope of this letter.

Accordingly, I suggest this application be rejected certainly insofar as it relates to Gapcover schemes.

Thank you for considering my submissions which I would be happy to expand upon if required.

Yours sincerely

Margaret Faux

Annexure C

# ANNEXURE C
# Margaret Faux
## PhD Candidate | Solicitor | RN | Founder and CEO

11 June 2021

Competition Exemptions Branch
Australian Competition & Consumer Commission
exemptions@accc.gov.au

Dear Exemptions

**RE: HONEYSUCKLE HEALTH (HH) AND NIB, AUTHORISATION AA1000542-DRAFT DETERMINATION**

I refer to my previous correspondence in relation to the above application dated 12 February 2021, and your draft determination dated 21 May 2021. I make the following further submissions.

1. A central focus of this application is to control out-of-pocket medical costs (OOPs).

2. Historically, all similar attempts have failed (including MPPAs), and have in fact had the opposite effect. Australian OOPs are now some of the highest in the world. This is attributable to the labyrinthine complexity of Australia's health financing arrangements and the constitutional protection of medical practitioners, outlined in my previous letter.

3. In my initial submission I expressly urged the ACCC to request details of proposed changes to NIB's gapcover terms and conditions, as follows:

   *"I would urge the ACCC to request comprehensive details of the comments skimmed over in points 2.10, 2.27 and 2.28 of the application; namely, what does HH and NIB mean by use of the words; 'extension' and 'replacement' of its Gapcover schemes."*

4. I am unable to see that such enquiry has been made even though NIB should have no difficulty providing this critically important information.

5. The draft determination appears to be largely based on a mistaken belief that statutory benefits cannot be denied. For those with no experience in the murky world of Australian medical billing, this is understandable, but mistaken. The private health insurers (PHI) can and already do block legitimate statutory benefits.

6. The mechanisms through which the PHI deny statutory benefits include exploitation of lax regulation, control of digital claiming channels and third line forcing.

7. By way of example, my organisation is working with one hospital where a PHI has blocked all statutory benefits completely, including the most basic 75% Medicare / 25% PHI claiming process, known as 'two-way claims'. The process through which this eventuated was of questionable legality and exploited the lack of knowledge of untrained administrative staff who thought the PHI was trying to help them. There is simply nothing the hospital can now do to collect the legitimate benefits to which it is entitled, due to the complex context.

8. At another site, third line forcing had a detrimental impact, when anaesthetists who were not bound by relevant contract terms, charged their usual gap fees.

9. In another large corporate group, the group CMO recently informed me the MPPA's being offered to the medical specialists by a PHI are attempting to force them to bulk bill. Bulk billing will not cover their running costs in their rooms.

# ANNEXURE C
# Margaret Faux
## PhD Candidate | Solicitor | RN | Founder and CEO

10. The above are just some examples of the methods used by the PHIs to try and control medical specialist fees. Another flowing from this application will be a likely reduction of gapcover benefits (NIB's are already some of the lowest) which will create a practical compulsion to force medical specialists to enter MPPA's.

11. A significant finding from my PhD is that Australia's health financing arrangements are profoundly complex and beyond the comprehension of anyone. With respect, any suggestion that this application with simplify and streamline fee arrangements for medical specialists is laughable. NIB's proposed MPPA contract rates will add more complexity, not less. NIB will still have its gapcover fee list, as will all of the other PHIs, and the MPPA's will add another layer to the current morass of rules and rates. There are already over 30 different payment rules and rates for every single MBS item number (***see attached articles***), as well as over two million medical billing rules.

12. Unlike others who have submitted responses to this application, I have no vested interest in the outcome. My company works in health systems around the world and the products and services we provide are not dependant on the status quo here in Australia. I am also personally in the fortunate position of being able to afford excellent health care and knowing the market as well as I do, I will always be able to navigate the system and exercise freedom of choice. My motivation is concern for the damage this will inflict on Australia's excellent Universal Health Coverage system, which is the subject of my doctoral research.

13. I am very concerned about what I perceive to be shortcomings in the due diligence process undertaken by the ACCC in relation to this application. The ACCC does not appear to know the details of how NIB's gapcover schemes will be changed, because it has not asked the question. Yet this information is central to the integrity of the application.

The issue of egregious OOPs is important, and there are many ways the ACCC can be involved in remedying this intractable problem, some of which I have outlined in my thesis. However, the two most likely outcomes of this application are increased consumer OOPs, and the further decline of the PHI market.

I again urge the ACCC to enquire further, and require NIB to provide granular details of proposed changes to its gapcover scheme, before making any final determination.

I would be happy to discuss further if required.

Yours sincerely
Margaret Faux

Attachments:
1. ***No payments, copayments and faux payments: are medical practitioners adequately equipped to manage Medicare claiming and compliance?*** Margaret Faux, Jonathan Wardle and Jon Adams. Internal Medicine Journal 2015 https://doi.org/10.1111/imj.12665
2. ***Medicare billing, law and practice: complex, incomprehensible and beginning to unravel*.** Margaret Faux, Jonathan Wardle and Jon Adams, Journal of Law and Medicine 2019 https://opus.lib.uts.edu.au/handle/10453/136958

Annexure D

ANNEXURE D

**Margaret Faux**
**PhD Candidate | Solicitor | RN | Founder and CEO**

26 July 2021

Competition Exemptions Branch
Australian Competition & Consumer Commission
exemptions@accc.gov.au

Dear Exemptions

**RE: HONEYSUCKLE HEALTH (HH) AND NIB, AUTHORISATION AA1000542**

I refer to my previous correspondence in relation to the above application, your draft determination dated 21 May 2021 and the pre-determination conference held on 8 July 2021. Thank you for permitting me a short extension of time to make the following further submissions.

The following submissions include some general information around the operation of Australia's very complex health financing arrangements. I have included this information as I believe it may assist the ACCC to achieve clarity around certain key issues when it weighs up consumer benefits/detriments that may result from this application.

The focus of my submissions remains on Gapcover schemes and MPPA's, which are the key areas likely to impact consumers. As previously stated, medical billing and compliance is the topic of my recently completed doctoral research. My PhD also discusses hospital billing (because medical and hospital billing are inextricably linked), however, consumers do not now and have never been privy to the details of hospital claims which are paid on their behalf by private health insurers (PHI), and therefore the nexus between hospital claims and patient out-of-pocket costs (OOPs) is more distant.

**The consumer perspective and Value Based Care (VBC)**

I have worked for decades at the interface of patients, payers, and providers, where health payments are transacted. It is a dark and disturbingly secret part of our health system that few understand.

As I alluded to in the conference, I believe it is very important for the ACCC to understand that there will be no consumer buy-in around this application, because consumers have no knowledge of what happens beneath the surface of health financing transactions. Patients do not know that their doctor or hospital has not been paid after they have been discharged from hospital. Claims for reimbursement are submitted to the PHI's for payment anywhere between three days and two years after the patient has been discharged from hospital, and the battles for payment that often ensue are fought behind the scenes by organisations like mine.

We do not burden patients with the battles we fight around payment, and in my experience, others who do the same work, adopt the same approach, which is protective of patients. For example, in a recent case, we did not call the patient to say something like:

> *'Thought we would just let you know that your health fund has refused to pay the cardiologist who resuscitated you after your post-operative cardiac event, because your policy doesn't cover cardiac care.'*

The cardiologist in that case instructed us to write the claim off, which is common. The patient will never know.

In time, as research into the alleged benefits of VBC matures, it will be interesting to see if the VBC datasets are examined with sufficient granularity to capture scenarios where patients were recorded as having achieved good health outcomes at a lower cost (which ticks both VBC boxes), the lower costs having been achieved because the PHI refused to pay for all or part of the treatment. It is a phenomenon I see daily, and I often ponder the extent to which it may be incorrectly reported in VBC success data around the world. It is my impression that the incidence of misreporting of VBC in this manner may be significant, and is an area ripe for focussed academic attention.

**A poorly understood Medicare principal which will cause this initiative to fail consumers**

In *Health Insurance Commission v Peveril [1994] HCA 8* the Australian High Court settled certain key issues concerning the legal nature of the Medicare benefit including who has contracts with whom in the context of a Medicare billing transaction. *Peverill* confirmed the existence of a contract between a medical practitioner and a patient.

The High Court has further deliberated upon this issue in various cases including *Wong v Commonwealth of Australia [2009] HCA 3*, when Kirby J characterised section 51(xxiiiA) of the Australian Constitution (which underpins Medicare's fee-for-service arrangements) as a rare constitutional guarantee because it protects both doctors and patients equally, by cocooning their relationship inside general principles of contract law. He stated:

> *"However, the prohibition on "any form of civil conscription" is designed to protect patients from having the supply of "medical and dental services", otherwise than by private contract, forced upon them without their consent."*

Even the simplest Medicare claims (to which PHI medical claims are pegged) are surprisingly complex legal transactions. In essence, Medicare benefits are payable for clinically relevant services only, but the fact that a service is not clinically relevant does not mean it cannot be provided, it just means there is currently no Medicare rebate for it. Common examples of non-clinically relevant services are booking or administration fees, some family meetings, and the burgeoning cosmetic botox and filler market.

Therefore, while possibly unethical, there is usually no legal barrier to doctors charging for non-clinically relevant services such as booking fees (there is one exception discussed in my thesis). In addition, the Services Australia Department, which administers the Medicare scheme, has no legal authority to collect and process information concerning income tax. This includes anything that does not attract a Medicare benefit, such as booking fees and things like common cosmetic Botox injections. If Medicare were to collect this type of information, it would be acting outside its permitted legal functions. Medicare therefore advises doctors as follows:

> *"Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. … When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient." (MBS Book)*

Additional examples confirming the legality of medical practitioners charging private fees for private contracted, non-clinical services are the GP co-ops in the Australian Capital Territory, who were expressly given government grant funding to operate as bulk bill clinics charging annual membership fees; many GP clinics now charge annual membership fees, and as recently as last week, the

Department of Health confirmed that doctors are free to charge private fees for non-clinically relevant services (**See Annexure A**) as long as the service is not billed to Medicare. These common transactions are never seen by the government or the PHIs because they are recorded on separate software systems.

So, booking fees are, prima facie, legal (with one exception) because they are non-clinically relevant services, always provided in the outpatient setting where the PHI's have no jurisdiction, negotiated as a private contract between the doctor and patient, just like cosmetic botox injections. Further, as I explained in my first submission, even if all such fees were declared illegal by a Court, doctors could simply shift the cost legally to the clinically relevant services they provide, and maintain their incomes.

Given the above, it is worth the ACCC considering why it is that despite the PHIs having alleged that booking fees are illegal for years, not one PHI has ever initiated legal proceedings to stop this alleged illegality, despite ample evidence of such practices being available to them. And further, what law has changed such that the ACCC can have confidence the HHBG application can solve this problem?

NIB's current Gapcover Terms and Conditions (T&C's) state:

> *"If you elect to charge for a service through MediGap, you acknowledge and agree that the Member will not be charged any additional booking, administration, technology or facility fees, or any other such fees related to that Treatment."*

Quite apart from being inconsistent with Medicare's advice and the provisions of the broader statutory scheme, there is an infinite array of ways in which doctors can easily and legally circumvent this requirement by arguing the fees *were not 'related to that Treatment'*.

For example, a failure of conservative treatment is an indication for surgery. Evidence of this is shown below in a decision of the Director of the Professional Services Review Agency, where a surgeon was severely punished and required to pay back $500K to Medicare for proceeding too quickly to a surgical intervention (among other things). The report is available at this link: **https://www.psr.gov.au/case-outcome/psr-directors-update-june-2019**

> "*An agreement with a general surgeon.*
> *The practitioner billed more than 17,000 services in the year under review, including more than 90 services on 59 days. The Director reviewed this practitioner's rendering of Medicare Benefit Schedule (MBS) items 104, 105, 18264, 32000, 32006, 32025, 32072, 32093, 32111, 32129, 32131, 32135, 32139, 32145, 32165, 35595 and 45200 and had no concerns in relation to MBS item 104. The Director had persisting concerns that:*
>
> - *records of consultations and procedures were either non-existent or inadequate;*
> - *MBS item 105 was often billed for consultations that were post-operative in nature or for the rendering of a therapeutic item;*
> - *consent to procedures for all therapeutic procedures was either not adequately obtained or not adequately recorded;*
> - *MBS requirements were not met for many services (in that multiple items were often billed for what peers might consider a single service or the service was not otherwise performed in accordance with the descriptor (or at all));*

- *not all services were clinically indicated, with the practitioner often appearing to proceed straight to a surgical option ahead of more conservative forms of treatment where only mild symptoms were identified; and*
- *clinical input was inadequate or inadequately recorded.*

*The practitioner acknowledged they engaged in inappropriate practice in connection with providing these items of concern. The practitioner agreed to repay $500,000, to be disqualified from providing MBS items 32131 and 32111 for 12 months, and will be reprimanded by the Director."*

The problem around this issue in the context of the HHBG application, is that, while Gapcover schemes provide a level of transparency (because Gapcover T&Cs and fee schedules are in the public domain) MPPA's will provide no such transparency. Being confidential contracts, MPPA's will introduce cavernous interpretive spaces around contract terms, which may or may not be consistent with the provisions of the vast statutory scheme regulating Medicare and the PHI's. In addition to this leading to potential backdoor boycotts of providers (described further below), medical practitioners who sign MPPA's will still have ample space and opportunities to charge patients OOPs. Consider this common example of a patient journey through conservative treatment:

1. A patient sees the GP with a painful knee. The GP refers the patient to an orthopaedic surgeon.
2. The GP referral has a 12-month duration commencing from the date of the first consultation with the surgeon, *not* the date on the referral. This is important because delays obtaining an appointment with the surgeon are irrelevant. The 12-month period starts on the date of the first surgical consultation and the referral remains open for 12-months from that date.
3. At the first consultation, the surgeon may initiate conservative treatment such as physiotherapy, and follow up in say 3-months. The patient pays say $500 for item 104 and receives an 85% rebate of $76.80, leaving the patient $423.20 out of pocket. There are no immediate plans for surgery and therefore it has nothing to do with the PHI at this stage.
4. Three months later the surgeon chooses to continue conservative treatment and suggests a steroid injection into the knee. Assume another $500 fee for the consultation.
5. A week later the surgeon does the steroid injection, in her/his rooms. Assume another $500 for the consultation and say $1000 for the injection. Still nothing to do with the PHI at this stage because surgery is not planned, and the PHI is not contributing financially to any of these treatments.
6. This process can continue for as long as the surgeon deems it necessary and during this journey the patient may also require repeat x-rays, pathology, and MRI's all of which incur additional OOPs. The HHBG cannot control this process and we already know that it is often these types of cumulative OOPs that patients incur out-of-hospital that impact them the most, rather than a single inpatient episode. The article at this link explains this well, and a table from the article is copied below
   https://thenewdaily.com.au/life/wellbeing/2019/12/01/breast-cancer-costs-health/

**Margaret Faux**
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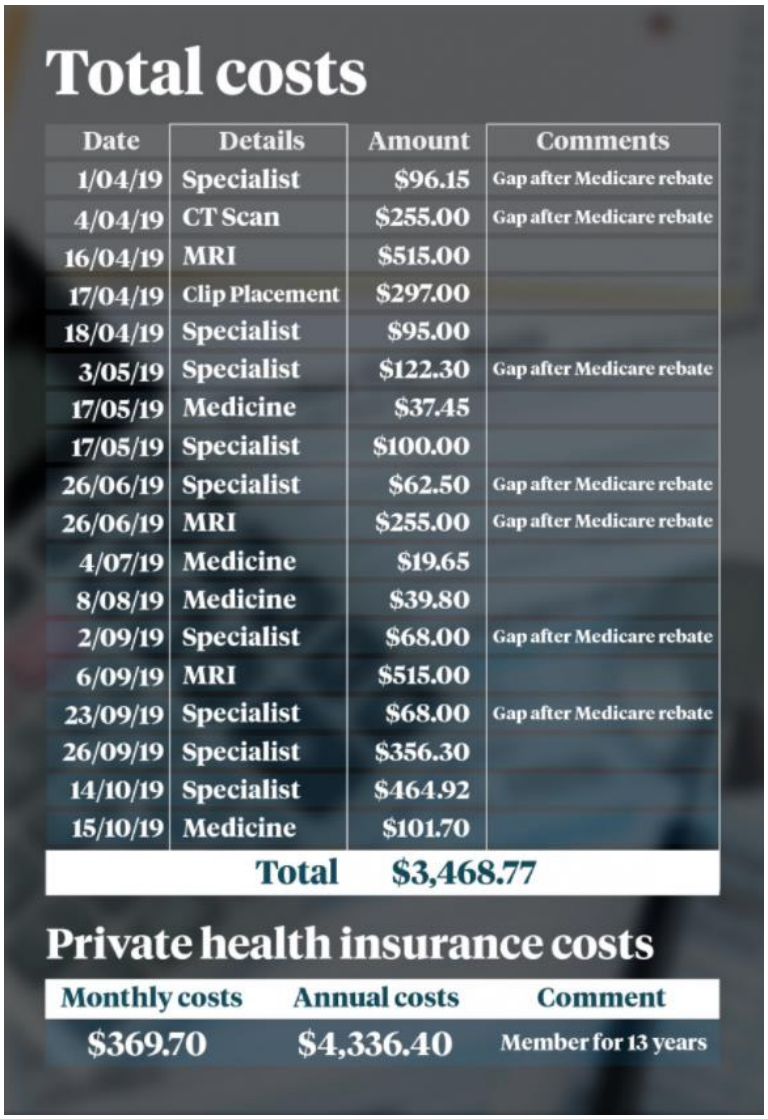

## Total costs

| Date | Details | Amount | Comments |
|---|---|---|---|
| 1/04/19 | Specialist | $96.15 | Gap after Medicare rebate |
| 4/04/19 | CT Scan | $255.00 | Gap after Medicare rebate |
| 16/04/19 | MRI | $515.00 | |
| 17/04/19 | Clip Placement | $297.00 | |
| 18/04/19 | Specialist | $95.00 | |
| 3/05/19 | Specialist | $122.30 | Gap after Medicare rebate |
| 17/05/19 | Medicine | $37.45 | |
| 17/05/19 | Specialist | $100.00 | |
| 26/06/19 | Specialist | $62.50 | Gap after Medicare rebate |
| 26/06/19 | MRI | $255.00 | Gap after Medicare rebate |
| 4/07/19 | Medicine | $19.65 | |
| 8/08/19 | Medicine | $39.80 | |
| 2/09/19 | Specialist | $68.00 | Gap after Medicare rebate |
| 6/09/19 | MRI | $515.00 | |
| 23/09/19 | Specialist | $68.00 | Gap after Medicare rebate |
| 26/09/19 | Specialist | $356.30 | |
| 14/10/19 | Specialist | $464.92 | |
| 15/10/19 | Medicine | $101.70 | |
| | Total | $3,468.77 | |

## Private health insurance costs

| Monthly costs | Annual costs | Comment |
|---|---|---|
| $369.70 | $4,336.40 | Member for 13 years |

The fact is that every surgeon has a full 12-month referral period in which to provide whatever services at whatever prices she/he likes. Further, even during a hospital admission, where the PHIs do have jurisdiction, their ability to ensure a no-gap experience will be limited to the simplest patients, who they may therefore cherry pick. Consider the following three recent real cases conveyed to me by a client:

<u>Patient 1:</u>

Patient was admitted for back surgery but did not recover well post-operatively and was referred to a pain specialist. The patient then required drug and alcohol treatment, then rehabilitation, then overdosed, then spent two nights in ICU, then had to be assessed in the emergency department for scheduling due to psychosis, then was discharged.

The only part of this case, where an application such as the HHBG may be able to ensure a no-gap experience for the patient is possibly the initial back surgery.

Patient 2:

The patient was admitted for hip replacement surgery, then required inpatient rehabilitation, then acquired a blood clot in the lung requiring referral to a respiratory physician, then a pre-existing neurological condition worsened, was then seen by a neurologist, then returned to inpatient rehabilitation.

The only part of this case, where an application such as the HHBG may be able to ensure a no-gap experience is possibly the initial hip surgery.

Patient 3:

A country patient was admitted with a deteriorating neurological condition and had emergency neurosurgery. The patient became paraplegic and required inpatient rehabilitation. The patient then acquired a chest infection requiring review by a respiratory physician. The patient deteriorated and was moved to ICU for ventilation. The patient's left shoulder then became septic requiring orthopaedic surgery for a washout of the infected joint. The patient returned to ICU but deteriorated further and subsequently required cardio-thoracic surgery for the removal of pus from the chest cavity. The patient is now receiving palliative care.

While the above cases represent complications of surgery, they are not uncommon. The HHBG application may discriminate against these types of patients or those with complex health needs, who may experience higher OOPs than patients who are more fit, less affected by chronic disease and luckier. The applicant may argue that community rating prevents this type of discrimination, but the phenomenon of what I have described as 'managed care creep' in my thesis happens behind the scenes where claims are inappropriately questioned, delayed, rejected, lost and so on.

I suggest that the applicant should be required to comprehensively answer the question of how it intends to provide a complete no-gap experience across the entire continuum of care, both inpatient and outpatient (without causing medical practitioners to shift costs to consumers as OOPs), and if it cannot, I submit that the public benefit argument of this application must fail.

**Applicant's lack of transparency**

In both of my previous submissions I have expressly urged the ACCC to request details of proposed changes to NIB's gapcover terms and conditions, because that is where indirect pressure will likely be hidden, with flow on effects to consumers as OOPs. The fact that the applicant has continually failed to respond to this specific issue is worrying.

Given the applicant's apparent unwillingness to be transparent about changes to its gapcover terms (which should be uncontroversial), if the ACCC decides to authorise the application, I would suggest restricting the authority to three years and 20% of the market. Absent any concerning conduct, it will then be a relatively simple process for the applicant to apply for an extension of the authority beyond the initial three-year period.

**Potential negative impact on consumers if forced into gold policies**

The Clinical Partners Program of the applicant (CPP) is currently only available for hip and knee replacements, which are covered under gold policies only. As I stated in the conference, I suggest the ACCC seeks written assurance from the applicant that it will not engage in any conduct, including

through 3rd parties intermediaries such as *iSelect* and *Compare-the-Market* that will push consumers to take up more expensive gold policies that they cannot afford and do not need. This would effectively do nothing more than shift consumer OOPs from doctors to the PHIs. The ACCC has already seen this type of conduct with Medibank Private https://www.accc.gov.au/media-release/medibank-in-court-for-alleged-misrepresentations-to-members-about-benefits

Granting of this authority should require written confirmation that the CPP will be made equally available to all policy holders not just gold policy holders.

**The potential for backdoor boycotts**

The HHBG application specifically states there will be no boycotting of any provider. However, the application also provides that the HHBG will assess medical practitioner compliance including 'accuracy of claims' and 'excessive use of MBS items', and may make findings of 'fraudulent claims' and would share such findings with other payers participating in the HHBG. Of concern is the fact that despite its assertions to the contrary, the HHBG application seems likely to lead to collective boycotts of providers if for example the HHBG makes a unilateral finding of criminal fraud by a provider, and circulates that decision among group participants.

It is unclear how the HHBG purports to have legal authority to make findings of fraud outside of the criminal justice system, and nor does the HHBG have any demonstrated expertise in medical billing compliance. In fact, the HHBG application expressly demonstrates gaps in the medical billing literacy of the applicant such as by incorrectly stating that the Department of Veterans Affairs (DVA) maintains its own no-gap scheme, enabled by a process of individually contracting with medical practitioners, who then do not charge co-payments to DVA policyholders. This is wholly incorrect.

Evidence of the very serious consequences that can result when unqualified individuals think they understand medical billing compliance were seen in the Federal Court case of *Bupa HI Pty Ltd v Andrew Chang Services Pty Ltd [2018] FCA 2033*, which is available at this link: https://www.judgments.fedcourt.gov.au/judgments/Judgments/fca/single/2018/2018fca2033

The case concerned MBS item number interpretation, which my thesis demonstrates, is profoundly complex. The facts of the case were essentially that Bupa asserted one interpretation of an MBS item, and Dr Chang another. The court preferred Dr Chang's interpretation, declaring that Bupa had:

> *"…breached the contract between it and Dr Chang being the "BUPA Medical Gap Scheme Terms and Conditions dated March 2016" (**Contract**) by purporting to deregister Dr Chang from the "Bupa Medical Gap Scheme" with effect from 15 August 2016 when it failed to comply with the express term of the Contract being the term providing for the "Bupa's Medical Gap Scheme deregistration procedure"."*

This case demonstrates the point I made during the conference that if the HHBG unilaterally deregisters a provider from the CPP, the only option for the provider will be to engage in expensive legal proceedings.

Accordingly, if this authorisation proceeds, I suggest that a clear communication channel, via a direct point of contact at the ACCC, is made available to all stakeholders, to report this type of backdoor boycotting, should it occur.

**91C Revocation of an authorization and substitution of a replacement**

In anticipation that this application, if granted, may require review and revocation, I have copied the revocation provisions of the consumer law below, which are obviously well known to the ACCC.

> *(3) If, at any time after granting an authorization, it appears to the Commission that:*
> *(a) the authorization was granted on the basis of evidence or information that was false or misleading in a material particular; or*
> *(b) a condition to which the authorization was expressed to be subject has not been complied with; or*
> *(c) there has been a material change of circumstances since the authorization was granted;*

I suggest the following should be flagged as potential future triggers for a revocation process:

- Evidence of the HHBG purporting to exercise authority over Medicare billing compliance.
- Evidence of the HHBG boycotting a provider based on a unilateral interpretation of a disputed contract term in a HPPA or MPPA.
- Evidence of the HHBG removing practitioner provider numbers from the ECLIPSE billing interface, to effectively block access to baseline statutory benefits. This is a phenomenon I have witnessed and alluded to in my previous submission document.

**The administrative burden will increase not decrease**

The suggestion made by the applicant that this application will reduce costly administrative burdens across the health payments landscape is just nonsense. While administrative work may reduce for HHBG payers, the burden will just be shifted to the other side of the transaction where I work, and where costs are quickly passed to patients.

For example, a private surgical operating list of 15 patients, would usually include a mix of patients insured with BUPA, Medibank Private, HCF, at least four other PHI, one or two workers compensation patients, a few DVA patients, a self-insured patient, and sometimes overseas visitors with international insurance. If the HHBG application goes ahead, more complexity will be added, not less. The billing rules and rates are already different for every patient on the list, and with the HHBG, we will also be required to engage in debates about the interpretation of confidential contract terms.

**Conclusion**

Evidence suggests that medical practitioners do not understand the operation of their health systems, and how to bill correctly. The published academic article attached as **Annexure B** describes this global phenomenon. It forms part of the literature review chapter of my thesis.

That said, the Australian medical profession must take some responsibility for the aggressive approach of payers like HHBG, having done nothing to address problems around medical billing compliance and OOPs.

Standing in the shoes of payers like the HHBG momentarily, I understand how worrying it would be to know for example, that unqualified individuals among the medical profession openly teach doctors how to ‘pack and stack’ MBS item numbers to extract as much as possible from the public

purse every time they see a patient. The profession continues to not only turn a blind eye to this outrageous conduct, but actively encourages it by accrediting this type of training so that doctors can earn continuing professional development (CPD) points for participating. The optics are unflattering – doctors earn CPD points for learning borderline medical billing practices that commodify patients. It is nothing short of a disgrace. To understand this, please see the case of *Anand & Anor v Armstrong & Anor [2020] SADC 34 (31 March 2021)* attached as **Annexure C**, and a commentary article about the case attached as **Annexure D**. The *Armstrong* case is also discussed in my thesis.

I wish to reiterate a statement I have previously made which is that I want solutions to OOPs too, and have worked tirelessly over the past decade quietly chipping away educating doctors on how Medicare and the PHIs work and how to bill correctly, and completing a PhD on the topic of Medicare claiming and compliance. To the best of my knowledge, I am the only experienced lawyer in Australia who teaches Medicare and medical billing law to doctors, including the ethical dimensions of billing decisions, responsible approaches to price setting, and the practical impacts egregious OOPs have on the proper functioning and sustainability of the entire health system.

The HHBG will not solve these problems because they are deeply structural and more complex and nuanced that the applicant understands. Solutions to problems like consumer OOPs will require multi-pronged approaches across regulation, education, and digital reform, not a buying group like the HHBG. At best, the HHBG will have no impact on OOPs, but at worse, it may increase consumer OOPs quickly and significantly, as doctors shift the cost burden to their patients.

I remain opposed to this application, but if it proceeds to authorisation, I urge the ACCC to consider imposing the recommendations I have made herein.

I would be happy to discuss further if required.

Yours sincerely

Margaret Faux

# CURRICULUM VITAE

# CURRICULUM VITAE

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## Introduction

Margaret is a Solicitor specialising in Medicare and Health Insurance Law, a Registered Nurse and has a PhD on Medicare claiming and compliance. Margaret worked for over a decade as a Registered Nurse in various public and private hospital settings and has over 30 years' experience in the operation of Medicare and Australia's health financing arrangements. Margaret has an adjunct research fellow appointment at Southern Cross University, researching medical billing and coding. Margaret has been published in the BMJ Open, the Journal of Law and Medicine, the Internal Medicine Journal, Human Resources for Health (a World Health Organisation Journal), PLoS One, and is a well-respected and sought-after speaker and author of information on health financing systems, both in Australia and overseas. Margaret is the Founder and CEO of Synapse Medical, a MedTech company providing digital medical administration solutions globally.

## Education

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| 2013 – 2021 | **Doctor of Philosophy,** Faculty of Health, University of Technology, Sydney. Research topic: Claiming and compliance under the Medicare Benefits Schedule: A critical examination of experiences, perceptions, attitudes and knowledge of medical practitioners. |
| 1991 – 1996 | **Bachelor of Laws,** University of Technology, Sydney |
| 1980 – 1982 | **Registered Nurse training,** Repatriation General Hospital Daw Park, Adelaide |

## Memberships, Appointments and Professional Associations

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| 2019-current | Executive Council Member, Indo-Australian Chamber of Commerce. |
| 2018-2020 | Executive Member, NSW Council for Women's Economic Opportunity. |
| 2018 – 2019 | Chair, NSW Health Chapter, Australia India Business Council. |
| 2017 | Bill and Melinda Gates Foundation, Honorary Advisor on "Health Insurance Law and Practises" in India. A project undertaken at the National Institute of Public Finance and Policy, Delhi, India. |
| 1996 – current | Member NSW Law Society |
| 1997 – 2007 | Kingsford Legal Centre (KLC), University of New South Wales, Sydney |

KLC is a part of the Faculty of Law at UNSW. The service provides free legal advice to consumers as well as practical legal training for undergraduate students in the LLB program

- Fortnightly free legal advice to consumers
- Education and training of undergraduate students enrolled in the Bachelor of Laws

## Employment

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| September 2009 -current | **Synapse Medical Services Aus Pty Limited**<br>Founder and CEO www.synapsemedical.com.au |
| 1996 – current | **Practising Solicitor** areas of practice include: Medicare and health Insurance, commercial transactions. |
| 1984 – current | **Registered Nurse,** non-practising |
| 2006 –2010 | **Pulse Medical Management Pty Limited**<br>Co-Company Director - medical billing company |
| 2001 – 2005 | **Solicitor, Sole Practitioner**<br>Areas of practice included, Family Law, Property and Wills. |
| 1998 – Current | **Practice Manager -** specialist medical practice, Darlinghurst |
| 1996 – 2001 | **Ashton Stedman Solicitors**<br>Employed Solicitor in a 2-partner legal firm located in Woolloomooloo, Sydney. Areas of practice: family law and general commercial law. |
| 1993 – 1995 | **Practice Manager -** General Practice, Bondi Beach |
| | **Health Care Complaints Commission –** peer review reporter. |
| 1991 – 1992 | **Loreto Nursing Home, Waverley –** geriatric nursing |
| 1990 – 1991 | **Scottish Hospital, Sydney –** casual nursing pool, surgical and medical and High Dependency unit |
| 1989 – 1992 | **Kirribilli Private Hospital –** geriatric nursing |
| | **Clinic nurse at Bondi Family Health Centre –** consulting rooms for 5 General practitioners |
| 1987 – 1988 | **Rose Bay private Hospital –** surgical and medical nursing |
| | **Tender Care Nursing Service –** agency nursing, palliative care |
| 1986 | **Allied Nursing Services –** agency work, predominantly at Royal North Shore Hospital accident and emergency department |
| | **Sydney Opera House –** first aid room, casual |

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| 1985 | **Macquarie Nursing Service –** agency work |
| | **Royal Prince Alfred Hospital –** casual pool, surgical |
| 1983-1984 | **St Vincent's Hospital, Darlinghurst, Sydney –** accident and emergency department, full time |

## Academic publications and conference presentations

**Margaret Faux, Jon Adams, Simran Dahiya, Jon Wardle:** Wading through molasses: a qualitative examination of the experiences, perceptions, attitudes and knowledge of Australian medical practitioners regarding medical billing.
Published in PLoS One in January 2022.
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0262211

**Faux, M., Adams, J. & Wardle, J:** Educational needs of medical practitioners about medical billing: a scoping review of the literature.
Published in Human Resources for Health, Hum Resour Health 19, 84 (2021).
https://doi.org/10.1186/s12960-021-00631-x

**MA Faux**: Frenetic law making during the COVID-19 pandemic: the impact on doctors, patients and the Medicare system.
Published in the Australian Public Law Blog April 2020

**MA Faux, JL Wardle and J Adams:** Medicare Billing, Law and Practice: Complex, Incomprehensible and Beginning to Unravel, June 2019
Published in the Journal of Law and Medicine (2019) 27 JLM 66, November 2019.

**MA Faux, JL Wardle, Angelica G Thompson-Butel and J Adams**: Who teaches medical billing? A national cross-sectional survey of Australian medical education stakeholders.
BMJ Open July 2018

**Speaker: World Congress of Public Health, Melbourne, 2-7 April 2017**
Presentation of two papers: The first on the constitutional challenges of health reform in Australia today, and the second on the level of knowledge of medical practitioners of the Medicare system.

**MA Faux, JL Wardle and J Adams**: No payments, co-payments and faux payments: Are medical practitioners adequately equipped to manage Medicare claiming and compliance? Internal Medicine Journal February 2015

## Industry contributions

**MA Faux, H Grain**: Telehealth is not quite the colt from old Regret but it sure as hell has got away. Pulse+IT Magazine May 2020

**MA Faux**: Is forcing GP's to bulk-bill the Covid items legal?
AusDoc.com May 2020

**MA Faux**: Billing in Byzantium.
Pomegranate Health; the podcast from the Royal Australasian College of Physicians, March 2020
https://www.racp.edu.au/pomegranate/view/ep56-billing-in-byzantium

**MA Faux:** "Unnecessary risk": GPs dumped in Medicare muddle.
The study referenced in the Australian Doctor article was published in BMJ 2018 was led by Margaret Faux. November 2018

**MA Faux:** Law trumps Medicare advice on bulk-bill vouchers.
Medical Observer, November 2018.

**MA Faux:** Could parts of Medicare ever be safely privatised? ABC Radio July 2016
https://www.abc.net.au/radio/programs/overnights/could-parts-of-medicare-ever-be-safely-privatised/7808606

**MA Faux**: Radio interviews 2SER 107.3
Is after hours care keeping patients out of emergency departments? July 2016
A look at the health professional behind your Medicare transaction. How knowledgeable are they about rebates? June 2015

**MA Faux:** Private Health Insurance: A look under the bonnet.
The Health Advocate December 2017

**'Seeking a Cure'** The Private Practice Magazine, April 2014

http://theprivatepractice.com.au/free-online-magazine

**'Number Crunch'** The Private Practice Magazine, December 2013

http://theprivatepractice.com.au/free-online-magazine

**'Access all Areas'** The Private Practice Magazine, September 2013

http://theprivatepractice.com.au/free-online-magazine

**'The Rules on Referrals'** The Private Practice Magazine, July 2013

http://theprivatepractice.com.au/free-online-magazine

**'Contracts, Claiming and the Colon'** The Private Practice Magazine, April 2013

http://theprivatepractice.com.au/free-online-magazine

**'Claiming on Consumables'** The Private Practice Magazine, December 2012

http://theprivatepractice.com.au/free-online-magazine

**'Note worthy'** The Private Practice Magazine, September 2012

http://theprivatepractice.com.au/free-online-magazine

**'Claiming Control'** The Private Practice Magazine, June 2012

http://theprivatepractice.com.au/free-online-magazine

**'Medicare Matters'** The Private Practice Magazine, April 2012

http://theprivatepractice.com.au/free-online-magazine

**'The Cheque's in the Mail'** Physicians Life, Psychiatrists Life, Surgical Life, January 2012

http://synapsemedical.com.au/_blog/Publications/post/The_cheque's_in_the_mailmanaging_arrears_and_bad_debt_in_private_practice/

**'Handle With Care'** The Private Practice Magazine, November 2012

http://theprivatepractice.com.au/free-online-magazine

**'Mind The Gap'** The Private Practice Magazine, September 2011

http://theprivatepractice.com.au/free-online-magazine

**'Too Much Information'** The Private Practice Magazine, January 2011

http://theprivatepractice.com.au/free-online-magazine

**'Myth Busting'** The Private Practice Magazine, September 2010

http://theprivatepractice.com.au/free-online-magazine

**'Private Practice in a Bag'** The Private Practice Magazine, June 2010

http://theprivatepractice.com.au/free-online-magazine

**Popular Media – Croakey blog of Crikey.com.au**

Tony Abbott's Medicare 'deforms' or How to Trick Senators 101

http://blogs.crikey.com.au/croakey/2014/12/16/tony-abbott%E2%80%99s-medicare-%E2%80%9Cdeforms%E2%80%9D-or-how-to-trick-senators-101/

Outsourcing Medicare: is it as easy as pi?

http://blogs.crikey.com.au/croakey/2014/09/09/outsourcing-medicare-is-it-as-easy-as-%CF%80/?wpmp_switcher=mobile

2014 the year of the co-payment: lessons from the NHS. August 2014

http://blogs.crikey.com.au/croakey/2014/07/28/2014-the-year-of-the-co-payment-lessons-from-the-nhs/

Abbott's Medicare reforms: today's crime is tomorrow's co-payment. August 2014

http://blogs.crikey.com.au/croakey/2014/07/20/abbotts%E2%80%99-medicare-reforms-%E2%80%93-todays-crime-is-tomorrow%E2%80%99s-co-payment/

GP co-payments: Deregulation of the bulk billing market. July 2014

http://blogs.crikey.com.au/croakey/2014/07/09/gp-co-payments-%E2%80%93-deregulation-of-the-bulk-billing-market/

Medicare co-payments: Has Tony Abbott closed Australia for (private health insurance) business? July 2014

http://blogs.crikey.com.au/croakey/2014/06/24/medicare-co-payments-%E2%80%93-has-tony-abbott-closed-australia-for-business/

**Invited Speaker**

July 2020 – **Preparation for Practice-Medical Billing: legal, practical and ethical consequences**
Royal Australasian College of Surgeons (RACS) webinar

June 2020 – **Australian Companies providing COVID-19 solutions**
Austrade, webinar showcase

June 2020 - **Medical billing and compliance in the post COVID era.**
Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ), webinar

May 2020 –**MBS item numbers in cancer care.**
Private Cancer Physicians of Australia (PCPA), webinar

December 2019 - **Private Practice 101-your questions answered**
South Australian Salaried Medical Officers Federation (SASMOF) seminar

August 2019 – **Private Medical Billing**
Royal Australian College of Surgeons

March 2019 – **Thinking outside the hospital Box**
Murdoch Hospital, Dubai presentation

May 2015 – **The Law Behind Medicare, Audits and Co-Payments**
Australian Primary Health Nurses Association National Conference

March 2015 – **Medicare and Medical Billing** - The Private Practice, comprehensive – open course for all specialist medical practitioners

November 2014 – **Medicare, the Law and Acing an Audit**
Webinar presentation for Darling Downs South West Queensland Medicare Local

September 2014 – **Medicare and Medical Billing** - The Private Practice, comprehensive course for rehabilitation physicians

August 2014 – **Medicare and Medical Billing** - The Private Practice, comprehensive – open course for all specialist medical practitioners

May 2014 - **Medical Billing 'From items to income' –** The Private Practice, comprehensive course for immunology and allergy physicians

October 2013 – **Medical Billing 'From items to income' –** The Private Practice, comprehensive course for respiratory physicians

July 2013 - **Medical Billing 'From items to income' –** The Private Practice, comprehensive course for all medical practitioners

May 2013 – **Medical Billing 'A labour of love'**
The Private Practice, comprehensive course for Obstetricians and Gynaecologists

July 2012 - **MBS claiming**.General Practice Registrars Association (GPRA) – webinar presenter

May 2012 – **Medical Billing 'A labour of love'**
The Private Practice, comprehensive course for Obstetricians and Gynaecologists

November 2011 - **Medical Billing 'From items to income' –** Medical Life, Part 3 course, Sydney . Medical practice course for all medical practitioners.

November 2011 – '**Admin-ectomy – cutting the boring costly bits from your practice'** Australasian Society of Cataract & Refractive Surgeons (AUSCRS) presentation to practice managers on outsourcing

November 2011, Brisbane – **Medical Billing 'The journey of a medical claim'**
The Private Practice, comprehensive course for all medical practitioners

November 2011, Perth – **Medical Billing 'The journey of a medical claim'**
The Private Practice, Medical Oncologist course

October 2011, Melbourne – **Medical Billing 'The journey of a medical claim'**
The Private Practice, comprehensive course for all medical practitioners

June 2011 – **Medical Billing 'A labour of love'**
The Private Practice, comprehensive course for Obstetricians and Gynaecologists

October 2010 – **Medical Billing 'From suture to salary'**
The Private Practice, comprehensive course for Dermatologists

October 2010 – **Medical Billing 'From suture to salary'**
The Private Practice, comprehensive course for Opthalmologists

June 2010 – **Medical Billing 'A labour of love'**
The Private Practice, comprehensive course for Obstetricians and Gynaecologists - co-presenter with Dr Andrew Pesce FRANZCOG, then President of the AMA.

## Awards & Prizes

- 2017 and 2018 – finalist India Australia Business and Community Awards in two categories: Best SME and best female leader
- 1992 - UTS – Australian Securities & Investments Commission Prize for Law of Associations, highest mark
- 1991 – UTS – Butterworth book prize for academic merit, 1st year Law
- 1983 – Book Prize, Repatriation General Hospital, Adelaide – 3rd year theory
- 1982 – Book Prize, Repatriation General Hospital, Adelaide – 2nd year theory
- 1981 – Book Prize, Repatriation General Hospital, Adelaide – 1st year theory