MinterEllison

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Dear Michael

Submission on draft determination for authorisation AA1000542-1

We refer to the draft determination issued by the ACCC (**draft determination**) in response to the amended application for authorisation by nib health funds limited (**nib**) and Honeysuckle Health Ltd (together, the **Applicants**) dated 6 May 2021 (**Application**) and the submissions received from the interested parties in response to the draft determination.

We have set out below the Applicants' submission in relation to the condition imposed under the draft determination and its response to the submissions of interested parties. Capitalised terms used in this letter are defined in the Application unless defined in this letter.

Some of the information in this letter is confidential to the Applicants and has been highlighted in yellow. The Applicants request that the ACCC treat the highlighted information as strictly confidential and that it be redacted from this document prior to publication on the ACCC's public register.

1. 40% market share cap condition

1.1 At paragraphs 4.110 and 4.113 of the draft determination, the ACCC outlines the proposed condition that Participants in the Broad Clinical Partners Program (**Broad CPP**) cannot represent more than 40% of the private health insurance market in any State or Territory. The Applicants accept that this condition addresses the concerns that the HH Buying Group could theoretically represent 100% of health insurers through the Broad CPP and that it falls within the 20% to 80% range that the Applicants proposed would be required to realise public benefits from the program. However, when the Applicants considered the practical impact of the ACCC's proposed condition, it found that it would likely prevent HH from including any of the major health insurers in the Broad CPP on a national basis.

1.2 The ACCC has agreed in principle with allowing major health insurers to join the Broad CPP. The practical reality of the 40% cap is that it would be unlikely that any of the major health insurers would be able to do so for all States and Territories. This is because the cap applies at a State and Territory level and some of the major insurers have significant market shares. For example, Bupa holds 48% market share in South Australia and HBF holds 50% market share in Western Australia.

1.3 If the Participants in the Broad CPP were nib, one large insurer and half of the AHSA member funds (by market share), the 40% cap would be breached in nearly every State or Territory.

1.4 Large insurers would see the benefit of joining the Broad CPP if they could do so nationally and it would not be an attractive proposition to offer the Broad CPP in selected States and Territories where the 40% cap is not breached. We have set out in Schedule 1 of this letter different market share scenarios if one large insurer participated in the Broad CPP.

1.5 Consequently, the Applicants submit that the proposed condition of a 40% market share cap for the Broad CPP be amended to enable at least one major health fund to join the Broad CPP on a national basis. The Applicants consider that an increase in the market cap to 60% would allow HH to represent one third of the AHSA funds (by market share), nib and one major insurer. While the Applicants would prefer the flexibility to offer the Broad CPP to more insurers than this, it appreciates the ACCC's objective of tempering any anti-competitive risks associated with the Broad CPP.

1.6 The Applicants consider that the increased market share cap is required to be able to extend the Broad CPP to at least one major insurer which would allow the realisation of the following public benefits:

(a) extension of 'no gap' experience for surgery to a broader group of consumers;

(b) reduced transaction costs for the large insurer compared to the creation of its own no gap programs;

(c) larger customer base for better engagement with a broader group of medical specialists; and

(d) facilitate the extension of the Broad CPP to cover more types of treatment and more geographical areas.

2. Submissions from interested parties

2.1 The Applicants have reviewed all the submissions from the interested parties in response to the draft determination that had been uploaded to the ACCC's public register up until Friday, 25 June 2021. The Applicants will review and respond to the remaining submissions from interested parties once they are made available. The vast majority of submissions are from individuals – predominantly medical practitioners, who oppose the proposed authorisation of the HH Buying Group on the basis that this will lead to the implementation of a managed care model. In fact, a large number of these interested parties have submitted the exact same or very similar template response setting out this 'managed care' allegation.[1]

2.2 The Applicants strongly refute these claims. We have substantiated in detail in the response to submissions dated 19 February 2021 (**February Response**) why the HH Buying Group will not lead to a managed care model and will not detrimentally impact the autonomy of the health provider or patient. However, given the volume of submissions on this point, it warrants a further response set out in section 3 below.

2.3 We have also identified some new issues raised by the interested parties, particularly the medical groups and associations. We set out these new issues and the Applicants' responses to them in section 4.

3. 'Managed care' allegations

3.1 The overwhelming issue raised by interested parties is that the HH Buying Group will change the current Australian healthcare system to a US-style managed care model, which is a flawed model of healthcare and will be detrimental to patients and doctors in Australia. The interested parties have not defined what they mean by 'managed care' but the main, recurring arguments raised are that the HH Buying Group will introduce a form of managed care into Australia that will result in reduced patient choice of health provider and impinge on the clinical autonomy of health providers.

3.2 The interested parties have not articulated the causal link between the creation of a buying group for healthcare services and the introduction of managed care, nor have they provided any reasonable or rational basis to support this claim. The Applicants strongly refute the allegation that the creation of the HH Buying Group can lead to such a fundamental change to the underlying framework of Australia's healthcare system. The interested parties' managed care concerns are focused on criticising the current and emerging aspects of the health system that

[1] See for example George Pratt's submission, which is replicated in approximately 14 other submissions (of the submissions available on the ACCC's public register as at 25 June, 2021).

are contrary to their personal interests, rather than being focused on the impact of the HH Buying Group to the public (e.g. value-based contracting including no gap programs which benefit consumers but may impact on the ability of interested parties to charge large gaps). These features of the current healthcare system will continue to exist and will progress with or without the HH Buying Group. The key difference is that without the HH Buying Group, the major insurers (including nib) will continue to progress with these developments while the smaller funds may be left behind if their current buying groups are not able to keep up.

3.3 The interested parties seem to be referring to the following features of the healthcare system as constituting managed care either individually or in combination:

(a) insurers having preferred networks of healthcare providers which then influence consumers' selection of their healthcare provider;

(b) value-based contracting or any funding model that is linked to performance;

(c) insurers controlling the healthcare provider that treats a consumer; and/or

(d) insurers controlling the nature of treatment that a consumer receives.

3.4 The Applicants' position is that the features in paragraph (a) and (b) do not constitute managed care. These are mechanisms that are already in place between health insurers and healthcare providers in Australia.

3.5 The features in (c) and (d) would constitute managed care and the Applicants strongly agree that they should not form part of Australia's healthcare system. The Proposed Conduct will not reduce patient choice or the clinical autonomy of medical specialists or hospitals. The current legal and regulatory controls will continue to prevent this from occurring. The Applicants would also be willing to accept additional conditions of the authorisation to further protect patient choice and clinical autonomy. We address each of the features below.

Preferred provider networks

3.6 The concept of health insurers contracting with a network of healthcare providers has existed for decades. These networks are critical to a health insurance business to provide a better member experience. The networks are vast and are not small or exclusive groups of providers. For example, nib contracts with over 90% of private hospitals in Australia. Under agreements with network providers, insurers agree to pay a higher amount in benefits for a health service than insurers are required to pay under the terms of a health insurance policy or under law, in exchange for the provider agreeing not to charge a member an out-of-pocket cost or to charge a reduced amount. Not only does it provide members with no or low cost options, it also allows insurers to require its network providers to have certain levels of accreditation and to meet quality and safety standards.

3.7 Preferred provider networks will influence consumer choice of healthcare providers as they will result in reduced or eliminated gap payments. Consumers will be influenced to choose providers that cost less. But consumers are not compelled to use an insurer's network of providers, they choose to do so. Therefore, the Applicants do not consider that this constitutes managed care. Without preferred provider networks, the amount of out-of-pockets costs would be at the complete discretion of healthcare providers and would create significant financial uncertainty for policyholders. Preferred provider networks provide consumers with more choice and promote competition among healthcare providers to the benefit of consumers.

Value-based contracting

3.8 The payment of health services that is dependent on the value of the care provided by the healthcare provider is a more novel concept, although insurers have for many years been adjusting their funding of private hospitals to take into account performance such as the number of sentinel events or hospital acquired complications that occur at the hospital. Value-based contracting goes further than looking at serious adverse events to determine performance on broader metrics linked to consumer outcomes. It considers patient outcomes in conjunction with provider quality and rewards good outcomes from care rather than the current paradigm which punishes providers for poor care.

3.9 The Applicants do not consider that this constitutes managed care. It does not remove patient choice and does not interfere with clinical autonomy. The linking of funding with good patient outcomes does not mean that the insurer will or can compel policyholders to use that particular provider. All value-based contracts with providers remain governed by the *Private Health Insurance Act 2007* (Cth) (**PHI Act**) which ensures that the insurer cannot become involved in the nature of the treatment provided or influence the clinical freedom of the medical provider.

3.10 The ACCC is not being asked to authorise value-based contracting. This is already lawful and consistent with Australian and international trends. Following a decade of accelerating uptake around the world, value-based health care (**VBHC**) is gaining traction in the public system in Australia. Western Australia and Victoria have conducted successful pilots in cancer and dental care respectively. NSW Health appear to be the most advanced and are running several large-scale VBHC programs. These include the development of a state-wide program for managing diabetes, creating the capability to collect Patient Reported Outcome Measures (PROMs), identifying and scaling evidence-based initiatives that treat specific diseases or conditions and developing the capability to Commission for Better Value (CBV).

3.11 The recent MBS Review Task Force has also identified significant areas of low value care (care that should not be provided or that by providing it the outcomes for the patient are erroneous or not substantive when compared to the cost of the procedure). In the MBS Review Task Force - Final Report 2020, the task force states:

> "*The Taskforce has made significant efforts to correlate MBS funding with the execution of high value activities. It has also identified and recommended the removal of MBS items to reduce the likelihood of low value care occurring and worked to clarify MBS item descriptors for clinicians, consumers, auditors and compliance officers. These efforts aim to support the integration of best practice care for patients, which was a frequent concern raised throughout the Review.*"

3.12 Even with the removal of certain MBS items, the MBS Review Task Force stated that this will not capture all types of low value care as it is possible to technically comply with an MBS item descriptor but not provide high value, appropriate care.

3.13 Rewarding high value care does not mean that insurers will not pay for low value care. For contracted hospitals, this will be the subject of negotiation with hospitals to arrive at a mutually agreeable position under the HPPAs. For non-contracted hospitals, insurers must pay minimum benefits under the PHI Act for all forms of care, regardless of whether they are high or low value.

3.14 Equally with medical specialists, the value-based funding model will be agreed under an MPPA. Other medical specialists will still be paid benefits regardless of the value of care provided by Medicare and health insurers (as detailed below).

<u>*Insurer controls patient choice of healthcare provider*</u>

3.15 The interested parties allege that the Proposed Conduct will effectively compel policyholders to use particular healthcare providers. A significant number of interested parties submit that consumers will have reduced choice of doctor, hospital and treatment if the HH Buying Group is formed.

3.16 The Applicants dispute these arguments and reiterate that consumers will retain the ability to choose their medical specialist, private hospital or other healthcare providers and, as articulated in the February Response, the Applicants consider that the Proposed Conduct will lead to a more informed and independent choice.

3.17 The only way in which an insurer could curtail patient choice is if they amended their health insurance policies to restrict cover to services provided by particular healthcare providers and refused to pay any benefits for other providers. This is conduct that could only be undertaken by individual insurers (which would be unlawful) and this is certainly not a model that HH would or could impose on the Participants of the HH Buying Group.

3.18 Commercially, nib and the Participants would not accept that their policyholders would have any limitations placed on their freedom to choose a healthcare provider. Legally, they would not be able to amend their products in this way as it would breach a number of provisions of the PHI Act including the obligation to pay minimum benefits to healthcare providers.[2] Further, the Department of Health has oversight over any changes made to health insurance products which would give the Department the opportunity to take enforcement action against insurers.

3.19 Health insurers are required under the PHI Act to pay hospitals a minimum amount of benefits for hospital accommodation (whether or not they are in an insurer's network) and are required to pay a minimum amount of benefits to medical practitioners. Medical practitioners have a legal right to receive a Medicare rebate paid by the Government equal to 75% of the MBS fee for services provided during an episode of hospital treatment for private patients. Health insurers are obliged to pay at least 25% of the MBS fee. Policyholders will always be able to choose their medical practitioner as they are entitled to 100% of the MBS fee for any medical practitioner of their choosing for medical services provided in hospital. The Proposed Conduct cannot change this.

3.20 The HH Buying Group would also be prevented from boycotting a healthcare provider under the cartel provisions of the *Competition and Consumer Act 2010* (Cth) (**CCA**)[3] and the draft determination expressly excludes the ability of the HH Buying Group to collectively boycott.[4]

3.21 The submissions relating to patient choice are not focused on the extension of nib's current hospital network, allied health network or medical gap scheme to other Participants, although this constitutes the bulk of the services that HH will be providing to insurers. The focus of the submissions is on the Broad CPP (and other value-based contracting models). However, the impact on policyholders is in principle the same as the current provider networks – providing policyholders with an additional option over and above the minimum benefits that insurers must pay, not removing any options or patient choice. The difference is that the Broad CPP will create a no gap experience for the whole episode of care.

3.22 Under the Proposed Conduct, policyholders will have the following choices when they require hospital treatment:

(a) choose a private hospital within the HH network with:

(i) a medical specialist that participates in the Broad CPP and have no gap for the whole episode of treatment;

(ii) a medical specialist that participates in the HH medical gap scheme and have a known gap or no gap for the specialists' services; or

(iii) a medical specialist that does not participate in the HH medical gap scheme and pay the gap payment determined by the specialist; or

(b) choose a private hospital that is not within the HH network and pay the fees determined by the hospital with:

(i) a medical specialist that participates in the HH medical gap scheme and have a known gap or no gap for the specialists' services; or

(ii) a medical specialist that does not participate in the HH medical gap scheme and pay the gap payment determined by the specialist.

3.23 The Broad CPP leads to the creation of option (a)(i). Policyholders will continue to have full discretion to decide from the above options. For example, if they prefer a surgeon that is not part of the Broad CPP then they have the choice to pay a gap for that surgeon's services (under the medical gap scheme if the surgeon participates or the gap determined by the surgeon). If they prefer to go to a hospital that is outside the HH network, a policyholder can also choose that hospital and pay the gap.

3.24 The question then is why are interested parties opposed to providing consumers with more choice. The Applicants' view is that the impact of a value-based contracting model such as the Broad CPP will have two different impacts on Providers compared to the existing preferred provider networks:

[2] Section 72-1 of the PHI Act.
[3] See sections 45AF, 45AG, and 45DB of the CCA.
[4] See paragraph 1.16, 4.108 and 4.144 of the draft determination.

(a) funding of Providers will be based on their performance. Although performance-based funding is not controversial in most industries, it is novel for the healthcare sector. Due to developments in data analytics, this is now possible; and

(b) it will create pressure on medical specialists to reduce out-of-pocket costs in order to compete with medical specialists participating in the Broad CPP.

3.25 This is evident in some submissions that oppose the introduction of price competition and seek to protect a medical practitioner's right to charge gaps. In particular, the submission of the Royal Australasian College of Surgeons (**RACS**) submits that a medical practitioner should maintain their independence in relation to billing. The Applicants' view is that a medical practitioner's independence to set prices should be fettered by competition, like any other service provider. The Proposed Conduct will drive more price competition through the expansion in the number of medical specialists participating in no gap programs and greater price transparency and information for consumers and GPs when selecting medical specialists.

3.26 Some interested parties express concern that doctors may feel coerced to become Broad CPP providers[5], and will not have discretion to opt out of the program, or to charge their patient a gap payment. This is factually incorrect as the Broad CPP is purely voluntary for medical specialists. Medical specialists that do not participate in the Broad CPP are able to respond by reviewing their gap practices and competing on price.

3.27 It is correct that some medical specialists may feel pressured not to charge large gap payments but this is simply the impact of improved price competition in the market which is a positive outcome for policyholders.

3.28 The Broad CPP will be available to Providers *in addition* to the existing medical gap scheme system, where Providers can choose to opt in and out of the scheme and choose when to charge patients no out-of-pockets or a known out-of-pocket cost. The Applicants are not seeking to dismantle the current medical gap scheme but rather, are adding a layer of choice for Providers, who can elect whether to stay in the current scheme, or join the Broad CPP, where they will be paid higher fees than what they would ordinarily be entitled to under nib's medical gap scheme and contribute to a guaranteed no gap experience for policyholders. The Applicants submit that it would not only be impossible to coerce doctors into contracting with HH but that the entry into a value-based contracting arrangement must be compelling and positive for the doctor to be willing to engage.

Insurer controls how a healthcare provider will treat policyholders

3.29 Some interested parties are concerned that HH will control or influence the type of treatment that clinicians provide to policyholders and impinge on their clinical autonomy.[6]

3.30 The Applicants reject the allegation that the Proposed Conduct will erode clinical autonomy. Under the Proposed Conduct, HH will be collectively negotiating and managing the existing network of hospitals, allied health providers and medical gap scheme for its member funds. These current agreements do not contain any provision that allow nib to dictate or influence the clinical decisions of healthcare providers. The interested parties again focus on the Broad CPP and value-based contracting, however, the same principle applies to these agreements in that they will not contain any provisions that interfere with clinical autonomy. Not only does this align with HH's ethos, nib (and all other insurers) are legally prohibited from doing so under the PHI Act. As noted in the February Response, section 172-5 of the PHI Act expressly prohibits insurers from limiting a medical practitioner's professional freedom to identify and provide appropriate treatments.

3.31 Further, insurers do not have the clinical expertise to made decisions about policyholders' treatment and any interference in clinical decision-making would raise legal risks for insurers of being joined to medical negligence claims. This is not a space that the Applicants have any intention to enter through the Proposed Conduct. HH's current MPPAs for the Clinical Partners Program contain the following provisions that make this abundantly clear:

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[5] Council of Procedural Specialists.
[6] Council of Procedural Specialists, Australian Medical Association, Nathan McCubbery.

(a) *'nib is not a health professional or practice and does not provide treatment to the Eligible Customer and shall at no time be deemed to provide any such treatment or services to the Provider's patients.'*

(b) *'nib will not interfere with and acknowledges the independence of the Provider providing Specified Services to Eligible Customers under this MPPA. Nothing in this MPPA limits the Provider's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments.'*

3.32 HH intends to continue including these provisions in its MPPAs under the Broad CPP or any other agreement with medical practitioners. In order to quell the interested parties' concerns, the Applicants would be comfortable if the ACCC imposed a condition in the final authorisation that required HH not to limit the professional freedom of medical practitioners. We have proposed some drafting for this condition in section 5.

3.33 The other allegation made by interested parties regarding clinical freedom is that medical specialists will be forced to participate in the Broad CPP if the hospital to which they are credentialled joins the program. The Broad CPP is centred on the medical specialist and involves entering an MPPA with the medical specialist which will apply when they practice at a network hospital. Therefore, there will be no pressure from the private hospitals on medical specialists as participating in the Broad CPP is driven by the medical specialists.

4. Response to new issues raised

Reduction in size of provider network

4.1 A number of the interested parties are concerned that the HH Buying Group may use its increased bargaining power to remove hospital groups from its hospital network or disadvantage smaller, more vulnerable private hospitals, which may in turn limit a patient's choice of hospital and treatment.

4.2 HH has no intention to reduce the size of nib's current hospital network. The Participants of the HH Buying Group will demand that HH provides access to a broad national network of hospitals to enable its policyholders to access a network hospital and no gap hospital accommodation. The negotiation and management of HPPAs for a national network of hospital is a key service offering of the HH Buying Group. The increase in bargaining power of HH bears no correlation on the need to provide this service. Despite their substantial market share, the major health insurers continue to have large hospital networks to ensure broad and varied choice of hospitals for their policyholders.

4.3 We also note that hospitals that are not part of an insurer's network are protected under the PHI Act through the payment of minimum benefits which for second tier accredited hospitals constitutes the payment of 85% of the average rate paid by the insurer under their HPPAs for the relevant hospital treatment.

4.4 Some interested parties contend that the addition of the HH Buying Group will result in a reduction of contracts with medical specialists.[7] They also submit that there may be less opportunity for patients to receive treatment in the most appropriate setting, such as the day hospital setting, as a result of the HH Buying Group.[8]

4.5 The Applicants dispute these claims. HH does not intend to contract with fewer medical specialists; rather, it seeks to enter into more MPPAs and contracts with specialists and to do so more effectively and efficiently. The Proposed Conduct will also have no impact on a medical practitioner's clinical decision whether to admit a patient to a day hospital. The HH Buying Group may have negotiated a HPPA with the day hospital or an MPPA with the medical practitioner, which will entitle the hospital and medical practitioner to larger benefits than under the PHI Act but this will have no impact on the medical practitioners' clinical decision to admit a patient to hospital. It may influence the day hospital or medical practitioner chosen by the patient but that is currently the case for HPPAs and MPPAs negotiated by a single health insurer. The medical practitioner is the best placed person to make the decision about the location of care.

[7] Day Hospitals Australia.
[8] Day Hospitals Australia.

4.6 The Applicants consider that the HH Buying Group's focus on value-based contracting will actually see smaller hospitals and day hospitals benefit from improved funding by health insurers. These hospitals generally provide excellent value care and would be prime targets to benefit from value-based contracting.

Viability of smaller funds

4.7 One of the concerns raised in the submissions is that the HH Buying Group may threaten the viability of the small health funds; specifically that nib could benefit from the potential exit of smaller funds as a result of market disruption, and that the smaller funds who form part of an existing buying group will be vulnerable in the event of aggressive competition between the buying groups.[9]

4.8 The Applicants disagree with this theory of competition. Competition between the buying groups will lead to more efficient prices for buying group services, better quality services and will drive innovation. This can only benefit smaller funds, who are the major customers of these buying groups, and the members of those funds. The Applicants consider that aggressive competition among buying groups should be encouraged. Members of existing buying groups would only join the HH Buying Group if they saw a clear advantage of switching given the inherent risk and complexities in changing buying groups.

4.9 As articulated in the Applicants' response to the submission of the Australian Health Service Alliance (**Response to AHSA**), providing access for small funds to the HH Buying Group will improve the competitive position of the participating funds and reduce their attractiveness to larger funds as takeover targets. The Applicants consider that rather than a deterrent, the HH Buying Group will be attractive to small funds who see the benefits in progressive contract models.

4.10 The Applicants submit that any concerns around the viability of smaller funds are not related to the Proposed Conduct and already existed before the Applicants sought authorisation for the formation of the HH Buying Group (e.g. capital requirements, compliance costs). The Proposed Conduct will actually address one of the causes of viability concerns which is the smaller funds' lack of resources to move towards value based or outcomes-based funding with existing buying groups in order to remain competitive with larger funds.

Driving out existing buying groups

4.11 Interested parties have posited that the HH Buying Group will achieve monopoly status and leverage this to engage in predatory pricing to secure market share and drive competing buying groups out the market.[10]

4.12 HH has no intention of driving out AHSA or ARHG and it is not part of its business objectives to achieve monopoly status in the buying group market. Rather, it is introducing competition in the current market which is effectively a monopoly operated by ASHA.

4.13 The interested parties have no basis to allege that HH would act unlawfully and charge subscription fees that are below cost to drive out AHSA and ARHG. In any case, the subscription fee charged to member funds is not the primary determinant for member funds when choosing a buying group. The greater financial impact on member funds is the ability of the buying group to purchase high-value health care, particularly in relation to hospital treatment which constitutes the most significant expense for health insurers.

4.14 While offering a competitive subscription fee, HH's focus will be competing with AHSA on the basis of the quality of its services and providing the opportunity for smaller funds to invest in modern contracting and health procurement services where they have been unable to do so previously because of their size and limited capacity.

4.15 Rather than driving out AHSA and ARHG from the market, the Applicants' view is that the introduction of the HH Buying Group will encourage existing buying groups to implement innovative funding models to retain their members. Introducing more competition in the buying group market is a positive outcome for the sustainability of smaller funds in the market.

[9] Australian Medical Association.
[10] Australian Medical Association.

Lack of regulatory oversight

4.16 Some submissions posited arguments about the lack of regulation of value-based contracting,[11] and one submission proposed the idea of the creation of an independent PHI regulator.[12]

4.17 The Applicants do not consider that commercial agreements between healthcare providers and insurers should be further regulated or require oversight by an independent regulator. Value-based contracts will impact on how healthcare providers are funded which is a commercial matter for the parties who will mutually agree on the terms. The prices paid for treatment will be above the minimum benefit level that insurers are required to pay under the PHI Act. The commercial terms of a value-based contract (like current HPPAs and MPPAs) will be more favourable than the default position under the PHI Act.

4.18 The PHI Act already provides appropriate protection in prohibiting insurers from entering into agreements with hospitals or medical practitioners that limit a medical practitioner's professional freedom.

4.19 In any event, the ACCC is not the appropriate body to determine whether value-based contracting should be regulated and the authorisation of the HH Buying Group is also not an appropriate process for imposing restrictions on value-based contracting for HH. This is a matter for the Federal Government.

Risks of data breaches and security threats

4.20 Some interested parties have raised concerns about the risk of data breaches as a result of the establishment of the HH Buying Group.[13] Specifically, some interested parties are concerned that Cigna, which has a presence in China, will have access to My Health Records through HH's data analytics, including those of the Australian Defence Force (**ADF**), and that this could be a threat to Australia's security in the event of military conflict with China.[14]

4.21 The Applicants refer to section 5 of their February Response which addresses previous submissions' concerns with privacy and information security risks. The response detailed HH's best practice approach to privacy and data governance and the requirements imposed on HH by virtue of the APRA Prudential Standard on Outsourcing. Maintaining the privacy of claims data or other personal information of Participants' members is of paramount importance to HH.

4.22 The Applicant reiterate that no personally identifiable information will ever be shared with Cigna. All personally identifiable information will be held by HH and will be stored in accordance with HH's Privacy Policy, Data Governance Policy and Information Security Management Policies. The disclosure of member data to HH will be undertaken on a de-identified basis for the purpose of data analytics and will only be identified if necessary for HH to perform its functions. The Applicants reiterate that HH operates independently of its joint venture partners, nib and Cigna.

4.23 HH is registered with the Australian Digital Health Agency as a provider organisation. HH employs registered nurses to provide a range of telephonic Health Management Programs to patients who are members of participating health funds. These clinicians access the My Health Record of individual patients to obtain information that can support clinical decision making, but only after the clinician has received the express consent of the patient to do so. HH's access to My Health Records is limited to this purpose. HH does not intend to access My Health Records for the purpose of the Proposed Conduct. However, it this were to change, HH would only ever access My Health Records if it received the express consent of the relevant policyholder.

4.24 HH currently has no contracts with the ADF. However, if this were to change, the ADF (or other organisations involved in matters of national security) have well established procurement and contracting processes in place to ensure that its suppliers manage and secure information to the highest of standards, and HH would be required to evidence and validate its ability to comply with those standards.

Detrimental impact on GPs and Medicare system

[11] Council of Procedural Specialists.
[12] Spine Society of Australia.
[13] Council of Procedural Specialists.
[14] Dr Shirley Prager, Ruja Varon.

4.25 Some submissions express concern with the impact of the HH Buying Group on General Practitioners (**GPs**) and that the HH Buying Group will threaten the universality of Medicare. They state that despite the Medicare principle that consumers are entitled to their practitioner of choice, consumers will forfeit their right to acquire the health services they prefer as a result of the HH Buying Group, which may impact on general practice.[15] They also submit that doctors should not be required to exclude patients on the basis of their health fund.[16]

4.26 The Proposed Conduct has no impact on the funding of GPs or primary care. Insurers are prohibited from funding any outpatient care that is currently funded by Medicare,[17] which includes outpatient consultations with GPs for Medicare eligible persons.

4.27 The Proposed Conduct will not impact on the freedom of policyholders to choose a medical practitioner whether they are specialists or GPs. It will simply provide more no gap options for admitted hospital care when choosing a specialist for a broader group of policyholders than only nib members.

4.28 The Proposed Conduct will not disrupt the current GP referral pathway to surgeons. The only impact of the Proposed Conduct on GPs will be that they will have information about specialists participating in the Broad CPP and would be able to inform to a larger group of policyholders that they are eligible for a no gap experience, rather than it only being available to nib members. It is in consumers' interests that GPs are provided with more transparency on choice of specialists based on a range of information, including financial costs from out-of-pockets.

Detrimental health impacts

4.29 Interested parties have raised concerns that the HH Buying Group would produce poorer physical and mental health outcomes and quality of life,[18] that would be reflected in Australia's morbidity and mortality statistics.[19] Some interested parties specify the risk that access to effective specialist treatments for chronic pain conditions and anaesthetists will be restricted.[20] Other submissions include claims that there will be further damage to an already dysfunctional mental health care system.[21]

4.30 The Applicants strongly disagree that the HH Buying Group would produce poorer health outcomes. The fundamental focus of HH is measuring the impact of treatment on patients and funding Providers according to the positive health outcomes for patients. The Applicants cannot comprehend how this focus will lead to poorer health outcomes. The interested parties have not provided any explanation or substantive evidence to link detrimental health impacts with the creation of the HH Buying Group. The Applicants are confident, based on the international experience, that value-based contracting will actually lead to improvements in the quality and safety of treatment provided by providing financial incentives that reward positive health outcomes for patients. The introduction of value-based care would see substantial investment in any technologies and medical services which could effectively improve health outcomes for policyholders.

4.31 The Applicants do not agree with claims of reduced access to specialist treatment for chronic pain conditions. There is no element of the Proposed Conduct that will reduce the number of specialists. As previously articulated, programs such as the Broad CPP constitutes an *additional option* for consumers to access specialist care and will not impact on existing medical gap schemes. This will be the case for all specialists including those treating patients with chronic pain conditions and including anaesthetists. In fact, the Applicants submit that the proposed value and outcomes-based funding would naturally invest in areas of medicine which, through evidence, can elicit a more efficient health care system with better outcomes for patients.

4.32 The Applicants are also confident that health benefits will be realised with respect to mental health through the Proposed Conduct. HH is very interested in co-developing alternative models of care that provide greater access to consumers to earlier support for mental health conditions, greater access to outpatient care and continued access to inpatient care where required. Whilst the Applicants accept the concerns regarding Australia's mental health system, this is largely

[15] Council of Procedural Specialists.
[16] Dy Lydia Twining.
[17] Section 126(1) of the *Health Insurance Act 1973* (Cth).
[18] Dr Bruce Hammonds, Dr Melinda Hill & Ors.
[19] Dr Asha Nicholson.
[20] Dr David Brown, Neuromodulation Society of Australia and New Zealand.
[21] Dr Melinda Hill & Ors.

attributed to the disparate funding mechanisms and the complex interplay between Federal and State public services, with isolated and inconsistent funding of private services. Aligning outcomes-based funding to support psychiatrists in the best application of care possible can only improve the coordination and funding of mental health care, and the overall mental health outcomes for the public. The Applicants submit that introducing the new funding mechanism would allow for better coordination of mental health services.

Discrimination against patients

4.33 Some submissions allege that the establishment of the HH Buying Group will result in discrimination against certain patients, or minority groups. Specifically, the Australian Orthopaedic Association (**AOA**) is concerned the HH Buying Group will discriminate against groups of patients including the elderly, socially isolated, those for whom English is a second language, rural populations, the chronically unwell and those with lower socioeconomic status. They also submit that these patients will be 'orphaned' in the private sector and forced into an overburdened public healthcare system. The Applicants note that the AOA has not provided any substantive reasoning to validate these claims.

4.34 The Applicants submit that no component of the Proposed Conduct seeks to introduce any limitation on access to services to any person or group of persons. In fact, the Applicants intend that the contrary outcome will be achieved as consumers will have more choices and better transparency about quality and cost of healthcare, to allow them to select the most appropriate Provider for their healthcare needs. This is available to all policyholders regardless of their age, race, medical conditions, socioeconomic status or where they live. For example, under the Clinical Partners Program, a medical specialist commits to a no gap experience for knee and hip replacements for all nib members, regardless of any underlying chronic conditions or any of the factors mentioned by the AOA.

4.35 It would also be unlawful for HH or its member funds to discriminate against its policyholders. Health insurers are prohibited under the PHI Act from improperly discriminating between policyholders in relation to any action they take or fail to take, or in any decision that they make.[22] This includes discrimination that relates to the suffering of a chronic condition or any other medical condition, age and where a person lives. General discrimination laws at the State and Federal levels would also prohibit HH and its member funds from discriminating against policyholders on the basis of their health, race or age.

4.36 The Applicants refute the allegation that patients will be 'orphaned' in the private sector and submit that the AOA has not provided any evidence as to how the Proposed Conduct would result in forcing patients into the public sector. HH and health insurers do not have the power to force policyholders into the public health system. The choice of going to a public or private hospital is solely at the hands of the policyholder. In fact, no gap programs such as the Broad CPP make private health insurance a more attractive proposition and would encourage consumers to use the private healthcare system due to the financial certainty it provides.

Inconsistent with government policies

4.37 RACS raised concerns that the Application is inconsistent with current Government policies, which allow practitioners to impose reasonable gaps to patients where appropriate.[23] They have also submitted that the HH Buying Group will undermine the current Department of Health policies which seek to protect the national interests of public healthcare.[24]

4.38 Medical practitioners' freedom to charge gaps will continue unless a medical practitioner voluntarily commits not to charge a gap under the Broad CPP. The Proposed Conduct will not mandate practitioners to surrender their right to charge gaps, nor does HH have the power to do so. Practitioners who do not participate in the Broad CPP will continue to be paid by health insurers and Medicare in exactly the same way as they are currently paid. This is akin to the current medical gap schemes under which practitioners agree to forgo their right to charge a gap in order to receive a higher level of benefits from health insurers. This difference being that practitioners commit to do so for all policyholders rather than on a patient by patient basis. This is

[22] Section 55-5 of the PHI Act.
[23] Royal Australasian College of Surgeons.
[24] Royal Australasian College of Surgeons.

a fundamental component of the Broad CPP to provide certainty to patients about having a no gap experience and to realise the public benefits outlined in the Application.

4.39 There is no compulsion to participate in the Broad CPP and it requires mutual agreement between parties to ensure that practitioners are paid based on their view of the value they hold in the system.

4.40 It is factually incorrect to state that this is contrary to government policy when the concept of medical practitioners voluntarily agreeing to not charge gaps has existed for decades under current medical gap schemes and MPPAs. The PHI Act specifically refers to the ability of insurers to contract directly with medical practitioners for services via MPPAs.[25]

4.41 Further, Government policy has been focused on reducing gaps charged by medical practitioners. The Department of Health has been implementing policies to assist consumers navigate the complexities around their healthcare, by increasing transparency around costs and promoting value-based treatment and care. They have recently developed the 'Medical Costs Finder' tool[26] and 'Decide if your doctor's fees offer good value' fact sheet.[27] The Applicants submit that the Proposed Conduct aligns with these objectives and, as such, reflects the government's policies rather than contradicts them.

5. Proposed conditions

5.1 Having reviewed the draft determination and the key concerns raised by interested parties in their submissions, the Applicants reiterate their willingness to accept the conditions of authorisation put forward above. By way of summary, the Applicants have identified the following conditions:

Cap on Broad Clinical Partners Program

(a) A condition that HH must not provide the Broad CPP services to private health insurers where this would result in the participants in the program representing more than 60% of the private health insurer market in any State or Territory, based on the number of hospital policies in the most recent APRA data.

Clinical autonomy

(b) A condition that HH must not facilitate the entry by a member fund into any MPPA that would limit the professional freedom of the medical practitioner, within the scope of accepted practice, to identify and provide appropriate treatment.

Patient choice

(c) A condition that HH will not, and will not require its member funds to, limit the freedom of policyholders to choose their preferred medical specialist, private hospital or other healthcare providers.

Please let us know if you would like to discuss any aspect of this response.

[redacted]

Yours faithfully
MinterEllison

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[redacted]
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[25] Section 172-5 of the *Private Health Insurance Act 2007* (Cth).
[26] Medical Costs Finder | Australian Government Department of Health.
[27] Decide if your doctor's fees offer good value | Australian Government Department of Health.

Schedule 1 – Broad CPP market share scenarios

Existing Buying Group	NSW (including ACT)	NT	QLD	SA	TAS	VIC	WA	Grand Total
Medibank	22.6%	40.9%	30.7%	19.4%	26.9%	31.1%	21.4%	26.1%
Bupa	22.9%	36.2%	31.4%	47.8%	32.7%	23.1%	10.9%	25.1%
HCF	20.1%	5.9%	8.0%	8.9%	4.8%	7.5%	4.7%	11.7%
nib	15.2%	3.2%	6.8%	4.1%	3.0%	8.5%	3.9%	9.5%
HBF	0.8%	1.7%	0.7%	0.5%	0.7%	1.1%	49.7%	6.9%
AHSA	17.2%	11.6%	21.5%	18.4%	31.3%	27.0%	5.3%	19.2%
ARHG	1.2%	0.3%	0.9%	0.7%	0.6%	1.7%	3.9%	1.5%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Scenarios								

[redacted]

Statistics used in this table are based on policyholders with hospital cover as disclosed in APRA's *Operations of private insurers annual report 2019.*