Autoriteit
Consument & Markt

Public

Loyens & Loeff N.V.
P.O. Box 71170
1008 BD Amsterdam

The Hague, 21 July 2021

Our reference:	ACM/UIT/557201
Contact person:	
Subject:	ACM/20/039827 ACM's response to planned inclusion of addendum in the health care agreement on medical specialist care 2021

Dear Mr. X,

On behalf of ZN (Zorgverzekeraars Nederland, an umbrella organization of ten health insurers in the Netherlands), you asked the Netherlands Authority for Consumers and Markets (ACM) for a response to the planned arrangements between ZN, the Netherlands Federation of University Medical Centres (NFU) and the Dutch Hospital Association (NVZ) regarding a scheme for providing and funding medical specialist care (including COVID-19 care) in 2021 (Draft memo of May 28, 2021). You contacted ACM regarding the compatibility of these proposed arrangements with competition rules.

This is our response, preceded by a brief summary of the background relevant to this case, and of the contents of the planned arrangements.

Background

In November 2020, ZN indicated to ACM that, like in 2020, it is necessary to make joint arrangements with NFU and NVZ for the year 2021 with regard to mitigating the financial effects of the COVID-19 pandemic on hospitals and university medical centers (collectively referred to as hospitals). With these arrangements, these three national organizations wish to guarantee the continuity of health care today and after the pandemic, and health insurers can fulfill their duty of care, now and in the future. On December 17, 2020, ZN[1], NFU and NVZ reached broad agreement on the funding of the medical specialist care (MSZ) for the claim year 2021. In the subsequent months, the parties involved fleshed out these broad strokes and drew up an intended agreement. Since November 2020, ZN has kept ACM informed about the contents of the planned agreement, and, on several occasions, answered questions for clarification purposes. During that period, ACM held in-depth conversations with NVZ and NFU, and it asked these umbrella organizations written questions, and has received answers to these questions. In addition, it sat down with individual health insurers, and it consulted with the European Commission. In addition, several market participants contacted ACM and expressed their concerns regarding the scheme's scope and its possible consequences. On May 28, 2021, you sent ACM the final draft version of the planned

[1] Health insurer EUCARE does not participate in the scheme.

Muzenstraat 41
2511 WB Den Haag
www.acm.nl
070 722 20 00

addendum to the health care agreement on Medical Specialist Care for 2021 (in Dutch: zorgovereenkomst 2021 Medische Specialistische Zorg), and on 23 June, you answered several questions.

The planned agreement

The draft agreement we received consists of three parts followed by specified list of health care providers (mostly hospitals)[2]. The first part focuses on arrangements about the reimbursement of regular health care, COVID-19 care, and catch-up care. The second part focuses on a generic COVID-19 reimbursement of additional costs, a safety net (when care is cancelled), and an availability compensation for a Phase 1 scale-up of IC units. The third part contains a hardship clause, which can only be invoked after parts 1 and 2 have been implemented.

These arrangements have been included in an addendum[3], which acts as a supplement to the individual arrangements between health insurers and health care providers in the health care agreement on MSZ for 2021. This 2021 Addendum has been concluded for the period in which the health insurer offers health care in 2021. The technical settlement of the agreement (draft or final) will take place in the subsequent years.

According to the three national organizations, the agreement on MSZ for 2021 takes into account, first of all, the costs associated with fighting COVID-19 and the additional health care associated with COVID-19 infections. In addition, it also takes into account the fact that the hospitals must temporarily scale down part of the regular health care services due to the fight against COVID-19, as a result of which the normal reimbursements for standard activities could not take place.

The agreement's basic principle is, according to the parties involved, that the health insurer and the health care provider act individually where possible, and act collectively, through their trade associations, where, as a result of the pandemic, such is needed in the patients' interests.

ACM's response

A joint agreement between health insurers and hospitals regarding the reimbursements of hospital care or any other costs that have been incurred may restrict competition. After all, uniformization of arrangements regarding these reimbursements/costs eliminates any differences between both health insurers as well as health care providers, and, as such, affects the incentive to differentiate oneself from others. This would subsequently lead to a reduction of health care, and to fewer incentives to procure in an efficient manner. That is why such arrangements are, in principle, not allowed, even if these only applied for a limited period of time.

On the basis of its own market studies and the information submitted by you, ACM has decided not to investigate further the compatibility of the collaboration with competition rules. In this context, it is relevant for ACM that it finds it sufficiently plausible that the collaboration agreement is necessary for countering the threats posed by the coronavirus (COVID-19) pandemic to the continuity of health care, both during and after the pandemic, and ACM finds it essential that the collaboration is temporary, with its duration having been limited to the claim year 2021. In this context, it is also

[2] Health care providers that do not treat COVID-19 patients *and* are confronted with cancellations or with changing treatment combinations which are demonstrably caused by fewer referrals from hospitals fall under a separate continuity scheme. These concern rehabilitation centers, for example.
[3] The addendum does not apply to CBT, PAAZ and PUK within the list of hospitals. A separate scheme will be created for these units. On the basis of the agreed upon principles for these units, it turns out that these do not significantly differ from the main scheme.

relevant for ACM that, in a recent letter[4] to the Dutch House of Representatives, ZN states that all parties involved assume that '2022 will be a "regular" year again where contracts will be concluded as usual […].'

More specifically, ACM sees that, in late 2020, although COVID-19 had already become a well-known phenomenon by then, there were still various and significant uncertainties regarding the impact on 2021. After all, during the period when, normally speaking, negotiations between hospitals and health insurers take place, it was still completely unclear how COVID-19 would evolve in 2021. That uncertainty was connected to the widely fluctuating number of infections, the question as to the extent to which the virus would flare up again, whether mutations would emerge that could alter the situation again within a short amount of time, and to the impact and pace of the planned vaccination program as the effectiveness and availability of the vaccines were still very uncertain at that point. As a result, it was not possible to make a well-substantiated projection about the pressure on hospitals, and about the extent to which it could be necessary to scale down regular health care again. It was essential to think in terms of scenarios, widely divergent scenarios for that matter.

Against that backdrop of uncertainty, it was important that hospitals were able to focus on the fight against COVID-19, while having assurances that any COVID-related costs would be reimbursed. ACM finds it sufficiently plausible that, without a joint scheme, continuity of health care could be jeopardized, and health insurers could not meet their duty of care, now and in the future.

Individual negotiations, too, could lead to a reduction of health care options if health insurers were not sure whether other health insurers also chipped in, and especially the largest health insurer in a particular region foots the bill as part of its duty of care. In a pessimistic scenario, this uncertainty could have negative effects on health care options in a region both during and after the pandemic.

The draft agreement for 2021 also reveals that the individual contracts between health insurers and hospitals for the claim year 2020 (which were concluded in the period before COVID-19 became relevant), in all their diversity, are rolled over to 2021. That means that health insurers differentiate themselves from each other in terms of procurement policies for 2021 too.

In addition, ACM notes that the collectively agreed upon reimbursements can, in virtually all cases, be directly linked to COVID-19 and are based as much as possible on the actual costs that hospitals incur. Many of the arrangements that have been included in the agreement concern processes, for example how something should be reimbursed, assessed, or arranged. The actual rates and other financial conditions of these arrangements (precisely those aspects on which health insurers are able to differentiate themselves from each other) follow or dovetail with the individual arrangements between health insurers and hospitals.

Considering the above, ACM recognizes the necessity of the arrangements that have been made, and sees that the collective arrangements have been kept as narrow as possible. Health insurers in 2021 therefore procure less collectively than in 2020. In addition, compared with the continuity contribution scheme with which health insurers financially supported hospitals, more incentives have been included in order to procure efficiently in 2021. Market participants have thus acted on ACM's warning in its letter of October 2020[5] that any collective arrangements regarding financial reimbursements to hospitals for 2021 do not go beyond what is necessary, and that the incentives to procure efficiently are kept intact as much as possible.

[4] ZN (2021, 30 June). ZN letter for the committee debate on MSZ. Reference FS-21-297.
[5] See ACM (2020, 27 October). ACM's response to the planned agreement on the distribution of the effects of the coronavirus (COVID-19) crisis among health insurers for 2020. Letter ACM/UIT/543322. Weblink.

The coronavirus (COVID-19) crisis also involved postponing regular health care. That is why, as opposed to 2020, a passage about catch-up care has been included in the draft agreement. One market participant shared its concerns with ACM, fearing that the arrangements with hospitals regarding catch-up care come at the expense of the opportunities of other health care providers, including independent treatment centers, to offer catch-up care.

ACM recognizes the necessity of the collective arrangements regarding catch-up care made between the umbrella organizations, as well as the important role of hospitals in catch-up care. ACM emphasizes that the arrangements cannot result in hospitals concluding arrangements only among themselves in order to catch up postponed care as quickly as possible, for example by distributing patients within and between regions. After all, that would not ensure full utilization of all available health care capacity, including the capacity outside hospitals, for catching up necessary care. That is not in the interest of patients, as their health could be seriously harmed as a result thereof. ACM will remain alert to any reports that, in practice, health care providers other than hospitals are excluded from providing catch-up care.

Expensive drugs

When formulating its response, ACM saw reason to pay specific attention to the arrangements in section 2.3 of the draft agreement concerning expensive drugs (DGM). The fact of the matter is that expensive drugs do not directly relate to COVID-19 or COVID-19-related care.

In the interest of patients and insured, ACM wishes to ensure that the markets for drugs (including expensive drugs) function well. One element of that oversight is that both health care providers and health insurers have sufficient incentives to procure actively and competitively in order to control as much as possible the costs of expensive drugs. After all, those costs represent an increasingly larger share of total health care costs.

In the section on expensive drugs, arrangements have been made about keeping the margin that health care providers achieved on expensive drugs in 2020 at a similar level in 2021 (margin retention). Such an arrangement could affect the incentives for health care providers to procure expensive drugs efficiently for 2021, thereby having possibly harmful effects on current and future insured. ACM has also received several reports from market participants that were worried about the arrangements in said section.

In connection with this point, ACM conducted a targeted market study, in which ZN, NVZ, and NFU were also asked written questions. With regard to the relationship between COVID-19 and the agreement on expensive drugs, ACM follows the detailed explanation given by these market participants that the margins (including margins on procurement) on expensive drugs are an integral component of hospital revenues. The margin maintenance agreement therefore forms an integral part of the financial certainty for hospitals for 2021 as intended with the draft agreement and which ACM characterized as necessary.

The market study also reveals that practically all contracts for expensive drugs between hospitals and drug manufacturers were concluded in the fall of 2020 before the various umbrella organizations discussed margin maintenance. As such, the margin maintenance agreement could thus have had very little influence on the negotiations between hospitals and manufacturers.

In addition, ZN, NVZ and NFU in their answers to ACM’s written questions explicitly said that the agreement on expensive drugs would only be valid for 2021, and that no extension of renewal of the agreement was under discussion.

On the basis of that information, ACM does not expect the agreement to have any negative effects on future negotiations between hospitals and drug manufacturers. Therefore, the efficiency incentives for the 2022 claim year and subsequent claim years remain in place.

ACM has also examined the possible effect of the agreement on expensive drugs (and the margin maintenance agreement in particular) on the negotiations between health insurers and hospitals, including the incentive to remain competitive in those negotiations. In the draft agreement, it has been explicitly included that, for 2021 too, bilateral negotiations between health insurers and hospitals will take place in order to update the price lists for expensive drugs, in the run-up to regular negotiations for 2022. As such, ACM finds it sufficiently plausible that the effects of the agreement on the negotiations between health insurers and hospitals will be limited (or even very limited).

Finally, ACM establishes that the draft agreement reveals that ZN, NVZ and NFU paid attention to safeguards in order to make sure that hospitals account to health insurers for their procurement strategies.

Final remarks

On the basis of the information regarding the facts and circumstances as described by you and that ACM has in its possession as well as on the basis of ACM's own market studies, ACM sees no reason to launch a further investigation into the compatibility with competition rules. In that context, ACM has established that, in the draft agreement, the parties involved have clearly acted on the warning that ACM gave in the fall of 2020 in its response to the solidarity scheme for 2020.

On a final note, I would like to extend my appreciation for the constructive manner in which you sought contact with us when drawing up the draft agreement, as a result of which, points for attention could, in that phase already, where necessary, be identified with an eye to competition rules.

Best regards,

The Netherlands Authority for Consumers and Markets,

on its behalf,

Bart Broers

Director

Health Care Department