NOTICE OF LODGMENT

AUSTRALIAN COMPETITION TRIBUNAL

This document was lodged electronically in the AUSTRALIAN COMPETITION TRIBUNAL and has been accepted for lodgment pursuant to the Practice Direction dated 3 April 2019. Filing details follow and important additional information about these are set out below.

Lodgment and Details

Document Lodged:	Annexures to Application to Tribunal for Review
File Number:	ACT 4 of 2021
File Title:	APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
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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.

23.07.2021 **National Association of Practising Psychiatrists**

Re: Honeysuckle Health and nib application for Authorisation AA1000542

NAPP asserts that the welfare of Australian patients, their carers and families, will be detrimentally impacted, and potentially harmed, by the conduct that will flow from ACCC approval of the Honeysuckle Health (HH) application. NAPP does not believe that patients, consumer groups and the public have been adequately consulted re this application, which threatens significant changes to the Australian healthcare system landscape.

Nib announced the establishment of the health services joint venture with Cigna Corporation in December 2019, "with the specific purpose of delivering better health outcomes" and indicated it would draw on "deep expertise" from its partner Cigna.[i]

NAPP represents Australian psychiatrists, clinicians who hold specialist expertise in assessment, formulation, diagnosis and treatment of patients with mental illness and, at times, dysfunctional systems. Denman, quoted in the RANZCP Victorian Faculty of Psychotherapy submission to the Victorian Royal Commission into Mental Health, indicated that "if a diagnosis is a label, then a formulation is more like a story, (and) ... gathers up all the … factors that have led to a person becoming unwell and considers how these factors interconnect. In doing so, it provides clues to the pathway out of suffering"[ii] and we add, provides clues as to that which might worsen the patient's situation, distress, risk and / or outcomes.

A key aspect of the formulation is developing understanding of the history of both the symptom and also the patient - the person - their developmental experiences in their family of origin, its transgenerational legacies and sociocultural milieu, caregivers' attitudes and responsivity, or lack thereof; what provisions have been available, when these have been perverted or restricted, resulting in abuses and / or neglect, and also how these factors have been experienced by and impacted upon the patient. Only when these dynamic factors across history can be gathered and considered, is it possible to understand the patient, their symptom(s) and contextual system and from this to develop truly individualised and appropriate treatment and risk responsivity.

Drawing from its members expertise in risk formulation and assessment, NAPP suggests to the ACCC that not only must HH's application be carefully examined but also the sociocultural and historical context from which it emerges and has been deeply influenced and informed. Only then can a truly nuanced and informed assessment of detriments, harms and risk flowing from the approval of the application be formed. This is especially important given nib has made clear that "there is a strong alignment" in how it and Cigna "see healthcare evolving"[i]; psychiatrists know that we must look at the past along with the present, in order to make informed decisions that will impact the future.

Stephen Milgate, CEO of the Council of Procedural Specialists, referenced the Productivity Commission's definition of Managed Care in his PDC verbal submission; "… any system whereby the payer for health care seeks to exercise some control over the care provided, in terms of cost, quality, and appropriateness of care, and even choice of the provider".[iii] He indicated clearly that the system detailed in the HH application correlated with managed care. RANZCP (The Royal Australian & New Zealand College of Psychiatrists) has made clear that "The formation of the HH buying group facilitates the concentration of the market power of up to 60% of private health insurers (PHIs) to enter into selective contracting with healthcare providers, which the RANZCP argues, reduces competition. This

concentration of power by the HH buying group would exert a very asymmetric force upon providers, who would have limited bargaining capacity should they decline a contract. The net effect is a gateway to managed care, in this case, under the name of “value-based” contracting, which drives PHI away from community-rating to risk-based capitated care”.[iv]

The Applicant has stated clearly in their ‘Response to interested party submissions’ that “The Fundamental focus of HH is … funding Providers according to the positive health outcomes for patients”. [v] It is made clear, albeit implicitly, that funding of Providers, will be negatively impacted by negative or neutral health outcomes for patients. It is impossible for such ‘value’-based funding by the insurer to not exert influence and progress to control over “the healthcare provider that treats a consumer’ and ‘the nature of treatment that a consumer receives’, which the Applicant has itself defined as “managed care” (paragraph 3.5). [v]

RANZCP has submitted to the ACCC that “The Proposal describes how the value of services from a particular Provider would be compared against peers, with the cost of their services then being ‘adjusted’ based on outcomes and quality of care. With the episodic nature of mental health problems, and the fact that many patients require ongoing treatment and management over a period of years, the RANZCP does not believe that the (private) health system is sufficiently developed to link payments to short term outcomes. The Proposal to link terms and conditions of private psychiatrists to outcomes may further create a financial disincentive for psychiatrists to see complex patients with treatment-resistant conditions, which would create a barrier for these patients accessing specialist care. The RANZCP recognises that mental health services, and private practice psychiatrists, must place consumers at the centre of care and have a recovery focus, not just a focus on clinical outcomes”. [iv] NAPP fully endorses these statements.

Multiple clinicians, including psychiatrists and dentists, speaking individually as well as representing multiple organisations and groups, gave verbal evidence to the ACCC of how insurer(s) influence and progressively exert increasing control over clinical practice and clinicians. It was clear how this would be facilitated by confidential (non-transparent), incentivising / disincentivising, unregulated, selective contracting. It was unfortunate that no media had been invited to or was present at the PDC to hear this important testimony.

A/Professor Jeffrey Looi, presented his (et al) paper ‘A clinical update on managed care implications for Australian psychiatric practice’, published in Australasian Psychiatry, which details the three major elements of managed care, “selective contracting, cost-cutting in the name of efficiency, and caps on the choice or quantity of services that are provided”.[vi] Looi made clear that the emergence of HH “aligned with the private health insurer NIB… will allow the insurer to selectively contract hospital, medical and allied health services through a separate business entity, thereby potentially allowing the development of managed care models which PHIs may consider offer business advantages”.[vi]

Looi et al note that “Psychiatry has not flourished in the US under managed care. … Managed care, through selective contracting, markedly constrains patient choice of provider, which is particularly important in psychiatric practice, where due to the personal nature of mental illness, the development of rapport and trust is essential to the therapeutic relationship. Similarly, the added administrative burden and development of clinical decision-making as a result of managed care guidelines and gatekeeping of treatment by non-clinical staff may hinder the collaborative planning of care between patients and psychiatrists. … the formalisation of a gatekeeping bureaucracy … will likely increase administrative burdens… as well as alienating patients from direct interactions with their psychiatrist”. Looi et al conclude by stating “Managed care is not a solution to the affordability of private psychiatric practice … It is essential that psychiatrists… advocate for person-centred, evidence-based healthcare, as opposed to ceding to a fiscally constrained managed care model”.[vi]

As such, it is imperative that the ACCC considers the sociocultural and historical impact of managed care from which the HH application emerges in making its assessment of the potential detriment(s) of approving the application. As we do not have this culture in Australia, we can look to the US for examples where “Cigna is the fourth-largest major

medical insurance company … by membership". Cigna offers health insurance and health services, dental, behavioral (mental) health, vision, supplemental health and retirement benefits.[vii]

Jonathan Herman, Founding Member of Herman Law Firm, wrote in 2016 in the American Bar Association (ABA) Health Law Section News & Information eSource re the upwards trajectory in health plan disputes involving the coverage of mental health benefits, referencing litigation cases against the five major health insurers, including Cigna. Herman, who publishes The Managed Care Litigation Update, wrote that across 2014 - 2016, "the common theme in these cases is that the payor is discriminating, restricting, or otherwise improperly limiting mental health coverage, or placing an undue burden on access to coverage … for the underlying mental health benefit".[viii]

Despite parity legislation implemented in the US to address the restriction of mental health care by insurers, the designation of treatment as "not medically necessary" reportedly happens "twice as often for mental health as for other medical conditions".[ix] Further, as the Parity implementation Coalition in Washington DC indicates, it is hard to follow up the hundreds of consumer complaints received, "because insurers refuse to release documents that would allow comparisons to be made between mental health and other health-related claims". [ix] We see this in the HH application already with the lack of transparency around the model of contracting and re the commercial negotiations processes. McCambridge writes that "… with limited oversight and no enforcement, the law does not have teeth sharp enough or monitoring systematic enough to deter insurers who wish to avoid paying claims". [ix] It was apparent in the ACCC PDC on 8th July 2021 that the ACCC does not have legislative capacity to scrutinise, much less regulate, contracts between private health insurers or third-party buying groups and providers. It would be negligent of the ACCC to approve an application that multiple different health and legal professional parties have declared on record will result in net detrimental impact, and with the full knowledge that there is "no specific regulatory oversight or limitation on how parties contract with each other in the medical supply chain" in place as part of due diligence to protect Australians' safety.[x]

Stephen Milgate declared at the PDC that approval of the HH application would result in "an unprecedented change in Australia's health care" and noted that "prior to the ACCC draft determination, there has been no public debate, no parliamentary debate, and little media reporting". Margaret Faux wrote in her submission to the ACCC that their Draft Determination "appears to be largely based on a mistaken belief that statutory benefits cannot be denied… The private health insurers (PHI) can and already do block legitimate statutory benefits" through mechanisms such as "exploitation of lax regulation, control of digital claiming channels and third line forcing".[xi]

Kantor Law wrote in 2014 re their victorious lawsuit against Cigna for wrongful mental health insurance denials. The settlement agreement required Cigna to "reprocess and pay hundreds of claims for nutritional counseling for mental health conditions, including eating disorders, to members who were wrongfully denied access to those benefits". [xii]

The lawsuit emerged from an investigation "into how Cigna administers their mental health benefits" after the New York Attorney-General received a complaint "from a family whose daughter suffered from anorexia nervosa. The complaint detailed that Cigna had denied their daughter access to insurance benefits for nutritional counselling, a necessary component of treatment for patients suffering anorexia". [xii] The investigation "revealed that Cigna had wrongfully denial of hundreds of claims for nutritional counselling for mental health conditions". The Founding Partner of Kantor & Kantor, LLP noted "Unfortunately, many of our clients have received similar insurance denials for the treatment of their eating disorder … I understand that eating disorders are life-threatening brain based mental illnesses, I understand that eating disorders have the highest mortality rate of all mental illnesses, and I also understand that evidence-based medical guidelines support the valuable role of nutritional counseling in the treatment of eating disorders. Regrettably, insurance companies do not always understand this critical need for appropriate and effective eating disorder treatment." Cigna was reported to have "unmistakeably violated" existing mental health parity laws designed to protect those with mental illness. Kantor Law indicated that the "settlement is of great significance, as it shines the spotlight on the continued and frequent mental health parity violations that the insurance industry would rather keep hidden in the shadows". [xii]

As psychiatrists know from working with survivors of childhood abuse and trauma in the mental health system, secrecy can be utilised as a tool to conceal gross violations, harms and abuses and facilitate their ongoing enactment. This is a serious concern when commercial-in-confidence contracting and concealed third party influence and pressures are brought into the doctor-patient relationship; there is a risk of repetition of abuse dynamics and re-traumatisation occurring in a cohort of patients that already have significant histories of abuse(s) and trauma. Detriment does not capture the catastrophic adverse effect(s) that third party intrusions can have upon the therapeutic relationship, which when protected and protective can mean the difference between a patient - a person - living or dying.

Psychiatrist Wendy Dean, with Talbot and Dean, has written about "the epidemic of physician distress" in the US and that "Massive information technology investments, which promised efficiency for health care providers, have instead delivered a triple blow: They have diverted capital resources that might have been used to hire additional caregivers, diverted the time and attention of those already engaged in patient care, and done little to improve patient outcomes".[xiii]

Dean has written that moral injury in healthcare clinicians "…occurs when we perpetrate, bear witness to, or fail to prevent an act that transgresses our deeply held moral beliefs. In the health care context, that deeply held moral belief is the oath each of us took when embarking on our paths as health care providers: Put the needs of patients first. That oath is the lynchpin of our working lives and our guiding principle when searching for the right course of action. But as clinicians, we are increasingly forced to consider the demands of other stakeholders — the electronic medical record (EMR), the insurers, the hospital, the health care system, even our own financial security — before the needs of our patients. Every time we are forced to make a decision that contravenes our patients' best interests, we feel a sting of moral injustice. Over time, these repetitive insults amass into moral injury." [xiii]

"Moral injury … describes the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control." [xiii] Such double binds in the healthcare system produce a healthcare system that over time becomes unsafe for patients - re-traumatising - and also for practitioners - with clinicians experiencing increasing levels of vicarious traumatisation and moral injury. [ii] Dean writes "The long-term solutions to moral injury demand changes in the business framework of health care. The solutions reside … in creating a health care environment that finally acknowledges the value of the time clinicians and patients spend together developing the trust, understanding, and compassion that accompany a true relationship. The long-term solutions to moral injury include a health care system that prioritizes healing over profit and that trusts its clinicians to always put their patients' best interests first." [xiii]

NAPP asserts this is the true definition of value rather than that asserted by for-profit insurers and managed care corporations. Such a system is not possible when doctors have confidential unregulated commercial contracts with third party insurers' buying groups. As detailed in the many submissions to and the reports emerging from the Victorian Royal Commission into Mental Health, working in or being 'cared' for by a system where "The agendas of the system and the participants (clinicians, patients) on the surface resemble each other but in essence they are different" is a dehumanising experience for all, leading to demoralisation, re-traumatisation, vicarious traumatisation, moral injury etc [ii, xiv] The parallels with managed care intrusion into clinical relationships is clear. "Respecting the autonomy of persons with mental disabilities necessitates 'our own emancipation from institutional thinking and practice''.[xv xvi]

The ACCC has received multiple written and verbal submissions that detail examples of how incentivising / disincentivising contracts over time exert influence and then control over clinical practice, detrimentally distorting clinical practice, the market, capacity for patient informed consent, access / choice of provider and treatment(s). There are an overwhelming number of detriments that flow from the conduct proposed in the HH application.

The American Psychological Association Practice Organization noted in 2005 that Cigna was the first managed-care organisation (MCO) to settle in a US nationwide class-action lawsuit, in which more than 4000 psychologists alleged

that the MCO companies “conspired to reduce and delay payments to psychologists and other nonphysician health professionals”. [xvii] The lawsuit was part of an “ongoing initiative by organized psychology to hold managed-care companies accountable for actions that harm patients and practitioners”. [xvii]

Cigna is a multinational managed healthcare and insurance company with multiple past and present law suits. The information and references NAPP have noted in this submission are freely available online.

According to the Violation Tracker corporate misconduct database [xviii], as of 21st July 2021, Cigna has paid $437,562,992 to settle violations / offences since the year 2000. Data collected on the Top 5 Offense Groups for Cigna list from top, government-contracting-related offences, consumer-protection-related offences, employment-related offences, competition-related offences and healthcare-related offenses. Top 5 Primary Offense Types, from top, are listed as False Claims Act and related, benefit plan administrator violation, consumer protection violation, kickbacks and bribery and insurance violation. Violation tracker is produced by non-profit The Corporate Research Project of Good Jobs First, which “focuses on identifying information that can be used to advance corporate accountability campaigns”. [xix]

Appelbaum and Parks wrote in 2020 that “Despite a series of federal laws aimed at ensuing parity in insurance coverage of treatment for mental health and general health conditions, patients with mental disorders continue to face discrimination by insurers. This inequity is often due to overly restrictive utilization review criteria that fail to conform to accepted professional standards”. [xx]

Landmark law suits were filed against Cigna and UBH - another managed care insurer - in April 2020 alleging the insurers conspired to underpay insurance claims for mental health treatments through the use of a third-party company, perpetrating a fraud upon patients and out-of-network providers who offered outpatient care. Lead Attorney Lavin said of the case, “Cigna and United’s use of Viant to systematically underpay treatment costs for addicts and the mentally ill is, sadly, just today’s example of insurers placing profits before behavioural health patients” (mental health patients). “Regulators have so far ignored complaints from patients and providers alike, so our clients are left with no alternative but to seek justice in the courts for themselves and for the millions of others who have been harmed by these unethical practices”. [xxi] [xxii] Napoli Shkolnik PLLC reporting on the lawsuits wrote that “According to the complaints, Cigna and United… justify ripping off insurance customers by manipulating benefits by applying secret rates that are arbitrary, deceitful, self-serving, and harmful to patients, all in order to grow profits and steer patients to in-network providers who cost the insurers less”. [xxi] NAPP was not able to find the outcomes of these cases online; they may still be in process.

In a precedent legal case in the US *Wit v United Behavioural Health*, 2017, the United States District Court for the Northern District of California found that the Insurer had “reneged on its fiduciary responsibility to policyholders by adopting treatment guidelines that focused on cost savings through limiting coverage to the management of acute mental health episodes”.[xxiii] This is one of the problems when we allow a for-profit insurer or buying group to define ‘value’. Gnaulati, a clinical psychologist and US-nationally recognised reformer of mental health practice and policy, quoted Judge Spero, who said that ““… it is a generally accepted standard of care that effective treatment requires treatment of the individual’s underlying condition and is not limited to alleviation of the individual’s current symptoms.” He added “… the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment.” In essence, Judge Spero sounded his gavel in favour of mental health treatment of sufficient duration to get to the heart of clients’ psychological difficulties, not the all-too-prevalent model endorsed by health insurers and perpetuated by academic researchers: short-term, crisis-management, protocol-driven therapies measuring progress in terms of symptom reduction.” [xxiii]

The managed care insurer had “illegally denied mental health and substance use coverage” when it “used internally developed medical necessity guidelines that comprehensively fell short of accepted standards of care”. The decision, issued by Judge Spero, described how internally developed medical necessity guidelines employed by the managed care insurer “were inconsistent with generally accepted standards of care articulated by various professional

associations (including American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Society of Addiction Medicine, and the American Association of Community Psychiatrists), the Centers for Medicare and Medicaid Services, peer-reviewed research, and expert consensus".[xxiv]

The American Psychiatric Association reported that the lead lawyer of the landmark case indicated that internal managed care insurer "company documents show that financial considerations consistently influenced decisions about authorization of care for the plaintiffs". "We were able to prove that financial considerations had infected the decision-making process and that people from the company's finance department were participating in the [writing of internal guidelines] to reduce benefit expense. And that they were kept regularly apprised of the company's performance."[xxv]

The conflict of interest when a clinician is contracted simultaneously to both an insurer, as well as their patients - a potentially irreconcilable double bind - seemed evident in the reporting that the testimony during the trial from "a president of one state psychiatric society (who was) also one of UBH's medical directors… was found to be not credible".[xxvi]

Psychiatrists in the US have written about how managed care insurers have denied clinically recommended treatment, despite their having asserted that patients needed it and would deteriorate, or even die, without it. [xxvii] [xxviii]

The *Wit v UBH* case emerged from the managed care insurer having denied coverage for 17-year-old Natasha Wit for her inpatient residential mental health treatment on the grounds that "her treatment does not meet the medical necessity criteria". "The reviewer suggested that she could safely be treated at a less restrictive level." "At the time, she was said to be suffering from a severe eating disorder, with medical complications that included amenorrhoea, adrenal and thyroid problems, vitamin deficiency, and gastrointestinal symptoms. She was also reported to be experiencing symptoms of depression and anxiety, obsessive-compulsive behaviors, and marked social isolation". [xx] Luckily, her family was able to afford to pay privately for the two months of residential treatment that she required. Max Tillett, a 21-year-old man with a heroin addiction, whose mother later joined the class action lawsuit, died from a drug overdose, 10 weeks after discharge from treatment, in the context of the health insurer having "refused a request to authorise continued care after his first 3 weeks in a residential treatment program for addictions - and denied the facility's urgent appeal of the decision". [xx]

"In holding that the largest health insurer in the United States knowingly failed to conform to accepted standards of treatment, the opinion in *Wit* constitutes a stunning repudiation of the industry." [xx] NAPP communicates clearly to the ACCC that the HH model and managed care processes under consideration for introduction into the Australian health care system pose clear and overwhelming detriments. Plakun, a medical doctor, who testified in the Wit case that the managed care company had withheld coverage of necessary care said "Before the verdict in Wit, insurance companies just set the standards, and no one had the power to call them out on the flaws in their version of generally accepted standards. Now the verdict states their standards are unlawful and put … financial interests over the needs of patients". Plakun declared "The basic take-home message to psychiatrists is 'When you thought insurance companies had a totally different sense from you of what patients needed in treatment, you were right and they were wrong and acting unlawfully'. That's an important message for psychiatrists to hear." [xxviii]

NAPP calls on the ACCC to consult broadly with the public and mental health consumer groups regarding consumers' responses and anticipated experiences as to the impact it would have to discover that one's psychiatrist was signed up into an incentivising / disincentivising, unregulated, commercial third-party contract of which the details were confidential. NAPP contends that such a discovery would result in anxiety, fear, at best call into question the trustworthiness of the psychiatrist and at worst, irreparably damage the therapeutic relationship. Working in mental health, we know what devastating effects the loss of faith and trust in a caregiver has on a person. 'Detriment' does not capture the devastating impacts such ruptures can have, including suicide.

On behalf of psychiatrist members, NAPP strongly opposes ACCC approval of the HH application. NAPP asserts that it would be negligent for the ACCC to knowingly approve the HH application without the relevant oversight and regulatory legislation being in place to protect Australians.

Nib may contend that HH's priority is to "help people lead healthier lives", which it indicates will emerge from "using data science to understand their current and future health risks and needs and then actively help them prevent, manage or treat that risk". [i] Nib contends that current Australian healthcare is "one size fits all" and that HH will offer personalised healthcare. NAPP notes that in the nib Business Strategy presented to Goldman Sachs Emerging Companies Conference in April 2019, where the harnessing of data science and digital technologies is detailed to result in better 'personalisation', that personalisation is documented written in inverted commas.[xxix] NAPP suggests this indicates that even nib is aware that its use of the term 'personalisation' is a euphemism; it should be understood as sales marketing / advertising, not necessarily as health care fact.

The data analytics that will be drawn upon, detailed in nib's 'From "sickcare" to "healthcare" system and "personalisation"' [xxix], in no way offers a genuine individualised experience of mental health care, which emerges from developing understanding and collaboration between patient and clinician within the therapeutic relationship.

Akhtar, reported in Business Insider in 2019, that New York was investigating a managed care insurer's "use of a medical algorithm that steered black patients away from getting higher-quality care". [xxx] She reported that the study had found "a widely-used algorithm gave more complex treatment to white patients than sicker black patients", was racially biased and pointed to "one of the many risks of implementing more AI in healthcare". The insurer had "touted its use of AI to provide better care". Akhtar noted that "experts and researchers have long called out the bias algorithms can perpetuate", citing examples of algorithms that had inadvertently discriminated against women, black people, perpetuated structural inequality and contributed to clinician burnout by stripping doctors and nurses "from the autonomy to diagnose and treat patients individually". Akhtar quoted the Director of nursing practice National Nurses United who said, "Traditionally, both nurses and doctors are independent professionals, but because it's now an industry, we're looking at care where algorithms are dictating care rather than professional judgement".[xxx]

NAPP notes the information provided by HH to the ACCC re its intention to use under the Proposed Conduct "standard sets of value, calculated by the International Consortium for Health Outcomes Measurement (ICHOM)".[xxxi] We assume this information is connected to the value based contracting that HH is proposing but has not shown to ACCC. NAPP has been unable to find evidence that the "standard sets of value" are internationally recognised by the broad scientific and medical community as claimed by HH. NAPP notes that the International Consortium for Health Outcomes Measurement (ICHOM) was established by a number of individuals and is based on ideas formulated by one of the Founders and others. While the concepts espoused by ICHOM might have some superficial appeal, NAPP is concerned that these are not consistent with the realities of psychiatric practice and, if implemented via ACCC approval of the HH application, will be detrimental to Australian patients and the Australian healthcare system.

NAPP also holds significant concerns re the intention of HH to "mine customer data". James Fernyhough has reported in the Australian Financial Review re this intention and that Nib Managing Director Mark Fitzgibbon has said that the community rating system, which is currently the only barrier to stopping nib from using mined data to "hike an individual's premiums", should be reviewed.[xxxii]

The ACCC assertion that the HH model of contracting is "is only likely to be implemented broadly if the Applicants can gain the agreement of Providers and there is also support from consumers" [x] carries the implicit message that if the model is no good, it will not find support; however, with respect, NAPP asserts that this is a misguided position.

NAPP raises concerns re the health literacy of the consumer population, their vulnerability to well-crafted marketing / health advertising. It is well known that doctors are also vulnerable to such marketing; this has resulted appropriately in doctors being ethically obliged to disclose the conflicts of interest they have to patients and society, which will be prevented by the secret nature of the commercial HH contracting.

NAPP notes that in 2020, Cigna had a total revenue of $160.4 billion, made a $8.5 billion profit and spent $180 million on measured media marketing.[xxxiii] [xxxiv] The Psychotherapy Action Network (PsiAN) in US has already detailed a precedent whereby a managed care insurer used marketing strategies to promote "cost-minimizing, brief treatments and (disparaging) high-caliber, long-term (psychotherapy) treatments it does not offer". [xxxv]

PsiAN wrote that the Insurer posed marketing that promoted its own services as medical research / evidence. They reported that a division of the American Psychological Association wrote to the Insurer's CEO stating "Unwitting consumers and other companies might accept the authority of this …paper, which contains false information, thereby restricting their options for treatments that work". [xxxv] Such precedents by managed care insurers restrict competition, restrict patient access to information re the full range of treatments (perverting the process of informed consent) and restrict patient access to the full range of treatments. Patients might also spend a considerable portion of their income on insurance policies that do not cover the treatment that is clinically appropriate to meet their individual needs. As a result of paying for the insurance policy, they may then be limited or prevented financially from sourcing the necessary treatment privately.[xxxvi] These forms of psychotherapy are not generally available or accessible within the public mental health system despite being first line for the sequalae of complex trauma, childhood abuse and neglect. [ii]

Ali Shana, writing in the Psychiatric Times re the 2019 Milliman Research Report, 'Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement', commissioned by Mental Health Treatment and Research Institute LLC, a not-for-profit subsidiary of The Bowman Family Foundation and which looks at the status of mental health parity based on insurance information, indicated that the 140-page report "showed continued and increased disparities between behavioral health care and physical health coverage, indicating possible evidence of noncompliant insurance practices".[xxxvii] Shana quoted Mark Covall, Executive Vice Chairman of the National Association for Behavioral Healthcare, "The Milliman findings emphasize what our members have been telling us for years: unfair managed care practices too often create barriers for patients to access the care they need". Shana reported that the Milliman report noted "that cost or poor insurance coverage was the top barrier to seeking effective mental health services for Americans." [xxxvii]

NAPP submits its deep concerns re the net detriments and risks that will flow from ACCC approval of the HH application. NAPP asks the ACCC to reverse its draft decision on the HH application and reject the application in its entirety.

Dr Philip Morris AM
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[ii] Hill, M. and Feiler, G. (2019), RANZCP Faculty of Psychotherapy (Victoria) Submission to the Royal Commission into Victoria's Mental Health System, accessible at http://rcvmhs.archive.royalcommission.vic.gov.au/RANZCP_01.pdf

[iii] Productivity Commission 2002, Managed Competition in Health Care, Workshop Proceedings, AusInfo, Canberra.

[iv] The Royal Australian & New Zealand College of Psychiatrists (July 2021), Submission to ACCC Re: Honeysuckle Health and nib application for Authorisation AA1000542 - draft determination

[v] Applicant's response to interested party submissions (30 June 2021), accessible at https://www.accc.gov.au/system/files/public-registers/documents/Applicant%27s%20response%20to%20interested%20party%20submissions%20-%2030.06.21%20-%20PR%20VERSION%20-%20AA1000542%20Honeysuckle%20nib.pdf

[vi] Looi, J.C.L. et al (11 July 2021), A clinical update on managed care implications for Australian psychiatric practice', Australasian Psychiatry, accessible at https://doi.org/10.1177/10398562211030011

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[x] ACCC (21 May 2021), Draft Determination, accessible at https://www.accc.gov.au/system/files/public-registers/documents/Draft%20Determination%20-%2021.05.21%20-%20PR%20-%20AA1000542%20-%20Honeysuckle%20Health%20and%20nib.pdf

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06.09.2021 **National Association of Practising Psychiatrists**

Re: Honeysuckle Health and nib application for Authorisation AA1000542

Response to MinterEllison 'Response to submissions following the pre-decision conference' on behalf of nib health funds limited (nib) and Honeysuckle Health Pty Ltd, dated 9th August 2021

"3.6 Consumers will often not become aware of a medical specialist's gap until the first consultation, as their GP will generally not have information about gaps on hand when recommending a specialist to their patients… After the first consultation, consumers are then reluctant to switch specialists even if the gap payments will be large. The Applicants submit that there is greater potential for economic coercion of consumers in the current state."

Psychiatric and other medical specialists and / or their administrative staff routinely provide patients with information re fees and rebates, usually at the time of booking the first appointment(s). This is part of financial informed consent. The unreferenced statement by MinterEllison misrepresents medical practitioners and is used to advance their own interests.

"9. Appropriateness of value-based contracting for mental health

9.1 Several submissions raise concerns that value-based contracting is not sufficiently developed to link payments to short term outcomes within mental health, due to the episodic nature and ongoing treatment of mental health problems.[16] They note that many patients require ongoing treatment over a period of years and that linking contractual terms to outcomes may further create a financial disincentive for psychiatrists to see complex patients with treatment-resistant conditions.[17] Further, even where a diagnosis is achievable, Dr Gary Galambos' submission notes that this is not a good predictor of the need or duration of an admission.[18]

9.2 The Applicants appreciate the complexity of introducing value-based contracting for mental health hospitalisations compared to say, joint replacements. HH does intend to develop value-based contracts in mental health. The contracts will be developed in consultation with hospitals and psychiatrists. They will be based on clinical best practice, respect the primacy of the specialist/patient relationship and look to address the existing gaps in care that are created by existing funding models."

NAPP communicates its deep concern that despite the applicants acknowledging that they "appreciate the complexity of introducing value-based contracting for mental health hospitalisations", they go on to state "HH does intend to develop value-based contracts in mental health". This demonstrates that the applicants have disregarded the advice of the specialist health professional bodies that represent the experts in diagnosis, research, advocacy and treatment of mental disorders. The maintained intention to progress the development of value-based contracts in mental health, despite experts in the field strongly communicating against this line of action indicates already that collaborative consultative processes will not be possible.

Given the current mental health system is at the beginning of longer-term processes of increasing psychiatrist numbers to meet clinical need, the system cannot afford the reductions in effectiveness, efficiencies and quality of mental health care that such contracting and its requirements will deliver. NAPP asserts that the impacts will be significantly detrimental at the level of the individual patient-clinician therapeutic relationship and more broadly at the level of the mental health care system. NAPP maintains that the value of such contracting is maintained at the level of financial return for the applicants.

NAPP notes further that nib and HH have not identified any existing gaps in care that are created by existing funding models as part of their application processes. An implication is that HH only intends to force value-based contracts on mental health care for its own purposes.

"10. ICHOM standards

10.1 The National Association of Practising Psychiatrists has raised concerns over the use of the International Consortium for Health Outcomes Measurement (ICHOM) to determine the value of care under the Broad CPP.[19] Specifically, they suggest that ICHOM is not internationally recognised by the broad scientific community as a standard set of values and therefore question the appropriateness of its use in the Broad CPP. Further, they raise concerns that the concepts of ICHOM are inconsistent with the realities of psychiatric practice.

10.5 … the Applicants are open to working with each medical specialty college to determine if better measurement systems exist for their specific craft group if ICHOM is deemed as not appropriate."

NAPP maintains that the ICHOM standard set is not recognised internationally, is not in general use within psychiatric practice, and is not consistent with the realities of psychiatric practice. NAPP is concerned that the use of such standard sets, if implemented via ACCC approval of the HH application, will be detrimental to Australian patients and the Australian healthcare system. NAPP maintains that the complexity of psychiatric practice, bringing together biopsychosociocultural dimensions developmentally, and across conscious and unconscious domains, can only be limited and / or impacted detrimentally by such standard sets.

Further, NAPP asserts that the movement to standard sets introduces unnecessary bureaucratic processes into the therapeutic relationship and as such, function to change the very nature of the therapeutic relationship, which is itself an important component of mental health care and healing. NAPP notes that major healthcare insurers in the USA have misused similar standard sets or algorithms for reporting treatment utilization with detrimental effects on the quality and duration of outpatient psychotherapy and the denial of benefits to insurance beneficiaries. There is no reason the use of similar standard sets by HH may not incur the same problems.

NAPP also respectfully indicates that psychiatrists in Australia have multiple representative organisations, including RANZCP, the National Association of Practising Psychiatrists, the Australian Medical Association section of psychiatry, and the Australian Doctors Federation that should be consulted regarding any and all developments that will affect psychiatric practice.

NAPP submits its deep concerns regarding the net detriments and risks that will flow from ACCC approval of the HH application. NAPP asks the ACCC to reverse its draft decision on the HH application and reject the application in its entirety.

Dr Philip Morris AM President NAPP	Dr Vivienne Elton Vice President, NAPP	Dr Melinda Hill Secretary, NAPP

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