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Public

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Number of enclosures : --
Your reference :
Our reference : ACM/UIT/580060
Contact person :
Subject : ACM/20/039827

Dear Sir/Madam,

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 nationwide arrangements between ZN, the Dutch Hospital Association (NVZ) and the Netherlands Federation of University Medical Centers (NFU) regarding COVID-19 care in 2022 (2022 Addendum to 2022 health care agreement on medical specialist care). You have contacted ACM in connection with 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. 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, already in an early phase, be identified with an eye to competition rules.

Background

In November 2021, ZN contacted ACM to announce that, contrary to the previous expectation that 2022 would be a normal contract year, it was necessary, particularly given the fact that the pandemic at that point took an unexpected turn because of the Omicron variant, to conclude, on top of the bilateral contracts, a limited and temporary set of joint nationwide arrangements with NFU and NVZ for the year 2022 with regard to mitigating the financial effects of the COVID-19 pandemic. With those arrangements, these three national organizations wish to provide hospitals and university medical centers (collectively referred to as hospitals) comfort regarding the COVID-related risks that they would incur in 2022. The arrangements would guarantee the continuity of health care, now and after the pandemic, and would be limited to the reimbursement of COVID-related costs that, it is expected, cannot be solved (or only to a very limited extent) through bilateral procurement, according to ZN.

On 23 December 2021[1], ZN, NVZ and NFU negotiated the broad outlines of a safety net scheme for 2022 for mitigating the financial effects of COVID-19. On 28 January, ACM indicated not to have any objections against the broad strokes of the new COVID-related arrangements between hospitals and health insurers

[1] https://nvz-ziekenhuizen.nl/nieuws/ziekenhuizen-en-zorgverzekeraars-maken-financiele-afspraken-over-corona

for 2022[2]. One major reason for that was that the planned arrangements went considerably less far than the arrangements for 2021 did, and allowed for hospitals and health insurers in 2022 to return to individual contracting as the basis for the distribution of health care funds.

In the subsequent months, the parties involved fleshed out those broad strokes into a planned agreement. In that context, ZN kept ACM informed of the thought process regarding the substance of the agreement, and, on multiple occasions, answered questions for clarification purposes. During that period, ACM was also in touch with NVZ and NFU. In addition, ACM also sat down with individual health insurers, individual hospitals, and consulted with the European Commission. On 16 June 2022, ACM received from you the final draft version of the joint COVID-related arrangements for medical specialist care (MSZ) for 2022.

The joint arrangements

The joint arrangements consist of three parts that have been drawn up for a specified list of health care providers that provide direct COVID-related care (particularly hospitals)[3][4]. The first part focuses on arrangements regarding the reimbursement of COVID-19 care, and includes the starting point that regular health care and catch-up care are reimbursed on the basis of bilateral arrangements. The second part includes additional COVID-related arrangements, and focuses on a generic COVID-19 reimbursement of additional costs[5], a reimbursement of production losses caused by Omicron in order to be able to cover the ongoing costs[6] of hospitals, and an availability compensation for a Phase 1 and 1+ scale-up of IC units[7]. The third part contains a hardship clause, which can be invoked by health care providers in case of a below-zero result caused by insufficient reimbursement of COVID-related costs, and a 'positive' hardship clause, which can be invoked by health insurers in case of an extremely positive result of a health care provider.

These arrangements have been included in an addendum, which acts as a supplement to the individual arrangements between health insurers and health care providers in the health care agreement on medical specialist care for 2022. The reimbursement of production losses caused by Omicron is limited to the first quarter of 2022. For the month of April, there is an opt-in clause for individual hospitals with regard to the reimbursement of production losses caused by Omicron. No further, concrete joint arrangements have been made for the situation where, after agreement has been reached on the substance of the addendum, COVID-related developments (such as new variants) occur. However, a pandemic clause has been added, which stipulates that parties will consult with each other if COVID-19 drastically disrupts the health care system, and the resulting harm cannot be mitigated through bilateral arrangements.

The parties involved indicate that, with these arrangements, they wish to facilitate financially the regional and national distribution of COVID-19 patients, next to the safeguarding of the continuity of health care, and that they wish to prevent hospitals and health insurers from competing with another on these aspects as that would jeopardize the distribution of patients among hospitals.

<u>ACM's response</u>

As already indicated in its response[8] to the parties' joint arrangements for 2021 for medical specialist care, a joint agreement between health insurers and hospitals regarding the reimbursement of hospital care or any other costs incurred may be anticompetitive. After all, uniformization of arrangements regarding these

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[2] https://www.acm.nl/en/publications/acm-has-no-objections-against-main-principles-new-covid-19-related-arrangements-between-hospitals-and-health-insurers
[3] Including all centers for clinical genetics and PAAZ/PUK. With regard to PAAZ and PUK, the application is limited to the part covering the generic additional costs (part 2). For the application of the hardship clause, they are an integral part of the hospital.
[4] Health care providers that do not treat any COVID-19 patients, but that do face substantial production losses resulting from demonstrably fewer tertiary referrals due to COVID-19 fall under a separate agreement that only contain arrangements with regard to Omicron, production losses, and a hardship clause. This concerns, for example, rehabilitation centers.
[5] For the additional costs, hospitals are reimbursed a percentage of their turnovers that depends on the risk level that was in effect prior to that period. The reimbursement varies between 0% in the case of an endemic risk level and 1.1% in the case of a serious risk level.
[6] Such as the costs for employees and fixed costs.
[7] This concerns a reimbursement for the provided availability in Phase 1/1+ of the scale-up of the health care provider's IC capacity by the health insurer. This concerns a one-off capped contribution for 2022.
[8] https://www.acm.nl/en/publications/acms-response-arrangements-between-zn-nvz-and-nfu-regarding-covid-19-related-costs-2021

reimbursements/costs eliminates (partially or completely) any distinction between health insurers and health care providers, and thus affects the incentive to perform better than other competitors. This may result in a reduction of health care services, and in fewer incentives to procure health care services efficiently. It can also stand in the way of a further development of health care organization in certain regions (which may be desirable or necessary even). That is why such arrangements are, in principle, not allowed.

In addition, there is a risk that joint arrangements go beyond what is necessary, because, in most cases, the hospital that is harmed the most is taken as the starting point, whereas much less elaborate schemes might suffice for other hospitals. Also, arrangements negotiated between national market participants carry the risk that it will result in a process where concessions are made back and forth. That may, for example, lead to the duration of the arrangements being longer than necessary or that 'other' topics are included. That is why ACM has been extra attentive to such risks.

First of all, ACM establishes that regular bilateral contracting (or the return thereto) forms the starting point for the procurement of medical specialist care in 2022, and the experiences of COVID-19 from 2021 have been used to realize this as much as possible. For ACM, that is of vital importance. Customization is possible through bilateral arrangements, and, in that way, the specific individual and/or regional situations of hospitals and health insurers can be taken into account as much as possible.

Furthermore, ACM establishes that the joint arrangements for 2022 are less far-reaching than those for 2021. For example, arrangements about catch-up care have no longer been included, as it has now turned out and as parties have concluded that such arrangements can be made bilaterally. The remaining joint COVID-related arrangements for 2022 have also fleshed out more intricately and more situation-specific than for 2021, and do not go beyond what is necessary. With regard to the generic additional costs, the reimbursement depends on the first quarter's risk level that is set afterwards. For the reimbursement of the production losses caused by Omicron, a distinction is made between hospitals with smaller turnovers (<300 million euros) and hospitals with higher turnovers.

ACM finds it plausible that, on the basis of the substantiation of the parties involved and other information, there was a need in late 2021 to make joint arrangements regarding the tariffs for COVID-related care and IC units. Health care accessibility may be jeopardized if individual negotiations about COVID-related care between health care providers and health insurers result in each individual organization's position becoming more important, and if that led to the undesirable situation that hospitals do not cooperate with the distribution of COVID-19 patients. This is especially the case if, on the basis of bilateral contracting, the treatment of COVID-19 patients is financially not or less profitable for a specific hospital, and, as a result thereof, there is insufficient willingness to treat those patients of the health insurer in question.

The market survey carried out by ACM has revealed there are concrete indications that some health insurers are not willing to reimburse COVID-related costs in bilateral contracting, as a result of which any necessary distribution of patients may be jeopardized, and other health insurers (predominantly the largest regional ones) will have to foot the bill.

In that context, ACM does note that, if structural free-rider behavior of specific health insurers results in them failing to fulfill their individual duty of care, it is the responsibility of the Dutch Healthcare Authority (NZa) to take enforcement action. In addition, if there is a structural need for uniform tariffs, it would be logical that the resulting tariff has a democratic justification, and is set by the NZa on the basis of a statutory provision that takes all relevant interests into account. ACM will communicate this message to the Ministry of Health, Welfare and Sport (VWS) and the NZa.

In the paragraphs below, ACM will discuss the period through April 2022 and the subsequent period separately.

Arrangements for up to and including April 2022

In light of the information submitted by you and of its own findings, ACM will not launch a further investigation into the compatibility of the collaboration with the competition rules with regard to the arrangements that apply to the first quarter of 2022. ACM finds it plausible that, also considering the specific

circumstances and characteristics of the Dutch health care system, the joint agreement for this period is necessary for safeguarding the continuity of health care, both during and after the pandemic.

More specifically, ACM establishes that, in the fall of 2021, health insurers and hospitals had the explicit intention to return to regular bilateral contracting in 2022, and that, in late 2021, individual negotiations were being held in earnest. This contracting process was abruptly and fundamentally disrupted by the extraordinary and unexpected severity of the Omicron variant, not only in terms of time and attention, but also in terms on substance: the considerable uncertainties that arose with regard to the impact of this variant on hospitals, with regard to the question of whether the COVID-related costs of hospitals would be reimbursed through individual contracting, and with regard to other risks to effective patient distribution, if necessary.

Against this backdrop, ACM therefore considers to a considerable degree the joint arrangements for early 2022 to be a short 'renewal' of the schemes for 2021, in order to have some additional time for continuation and a proper completion of the bilateral negotiations that had been thwarted by the unexpected and impactful disruption caused by the Omicron variant. For returning to bilateral contracting, ACM deems it plausible that there was a need for addressing the uncertainties that came with the Omicron variant. In that context, the arrangements do justice, in terms of substance, to the suggestion to reduce the scope as much as possible compared with 2021. On the basis of the information submitted by the parties and its own information, ACM finds it plausible that, without a joint scheme, the continuity of health care would be jeopardized, and health insurers would not be able to fulfill their duty of care, now and in the future.

ACM finds the need for renewing the arrangements regarding the reimbursement of production losses caused by Omicron in April insufficiently substantiated. ACM will though, in light of its general prioritization policy[9] and current circumstances, not launch a further investigation into the joint arrangements for that month.

Period after April 2022

For the rest of 2022, no joint arrangements have been made regarding the reimbursement of production losses caused by Omicron. In ACM's opinion, there is no reason for doing so either. It is possible to include arrangements regarding reimbursement of production losses caused by COVID-19 in the regular bilateral contracting cycle. Previous experiences and schemes have made everyone familiar with the different aspects of the effects of production losses on hospitals. Consultations between ACM, health insurers and hospitals, too, have also revealed that there is sufficient confidence that, in the future, it is possible to make arrangements regarding this issue through bilateral contracting.

The addendum for 2022 and discussions initiated by ACM have revealed that hospitals and health insurers have different opinions about the question in which phase[10] there may be reason to come to a joint agreement regarding production losses should COVID-19 flare up again later in 2022. In that context, ACM reiterates that, at this point, it does not see any need for such arrangements. At the same time, ACM cannot rule out any extraordinary or new circumstances where, for example, the impact of the pandemic on hospitals manifests itself in an entirely new way than currently imaginable, and hits the hospital landscape in such a way that a disruption to our health care system becomes a looming threat. In that context, ACM thinks of situations not sooner than the declaration of phase 2d by the Minister of Health, Welfare and Sport involved. This should be seen in conjunction with the characterization that, in that phase, a serious danger exists to the national continuity of health care, which will lead to top-down national coordination, and thus to a restriction of the opportunities for hospitals to differentiate themselves from each other, and to make operational and strategic decisions independently.

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[9] ACM uses three criteria on the basis of which it assesses requests for enforcement or reports about possible violations: what is the degree to which the behavior harms consumer welfare, what is the scope of society's interest in ACM's action, and to what extent is ACM able to take action effectively and efficiently. In this case, the first criterion in particular forms the basis for ACM's conclusion.

[10] For more information about the different phases, see figure 2.1 National policy framework OTO (lnaz.nl)

Finally

In light of the above information regarding the facts and circumstances as described by you, and the information that ACM has (including the findings from our own market survey), ACM will not launch any further investigation into the compatibility of your joint arrangements with the competition rules.

Although ACM understands the desire among umbrella organizations to sit down collectively in late 2021, considering the unexpected and impactful disruption caused by Omicron, it also establishes that several hospitals and health insurers were able to make bilateral arrangements about the reimbursement of COVID-related costs. Based on discussions held as part of its investigation, ACM concludes that, subsequently, the impetus, the rationale and perhaps also the opportunity to conclude individual contracts in late 2021 were disrupted when it became clear that the umbrella organizations were talking about a joint scheme. In such a situation, there is the risk that, as such, the need for a joint agreement becomes a foregone conclusion. Against this backdrop, ACM will soon sit down with ZN, as well as with NVZ and NFU and discuss your responsibilities and roles (and the boundaries thereof) as umbrella organizations when initiating and designing joint arrangements at times when you believe there is reason to do so.

Yours sincerely,

the Netherlands Authority for Consumers and Markets,

Bart Broers
Director
Healthcare Department