MinterEllison

9 March 2021

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Australian Competition & Consumer Commission
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Dear Michael

Application for authorisation AA1000542-1: Further response to submissions from interested parties

We refer to the application for authorisation by nib health funds limited (**nib**) and Honeysuckle Health Ltd (**Applicants**) dated 23 December 2020 (**Application**).

In our letter dated 19 February 2021, the Applicants responded to the first set of submissions from interested parties (**First Response**). In this letter, the Applicants respond to the second set of submissions received from the interested parties listed in the Annexure.

We have set out below the key concerns raised by these interested parties in their submissions and the Applicants' comments in response. Capitalised terms used in this letter are defined in the Application.

1. Existing buying groups already realise public benefits

1.1 Several submissions raised the point that the public benefits from the Proposed Conduct are already realised by the existing buying groups in the market. Specifically:

(a) Australian Health Services Alliance (**AHSA**) submits that it has been providing differential contracting and funding models to the industry for 25 years and has already realised the public benefits for its members such as reduced premiums;

(b) information sharing benefits will not be realised as the members of the existing buying groups already have access to the information and associated data analytics. Furthermore, it is suggested that these public benefits can be achieved without engaging in collective bargaining;[1]

(c) healthcare providers already benefit from the inclusion of other healthcare payers in existing buying groups (such as TAC and WorkSafe who are AHSA members);[2]

(d) there is no evidence to suggest that the pricing achieved by the existing buying groups is inefficient or inferior;[3] and

(e) granting authorisation will dilute the public benefits that are already being achieved by the existing buying groups, rather than achieving new public benefits.[4]

[1] AHSA; Council of Procedural Specialists.
[2] AHSA.
[3] Adventist HealthCare.
[4] Australian Private Hospitals Association (**APHA**).

Public benefits are already realised by existing buying groups

1.2 The Applicants acknowledge that public benefits have been realised by existing buying groups in AHSA and ARHG. These benefits provide evidence to support the public benefits that can be achieved through private health insurers collectively purchasing health services. However, the Applicants believe that the following additional public benefits can be realised through the Proposed Conduct:

(a) access to more sophisticated data analytics (as discussed below);

(b) the HH Buying Group can achieve more efficient pricing for health services (as discussed below);

(c) the addition of more competition in the buying group segment of the market will drive innovation; and

(d) offering value-based contracting and a wider range of services (refer to paragraph 1.10 regarding AHSA not engaging effectively in direct medical specialist contracting).

1.3 The Applicants have received expressions of interest from the market in the new offering that is proposed through the HH Buying Group. This also supports the view of the Applicants that the Proposed Conduct will provide additional public benefits than is currently being offered by existing buying groups. The achievement of the HH Buying Group's objectives and realising public benefits is in the interests of consumers and payers.

1.4 The historical success of existing buying groups should not preclude other buying groups from achieving better or improved outcomes for consumers and payers through new innovations. HH would not have embarked on the proposal of an alternative buying group option unless it held the belief that it could demonstrate this capability to potential participants.

Healthcare payers already benefit from information sharing and data analytics

1.5 HH is a health data science company with significant capability in data science, analytics and forecasting. The Applicants believe that HH capabilities in data and analytics will be superior to existing offerings. The Applicants do not agree that participants of existing buying groups are already benefiting from the same level of sophistication in data analytics that participants would access through the HH Buying Group. In addition, the current buying groups are not conducting activities in value based purchasing and the Applicants consider that they can achieve significant further benefit given their high capability and experience in this area. The Applicants submit that further benefit exists through the Proposed Conduct than what is currently being offered by other buying groups. HH will only be able to attract the switching of participants from other buying groups if it can evidence this superior capability to them.

Existing buying groups purchase at competitive levels

1.6 Competition and confidentiality issues prevent HH having access to any direct evidence that existing buying groups are buying at levels of pricing that are inefficient or inferior to what is currently contracted by nib. However, it can present anecdotal evidence. nib was a member of the AHSA from August 2005 to June 2010 after which the health services contracting function was brought back in-house to nib. nib left the AHSA due to its view that it could achieve better health contracting outcomes.

1.7 In October 2017, nib acquired the GU Health business and in April 2018 GU Health transitioned from AHSA hospital contracts to nib hospital contracts. Following the transition, the gross margin of the GU Health business improved considerably despite a reduction in the rate of premium increases for GU Health products which were below industry average (2.84% in April 2018 and 1.80% in April 2019 versus the industry averages of 3.95% and 3.25% respectively). This suggests a reduction in the prices paid for health services after the transition and therefore, an improvement in underwriting performance.

1.8 nib's experience in acquiring GU Health and switching from AHSA hospital contracts to nib hospital contracts suggests that further benefit could be realised for payers and their customers compared to what existing buying groups have achieved.

Existing buying groups are already doing value-based contracting

1.9 There is no evidence that AHSA is providing any value-based contracting, nor are the Applicants or broader market aware of any value-based initiatives from AHSA. HH and nib have displayed and exampled evidence of value-based contracting through the medical contracting approach adopted in the Clinical Partners Program. This initiative has been criticised by AHSA senior management who at the Day Hospitals Australia conference in November 2020 stated that they believe it is "odd" for health insurers to seek to have direct relationships and fund medical specialists for value-based work.

1.10 Similar public statements were made by AHSA at the conference stating that value-based or outcome-based contracting is "a bit of a fallacy." In this presentation, AHSA stated that the largest gap in getting to value and outcome-based funding is a lack of data and transparency on outcomes. AHSA's representations in its submission that it already conducts value-based contracting and that no additional data is needed directly contradicts these public statements. This also supports the Applicants' views that it can perform superior services in information sharing and data analytics than the current buying groups.

Authorisation would dilute the benefits currently achieved by existing buying groups

1.11 The Applicants accept that the public benefits being realised by existing buying groups may reduce in the short term if participating funds leave those groups. However, as outlined above, the HH Buying Group would provide an alternative and unique opportunity for funds that are currently part of an existing buying group. As the public benefits that the HH Buying Group will realise will be diverse and additional to that provided by existing buying groups, it will not result in an overall dilution of benefits. Additionally, the AHSA hold significant market share and the Applicants do not see that a loss of some of this would be a significant encumbrance to the survivability of the organisation.

1.12 In the long term, the Proposed Conduct will increase competition in the market for buying group services and likely to drive greater innovation and efficiencies from existing buying groups in response to competition from the HH Buying Group. A more competitive market where buying groups are actively competing on the quality of their services that they are providing, will deliver better outcomes for participant funds and ultimately, consumers through lower premium increases.

1.13 In addition, competing buying groups are likely to deliver their services at more competitive rates for participant funds. The Applicants agree with some of the submissions that buying groups are integral to smaller funds in managing the transactional cost of running and managing provider networks. The Applicants believe that they can perform these services at a more efficient price than the current incumbents and that this would result in additional transactional savings to payers. Ultimately, this will also drive a competitive marketplace which will force all players to compete harder on product, service offering and price. This further supports the Application and value proposition to improve transactional costs as it will provide a competitive market with a viable alternative to the current incumbents.

1.14 The Applicants see that one of the strongest value propositions they offer to the market is to introduce innovation and a more unified system-based approach to funding which has not occurred in the market to date given the stagnation associated from a lack of competition in buying groups available to funds for the last 25 years. Hence, the Applicants remain of the view that significant additional public benefit can be realised.

2. Market power of the HH Buying Group

2.1 Some interested parties submitted that the Application does not accurately describe the market for the HH Buying Group, and the impact the HH Buying Group will have on specific markets. Specifically, the following was raised:

(a) Australian Private Hospital Association is concerned that the HH Buying Group will have an excess of power in specific regional markets if particular insurers joined the HH Buying Group;

(b) Adventist HealthCare submitted that the market shares for private health insurers vary significantly between States, and can exceed the amount of any large insurer at the national level. Specifically, the Application significantly understates the market dominance

the HH Buying group would have in regions such as Latrobe and, Mildura, where smaller health insurers such as St Lukes and Westfund have significant market shares; and

(c) Adventist HealthCare submitted that the reliance on second tier default rates as an alternative to negotiating with the HH Buying Group is too great and unacceptable, and that second tier rates have been 'gamed' by insurers.

Market power in regional markets

2.2 The Applicants submit that the relevant geographical scope of the private health insurance market is national rather than a localised or regional area. The Proposed Conduct will not impact on competition in the supply of private health insurance services. In relation to the market for health services which the Applicants accept can be localised, most of the health insurers that are currently purchasers in those regional markets are already part of an existing buying group and the Applicants do not accept that participants switching from AHSA to the HH Buying Group would lead to increased purchasing power in any regional area. For example, the regional areas of Latrobe and Mildura were referred to in the submission of Adventist HealthCare as being of concern. GMHBA and Westfund, which operate in these areas, are AHSA members and any purchasing power they currently enjoy through AHSA in that regional area will not be increased by switching to the HH Buying Group and if anything would dilute if only one of the insurers switched.

2.3 In contrast, some hospital provider groups have significant regional presences and significant market power as suppliers of hospital services such that any increase in buying power as a result of the HH Buying Group would not have a detrimental impact on competition as it would countervail the strong bargaining position of those hospitals. For example, in the 2014 ACCC authorisation for the Catholic Negotiating Alliance (**CNA**),[5] Little Company of Mary Hospital Group accounted for 58% of Tasmanian hospitals based on bed numbers and Healthscope accounted for a further 30% of beds in this State. In reviewing this, the ACCC deemed that even with these market shares for CNA members at a State level were not detrimental to the public interest. Arguably Tasmanian centric funds (such as St Lukes which holds 85% of its total insured membership in Tasmania and covers 20% of the insured population in Tasmania) are not close to being as significant as the hospital provider market share in this State and, even combining all of the funds listed as concerned with nib's market share for Tasmania, it would still only result in a 25% market share. This remains lower than the largest singular market share in this State with BUPA at 32%.

2.4 Accordingly, the Applicants submit that the Application appropriately accounts for the nuances of competition in regional markets, and will not create any competitive detriment in these areas. Furthermore, the Applicants submit that any risk of competitive detriment is alleviated by the fact that many of these regional funds are already participants of an existing buying group, and by the fact that the buying power of hospitals in these markets is likely to be significantly higher than the likely market share of the HH Buying Group.

Second tier rates 'unacceptable'

2.5 The Applicants submit that the assertion that second tier rates have been 'gamed' by health insures is unfounded and in any case, not relevant to the Proposed Conduct or the Application.

2.6 Additionally, the Applicants submit that second tier rates actually reduce competition in the market by disproportionately advantaging hospitals in the negotiation process. A hospital which is second tier approved is guaranteed a floor price of 85% of what the fund pays other similar hospitals in the same State. The hospital is then also permitted to charge out-of-pocket costs to the funds' members at their discretion and without a cap. Ultimately the second tier system is anti-competitive construct that has contributed to the inefficiencies and increased healthcare cost which ultimately place pressure on premiums for consumers.

2.7 Furthermore, the Applicants submit that the Proposed Conduct will not force healthcare providers who do not enter into negotiations with the HH Buying Group to adopt second tier rates (if available). Rather, the Proposed Conduct will provide an additional tier of payment option (on top of all of the existing ones) to providers that they can choose to engage in. All of the existing methods of funding will still be available for providers to engage in with Participants. If a hospital decides not to enter into an agreement with the Participants of the HH Buying Group (under any of its funding models), the second tier system does provide second tier hospitals with a safety net

[5] St Vincent's Health Australia Limited – Revocation and Substitution – A91400.

and the payment of benefits that are significantly higher than those set by the Commonwealth Department of Health under the *Private Health Insurance (Benefit Requirements) Rules 2011* (**Benefit Rules**).

3. Impact on medical specialists

3.1 Some interested parties submitted that the Proposed Conduct would significantly impact the funding, engagement and practices of medical specialists. Specifically, the interested parties raised the following:

(a) specialists will be incentivised to avoid more complex cases;[6]

(b) regional and rural providers who did not engage with the HH Buying Group could be excluded from employment opportunities at private hospitals;[7]

(c) smaller providers will be unable to negotiate or will be disadvantaged in negotiations with the HH Buying Group;[8]

(d) participation in MPPAs is overstated in the Application and the HH Buying Group is unlikely to achieve the level of uptake described;[9] and

(e) the Proposed Conduct will increase the complexities around medical practitioner fees, and consumers will be impacted as a result.[10]

Disincentivises practitioners from taking on complex cases

3.2 The Applicants submit that the Proposed Conduct will not result in practitioners being disincentivised from taking on complex or difficult patients. Firstly, there is no evidence that the most complex patients are treated by the most experienced or skilled doctors and the lack of transparency in the current healthcare system means that GPs are unable to determine which doctors are the most appropriate for their particular patient's needs. This asymmetry of information is one of the largest barriers to consumers in accessing affordable and effective care. Research previously released between Medibank and the Royal Australasian College of Surgeons (RACS) in 2014 indicated that no correlation existed between the size of the fee and the quality of the surgery.

3.3 Additionally, the Applicants submit that the Proposed Conduct will not bias providers to administer services deemed 'appropriate' by insurers because of statistical efficiencies. HH's current approach to procedure selection has been based on the best opportunity for more effective care and targeted to areas where medical specialists feel that the current fees are not commensurate with the work involved for more innovative models of care. For example, nib's Clinical Partners Program has focused on this in the Newcastle/Hunter Region with great success. The payment model was established in conjunction with the orthopaedic specialists based on each provider's preferred model of care.

3.4 Programs such as these provide an additional funding option for medical practitioners and do not eliminate the current funding options. It is also in the consumer's interest that insurers focus funding towards procedures where statistical evidence supports improved outcomes as this will drive better adoption and use, as well as result in improved health outcomes for consumers. Accordingly, the Applicants submit that the Proposed Conduct will not result in insurer controlled choice of healthcare services, but rather will assist consumers and GPs to determine which services are particularly appropriate to certain funding models in the circumstances by creating greater transparency.

3.5 Importantly, the aim of the Proposed Conduct is to build on the existing healthcare options by creating an additional framework through which GPs and patients can choose the types of services they receive based on practitioner outcomes, rather than fee-for-service. The Applicants submit that this increased transparency will improve decision making and lead to better health outcomes for consumers.

[6] Spine Society of Australia.
[7] Australian Society of Anaesthetists.
[8] Australian Society of Anaesthetists.
[9] Margaret Faux; Council of Procedural Specialists.
[10] Margaret Faux.

Regional and rural providers excluded

3.6 The Applicants do not consider that the Proposed Conduct will impact regional and rural providers' employment opportunities in private hospitals. The Proposed Conduct does not involve, nor do the Applicants seek authorisation for, collective boycott activities. The Proposed Conduct merely seeks to facilitate commercial arrangements between healthcare payers and healthcare providers, and does not serve to restrict employment of providers.

3.7 Additionally, the Proposed Conduct does not prevent regional and rural providers from receiving funding for services through the existing methods such as gap cover schemes.

Participation in MPPAs overstated

3.8 In response to submissions relating to uptake of MPPAs being overstated in the Application, the Applicants agree that the use of and participation in MPPAs is low in the market. However, low uptake does not preclude the benefits of MPPAs from being realised. The relative number of MPPAs is not reflective of the degree of coverage that they achieve. For example, the nib Clinical Partners Program only initially covered 5 orthopaedic surgeons (<1%) in the first year of the Program. However, due to the geography of coverage relative to the membership base of nib, these MPPAs covered approximately 10% of nib's total knee replacements and total hip replacements. Additionally, the success of this Program has now seen the number of participating providers increase to 16 providers and covers areas including Illawarra, Melbourne, Gold Coast and (most recently) North Sydney and the Central Coast. These latest expansions have been through provider-initiated engagement (providers contacting HH and requesting to join the Clinical Partners Program) which further indicates that the stated benefits are achievable and that a reasonable portion of providers are interested in these funding models and approaches to care delivery.

3.9 Additionally, with the implementation of value-based contracting, there is likely going to be greater uptake of MPPAs as medical specialists may wish to benefit from the outcome based model of funding services. As noted above and in the Application, the Proposed Conduct does not intend to limit use of or change the existing models through which specialists (and providers of healthcare services generally) can engage with payers of healthcare. Rather, the aim is to provide an alternative tier through which service providers may choose to contract with payers, with the hope that the value-based model incentivises providers to achieve better health outcomes for their patients.

3.10 The Applicants note that multiple submissions requested further information relating to the terms and content of the MPPAs. nib and HH have previously engaged with the Australian Medical Association and Department of Health on the Clinical Partners Program and provided redacted versions of the contracts to demonstrate that the nature and terms of the arrangements do not interfere with the clinical autonomy of the specialist.

Increased complexities in medical practitioner fees

3.11 It was submitted that the Proposed Conduct will have the antecedent effect of increasing the complexity of medical practitioner fees, ultimately resulting in increased prices for consumers. The Applicants submit that the complexity of adding another funding model to medical practitioner's billing systems is overstated and this has not deterred participation in the Clinical Partners Program, in nib's experience. Further, it has not impacted the complexity for nib's Clinical Partners surgeons, and the funding model is based on existing billing configuration. Surgeons must also set up a rate for each fund and item and the approach to the Clinical Partners Program has not changed how this is done or introduced additional complexity. In fact, participating providers in the Clinical Partners Program have commented that they have enjoyed not having to discuss out-of-pocket fees with their patients and the approach to the funding with these providers has matched the existing mechanisms used to bill by these surgeons through the nib Medigap Scheme. The Applicants do not agree that this change in medical practitioner fees will increase prices for consumers, and submit that the success of the Clinical Partners Program is evidence of the efficiencies that can be realised by medical practitioners. Increased participation in the Clinical Partners Program will mean that more consumers will have greater certainty as to their out-of-pocket expenses. Accordingly, there is no increase to the price for consumers, rather there is greater certainty as to the price.

3.12 Submissions were also made that the Applicants are not qualified to manage billing practices and that medical practitioners will likely be required to engage external billing services at an extra cost.

The Applicants note that they do not propose to manage billing services under the Proposed Conduct for medical practitioners. Participants in the Clinical Partners Program maintain their existing billing practices through their Patient Management Systems (PMS) and bill as they would have previously through Eclipse electronic claiming with the relevant fund. A decision of a specialist to use a billing agent is solely up to the specialist and not required due to the Proposed Conduct.

Price competition lost

3.13 Submissions were made that price setting will be difficult for doctors and the present system where doctors compete on cost will be lost. The Applicants submit that the impact of the Proposed Conduct will be the opposite and that price competition between doctors will be increased. In the present system, price competition between doctors is not vigorous and referrers (GPs) have little to no visibility or confidence of what a medical specialist will charge for a procedure. The consumer will generally only be told of the out-of-pocket expense after they have undergone an initial consultation (usually involving a significant gap payment) and then after having been told a surgical procedure is needed and they are booked in for the procedure. At this point is difficult for a consumer to "shop" around and, even if they did so, it is almost impossible for them to identify what or if other specialists will charge for the same procedure. To stipulate that current practice by medical specialists operates in a transparent and efficient manner or that doctors currently compete vigorously on price is simply not supported by any evidence. The Proposed Conduct will improve access to price information for GPs and consumers and will stimulate price competition in relation to both price and quality among medical specialists.

4. nib's practices and involvement of Cigna Corporation

4.1 Multiple submissions raised concerns relating to nib's practices, including the quality of nib's Clinical Partners Program and the involvement of Cigna Corporation. Specifically, it was submitted that:

(a) nib's existing provider network is not substantive compared to other private health insurers;[11]

(b) the Clinical Partners Program has the potential to see less than optimal health care being delivered as providers cannot choose to opt-out on a patient-by-patient basis which has the potential to reduce health outcomes;[12]

(c) nib's existing Clinical Partners program refers a proportion of patients to home-based rehabilitation program, rather than hospital-based programs for which nib receives a benefit. Accordingly, expansion of the buying group would directly benefit nib;[13] and

(d) nib's existing rates are not as good as the rates negotiated by existing buying groups;[14]

(e) the involvement of Cigna Corporation in the Proposed Conduct is concerning given it has recently been subjected to concerns from the U.S. Justice Department for its conduct in the healthcare sector,[15] and Cigna has been criticised on multiple occasions for its conduct relating to the fraudulent denial of claims.[16]

4.2 The views from various interested parties about nib's business or Cigna are not relevant to determining whether the Proposed Conduct will generate public benefits. While the nib contractual framework and provider networks will be used as a starting point, HH will, over time, adjust its offering to meet the needs of all participants of the HH Buying Group and not solely nib. Nevertheless, the Applicants provide a response to these comments.

nib's existing provider network is not substantive

4.3 The Applicants disagree with the assertion that nib's provider networks are not substantive and there is no evidence to support this comment. With respect to hospital and provider networks, nib's network and coverage of hospital and its Medigap specialist network is equivalent in breadth

[11] AHSA; Adventist HealthCare.
[12] Australian Society of Ophthalmologists.
[13] APHA.
[14] AHSA.
[15] AHSA; Adventist HealthCare; Members Health Fund Alliance.
[16] Members Health Fund Alliance.

to other funds and the AHSA. nib networks cover a comparable number of hospitals as the AHSA with 89% of private hospitals covered by a hospital contract. Current nib networks also hold comparable numbers of medical specialists for the GU Health Known Gap and nib No Gap network as the AHSA with over 36,000 providers registered across these networks.

4.4 While the current networks cover comparable networks it is also worth acknowledging that HH would not be able to attract participants to the HH Buying Group if it offered a sub-standard breadth of provider networks as this is a key requirement for participants and the members they represent.

Clinical Partners Program will reduce health outcomes

4.5 The Applicants submit that they have seen no evidence of reduced health outcomes in the current Clinical Partners model that is presently offered by nib. Additionally, the Applicants submit that no aspect of the payment model would drive a bias of patient selection towards less difficult to treat patients. Participating specialists agree to accept a higher fee for 100% of patients funded through the Program, and since the Program commenced two years ago, more than 1,000 patients have received services through Clinical Partners. No participating specialist has raised any concerns or issues over the Program nor reported any reduced health outcomes.

4.6 It is not clear to the Applicants how a medical practitioner's voluntary participation in the Clinical Partners Program (or a similar program) would incentivise practitioners to provide poorer services. Their clinical freedom is not restricted but rather their freedom to charge out-of-pocket expenses is restricted. Presently, the Clinical Partners Program has shown equal or better health outcomes when compared to the previous outcomes of the participating specialists.

nib will disproportionately benefit from referrals to home-based rehabilitation

4.7 The Clinical Partners Program has been very successful at changing the paradigm of care for major joint replacement. The program focuses on surgeon lead care pathways, removes out-of-pocket costs to consumers and reduces costs to the health care payer (which ultimately drives more affordable health insurance). The Applicants note that hospital providers are the interested parties that have raised concerns with consumers having increased access to home-based rehabilitation as hospital providers have historically benefited from high rates of in-hospital rehabilitation. These utilisation rates cannot be explained by patient characteristics including age and clinical complexity, suggesting that some proportion of this in-hospital rehabilitation is low value care. Reductions that do occur in the rates of in-hospital rehabilitation will be driven by the surgeon and is not a decision that is made by nib.

4.8 The Applicants highlight that consumers benefit from the Clinical Partners Program through the elimination of out-of-pocket expenses, the option of having home-based rehabilitation and ultimately, in the form of lower premium increases. Since the launch of the Clinical Partners Program in February 2019, over 1,000 nib members have participated in the program and have saved over $2 million in potential out-of-pocket costs. In addition, in-hospital rehabilitation has fallen from 45% for the participating surgeons to approximately 15% while more members have accessed care at home based on the surgeon’s assessment of their care needs and appropriate location of care.

4.9 Through the Proposed Conduct, this benefit would be multiplied by allowing other health care payers to participate and, as a result, would broaden the public benefit of this program by widening the consumers able to access the services. The success of this program has proven, contrary to many of the interested parties' comments, that value-based care is achievable in Australia. The program has achieved equivalent or better quality health outcomes to consumers while reducing the cost of the health care system costs to the funder and, more importantly to the consumer. In achieving this, it has proven that collaboration between medical specialists and health care payers is a scalable approach to health funding that can achieve the “quadruple aim” of improved health outcomes, lower healthcare costs, improved patient experience and improved provider experience.

Involvement of Cigna Corporation

4.10 HH is a 50/50 joint venture between nib and Cigna. In November 2020, Cigna was recognised for excellence in corporate sustainability leadership, with the Dow Jones Sustainability Indices (DJSI) ranking Cigna first in the health care providers and services industry for the second consecutive year. Cigna’s score of 79 lead the health care providers and services industry sector, where the

industry average score was 28. The company ranked especially high in the following categories: code of business conduct, supply chain management, environmental reporting, human capital development, partnerships towards sustainable healthcare, privacy protection, occupational health and safety and marketing practices. The Applicants would also highlight that there has been no decision made by the courts on the particular matter highlighted by the interested parties.

5. Member impacts

5.1 Some submissions raised concerns relating to the impact the Proposed Conduct will have on members. It was submitted:

(a) there is no evidence to support the assertion that the Proposed Conduct will result in transactional costs savings, and that those savings will be passed onto consumers or result in better health outcomes.[17] Transactional cost savings are a benefit to the healthcare payer, not the consumer;[18]

(b) the Applicants do not appreciate that they cannot achieve the stated aim of controlling out-of-pocket expenses. Existing uncertainties about out-of-pocket costs are not the result of uncertainties from doctors (who often use indexed rates) but the result of Medicare and insurers failing to index rebates;[19] and

(c) collective negotiations of HPPAs and MPPAs may reduce product differentiation between different health funds, stifle product design and reduce consumer choice and competition.

Transaction cost savings will not be passed onto consumers

5.1 The First Response outlines how the Proposed Conduct will lead to reduced transaction costs. The cost of running an optimal contracting function is significant and prohibitive to most small funds. Funds must negotiate over 250 contracts to hold an effective and efficient network of hospital providers, for example. Conversely, hospital providers only need to negotiate with 7-8 payers to establish contracts with all funds (due to the use of the AHSA as an existing buying group). Accordingly, the HH Buying Group creates significant efficiencies for payers of healthcare services without disadvantageously impacting the contracting operations of providers of healthcare. The Proposed Conduct will also lead to additional cost savings as participant funds have access to more competitive prices for health services and better value care.

5.2 The Applicants submit that these transactional cost savings (and other savings) will be passed onto consumers. The private health insurance market is highly competitive with insurers competing on price, product design and member experience. Further, consumers have made it very clear that their two biggest pain points with respect to private health insurance is the level of premiums and out-of-pocket costs when they do need to claim. The Applicants highlight that premium increases are Ministerially approved and that insurers are continually under pressure to keep premium increases low to ensure approval is received. Pressure from consumers, government and the competitive nature of the market will lead to reduced transactional and administrative costs flowing through to consumers. This is evidenced in the submission of AHSA which refers to the members of that buying group benefitting from reduced healthcare costs and premiums.

No elimination of out-of-pocket costs

5.3 Some submissions raised concerns that the Proposed Conduct could not purport to eliminate out-of-pocket expenses or provide greater certainty to members as to gap amounts. Additionally, it was submitted that the uncertainty will always remain on account of Medicare and insurers' failure to index rates.

5.4 The Application does not refer to the elimination of out-of-pocket expenses in every possible scenario. Rather the Proposed Conduct will involve partnering with portions of the market to provide additional payment options to consumers and in turn give better certainty in relation to out-of-pocket costs. The statement that control of out-of-pocket costs in certain segments of the market cannot be achieved is contrary to evidence of the success already established through nib's Clinical Partners Program which has allowed consumers to know, prior to receiving treatment, how much money they will be expected to pay for the treatment. This is achieved by

[17] Council of Procedural Specialists; Australian Society of Anaesthetists, AHSA.
[18] Council of Procedural Specialists.
[19] Australian Society of Anaesthetists.

contractually restricting providers from charging gaps. It is in the consumers' best interests that options like this be introduced into the wider health market given the asymmetry of information between the consumer and the providers. Consumers and the GPs often have little transparency on medical specialist fees and little to no information on quality and outcomes.

5.5 The Applicants submit that it is in the best interest of consumers to provide alternative options for care, as well as certainty on the potential costs associated with a procedure that will be covered by their health insurance policy. The Applicants submit this should include options which provide guarantees of no out-of-pocket costs for procedures which have traditionally resulted in large costs to consumers.

5.6 The Application does not blame doctors for the existence of out-of-pocket expenses or speculate as to why a doctor may or may not charge an out-of-pocket expense. This is not relevant to the Proposed Conduct. What is relevant is that out-of-pocket expenses are being charged to consumers and there is consumer dissatisfaction with this situation. The Proposed Conduct is aimed at introducing new options to consumers which guarantee no out-of-pocket expenses. For example, nib's Clinical Partners Program (which was set up and run by HH employees) gives consumers in the Newcastle and Hunter Region, as well as their GPs, the option to have a guarantee on no out-of-pocket expenses for the surgeon and anaesthetist for major joint replacement with six leading surgeons in the region. The Applicants submit that this additional payment option tier is therefore in the consumers' best interest.

Stifling product design

5.7 Adventist HealthCare submitted that the Proposed Conduct may allow insurers to change the types of products they offer, suggesting that the product offering will be reduced as a result of the standard contract conditions and terms that will be negotiated by the Buying Group.

5.8 The Applicants submit that the Proposed Conduct does not alter the types of products offered by insurers, or the terms and conditions of existing policies. Participation in the Buying Group and implementation of value-based contracting does not require new policies or products to be offered to consumers. Rather, the Proposed Conduct will allow consumers to receive increased choice of providers, greater transparency with out-of-pocket costs and reduced premiums through existing products and policies.

5.9 The Applicants do not view this concern as a material or likely concern. The overarching purpose of the HH Buying Group is to improve the value of health care purchased and thereby improve the value of the underlying health insurance product. This should increase consumer satisfaction with private health insurance generally and improve participation in the health insurance industry. Product design and configuration is highly regulated by the requirements under the *Private Health Insurance (Complying Product) Rules 2015* (**Complying Product Rules**) and the PHI Act. Recent reforms have also seen the introduction of clinical categories and product tiers which ensure consumers can more easily understand what their product covers and compare products between different health insurers. The respondents' concern on this issue represents a lack of understanding about how private health insurance product configuration works under the legislation and how product configuration works in relation to product tiers and the Complying Product Rules. HPPAs and MPPAs do not change the requirements for how benefits are paid in relation to minimum benefits under the Benefit Rules and the Applicants do not see how this could eventuate under the current legislative reforms and requirements.

6. Information sharing

6.1 Submissions were made relating to information sharing components of the Proposed Conduct. Specifically, the interested parties submitted that:

(a) disclosing provider information to payers of healthcare services without the knowledge of the provider lacks procedural fairness and is a breach of privacy laws, and it is unlikely providers will consent to such terms.[20] Information sharing, specifically in relation to a breach of contract by a provider, is not justified, is punitive and is a denial of natural justice;[21]

[20] Australian Society of Anaesthetists..
[21] Adventist HealthCare.

(b) the Proposed Conduct increases information asymmetry between providers and payers of healthcare;[22] and

(c) the size and scale of information sharing proposed is not necessary to realise the public benefits.[23]

Disclosing provider information without consent

6.2 As noted in the First Response, the Applicants have adopted, and will continue to adopt, a best practice approach to both privacy and data governance. Any information shared with participants of the HH Buying Group will be high level, de-identified and aggregated information necessary to facilitate effective negotiations and contract administration. The Proposed Conduct will not involve the sharing of any personal information between Participants, including that of individual providers, without appropriate consent.

6.3 HH is the agent for the negotiation and management of contracts and the contract is between the provider and the Participant. If a provider breaches the contract, then HH, as the managing agent, would be required to manage the breach with both the provider and the Participant. Where this breach extends across multiple contracts, HH would be obligated to manage each breach independently with the provider and relevant Participant. Information about the contract breaches would not be shared between Participants. This does not alter the manner in which the breach is managed through the dispute resolution clauses in the contracts.

Increase in information asymmetry

6.4 It was submitted that the Proposed Conduct will increase the information asymmetry that currently exists between providers and payers of healthcare services. The Applicants submit that the Proposed Conduct will not create or exacerbate this asymmetry, and in fact will improve the information available to the parties through the sharing of de-identified information generated through data analytics and improved information about quality and value of health. Frequently, providers cite, during a negotiation, that a fund is the "worst" payer compared with other payers and that, due to this, a disproportionate increase is required on rates. The payers have no visibility regarding what other payers are funding with the provider. Through sharing of aggregate price information, the Proposed Conduct will reduce this asymmetry and allow for better value-based contracting and funding decisions. This effectively reduces the asymmetries facing smaller funds as they are able to obtain equitable outcomes through negotiations that rely on the aggregated body of data and ensure smaller payers are able to maintain competitive prices.

6.5 Furthermore, as noted by AHSA in their submission, the existing buying groups already engage in a similar degree of information sharing which has not resulted in any competitive detriment or exacerbation of information asymmetry that exists in the market.

Scale of information not necessary

6.6 The Applicants submit that the scale of the HH Buying Group allows for greater data to be collected, leading to more accurate outcome-based analysis. The purpose of information sharing is to allow HH to collect enough information to generate accurate commercial models required for value-based and outcome-based funding required for the implementation of the Proposed Conduct. Sharing of information is vital to the principle service of a buying group and it should be recognised that not all funds or potential participants have the same capabilities to gather and analyse the data required for negotiation.

6.7 Accordingly, the ability to engage in the level of data analysis required to achieve accurate results would be significantly limited if the Applicants could not engage in the Proposed Conduct. Without that level of accurate data analysis, value-based contracting could not be implemented across the market.

7. Submission of Margaret Faux

7.1 Margaret Faux expresses her view about the legal issues with Gap Cover schemes and the terms and conditions of nib's MediGap scheme which the Applicants strongly disagree with and is also not relevant to the Application. She also refers to the failure of Gap Cover schemes to eliminate

[22] Australian Society of Anaesthetists.
[23] Council of Procedural Specialists.

out-of-pocket expenses for consumers. The Applicants agree that Gap Cover schemes do not guarantee a known or no gap experience for consumers and the reason for that failure is that medical practitioners retain discretion to charge out-of-pocket expenses to consumers on a patient-by-patient basis. This critique is not relevant to the Application to form the HH Buying Group. The purpose of the HH Buying Group is not to reform nib's MediGap scheme and GU Health's Known Gap scheme (which will be used as the base scheme for participants) but rather, it is to provide an alternative and additional framework for medical practitioners to charge consumers that addresses the current issues with Gap Cover schemes by controlling gaps. For example, under the Clinical Partners Program, participating surgeons agree not to charge consumers out-of-pocket costs for all their patients that are members of the relevant fund.

7.2 Ms Faux highlights that the Application does not address the impact of the Proposed Conduct on private patients in public hospitals. Private health insurers do not enter into HPPAs with public hospitals and public hospitals do not generally charge private patients out-of-pocket costs (otherwise this would disincentivise the patient to elect to be admitted as a private patient). Therefore, public hospitals would not engage in new models of funding that will be offered through the HH Buying Group and the Applicants submit that there would no impact on private patients in public hospitals.

7.3 Ms Faux comments that private health insurers do not have the ability to monitor provider compliance with Medicare rules. The Applicants wish to clarify that the references to provider compliance in the Application relate to compliance by providers with the terms of their agreement with health insurers and not Medicare benefit rules.

7.4 Ms Faux raises concerns about the impact of the Proposed Conduct on veterans whom she claims are likely to experience out-of-pocket costs if the Department of Veterans' Affairs (DVA) joined the HH Buying Group. Since the purpose of the HH Buying Group is to achieve the opposite effect (as discussed above), the Applicants consider that this view has no basis.

8. **Matters addressed in First Response**

8.1 We note that the submissions received also raised issues similar to those raised in the initial set of submissions. These issues related to:

(a) scope of the Proposed Conduct being vague and uncertain, particularly in relation to the potential participants;

(b) the potential degree of market power of the HH Buying Group and impact on smaller providers;

(c) querying the public benefits associated with value-based contracting; and

(d) the risk of the implementation of a managed model of care in Australia.

8.2 We refer to our First Response for the Applicants' response to those matters.

Yours faithfully
MinterEllison

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Annexure

1. Department of Veterans' Affairs
2. Australian Society of Anaesthetists
3. Adventist HealthCare Limited
4. Margaret Faux
5. Australian Health Service Alliance
6. Medical Surgical Assistants Society of Australia
7. Australian Private Hospitals Association
8. Spine Society of Australia
9. Council of Procedural Specialists
10. Australian Society of Ophthalmologists
11. Members Health Fund Alliance