MinterEllison

23 December 2020

BY EMAIL

Connie Wu
Assistant Director, Mergers Exemptions and Digital
Australian Competition & Consumer Commission
Level 5, 1 William Street
Perth 6000

Dear Connie

Application for authorisation by Honeysuckle Health Ltd and nib health funds limited

We act for nib health funds limited and Honeysuckle Health Ltd (**Applicants**).

The Applicants are seeking to create a buying group for healthcare payers and are applying for authorisation on behalf of themselves and the Participants in relation to the Proposed Conduct. Please find enclosed an application for authorisation in respect of the Proposed Conduct, dated 23 December 2020, for your consideration.

The Applicants request that the information contained in Annexures B, C and D be excluded from the public register because of their confidential nature. The Applicants submit that the information contained in Annexures B and C is commercially sensitive and if released may give the Applicants' competitors a commercial advantage. Furthermore, the information in Annexure D contains personal identifying information of interested parties and should not be made available to the public.

Please do not hesitate to contact us if you have any questions in relation to this application or require any further information.

Yours faithfully
MinterEllison

Noelia Boscana
Partner

Contact: Noelia Boscana
T:
OUR REF: 1313530

MinterEllison

23 December 2020

Application for authorisation under section 88(1) of the *Competition and Consumer Act 2010* (Cth)

Lodged by: Honeysuckle Health Pty Ltd

on behalf of itself and nib health funds limited

1. Background

1.1 This application is made to the Australian Competition and Consumer Commission (**ACCC**) by **Honeysuckle** Health Pty Ltd (**HH**) on behalf of itself and nib health funds limited (**nib**) (**Applicants**).

1.2 HH provides services to healthcare payers in Australia and New Zealand. These services currently include health analytics (e.g. measurement of impact of health interventions, population risk stratification and provider benchmarking), health management programs (e.g. telephonic programs to support patients transition from hospital and manage chronic diseases) and contract negotiation and management services for nib. HH is a joint venture between nib and Cigna. Both Cigna and nib own 50% of HH.

1.3 Cigna is a global health services company dedicated to improving the health, wellbeing and peace of mind of the customers it serves. All products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. Such products and services include an integrated suite of health services, such as medical, dental, behavioural health, pharmacy, vision, supplemental benefits, and other related products including group life, accident and disability insurance. nib is an Australian private health insurer with approximately 10% market share in Australia and provides health insurance products to three main market segments - Australian residents, international workers and international students. nib underwrites insurance products for several other brands including GU Health, Suncorp (APIA, AAMI and Suncorp) and Qantas.

1.4 From 1 October 2020, nib appointed HH to act as its agent to provide data analytics, contract negotiation, procurement and administration services in relation to nib's contracts with hospitals, medical specialists, general practitioners and allied health professionals (the contracting services). HH and nib seek authorisation for HH to provide the contracting services to additional health care payers and form a joint buying group (**HH Buying Group**) for the purposes of collective bargaining with providers to purchase health services. The Proposed Conduct does not involve a collective boycott. This application is made for the benefit of any healthcare payer who joins the HH Buying Group (**Participant**) which may include:

a) private health insurers registered under the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth);

b) international medical and travel insurance companies;

c) government and semi-government payers of healthcare services such as workers' compensation and transport accident scheme operators and Department of Veterans Affairs scheme (**DVA**); and

d) any other payer of health services as notified by HH to the ACCC

(**healthcare payers**).

1.5 In the short term, the most likely Participants are private health insurers. Currently, the four largest health insurers, Medibank, Bupa, HCF and HBF, undertake the contracting services as an internal function.[1] The remaining health insurers engage in collective bargaining through one of two buying groups, the Australian Health Services Alliance (**AHSA**) and the Australian Regional Health Group (**ARHG**). Of the 36 private health insurers, the AHSA represents 27 and the ARHG represents four. The Applicant anticipates that private health insurers that currently outsource their contracting services to AHSA or ARHG are the healthcare payers that are most likely to join the HH Buying Group. The major health insurers are unlikely to join the HH Buying Group but may be interested in purchasing bespoke parts of the contracting services to supplement their internal contracting function. nib was previously a member of AHSA and it withdrew from AHSA in 2011 when it built its own internal contracting function.

[1] Honeysuckle Health's understanding is that HBF contract directly with hospitals in WA and indirectly through the AHSA for all other states

1.6 Health insurers pay benefits for health services under health insurance policies issued to individuals. Customers generally make claims for benefits on-the-spot with a Provider at the time they are receiving treatment (eg. through electronic claiming system or at a private hospital). The Provider receives benefits directly from the insurer and may collect any additional amounts from the Customer (known as 'gaps').

1.7 Under contracting arrangements between health insurers and Providers, Providers generally agree not to charge a gap to the Customer (for some or all services) and health insurers agree to pay more in benefits. This creates a network of Providers that health insurers can promote as being health services where their Customers can receive a no gap or known gap experience.

1.8 For other types of healthcare payers such as international medical, travel and life insurance companies, as well as government and semi-government payers of healthcare services (Other Healthcare Payers), payment to Providers usually occurs pursuant to the terms of the insurance policy or the liability scheme, and the fee is usually paid in full by these types of healthcare payers. Accordingly, there is less likely to be a 'gap' exposure for consumers and therefore, less likely for these types of insurers to negotiate contract arrangements with Providers. As a result, we do not expect these types of healthcare payers to form a material portion of the HH Buying Group.

2. Parties to the proposed conduct

2.1 Applicant for authorisation:

(a) Honeysuckle Health Pty Ltd (ACN 637 339 694)

Address (registered address)	Contact person	Description of business activities
1/6 Newcomen St, Newcastle NSW 2300	Rhod McKensey Chief Executive Officer	Honeysuckle Health provides services to health payers in Australia and New Zealand including the contracting services, health data analytics, health measurement programs and health management programs.

(b) nib health funds limited (ACN 000 124 381)

Address (registered address)	Contact person	Description of business activities
22 Honeysuckle Drive, Newcastle NSW 2300	Roslyn Toms General Counsel	nib is an Australian health insurer with approximately 10 per cent market share in Australia. It provides insurance to three predominant markets: Australian residents, international workers and international students. nib underwrites GU Health, Suncorp and Qantas health insurance.

2.2 Email address for service of documents in Australia

Noelia Boscana, Partner, MinterEllison

[redacted]

T [redacted] M [redacted]

2.3 Details of other classes of persons on whose behalf authorisation is sought

2.4 The class of persons who may engage in the Proposed Conduct other than the Applicant, are healthcare payers who wish to become Participants.

2.5 Description of the Proposed Conduct

Structure of HH Buying Group

2.6 HH is seeking authorisation to undertake the contracting services, for healthcare payers in relation to hospitals, medical specialists, general practitioners and allied health professionals (**Providers**), as further described below (the **Proposed Conduct**).

2.7 HH intends to negotiate a bilateral participation agreement with each Participant to undertake the contracting services in relation to some or all of the Providers. Participants can opt to purchase some or all of the different categories of contracting services.

2.8 In relation to negotiated contracts (with hospitals and medical specialists), HH proposes to implement the Proposed Conduct by using nib's existing contracts with Providers, with the consent of the Providers. HH will negotiate with Providers to purchase their services on behalf of the Participants using the same base agreement that the Provider has negotiated with nib. HH will then negotiate new contracts on behalf of Participants as the nib-based contracts expire or enter into contracts with new Providers. The Participants will unilaterally determine whether to enter into an agreement with each Provider based on the negotiated terms and conditions. If they choose to do so, Participants will execute an agreement with the Provider. HH will not be party to the agreement. HH will then undertake contract administration services for that agreement.

2.9 If Participants do not wish to enter into an agreement on the negotiated terms and conditions, Participants will still be permitted to negotiate directly with Providers and enter into agreements independently of the HH Buying Group on their own terms and conditions. This could either be completed between the provider and the fund or, alternatively, with HH acting as an agent for the fund but outside of the buying group terms, conditions and offer. Furthermore, the Proposed Conduct will not prevent Providers from offering healthcare services to other insurers, buying groups or healthcare payers that are not participating in the HH buying group, and will not restrict the terms and conditions on which the Provider is entitled to enter those agreements. Providers will also not be prevented from contracting with Participants individually, or with a different set of participants than that proposed by the HH buying group.

2.10 For contracts with Providers based on standard terms and conditions (medical gap scheme and general treatment networks), HH proposes to extend these schemes to the Participants and would provide sufficient notice to Providers to enable Providers to operationalise the change.

2.11 Authorisation is not sought for the HH Buying Group to engage in the collective boycott of any services of a Provider.

Nature of contracting relationships with Providers

2.12 The Proposed Conduct will involve the provision of four broad categories of contracts including hospital contracting, medical specialist contracting, medical gap scheme and general treatment contracting. These are described in detail below.

Hospital contracting

2.13 Hospital contracting involves agreements between healthcare payers and private hospitals (occasionally public hospitals) under which the parties agree on the rates and other terms and

conditions for the provision of hospital treatment to the healthcare payer's customers (**Customers**). In the private health insurance industry, the agreements are referred to as hospital purchaser provider agreements (**HPPAs**). Under HPPAs, hospitals agree not to charge out-of-pocket costs to Customers and are used by health insurers to provide financial certainty to its Customers.

2.14 nib has a network of private hospitals that have HPPAs with nib and HH is providing contracting services for that network on behalf of nib.

Medical specialist contracting

2.15 Medical specialist contracting refers to agreements between healthcare payers and medical specialists such as radiologists, pathologists and surgeons. The parties agree on rates and other terms and conditions for the provision of the medical specialists' professional services during the hospital admission of Customers. In the private health insurance industry, the agreements are referred to as medical purchaser provider agreements (**MPPAs**). MPPAs are used by health insurers to provide financial certainty to its Customers in relation to potential out-of-pocket costs for professional services. The network of MPPAs that nib currently has in place falls into two categories – MPPAs with radiologists and pathologists and the MPPAs for the Clinical Partners Program.

2.16 nib's MPPAs with radiologists and pathologists are entered into with radiologists and pathologists that provide services such as x-rays, ultrasounds and blood tests to Customers during their admission at a private hospital that is part of nib's network (ie. nib has an HPPA with that private hospital). These services are not included in the scope of services that are provided to Customers by the private hospital. They are services provided directly to the Customer by the radiologist or pathologist under separate contractual arrangements with the Customer. Without an MPPA, Customers may incur out-of-pocket expenses for the radiology and pathology services received during a hospital admission.

2.17 Under nib's Clinical Partners program, nib has entered into MPPAs with orthopaedic surgeons, anaesthetists and assistant surgeons for the provision of their professional services for orthopaedic joint replacements provided to Customers. Under these MPPAs, the medical specialists agree on fees paid by nib for their services and agree not to charge Customers any gap for their professional services. The medical specialists are paid a higher fee than what they would otherwise be entitled under nib's medical gap scheme. The medical specialists also agree on data sharing and quality target requirements. Unlike nib's medical gap scheme, Clinical Partners Providers cannot choose to opt-out of the program on a patient-by-patient basis. This provides certainty that all nib customers will have a no gap experience with these medical specialists.

Medical gap scheme

2.18 Under medical gap schemes, health insurers offer to pay medical specialists a set fee for each type of professional service they provide to Customers in hospital, in accordance with a standard set of terms and conditions. The set fees are higher than what insurers are otherwise required to pay under the PHI Act and medical specialists agree not to charge Customers an out-of-pocket amount or agree to limit the amount the Customer is charged at a fixed amount (eg. $500) in the case of known gap schemes.

2.19 Medical specialists registered under a medical gap scheme are permitted to opt-in or opt-out of the scheme on a case by case basis (per treatment and Customer). By opting-in, the medical specialist agrees to be bound by the terms and conditions of the medical gap scheme.

2.20 Currently, HH acts on behalf of nib in the management and administration of the nib MediGap scheme (no-gap scheme) that applies to nib, Qantas and Suncorp-branded health insurance policies and the GU Health Medical Gap Network (no-gap or known gap scheme) that applies to GU Health-branded health insurance policies.

General treatment networks

2.21 General treatment networks are arrangements with Providers for services that are not provided in hospital. These providers generally include physiotherapists, dentists, optometrists and chiropractors which are covered under the 'extras' component of private health insurance products. It also includes a network of general practitioners and medical specialists providing professional services out-of-hospital for international students and international workers covered under international health products (health insurers are prohibited from covering these services for Australian residents).

2.22 Providers that are registered with a general treatment network, agree to a standard set of terms and conditions and schedule of rates for each type of service.

HH acts on behalf of nib in the management and administration of its general treatment network branded as the First Choice Network. nib has two bespoke agreements with optical and dental providers under which the providers operate nib-branded centres. HH also manages these agreements.

Nature of Proposed Conduct

2.23 In relation to the four types of contracts, the Proposed Conduct will involve HH engaging in the following types of services:

(a) for hospital and medical specialist contracting, contract negotiations with Providers;

(b) for the medical gap scheme and general treatment network, management and administration of the schemes; and

(c) for all four types of contracting, data analytics, contract management and dispute resolution.

Data analytics and contract negotiations

2.24 HH will initially engage in collective negotiations with Providers that currently have HPPAs and MPPAs with nib in order to agree to new contracts with the Participants based on the Provider's existing agreement with nib.

2.25 On an ongoing basis, HH will negotiate new HPPAs and MPPAs on behalf of nib and all Participants as the current agreements expire or with new Providers. HH will act as the lead agent in the negotiations after consultation with the Participants. This will involve:

(a) aggregation of Participant claims data for the Provider and undertaking data analytics to establish benchmarks relating to quality of service, price and application of services (see further details below);

(b) conducting collective commercial negotiations on behalf of Participants based on information of the HH Buying Group. HH will negotiate one set of terms and conditions including price schedules, business rules for payment of benefits and quality and performance targets for all Participants for each HPPA or MPPA with a Provider; and

(c) once HH receives instructions that a Participant wishes to enter into an HPPA or MPPA on the negotiated terms and conditions, coordinate the execution of the HPPA or MPPA between the Participant and the Provider (or execute the contract if HH has signing authority).

2.26 The HH Buying Group will be voluntary and the Participants will unilaterally determine whether to enter into an HPPA or MPPA based on the terms and conditions negotiated by HH.

Extension and management of medical gap scheme and general treatment network

2.27 HH will initially engage with Providers registered in the nib MediGap Scheme, GU Health Medical Gap Network and the First Choice Network to notify them of the extension of these schemes to the Participants.

2.28 HH intends to replace the nib Medigap scheme and the GU Health Medical Gap Network with a new HH scheme which will have some variations in the terms and conditions.

2.29 For general treatment networks, HH intends to create new specific networks tailored to meet a Participant or group of Participants' individual requirements such as the requirement to have a strong network of Providers in a regional area or to have a fee structure that is more suited to the manner in which some Participants pay benefits.

2.30 On an ongoing basis, HH will manage the medical gap scheme and general treatment networks, review the schedules of rates and terms and conditions and actively manage the registered Providers of the schemes and networks. This includes ensuring adherence to requirements around registration, qualification and other terms and conditions of the schemes and networks.

Contract management and dispute resolution

2.31 HH will offer to provide the Participants with contract administration and management services and dispute resolution services on behalf of nib and all Participants for the contracting services that they engaged HH to undertake which may include:

(a) all HPPAs and MPPAs that were entered into by the Participants based on the terms and conditions negotiated by HH; and

(b) the agreements between Participants and Providers registered in the medical gap scheme and/or general treatment network,

(**Managed Agreements**).

2.32 This will involve HH acting as agent for the HH Buying Group to facilitate:

(a) administration of, and compliance with, the terms and conditions of the Managed Agreements;

(b) dispute resolution and management of disputes between Participants and Providers arising under the Managed Agreements;

(c) management and investigation of Customer complaints relating to Providers party to the Managed Agreements;

(d) collection and management of data submission from Providers to Participants under the Managed Agreements; and

(e) reporting and oversight of the parties' adherence to terms and conditions of the Managed Agreements and performance and quality targets.

Data analytics

2.33 HH will provide the Participants with data analytic services as part of contract negotiations but also on an ongoing basis to assess the performance of each Provider and benchmark their performance for each Participant against the aggregated data for the HH Buying Group including an assessment of:

(a) Provider quality (e.g. rate of hospital acquired complication, length of hospital stay, unplanned readmission to theatre, conversion to ICU, etc.)

(b) Provider Compliance (e.g. accuracy of claims, compliance with the contract terms, complaints, etc.);

(c) benefits paid to the Provider by Participants (e.g. cost per episode against national peer groups, change in cost over time, cost variability reporting across the Provider network, etc);

(d) access to the Provider's services (e.g. network coverage, member access issues, etc); and

(e) efficiency and value of treatment provided by the Provider (e.g. establishment of quality scoring of Providers and ranking of value and efficiency against quality).

2.34 Subject to confidentiality and privacy obligations, HH would also share information pertaining to one Participant with the HH Buying Group to the extent the information is related to the Managed Agreements or services provided by HH to the Participants. This may include the sharing of information on issues such as a breach of contract by a Provider or the discovery of fraudulent claims made by a Provider in relation to the Managed Agreement of one Participant which would be relevant to other Participants who contract with that Provider.

2.35 Provisions of the CCA which may apply to the Proposed Conduct

2.36 The relevant provisions of the CCA which may apply to the Proposed Conduct include:

(a) making or giving effect to a contract, arrangement or understanding that may include a cartel provision (Division 1 of Part IV);

(b) making or giving effect to a contract, arrangement or understanding that has the purpose or would have the effect, or likely effect, of substantially lessening competition (section 45(1)(a) and (b));

(c) engaging with one or more persons in a concerted practice that has the purpose or has or is likely to have the effect, of substantially lessening competition (section 45(1)(c));

(d) a corporation that has a substantial degree of power in a market engaging in conduct that has the purpose, or has or is likely to have the effect, of substantially lessening competition (section 46(1)); and / or

(e) engaging in the practice of exclusive dealing (section 47(1)).

2.37 Rationale for the Proposed Conduct

2.38 The rationale for the Proposed Conduct is to enable Participants to streamline contract negotiation, procurement and management procedures. The streamlined processes will improve efficiencies by virtue of the reduced transactional and administrative costs, and increase information sharing and data analytical capabilities resulting in better health outcomes and reduced premiums for Customers.

2.39 Term of authorisation sought and reasons for seeking this period of time

2.40 Authorisation for the Proposed Conduct is sought for 10 years from the date of final determination by the ACCC.

2.41 Given it is common practice for HPPAs and MPPAs to be 3 years duration, authorisation for 10 years will enable the HH Buying Group to continue to operate across two renewal cycles. It will also allow sufficient time for HH to implement innovative models of funding of healthcare that focus on driving quality and providing value, and for Participants and their Customers to realise the cost, quality and efficiency benefits of engaging in the HH Buying Group.

2.42 Provide documents submitted to the applicant's board or prepared by or for the applicant's senior management for purposes of assessing or making a decision in relation to the proposed conduct and any minutes or record of the decision made

2.43 None.

2.44 Names of persons or classes of persons who may be impacted by the Proposed Conduct and details of how / why they might be impacted

2.45 The class of persons potentially affected by the Proposed Conduct are:

(a) private health insurers that do not join the HH Buying Group;

(b) private hospitals;

(c) medical specialists and general practitioners; and

(d) allied health providers such as physiotherapists, dentists, optometrists, chiropractors.

Please refer to section 4 below as to how each class of persons may be impacted.

3. Market information and concentration

3.1 Describe the products and/or services, and the geographic areas, supplied by the applicants. Identify all products and services in which two or more parties to the proposed conduct overlap (compete with each other) or have a vertical relationship (e.g. supplier-customer).

3.2 The Applicants submit that the relevant markets are:

(a) national market for private health insurance;

(b) national market for international medical and travel insurance;

(c) State-based or localised market for hospital services;

(d) localised market for medical specialist services for each specialty practice; and

(e) localised market for each type of allied health service (eg. physiotherapists, dentists, optometrists, chiropractors, etc).

3.3 nib and the Participants compete with each other as purchasers of health services in the markets set out in paragraphs (c) to (e) above and as suppliers of private health insurance.

Private health insurance market

3.4 The market share of each private health insurer, measured as a share of total hospital policies as at June 2019 are set out in the table below.[2] The table also sets out which party undertakes contracting services for each private health insurer.[3]

Insurer	Party that undertakes contracting services	National Market Share Hospital Policies June 2019
Medibank	Medibank	26.0%
Bupa	Bupa	25.1%
HCF	HCF	11.7%
nib	HH	9.5%
HBF	HBF and AHSA	6.9%[4]
Australian Unity	AHSA	2.9%
Teachers Health	AHSA	2.7%

[2] *Operations of Private Health Insurers Annual Report 2018-2019*, published by APRA on 5 November 2019.
[3] Sourced from market knowledge and information available on AHSA's and ARHG's websites respectively.
[4] HBF contract directly with hospitals in WA and indirectly through the AHSA for all other States and Territories. HBF's policyholders in WA represent a national market share of 6.14%. HBF's policyholders in other States and Territories represent a national market share of 0.72%.

GMHBA	AHSA	2.5%
Defence Health	AHSA	2.2%
CBHS Health	AHSA	1.7%
HIF	AHSA	0.8%
Westfund	AHSA	0.7%
Queensland Teachers	AHSA	0.6%
health.com.au	AHSA	0.6%
Health Partners	AHSA	0.6%
CUA	AHSA	0.6%
Peoplecare	AHSA	0.5%
Queensland Country Health	AHSA	0.5%
Railway & Transport	AHSA	0.4%
Doctors' Health Fund	AHSA	0.4%
Police Health	AHSA	0.3%
Navy Health	AHSA	0.3%
MO Health	AHSA	0.2%
Phoenix Health	AHSA	0.2%
National Health Benefits Australia	AHSA	0.1%
Health Care Insurance	AHSA	0.1%
Transport Health	AHSA	0.1%
ACA Health	AHSA	0.1%
Nurses & Midwives Health	AHSA	0.1%
Reserve Bank Health	AHSA	0.0%
Emergency Services Health	AHSA	0.0%
CBHS Corporate Health	AHSA	0.0%
Latrobe Health	ARHG	0.8%
St Lukes Health	ARHG	0.5%
Mildura District Hospital Fund	ARHG	0.2%
Cessnock District Health	ARHG	0.0%

3.5 Market shares as purchasers of health services is shown in the table below. Note that our understanding is that HBF contract directly with hospitals in WA and indirectly through the AHSA for all other States and Territories.

Party undertaking contracting services	Participating health insurers' market share based on 2019 hospital policies
Medibank	26.0%
Bupa	25.1%
AHSA	20.0%
HCF	11.7%
Honeysuckle Health	9.5%
HBF	6.1%
ARHG	1.5%

3.6 We have also provided in Annexure A market shares based on total policies and revenue.

Market for Other Healthcare Payers

3.7 A useful lens through which to define the market for private healthcare is examining the sources of health expenditure funds. The Australian Institute of Health and Welfare (**AIHW**) publish detailed data on this topic. A key table from their 2018-2019 health expenditure data is shown below.

Table A3: Total health expenditure, current prices, by area of expenditure and source of funds, 2018–19 ($ million)

	Government						Non-government				
	Australian Government										
Area of expenditure	DVA	Health and other	Premium rebates	Total	State and local	Total	HIF	Individuals	Other	Total	Total health expenditure
Hospitals	1,321	23,702	3,332	28,354	33,280	61,634	9,689	3,689	4,036	17,415	79,049
Public hospital services	579	23,582	342	24,504	32,229	56,732	995	1,444	2,630	5,068	61,801
Private hospitals	741	120	2,989	3,851	1,051	4,902	8,694	2,246	1,407	12,347	17,248
Primary health care	1,333	25,783	1,049	28,165	10,508	38,672	3,051	21,351	2,474	26,876	65,549
Unreferred medical services	688	9,322	. .	10,009	—	10,009	. .	833	1,416	2,249	12,259
Dental services	80	796	718	1,594	840	2,435	2,089	6,051	52	8,192	10,627
Other health practitioners	256	1,789	313	2,359	7	2,366	910	2,039	502	3,451	5,817
Community health and other	. .	1,841	—	1,841	8,371	10,212	1	133	245	379	10,590
Public health	. .	1,361	. .	1,361	1,290	2,651	. .	15	193	208	2,859
Benefit-paid pharmaceuticals	309	9,941	. .	10,250	. .	10,250	. .	1,479	. .	1,479	11,729
All other medications	. .	732	17	750	. .	750	51	10,800	67	10,917	11,667
Referred medical services	. .	14,388	612	15,000	. .	15,000	1,780	3,382	. .	5,162	20,161
Other services	204	2,731	931	3,867	3,929	7,796	2,709	3,438	219	6,365	14,162
Patient transport services	144	125	96	365	3,083	3,448	280	488	96	864	4,312
Aids and appliances	2	624	262	888	. .	888	761	2,937	120	3,818	4,706
Administration	59	1,982	574	2,614	846	3,460	1,668	12	3	1,684	5,144
Research	2	5,009	. .	5,012	873	5,885	. .	2	410	413	6,298
Total recurrent expenditure	**2,860**	**71,612**	**5,924**	**80,397**	**48,591**	**128,988**	**17,229**	**31,862**	**7,140**	**56,231**	**185,219**
Capital expenditure	. .	188	. .	188	4,377	4,565	. .	. .	5,882	5,882	10,447
Medical expenses tax rebate	. .	50	. .	50	. .	50	. .	–50	. .	–50	—
Total health expenditure	**2,860**	**71,851**	**5,924**	**80,635**	**52,968**	**133,603**	**17,229**	**31,812**	**13,022**	**62,063**	**195,666**

. . not applicable

— rounded to zero

Source: https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2018-19/data

3.8 Focusing on the $17,248 million expenditure on private hospitals, reallocating the Premium rebates column (which represents the Australian Government's contribution to private health insurance premiums through the Australian Government Rebate) back to health insurance and including a breakdown of the "Other" column from Table 3.16 of the same report to include Workers compensation insurers and transport accident insurers produces the following table:

Private hospital funder	$ millions	Share
Private health insurers	11,683	67.7%
Individuals	2,246	13.0%
State and local government	1,051	6.1%
DVA	741	4.3%
Workers' compensation insurers	400	2.3%
Transport accident insurers	256	1.5%
Other Federal government	120	0.7%
Unknown	751	4.4%
	17,248	100.0%

3.9 Private health insurers and individuals account for 80.7% of revenue received by private hospital operators. DVA represents 4.3%, workers compensation insurers throughout Australia 2.3% and transport accident insurers 1.5%. There is a remaining Unknown percentage of 4.4%.

Market for travel insurance and short-term International Private Medical Insurance

3.10 Included in either the Individuals spend of $2.2 billion or the Unknown spend of $751 million, is hospitalisation for overseas tourists and short-term overseas workers. Typically, tourists and short-term workers take out insurance in their home country before travelling to Australia. Given their lack of scale in the Australian market, the overseas domiciled insurer will usually not have negotiated network access arrangements in Australia.

3.11 If the traveller requires medical services whilst in Australia, they will be required to pay the “rack rate” for the service out-of-pocket and then seek reimbursement from their insurer when they arrive home. One of the issues this creates is a bad debt risk for the hospital provider. Due to the lack of a certainty of payment, hospital providers embed within the “rack rate” a loading to offset the risk of the overseas visitor leaving the country without paying their bill. For international travel insurers, without the volume and local knowledge to develop networks, the increased “cost of production” is passed through to travellers in the form of higher insurance premiums.

3.12 nib has been approached by a number of these companies over the last 4-5 years seeking to negotiate “network access” arrangements. The size of these potential contracts is small - combined these groups would represent less than 0.5% of the total market for private hospital services.

Department of Veterans Affairs (DVA) scheme

3.13 Under the DVA scheme, eligible veterans are able to receive hospital services free with no gap expenses. The DVA arrangements represent a 4.3% share of the total expenditure on private hospitals and involve contracting directly with private hospitals through a tender process for the provision of the healthcare services. For GPs and medical specialists, the DVA maintains their own no-gap scheme. This involves contracting individually with these types of Providers.

3.14 DVA policyholders are not required to make any co-payment to medical specialists or hospitals. The average age of the DVA population is rapidly increasing and, consequently this segment of the market is reducing in activity and relevance with hospital providers. As this reduction continues it will place increasing price pressure on DVA as they lose market share and power to obtain competitive rates.

Workers compensation schemes

3.15 Each of the eight Australian states and territories has their own workers’ compensation scheme and the Commonwealth has three separate schemes. As per the table above, workers compensation schemes in total represent 2.3% of total private hospital funding. New South Wales has the largest scheme and would represent approximately 0.7% of total private hospital funding.

3.16 Each scheme manages their own contracts with medical and hospital providers. For example, the NSW scheme, administered by icare, has recently experienced significant increases in medical costs. icare is required to pay surgical fees that are gazetted by the State Insurance Regulatory Authority (**SIRA**). These gazetted rates are set by SIRA at 150% of the Australian Medical Association's (**AMA**) recommended rate.

3.17 This is higher than any other Australian workers compensation scheme and much higher than private health insurer and DVA scheme. For example, nib's Medigap scheme is set at an average of 50% of the AMA's recommended rates and the DVA scheme is set at 52%.

3.18 Ultimately these higher specialist fees are passed through to NSW companies in the form of higher workers' compensation premiums.

Transport Accident Schemes

3.19 Each Australian state runs its own compulsory transport accident insurance scheme. In NSW, Queensland, South Australia and the ACT, drivers can choose from a panel of compulsory third party (**CTP**) providers. In the other States, transport accident schemes are provided by a state-owned or government-licensed insurer. As per the table above, transport accident insurers represent 1.5% of total private hospital funding. Similar to workers compensation schemes, transport accident insurers typically manage their own contracts with medical and hospital providers.

Private hospital market

3.20 The table below shows the market shares of private hospital provider large groups.[5]

Hospital Provider Group	Market share
Ramsay	21.6%
Healthscope	13.7%
Healthe Care	9.3%
St John of God	5.5%
St Vincents Health	3.4%
Mater Misericordiae Limited	3.1%
Little Company of Mary	3.1%

3.21 Describe the relevant industry or industries. Where relevant, describe the sales process, the supply chains of any products or services involved, and the manufacturing process.

3.22 Please refer to section 1 (Background).

3.23 In respect of the overlapping products and/or services identified, provide estimated market shares for each of the parties where readily available.

3.24 Please refer to section 3 for market shares of nib and potential Participants.

3.25 In assessing an application for authorisation, the ACCC takes into account competition faced by the parties to the proposed conduct. Describe the factors that would limit or prevent any ability for the parties involved to raise prices, reduce quality or choice, reduce innovation, or coordinate rather than compete vigorously. For example, describe: existing competitors, likely entry by new

[5] Compiled by nib based on publicly available sources.

competitors, any countervailing power of customers and/or suppliers; and any other relevant factors.

3.26 Please refer to section 6 (Public Detriments) for an analysis of each health services market and any potential impacts on competition from the Proposed Conduct.

3.27 In relation to the market for private health insurance, insurers are highly regulated and any increase in premiums is subject to approval by the Commonwealth Minister for Health on an annual basis. The Minister has an expectation that the industry will limit premium increases to a target percentage which places pressure on health insurers to keep costs down and they have limited ability to increase premiums in response to health inflation. Therefore, coordination among competitors in the HH Buying Group will not lead to premium increases for Consumers and will in fact do the opposite and drive down costs (administrative and benefit outlays) to support Participants in keeping premium increases low.

4. Public benefits

4.1 Describe the benefits to the public that are likely to result from the proposed conduct. Provide information, data, documents or other evidence relevant to the ACCC's assessment of the public benefits.

4.2 The Proposed Conduct will generate public benefits in the form of transaction costs savings and efficiencies for healthcare payers, healthcare providers and members, encouraging transition towards value based contracting and information sharing resulting in better health outcomes for consumers at a lower cost resulting in more efficient pricing for hospital services and ultimately, reduced premiums for consumers. As private health insurers constitute the vast majority of purchasers of private health care (around 70% of private hospital services according to AIHW data), we will focus on public benefits in the private health insurance industry.

Transaction costs savings and increased efficiencies

4.3 Authorisation for HH to engage in collective bargaining will result in significant transactional and administrative cost savings for Participants. nib's network of Providers consists of:

(a) 565 private hospitals;

(b) 21,764 medical specialists;

(c) 3,049 general treatment clinics and over 15,900 providers.

This requires nib to:

(d) negotiate over 500 contracts per year; and

(e) manage over 3,500 agreements.

4.4 The negotiation of HPPAs in particular can be time consuming and at times, protracted with some HPPAs taking up to 16 months to negotiate and the average large hospital group negotiation taking between 6 to 8 months. The process involves complex negotiation on legislative issues, terms and conditions relating to payment structures, audit, recoveries and obligations by both parties as well as the associated business rules and clauses which detail the nature of how payments are made for health care services (which are volatile in nature due to each individual's condition). Some hospital group HPPAs involve up to 70 hospitals. In addition to negotiating the general contractual terms, each hospital in a hospital group will have an individual rate schedule (list of prices for hospital treatment) and each is negotiated individually with the requisition commercial modelling to be done at the individual level and then "rolled up" to understand both party's (fund and hospital groups) material change in value of the contract. As the business rules and contractual terms impact this modelling the processes generally involves a number of in-person meetings (in particular at commencement of negotiation) before weekly meetings to cover off specific areas and issues. A working document (contract) is created and a separate issues log maintained on the negotiation. The working document is exchanged periodically between the

parties and is marked up with comments, issues, requested changes etc. Once the contract terms are close to finalisation the rate modelling commences with each hospital and these rate schedules are exchanged in a similar manner to allow each organisation to model the predicted impact in change of terms (contract clauses), payment models for each service (daily rate to Diagnosis Related Grouping) and price. The modelling is generally conducted on an agreed period of 12 months of previous activity. Once all parties are satisfied with the outcome the negotiation is finalised and contracts executed. On issues which cannot be resolved, these are generally escalated by one or both parties to more senior staff and or executives to resolve. Once a position has been agreed at this higher level it is then briefed back to the negotiation teams who work together to ensure it is adequately reflected in the contractual terms.

4.5 Historically, nib's health services contracting function required approximately 25 staff and cost approximately $5 million per annum to operate. The size and cost of this function is largely independent of the size of the health insurer. Any health insurer that has national coverage and maintains its own health services contracting function would need to support a function of a similar size due to the breadth of the Provider networks.

4.6 The HH Buying Group would reduce the need for duplication of the resources and processes involved in the contracting services and reduce costs for Participants. Economies of scale and scope would be realised as each Participant joins the HH Buying Group and greater efficiencies achieved. Under the HH Buying Group, it is proposed that the fee for Participants would correlate with transactional costs so that any savings that arise as Participant numbers increase, would be distributed between Participants under the Participation Agreement through reduced fees.

4.7 The formation of the HH Buying Group to perform the contracting services will create significant administrative cost savings as each Participant does not need to replicate the same infrastructure. As HH is currently undertaking this function, the marginal cost of HH performing the contracting services for each Participant would be low. HH would distribute the cost of undertaking nib's contracting services across the Participants, thereby significantly reducing each Participant's costs and presenting an opportunity for transaction cost savings and increased efficiencies. We have set out in Annexure B an example of how the participation fee for the HH Buying Group would decline as Participants join.

4.8 These efficiencies can be realised with health insurers that are already part of the AHSA or ARHG buying groups. HH modelling suggests that the participation fee for the HH Buying Group will be competitive with the AHSA's or ARHG's membership fees and would provide a broader scope of services particularly in relation to data analytics. In any case, the HH participation fees would be substantially lower than running an effective internal function. We have set out in Annexure C the basis of the modelling undertaken by HH in comparing the competitiveness of the participation fee for the HH Buying Group with other buying groups.

4.9 The Proposed Conduct will also create the following benefit for the Providers (albeit more limited if most of the Participants were previous members of AHSA or ARHG):

(a) simplifies backend billing processes as the Participants would have the same contract, rates and billing rules which results in significant reduction to the operational and administrative costs for Providers;

(b) consistent funding agreements enable Providers to more easily establish care pathways and work with medical specialists on improving the quality and cost of health care; and

(c) reduced cost to negotiate and manage relationships with health insurers. Negotiation of agreements, particularly HPPAs, create a significant burden and cost to Providers and having reduced numbers of negotiations allow Providers to reduce the costs associated with establishing, negotiating and managing contracts with health insurers.

Greater choice of buying group

4.10 The HH Buying Group would provide health insurers with an alternative buying group to the AHSA and provide greater choice. ARHG is not a viable alternative to AHSA for health insurers because

of their lack of scale and ability to implement more sophisticated contracting mechanisms. Increased competition between different buying groups would also foster greater innovation and incentivise the buying groups to provider better value and quality of services to its participants.

4.11 The HH Buying Group would provide a differentiated model of funding such as value-based contracting, as further described below, and a buying group model that has been authorised by the ACCC.

Better health outcomes at a lower cost

4.12 HH intends to work collaboratively with Providers to implement more efficient "value-based" contracting relationships. In relation to hospital contracting, this type of contracting involves comparing health outcomes with costs of services to determine the value of the service. The agreed contracting price for healthcare services will be informed by the value of the service, rather than on the existing cost base. This transition from "fee-for-service" to "value-based" contracting aligns with many other health systems globally which have seen improvements in health outcomes and reduced costs from the transition. As an example, in the United States, Cigna created its first commercial value-based model in 2008. Today, 67% of Cigna's claim spend in the United States has shifted to value-based models. Cigna continues to grow its value-based models and expects to have over 1,000 value-based arrangements across hospitals, specialists, and general practitioner groups in 2021.

4.13 As a result of its shift to value-based contracting, Cigna has been able to improve cost outcomes and quality outcomes over time. From 2010 to 2018, Cigna had the lowest reported medical cost trend in the US at 3.6% (key competitors were between 5.5% and 6.0%). By 2021, Cigna is ambitiously targeting to manage medical cost trend to the same level as CPI. Value-based reimbursement arrangements have been a key component of that success.

4.14 More specifically, Cigna has seen very strong results in its top performing value-based arrangements:

- 11% better quality scores than market for primary care providers;
- 14% improved costs for specialist groups; and
- 2% lower readmission rates for hospitals.

4.15 Value based contracting takes many forms. In its most simple form, HH would initially compare the value of services from a particular Provider against peers in the local region, state as well as nationally. Based on the outcomes and quality of care achieved by the Provider, the cost of the services would be adjusted (either through price or structure) to match the value being delivered by the Provider. If the Provider achieves higher than standard quality outcomes, then the insurers would pay more to the Provider and if the standard quality outcomes were below average, insurers would pay less for these services. The mechanism for this adjustment would form part of the commercial negotiations process and could take a number of forms including price adjustment to reflect the quality of service, payment of performance incentives if agreed benchmark outcomes are exceeded or changes to payment structures which drive improved efficiency to match the outcomes associated with the Provider.

4.16 Current approaches to contracting generally focus solely on cost of care of the services and most funds, and buying groups such as the AHSA and ARHG, have historically focused on cost of care to determine payment structure and price of services. Larger funds tend to have greater access to the complex analytics and data science required to support the development of value-based funding models. Through the HH Buying Group for small and medium funds, it will effectively improve and normalise the Participants' ability to manage benefit outlay and match larger more mature competitors in accessing value based contracting services.

4.17 Health systems that have moved to value-based contracting, which by definition, better aligns incentives between the payer and provider, have seen both improvements in health outcomes and lower costs. This shift is fundamentally underpinned by broad data and mature and sophisticated

data science capabilities. The establishment of outcomes data is complex by its nature and requires the collection of sufficient data for statistical relevance (which is difficult, if not exclusionary requirement for small insurers), the establishment of outcome measures and quality based on relevant clinical and international literature, and the normalisation and risk adjustment of the patient population to ensure like-for-like comparison in the provision of services.

4.18 HH intends to collect and aggregate claims data and Hospital Casemix Protocol (HCP) data of Participants to establish benchmarks on the outcome of services in relation to both procedures and Diagnosis Related Grouping (DRG). This outcomes-based data would then be normalised and risk-adjusted for the variances in patient population (e.g. age, co-morbidities and demographic factors including gender) and a relative outcome scale established for each Provider at a procedure level. This would include quality data and information such as Hospital Acquired Complications as well as efficiency data such as excessive bed days or excessive use of Medicare Benefits Schedule (**MBS**) item numbers.

4.19 Once the quality scoring is established, HH will be able to use this benchmarking to assign a relative value score to each Provider at a procedure or DRG level as well as an aggregated weighted average for the Provider. This will then inform the basis for price and payment structure negotiations of HPPAs and will drive improved outcomes for Participants through more appropriate pricing at a procedure level for hospitals service purchased. Ultimately this will drive improved outcomes for Customers as they benefit from improvements in the quality of service from Providers or through more sustainable and affordable private health insurance due to better control by Participants of benefit outlay.

4.20 Additionally, the Proposed Conduct will encourage greater involvement by Providers in the lifecycle of the contracting process. The potential size and calibre of the HH Buying Group will drive uptake of value-based contracting by encouraging healthcare providers to be more engaged in innovative funding models that improve outcomes for Customers.

4.21 In relation to general treatment networks, such as dental networks, the ability to collectively acquire these services on behalf of a number of insurers will see improved volume provided to the Providers of these services who have been selected based on quality criteria, while pairing this with better pricing and value for Customers and the healthcare payers. As the health insurance products which cover these services typically pay a percentage of the cost, any price negotiation and discount is of benefit to both the payer and Customers who hold the insurance policy.

4.22 The key advantage of driving value-based contracting through the HH Buying Group rather than nib alone is that HH will be able to get more buy-in from Providers if HH is representing a larger Customer base. Value-based funding, by its nature, allows Providers to be more innovative and considered in the application of care. This allows a Provider to ensure that quality is maintained or increased while efficiency and cost of service delivery is improved. To make this viable for Provider to invest in, and operationally develop, providers require a reasonable volume of care to occur through these mechanisms. By forming a buying group for the development and purchasing of value-based funding mechanism, HH will provide enough scale to Providers to validate the investment and opportunity.

4.23 Likewise, the scale of smaller health insurance funds is likely to be insufficient to develop and implement value-based funding as stand-alone funds. By forming the HH buying group this will provide opportunity to small Participant funds to be involved in more modern and effective health procurement funding models which will ultimately translate into better affordability for members.

Access to data analytics and Information

4.24 Generally, only larger health insurers have access to the body of information and data analytics capabilities required to support the development of value-based contracting. The Proposed Conduct will provide Participants, who are likely to be smaller health insurers, with access to data analytics tools and technology. HH's data analytics undertaken as part of its contracting services will use claims and HCP data of all Participants. This will reduce information asymmetry and allow smaller insurers to obtain insights from information analysed across all Participants, that

they would otherwise not have. This will assist smaller insurers to more effectively engage in the contracting process and increase access for them to value-based contracting.

4.25 In addition to the benefits in relation to hospital services, data analytics and information sharing would allow HH to develop reliable and efficient networks of medical specialists and extras providers across various speciality groups and geographic networks. Increased information sharing and access to data analytics will increase use of efficient providers who deliver improved standards of care and allow participant funds the ability to provide better and more transparent information to members, which will result in a better informed and empowered consumer of health care services.

No gap experience for Customers

4.26 The uncertainty around the extent of gaps that Customers face in the private healthcare system is one of the major concerns or causes of dissatisfaction for Customers. For example, according to IPSOS' 2019 Healthcare & Insurance Australia Study, the most important driver for customer satisfaction with respect to their health insurer is 'Rebates on Services' (i.e. out-of-pocket costs) with the average fund scoring 5.8 out of 9 on this aspect. This uncertainty is partly derived from the multitude of contractual relationships that are created when a Customer receives hospital treatment – separate contracts between the Customer and the private hospital, medical specialist, anaesthetist, assistant surgeon, radiologist, pathologist, etc.

4.27 The HH Buying Group would broaden access to nib's Clinical Partners Program which is a unique industry offering where nib engages with the surgeon, assistant surgeon and anaesthetists to bring a zero-gap experience for Customers for knee and hip replacements. The HH Buying Group would allow this offering to be made available to Customers of Participants. It also provides HH with a larger Customer base to be able to engage with a broader group of medical specialists so that the program can be expanded to cover more types of treatment (the program currently only covers hip and knee replacements) and more geographical areas.

4.28 The development and expansion of the Clinical Partners Program will focus on efficient and effective Providers who provide quality standards of care based on the available hospital quality and outcomes data. The establishment of MPPAs with these Providers will drive more volume to them (as health insurers will be able to actively promote the financial certainty for Customers and referrers) and will also serve to place pressure on non-participants specialists to moderate their out-of-pocket practices due to the risk of loss of patient volume. Ultimately, in both instances the Customer is better protected from excessive out-of-pocket exposure when undergoing large and complex surgical procedures.

4.29 The HH Buying Group would also have the additional scale to expand its network of private hospitals with HPPAs and health professionals participating in the medical gap scheme and general treatment network which would also contribute to more no gap experiences for Customers.

4.30 The public benefit of an expanded Clinical Partners Program and the creation of potentially further no gap funding initiatives is that a greater number of Customers would have the benefit of the certainty of a no gap hospital or health experience. It would also go some way towards addressing a key concern of Customers and encourage further Australians to use the private healthcare system, alleviating the pressure on the public system.

Countervailing hospital bargaining power

4.31 Some Providers have much stronger bargaining power in the negotiation of agreements with healthcare payers which can impede the parties from achieving efficient pricing outcomes for health services. This is particularly the case in the private hospital market where the 5 largest hospital provider groups account for over 50% of the market.

4.32 Some of the smaller private hospitals can also have a high degree of bargaining power due to their iconic status and reputation, or due to their location in regional and remote communities.

4.33 This leads to inconsistencies in pricing for the same hospital procedure across different hospitals with the more powerful hospital groups being paid higher prices without any commensurate in value for the Customer. Two examples of this are procedures for cataracts (MBS item 42702) and oocyte retrieval (MBS item 13212) where the median cost charged by large hospital groups is 181% and 149% of the national median cost respectively.

4.34 This results in hospital pricing that is above the competitive and efficient price for treatment in particular hospitals.

4.35 The Proposed Conduct will enable the HH Buying Group to improve its bargaining position to countervail the power of some of the hospital groups which would lead to more efficient hospital pricing.

Reduced healthcare costs and premiums for members

4.36 The public benefits outlined above have the combined effect of increasing the value of the benefits paid by healthcare payers for health services and reducing overall spend particularly in relation to hospital benefits. This will be achieved in the short term through more efficient pricing and in the longer term through increased quality of care which will reduce the volume of health services being purchased. In FY19 the private health insurance industry paid $15.7 billion in hospital benefits which represented 74%6 of all benefits paid by private health insurers for that period.

4.37 The reduction in healthcare costs is of particular importance to the smaller health insurers who are likely to be Participants and have more limited access to capital. It would ease the current pressure on health insurers struggling with escalating healthcare costs and inflation coupled with increased cost of regulatory compliance and changes to capital adequacy requirements.

4.38 The flow on effect of reductions in benefit outlays and transactional costs savings from the HH Buying Group is that it reduces pressure on premium increases for health insurance policies by the Participants, whilst also improving patient outcomes through value-based contracting and incentivised performance based outcomes. Reduced premium increases encourages participation in private health insurance and reduces pressure on the public health system.

Public benefits for Other Healthcare Providers

4.39 Hospital and medical purchasing is at a significantly lower scale for other purchasers of private medical services compared to private health insurers. This creates an opportunity to partner with these purchasers to increase their sophistication and better align incentives with health care providers.

4.40 Similar to insurers, Other Healthcare Providers will benefit from transaction costs savings as a result of the Proposed Conduct particularly those that have ongoing arrangements with health service providers akin to insurers. This will enable schemes such as the Department of Veteran's Affairs hospital cover scheme to pass on greater benefits to veterans, or reduce general expenditure. Furthermore, for those that do not have arrangements with health service providers and instead rely on the established rates for services will gain access to more efficient pricing models.

4.41 Importantly, and as noted above in respect of private health insurers, the Other Healthcare Providers will benefit from the data analytics and associated "value-based" contracting models. Only larger private health insurers will have access to the quantity and quality of data required to effectively engage with data analytics and achieve meaningful results. The Other Healthcare Providers will be able to benefit from the data sharing, and third party data analytics, in circumstances where they otherwise would not have the relevant data, finance or experience to implement. Furthermore, as a result of the Proposed Conduct the Other Healthcare Payers will be

[6] *Operations of Private Health Insurers Annual Report 2018-2019*, published by APRA on 5 November 2019.

able to consider implementing "value-based" contracting with the ultimate goal of offering better quality of care, and accordingly improving the health of its members.

5. Public detriment (including likely competitive effects)

5.1 Describe any detriments to the public likely to result from the proposed conduct, including those likely to result from any lessening of competition. Provide information, data, documents, or other evidence relevant to the ACCC's assessment of the detriments.

5.2 The potential public detriments from the Proposed Conduct would be minimal (if any) in the markets for health services and would be outweighed by the public benefits set out above. The health insurers that are most likely to be Participants are members of existing buying groups. As insurers would be switching from one buying group to another, it would not substantially change the current market dynamics in the market for health services. The key difference being that nib would be a party to the HH Buying Group.

5.3 The other key reason that potential public detriments would be minimal is that the Providers have statutory rights (assigned from members) to be paid benefits from insurers and Medicare and do not rely wholly on agreements with health insurers. We consider each type of contracting service in turn.

5.4 In relation to the market for the supply of private health insurance to consumers, the potential public detriments from the Proposed Conduct (if any) would be very limited. The Proposed Conduct will not impact the way healthcare payers compete with one another in relation to the setting of premiums, the products they provide, or their sales strategy, rather it will only impact the way that healthcare payers engage with suppliers of health services as described above and the reduction in health care costs. Accordingly, there the Proposed Conduct will have very little impact on the way private health insurance is supplied to consumers other than easing the pressure on premium increases due to cost reductions. This position is supported by the fact that buying groups in respect of health services already exist and have not impacted or acted as a detriment to competition in the supply of private health insurance.

Hospital contracting

5.5 The market for private hospital services is likely to be State-based or local market as consumers are unlikely to travel long distances to acquire hospital services. As purchasers of hospital services, the HH Buying Group would potentially have a stronger bargaining position than if nib or each Participant negotiated agreements with private hospitals individually.

5.6 We have set out below the market share figures on a State and Territory basis for each private health insurer or buying group based on hospital policies as disclosed in APRA's *Operations of private health insurers annual report 2019.*

Contracting Group	NSW (including ACT)	NT	QLD	SA	TAS	VIC	WA	National
Medibank	22.60%	40.90%	30.70%	19.40%	26.90%	31.10%	21.40%	26.10%
Bupa	22.90%	36.20%	31.40%	47.80%	32.70%	23.10%	10.90%	25.10%
HCF	20.10%	5.90%	8.00%	8.90%	4.80%	7.50%	4.70%	11.70%
nib	15.20%	3.20%	6.80%	4.10%	3.00%	8.50%	3.90%	9.50%
HBF	0.80%	1.70%	0.70%	0.50%	0.70%	1.10%	49.70%	6.90%
AHSA	17.20%	11.60%	21.50%	18.40%	31.30%	27.00%	5.30%	19.20%
ARHG	1.20%	0.30%	0.90%	0.70%	0.60%	1.70%	3.90%	1.60%

In the unlikely event that every member of AHSA joined the HH Buying Group, market shares by State and Territory are likely to be as set out below.

Insurer	NSW (including ACT)	NT	QLD	SA	TAS	VIC	WA	National
HH Buying Group	34.0%	17.0%	29.6%	23.7%	14.4%	34.7%	13.2%	29.5%
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%
HBF	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	49.7%	6.1%
ARHG	0.4%	0.1%	0.2%	0.2%	21.2%	3.6%	0.0%	1.5%

5.7 The most impacted State-based markets would be New South Wales and Victoria if all of AHSA's members joined the HH Buying Group as it would give the HH Buying Group the highest market share in those States.

5.8 The increased market share of the HH Buying Group would to some extent, countervail the strong bargaining position of the large hospital groups such as Ramsay and Healthscope that allows for supra-competitive prices for hospital services. We submit that the increase in HH Buying Group's market share will allow it to leverage its position in order to put pressure on hospital pricing so that it falls below supra-competitive and inefficient levels. The HH Buying Group is unlikely to have sufficient bargaining power or incentive to drive hospital pricing below competitive prices. Due to the national network of hospitals operated by the large hospital groups, the HH Buying Group will continue to be reliant on having an HPPA with them. This will also be the case for smaller iconic hospitals that the HH Buying Group must have in the hospital network due to demand from Customers.

5.9 Health insurers are effectively subject to a price floor under the PHI Act and Rules for hospital treatment. The legislative regime requires health insurers to pay benefits for hospital treatment at either the specified rates in the *Private Health Insurance (Benefit Requirements) Rules* (**Rules**) or rates calculated under the Rules for second-tier eligible hospitals. The latter rates are calculated by taking 85% of the average rate for that treatment in the insurer's HPPAs with comparable hospitals. If a hospital does not have an HPPA with the HH Buying Group, insurers must still pay these minimum benefit amounts. Customers of the HH Buying Group would still have the option of purchasing services from that hospital but are more likely to incur out-of-pocket expenses.

5.10 Based on nib's experience in moving from AHSA membership to undertaking its own HPPA negotiations, the Applicants submit that the increase is likely to assist the HH Buying Group to negotiate additional obligations relating to quality of treatment, performance, reporting and have more engagement from hospitals on innovative funding models. The Applicants expect that greater market share would incentivise hospitals to engage more collaboratively with the HH Buying Group during HPPA negotiations.

Medical specialist contracting

5.11 The impact of the HH Buying Group would be minimal in the market for medical specialist services which would be localised geographic areas of competition and a separate market for each specialty of practice.

5.12 The negotiation of MPPAs with medical specialists involves negotiating the rates that medical specialists would accept for not charging a gap to Customers.

5.13 The HH Buying Group is likely to increase the proportion of potential Customers of the medical specialist that are being represented in the MPPA negotiations. The Applicants submit, again on the basis of nib's experience as an AHSA member, that this will not change the negotiation dynamics in relation to price but is more likely to lead to greater engagement on innovative funding models such as the Clinical Partners Program. This is because MPPAs are not critical to

medical specialists but are seen as an optional arrangement. If a medical specialist was not prepared to enter into an MPPA with the HH Buying Group, they have statutory rights (assigned from members) to be paid for their professional services which would generally comprise of benefits paid by Medicare (75% of the Medicare Benefits Schedule fee for the service), benefits paid by the insurer (25% of the Medicare Benefits Schedule fee or more if the medical specialist participates in a medical gap scheme) and out-of-pocket expenses paid by the Customer (if any). Therefore, in MPPA negotiations, insurers often do not have strong bargaining power when negotiating with medical specialists despite the differential in size of the organisations as medical specialists are simply agreeing to cap their fees and relinquish their right to charge out-of-pocket expenses.

Medical gap scheme and general treatment network

5.14 In relation to the medical gap scheme and general treatment network, the HH Buying Group would not be negotiating agreements with Providers. Due to the large number of individual health providers in the industry (circa 50,000), the HH Buying Group will be managing schemes based on a standard schedule of rates and terms and conditions. nib's current scheme is determined on a state basis for dental and physiotherapy networks and a national basis for other types of general treatment networks and its medical gap scheme. Therefore, any changes to the buying power in the local markets for medical specialists or general treatment providers due to the HH Buying Group would not impact the setting of prices or terms and conditions for the medical gap scheme and general treatment network.

5.15 These schemes are voluntary, and Providers have the option to register to be part of these networks and receive additional benefits for agreeing to 'no gap' arrangements and other terms and conditions. General treatment providers also have the option of not being part of an insurer's network and will still be paid benefits in accordance with the policies of the health insurers. As discussed above, medical specialists have the option not to register with the medical gap schemes and continue to have statutory rights (assigned from members) to be paid benefits from Medicare and health insurers. Health insurers are incentivised to provide attractive rates to Providers under the medical gap scheme and general treatment networks to encourage participation.

5.16 The only agreements that are negotiated in this space are agreements relating to the operation of an insurer's branded optical or dental centres or potentially, agreements with networks of providers such as dentists that may be bespoke and negotiated. HH's involvement in the negotiation and management of such contracts would be undertaken on an individual basis for the relevant insurers.

5.17 The Applicants submit that the Proposed Conduct will have minimal (if any) detrimental impact on Customers or other classes of persons and that the substantial public benefits from the Proposed Conduct as set out in this application will result in a net public benefit.

Other Healthcare Payers

5.18 In relation to Other Healthcare Payers, the Applicant submits that there will no public detriments emerging from the Proposed Conduct. The relative bargaining power of the Other Healthcare Payers is small, accordingly their ability to achieve commercial and competitive results in negotiations with Providers is limited, resulting in some cases of inefficient pricing. Should the Other Healthcare Payers participate in the HH buying group, any increase in bargaining power will allow them to increase their bargaining power and accordingly, their negotiating position. As noted above, given the countervailing bargaining power of Providers is large any marginal increase in bargaining power for these types of healthcare payers will not significantly impact competition.

5.19 Similarly, travel and medical insurers make up a small percentage of the healthcare payer market. Accordingly, their joining the buying group will not materially alter the competitive position of Providers in such a way as to improperly displace the countervailing bargaining power in the market.

5.20 The Applicant recognises that government and semi-government healthcare payers form a large part of the healthcare payer market. However, in practice these schemes invest in and create their own Provider networks, and are subject to extensive public policy constraints when tendering and making agreements. Accordingly, in the Applicant's view these healthcare payers are less likely to join the HH Buying Group.

Future without the Proposed Conduct

5.21 In a future without the Proposed Conduct, nib will continue to use the contracting services offered by HH. nib along with other healthcare payers will, on an ongoing basis, incur high amounts of transaction costs associated with the time consuming and protracted negotiation of HPPAs. Similarly, Providers will continue to incur the administrative and cost burdens associated with the operational side of backend billing and the repeated negotiation and management of contracts with health insurers.

5.22 Other Healthcare Payers will also continue to pay inefficient prices and incur excessive transaction costs, resulting in increased premiums for customers and greater administrative costs for Providers. Significantly, without the Proposed Conduct healthcare payers will face great difficulty in implementing the more efficient "value based" contracting relationships. Smaller healthcare payers particularly will not have access to the type and scale of data required to transition away from a "fee for service" model. This is because the lack of data sharing will result in there being no data to form the basis of the price and payment structure of value based contracting. As a result, healthcare payers, Providers and customers will benefit from the more efficient quality and price of healthcare services. In addition, without the Proposed Conduct, the multitude of contractual relationships that exist when a customer attends a hospital will remain and accordingly, the basis on which the customer will be required to pay a gap will remain unclear resulting in continuing uncertainty for customers relating to the pricing of healthcare services.

5.23 Accordingly, in a future without the Proposed Conduct, the current costs model and associated expenses will remain for healthcare payers, Providers and customers. Healthcare payers will have less choice about which buying groups to participate in, reducing competition between buying groups, and will be less inclined to implement improved and innovative funding and service models, reducing the potential for cost savings. Without the scale provided by the HH Buying Group, HH may have greater difficulties engaging with Providers to implement and invest resources in transitioning to innovative funding models, particularly where Providers have guaranteed funding streams under private health insurance legislation and through Medicare.

6. Contact details of relevant market participants

6.1 Identify and/or provide names and, where possible, contact details (phone number and email address) for likely interested parties such as actual or potential competitors, key customers and suppliers, trade or industry associations and regulators.

6.2 Please see contact details in the Annexure D.

7. Additional information

7.1 Provide any other information or documents you consider relevant to the ACCC's assessment of the application

7.2 None.

8. Declaration by applicant

8.1 The undersigned declare that, to the best of their knowledge and belief, the information given in response to questions in this form is true, correct and complete, that complete copies of documents required by this form have been supplied, that all estimates are identified as such and are their best estimates of the underlying facts, and that all the opinions expressed are sincere.

8.2 The undersigned undertake(s) to advise the ACCC immediately of any material change in circumstances relating to the application.

8.3 The undersigned are aware the giving false or misleading information is a serious offence and are aware of the provisions of sections 137.1 and 149.1 of the Criminal Code (Cth).

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Rhod McKensey

Chief Executive Officer, Honeysuckle Health Pty Ltd

This 23rd day of December 2020

Annexure A – Alternate market share figures

The market share figures in this Annexure A are based on APRA's *Operations of private health insurers annual report 2019*.

Market Share based on total of Hospital and Extras Policies

Insurer	Party that undertakes contracting services	National Market Share Total Policies June 2019
Medibank	Medibank	26.9%
Bupa	Bupa	25.8%
HCF	HCF	11.1%
nib	nib	9.1%
HBF - WA	HBF	6.7%
HBF – other States and Territories	AHSA	0.7%
Australian Unity	AHSA	2.7%
Teachers Health	AHSA	2.4%
GMHBA	AHSA	2.3%
Defence Health	AHSA	2.1%
CBHS	AHSA	1.5%
HIF	AHSA	0.8%
Westfund	AHSA	0.8%
Health Partners	AHSA	0.7%
Latrobe Health	ARHG	0.7%
CUA	AHSA	0.6%
health.com.au	AHSA	0.6%
TUH	AHSA	0.6%
Peoplecare	AHSA	0.5%
St Luke's	ARHG	0.5%
QCH	AHSA	0.4%
rt health	AHSA	0.4%
Police	AHSA	0.3%
Navy Health	AHSA	0.3%
Doctors Health	AHSA	0.3%
Mildura District Hospital Fund	ARHG	0.2%
myOwn	AHSA	0.2%
Phoenix	AHSA	0.1%
Healthcare Insurance	AHSA	0.1%
Transport Health	AHSA	0.1%

onemedifund	AHSA	0.1%
ACA Health	AHSA	0.1%
Nurses & Midwives	AHSA	0.1%
Hunter Health	ARHG	0.0%
Reserve Bank	AHSA	0.0%
CBHS Corporate	AHSA	0.0%
Emergency Services Health	AHSA	0.0%

Party that undertakes contracting services	Participating health insurers' market share based on June 2019 Total Policies
Medibank	26.9%
Bupa	25.8%
AHSA	19.0%
HCF	11.1%
nib	9.1%
HBF	6.7%
ARHG	1.4%

Market Shares based on Premium Revenue

Insurer	Party that undertakes contracting services	National Market Share Total Premium Revenue FY19
Bupa	Bupa	26.6%
Medibank	Medibank	25.7%
HCF	HCF	11.3%
nib	nib	8.2%
HBF - WA	HBF	6.1%
HBF – other States and Territories	AHSA	0.7%
Teachers Health	AHSA	2.8%
Australian Unity	AHSA	2.8%
Defence Health	AHSA	2.3%
GMHBA	AHSA	2.3%
CBHS	AHSA	1.8%
Westfund	AHSA	0.8%
TUH	AHSA	0.8%
HIF	AHSA	0.7%
Latrobe Health	ARHG	0.7%

Health Partners	AHSA	0.7%
Peoplecare	AHSA	0.6%
CUA	AHSA	0.6%
St Luke's	ARHG	0.6%
Police	AHSA	0.5%
QCH	AHSA	0.5%
health.com.au	AHSA	0.5%
rt health	AHSA	0.5%
Doctors Health	AHSA	0.4%
Navy Health	AHSA	0.4%
Mildura District Hospital Fund	ARHG	0.2%
Phoenix	AHSA	0.2%
onemedifund	AHSA	0.1%
myOwn	AHSA	0.1%
Healthcare Insurance	AHSA	0.1%
ACA Health	AHSA	0.1%
Transport Health	AHSA	0.1%
Reserve Bank	AHSA	0.1%
Nurses & Midwives	AHSA	0.1%
Hunter Health	ARHG	0.0%
Emergency Services Health	AHSA	0.0%
CBHS Corporate	AHSA	0.0%

Party that undertakes contracting services	Participating Australian health insurers' market share based on Total Premium Revenue for FY19
Bupa	26.6%
Medibank	25.7%
AHSA	20.6%
HCF	11.3%
nib	8.2%
HBF	6.1%
ARHG	1.5%