Determination

Application for authorisation
lodged by
Honeysuckle Health Pty Ltd and
nib health funds limited
in respect of
the Honeysuckle Health Buying Group
Authorisation number: AA1000542

21 September 2021

Commissioners:	Sims
	Keogh
	Rickard
	Brakey
	Crone
	Ridgeway

Summary

The ACCC has decided to authorise Honeysuckle Health (HH) and nib (together, the Applicants) to form and operate a buying group (HH Buying Group) to collectively negotiate and manage contracts with healthcare providers (including hospitals and medical specialists) on behalf of private health insurers (PHIs), medical insurance providers and other payers of healthcare services until 13 October 2026.

Authorisation is granted with a condition that the Applicants must not supply services to Medibank, Bupa, HCF and HBF in Western Australia (Major PHIs).

The application for authorisation

HH currently provides 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 Applicants seek authorisation for HH to provide these services to additional healthcare payers and form a joint buying group (the Proposed Conduct).

The Applicants have not sought authorisation for the HH Buying Group to collectively boycott the services of any healthcare provider. This means that the HH Buying Group is not authorised to collectively refuse to deal with any healthcare provider.

Consultation and amendments to the application for authorisation

There has been significant opposition to the application for authorisation from healthcare providers. In response to these concerns, as well as issues identified by the ACCC, the Applicants amended their original application to exclude Major PHIs from participating in the HH Buying Group in relation to hospital contracting, medical gap schemes and general treatment networks.

In the amended application, the Applicants sought authorisation for HH to provide contracting services to all PHIs, including major PHIs, in relation to the Broad Clinical Partners Program (BCPP), subject to a condition that the HH Buying Group would be allowed to represent a maximum of 80 per cent of the national private health insurance market (based on the number of hospital policies) in relation to the BCPP. The BCPP is a program under which HH enters into agreements with medical specialists to ensure that customers are not charged out-of-pocket costs for the range of medical services provided during an episode of hospital treatment (currently only for joint replacement surgery, but it is proposed to apply to other services in the future).

Public benefits

The ACCC considers the Proposed Conduct is likely to result in the following public benefits:

- **a greater choice of buying groups for smaller PHIs and increased competition between these buying groups, and**
- **improved access to information for smaller PHIs, through the option to utilise a particular type of data analytics based on aggregated data of all members of the buying group, which would not otherwise be available to those PHIs and will likely assist them to develop and offer more competitive insurance products and services.**

Increased competition between buying groups is likely to foster greater innovation and incentivise the buying groups to provide better value to their participants. In turn, and in combination with the improved information available to them, smaller PHIs are

likely to be able to compete more effectively with the Major PHIs to attract customers by offering reduced costs or better services to the benefit of PHI consumers.

The ACCC considers the Proposed Conduct is also likely to result in some public benefits for consumers through the BCPP. The ACCC accepts that the BCPP delivers benefits to existing nib members by giving them the certainty of a no gap experience for the range of services involved in knee and hip replacements with certain medical specialists. To the extent that the program is widened to include new participants in the HH Buying Group and additional procedures and specialists, the ACCC considers this is likely to result in public benefit by extending an increased no gap experience and certainty of costs for customers of those participants.

Public detriments

The ACCC considers that if the Proposed Conduct enabled small and Major PHIs to join the BCPP up to the point where they represented 80 per cent of hospital policies, this would be likely to result in public detriment by creating an imbalance in bargaining power between PHIs and medical specialists, leading to inefficient outcomes in the provision of health services by medical specialists.

In order to address the concern regarding an imbalance in bargaining power, and to ensure the net public benefit test is met, the ACCC has imposed a condition of authorisation that prohibits HH from supplying BCPP services to Major PHIs. The ACCC considers that this will not compromise the public benefits of the Proposed Conduct, because Major PHIs have the scale to develop similar no gap experience programs and can do so without the need to join the BCPP.

The ACCC notes that even without the Major PHIs involved, the HH Buying Group could comprise nib and a significant number of smaller PHIs collectively negotiating with individual medical specialists. The ACCC recognises this is a different type of arrangement to the collective bargaining arrangements that it has previously authorised, which typically involve the aggregation of a number of smaller entities to negotiate with a larger buyer or seller.

However, the ACCC considers that the HH Buying Group's bargaining power in this situation is limited by the *Private Health Insurance Act 2007,* which provides that in respect of in-hospital medical services provided to private patients PHIs must pay specialists at least 25 per cent of the Medicare Benefits Schedule (MBS) fee for the service (which is set by the Federal Government). The remaining 75 per cent of the MBS fee is payable by Medicare. This means that PHIs (including nib and other HH members) cannot refuse to make a minimum level of payment to specialists with whom the PHI has no Medical Purchaser Provider Agreement (MPPA). Accordingly, the practical effect of any increased bargaining power will be smaller than in other circumstances where buyers are legally permitted to completely bypass a given supplier by refusing to acquire their products or services.

The ACCC considers that there is insufficient evidence that the Proposed Conduct is likely to result in an imbalance in bargaining power between the HH Buying Group (comprising nib and a number of smaller insurers) and hospitals.

The ACCC also notes the HH Buying Group will not be negotiating agreements with individual providers in the general treatment network, which includes physiotherapists, dentists, optometrists and chiropractors. Any changes in the buying power of the HH Buying Group are unlikely to impact the setting of prices or terms and conditions for the general treatment network.

Concerns about US-style managed care

The ACCC acknowledges that many medical practitioners and their peak representative bodies have raised concerns that the 'value-based' contracting model proposed by the Applicants will lead to the introduction of US-style managed care in Australia.

Authorisation by the ACCC exempts the Applicants from specified sections of the *Competition and Consumer Act 2010*. Apart from this, it does not alter any existing legal requirements, restrictions or policy settings regarding healthcare in Australia. Value-based contracting is already occurring and will most likely continue in the industry regardless of the formation of another buying group. It is clear nib/HH and other (larger) PHIs are likely to continue to adopt a value-based contracting approach to negotiating with providers even if the authorisation was not granted.

The ACCC has carefully considered how interested party concerns about value-based contracting and the possible introduction of US-style managed care factor into the net public benefit test that must be satisfied in order to grant authorisation. The ACCC recognises that a buying group with sufficient market power and which uses inducements or threats to influence the nature of treatment that medical practitioners and hospitals provide patients, or offers strong financial incentives to patients regarding their choice of practitioner, might be very difficult for many of its participants and members' customers to resist. This may in turn lead to pressure for others to adopt similar arrangements and embolden other insurers to do the same.

The ACCC considers that there has been insufficient evidence provided to support the claim that the Proposed Conduct is likely to cause or lead to US-style managed care in Australia. In any event, if this conduct were to arise it would contravene other legislation as outlined below.

The ACCC notes that the *Private Health Insurance Act 2007* (PHI Act), administered by the Commonwealth Department of Health, prohibits PHIs from limiting the professional freedom of medical practitioners. Further, the obligation on insurers under the PHI Act to pay at least 25 per cent of the applicable MBS fee prevents PHIs from altogether refusing to fund treatments by healthcare providers. Authorisation of the Proposed Conduct does not alter the existing legal requirements in the PHI Act, including provisions that ensure or preserve the clinical autonomy of medical practitioners and patient choice. Medical practitioners concerned that their autonomy has been or could be compromised should seek assistance from the Commonwealth Ombudsman or the Commonwealth Department of Health.

The ACCC notes that concerns about the introduction of managed care are not new and that the same arguments were raised by medical practitioner groups opposing legislation permitting the introduction of MPPAs in the mid-1990s.

Overall, the ACCC considers that the Applicants' implementation of value-based contracting is unlikely to change the current Australian healthcare system to a US-style managed care model. In any event, some Australian insurers are already implementing value-based contracting and it appears likely that this will continue. The future without the Proposed Conduct is likely to be one where value based contracting continues to exist.

Balance of public benefits and detriments

On balance, and with the condition of authorisation that has been imposed, the ACCC considers that the Proposed Conduct is likely to result in a public benefit and that this public benefit would outweigh any likely detriment to the public from the Proposed Conduct.

Length of authorisation

The Applicants sought authorisation for 10 years. The ACCC understands that the majority of agreements with private hospitals and medical practitioners have a two to three year term and HH is likely to require time to establish the HH Buying Group and put in place arrangements with healthcare providers. In light of this and the ACCC's assessment of the public benefits and detriments of authorisation, the ACCC considers it appropriate to authorise the Proposed Conduct for five years, rather than the 10 years sought. This will give the ACCC an earlier opportunity to re-assess any public benefits or detriments that have resulted from the Proposed Conduct if the Applicants decide to apply for re-authorisation in the future.

In these circumstances, the ACCC grants authorisation with a condition until 13 October 2026.

1. The application for authorisation

1.1. On 24 December 2020, Honeysuckle Health Pty Ltd (**HH**) and nib health funds limited (**nib**) (together, the **Applicants**) lodged application for authorisation AA1000542 with the Australian Competition and Consumer Commission (the **ACCC**). HH and nib sought authorisation for 10 years for HH to form and operate a buying group (the **HH Buying Group**) to collectively negotiate and manage contracts with healthcare providers (**Providers**). This application for authorisation AA1000542 was made under subsection 88(1) of the *Competition and Consumer Act 2010* (Cth) (the **Act**).

1.2. The ACCC may grant authorisation, which provides businesses with protection from legal action under the competition provisions in Part IV of the Act for arrangements that may otherwise risk breaching those provisions, but are not harmful to competition and/or are likely to result in overall public benefits.

Amendments to the application and key steps in the authorisation process

1.3. In response to concerns raised by the ACCC and interested parties, the Applicants have made a number of amendments to the application.

1.4. On 8 April 2021, the Applicants amended their application to exclude Medibank Private Limited (**Medibank**), Bupa HI Pty Limited (**Bupa**), the Hospitals Contribution Fund of Australia Limited (**HCF**) and HBF Health Limited (**HBF**) in relation to its contractual arrangements with Providers in Western Australia (**HBF WA**)[1] (each, **a Major PHI**) from the Proposed Conduct in relation to hospital contracting, medical gap schemes and general treatment networks.

1.5. On 21 April 2021, the Applicants further amended their application to limit the medical specialist contracting services offered by the HH Buying Group to the Broad Clinical Partners Program (**BCPP**) (under which patients would receive a no gap experience for the whole episode of care for a surgical procedure). At this time, the Applicants advised they were open to the imposition of a condition that would only allow the HH Buying Group to represent a maximum of 80 per cent of the national private health insurance market (based on the number of hospital policies) in relation to the BCPP.

1.6. On 6 May 2021, the Applicants lodged another amended application. All versions of the applications are available on the ACCC Public Register.

1.7. On 21 May 2021, the ACCC issued a draft determination proposing to grant authorisation for the Proposed Conduct, with a condition, for five years.

[1] The non-Western Australian business of HBF is currently managed by the Australian Health Services Alliance (AHSA).

1.8. On 16 June 2021, the ACCC extended the date by which the ACCC must make a final determination to 1 October 2021.

1.9. On 8 July 2021, the ACCC held a pre-decision conference in order to discuss the draft determination. The pre-decision conference is discussed in more detail in paragraphs 3.32 to 3.35.

1.10. Following the draft determination and pre-decision conference, the ACCC requested and received (on a confidential basis) copies of nib's template agreements with hospitals and medical specialists. The Applicants subsequently provided a redacted version of the agreement with medical specialists, which was placed on the Public Register.

1.11. The ACCC also requested and received (on a confidential basis) copies of HH's and nib's Board papers relating to the Proposed Conduct.

1.12. On 27 August 2021, the Applicants responded to the ACCC's proposed condition of authorisation. This response is on the Public Register.

The Applicants

1.13. HH is a health services and specialist data science company that provides services including health analytics and health management programs. In December 2019, HH was established as a joint venture between nib and Cigna (with each owning 50 per cent of HH). The Applicants state that HH operates independently of nib and Cigna. 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.

1.14. nib is an Australian health insurer supplying approximately 10 per cent of national private health insurance policies[2], providing health insurance to Australian residents, international workers and international students. nib is also Australia's third largest travel insurance provider, and also underwrites GU Health, Suncorp and Qantas health insurance.

1.15. Cigna is a global health services company. It provides a range of health services (medical, dental, pharmacy, vision), as well as related products including group life, accident and disability insurance.

Parties to the Proposed Conduct

1.16. The Applicants sought authorisation for and on behalf of:

(a) private health insurers (**PHIs**) registered under the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) except for certain PHIs in the circumstances specified below at paragraph 1.18.

(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 the Department of Veterans Affairs scheme (DVA), and

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

(**Participants**).

1.17. Together, the healthcare payers described in paragraph 1.166 (b) to (d) are referred to as **Other Healthcare Payers** in this determination.

[2] Based on total of Hospital and Extras Policies from APRA's Operations of private health insurers annual report 2019.

The Proposed Conduct

1.18. The Applicants sought authorisation for the following conduct:

(a) as regards Medibank, Bupa, HCF and HBF WA (each a '**Major PHI**'):

- HH to operate the BCPP involving the provision of services to any Major PHI
- each Major PHI to acquire contracting services from HH, but only in relation to the BCPP, and

(b) as regards all other PHIs (including HBF's arrangements with Providers outside Western Australia), Other Healthcare Payers and any other healthcare payer notified by HH to the ACCC (**Other Participants**):

- HH to form and operate the HH Buying Group, including the BCPP, involving the provision of services to Other Participants, and
- Other Participants to acquire contracting services from HH,

(collectively, the **Proposed Conduct**).

1.19. The key features of the Proposed Conduct are:

- The Applicants sought authorisation for HH to provide contracting services to additional healthcare payers (HH already provides these services to nib) and form a joint buying group.
- Under the Proposed Conduct, it would not be open to Medibank, Bupa, HCF, or HBF in Western Australia to be part of the general buying group and acquire contracting services from HH in relation to hospital contracting, medical gap schemes and general treatment networks.
- However, it would still be open to Medibank, Bupa, HCF and HBF in Western Australia to acquire HH's contracting services relating to HH's BCPP. This is a program under which HH enters into agreements with medical specialists to ensure that patients are not charged out-of-pocket costs for medical services provided during an episode of hospital treatment (currently only for joint replacement surgery, but it is proposed to apply to other services in the future).

1.20. All references to 'health services' or 'healthcare services' in the application also include any goods that may be provided as part of the provision of such services.

1.21. The Applicants submitted that they are open to the imposition of a condition in relation to the Proposed Conduct described in paragraph 1.18(a). The Applicants submitted that such a condition would require the Applicants to ensure that prior to agreeing to provide contracting services relating to the BCPP to HBF WA, Medibank, Bupa or HCF, it must ensure that the addition of that Participant will not result in HH providing the BCPP services to more than 80 per cent of the national PHI market measured as a share of total hospital policies, based on the latest market share statistics published by APRA.

Conduct voluntary, and no collective boycott

1.22. 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 will be able to opt to purchase some or all of the different categories of contracting services.

1.23. The Applicants have not sought authorisation for the HH Buying Group to engage in the collective boycott of any services of a Provider. This means that the HH Buying Group is not permitted to boycott any Providers that refuse to deal with the group.

The Proposed Conduct will involve four categories of contracting

1.24. The four broad categories of contracting intended to be covered by the HH Buying Group are:

(a) *Hospital contracting* – Hospital purchaser provider agreements (**HPPAs**), where hospitals agree not to charge out-of-pocket costs to customers of healthcare payers (**Customers**), and are used by PHIs to provide financial certainty to their customers

(b) *Medical specialist contracting* – Medical purchaser provider agreements (**MPPAs**), used by health insurers to provide financial certainty to Customers in relation to potential out-of-pocket costs for specialist services (e.g. radiologists, pathologists, surgeons)

(c) *Medical gap schemes* – where health insurers pay a set fee for each type of professional service provided to their Customers in hospital, 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 (e.g. $500), and

(d) *General treatment networks* – arrangements with Providers for services that are not provided in hospital (e.g. physiotherapists, dentists, optometrists) that are covered under the 'extras' component of private health insurance products.

Services provided by HH in each category of contracting

1.25. For the four types of contracting, the Proposed Conduct will involve HH engaging in the activities outlined below.

For hospital and medical specialist contracting – data analytics and contract negotiations

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

1.27. HH intends to negotiate new HPPAs and MPPAs on an ongoing basis on behalf of nib and Participants as the nib-based contracts expire or enter into contracts with new Providers. HH intends to act as the lead agent in the negotiations after consultation with the Participants. This will involve:

- 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
- conducting collective commercial negotiations on behalf of Participants, and
- 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).

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

1.29. 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.

1.30. If a Participant does not wish to enter into an agreement on the negotiated terms, the Applicants submit that Participants can negotiate directly with Providers and enter into agreements independently of the HH Buying Group on their own terms and conditions.

1.31. The Proposed Conduct will not prevent Providers from offering services to other insurers, buying groups or healthcare payers that are not part of the HH Buying Group. Further, it will not restrict the terms and conditions upon which Providers are entitled to enter those agreements. Similarly, Providers will be able to contract with Participants individually or with a different set of Participants to those proposed by the HH Buying Group.

For the medical gap scheme and general treatment networks – management and administration of the schemes

1.32. HH intends to engage with Providers registered in nib's existing medical gap schemes and general treatment network to notify them of the extension of these schemes to Participants.

1.33. 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.

For all categories – contract administration, dispute resolution and ongoing data analytics

1.34. HH intends to provide contract administration and management services, and dispute resolution services to Participants for the contracting services that they have engaged HH to undertake.

1.35. HH will also provide 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. This would include an assessment of the following:

- provider quality
- provider compliance
- benefits paid to the Provider by Participants
- access to the Provider's services, and
- efficiency and value of treatment provided by the Provider.

1.36. Subject to confidentiality and privacy obligations, HH would also share information concerning one Participant with the HH Buying Group to the extent the information is related to agreements facilitated by HH or services provided by HH to the Participants. This could include information such as contract breaches by a Provider, or the discovery of fraudulent claims made by a Provider in relation to an agreement with one Participant, which would therefore be relevant to other Participants who contract with that Provider.

<u>The Proposed Conduct involves 'value-based' contracting</u>

1.37. The Proposed Conduct involves a value-based contracting model, which HH describes as comparing health outcomes with the costs of providing services to determine the value of the service from the healthcare payer's perspective.

1.38. Under this model, HH would initially compare the value of services from a particular Provider against peers in the local region, State or Territory and 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.

1.39. Information sharing and data analytics between members of the HH Buying Group will provide the necessary information to assess the performance of Providers and benchmark their performance for each Participant against the aggregated data for the HH Buying Group.

1.40. The Applicants state the BCPP, which provides a no gap experience to consumers for the suite of services involved in knee and hip replacements with certain medical specialists, is an example of value-based contracting.

1.41. The Applicants submit that current approaches to contracting generally focus on cost of care of the services and most funds, and existing buying groups (the Australian Health Services Alliance (**AHSA**) and the Australian Regional Health Group (**ARHG**)) have historically focused on cost of care to determine payment structure and price of services.

1.42. Value based contracting will be discussed further in the context of the Applicants submissions that making value-based contracting available to buying group members will result in better health outcomes at a lower cost and is therefore a public benefit.

2. Background

2.1. There are currently 36 PHIs in Australia, with the four largest health insurers (excluding nib) accounting for approximately 70 per cent of health insurance policies nationally. The four largest health insurers manage their contracting services internally. The remaining PHIs engage in collective bargaining through one of the two existing buying groups - 27 health insurers are part of AHSA and four health insurers are part of ARHG. nib was previously a member of AHSA and withdrew in 2011 when it built its own internal contracting function.

2.2. Healthcare payers pay benefits to Providers for health services (provided to individuals) 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 (e.g. 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').

2.3. Under some agreements between health insurers and Providers, Providers agree not to charge a ‘gap’ to the customer and the health insurer agrees to pay more in benefits to the Provider. This arrangement creates a network of Providers that healthcare payers can promote as being health services where their customers can potentially receive a no gap experience. Providers therefore receive higher benefits from healthcare payers for providing a little to no gap experience to customers of that healthcare payer.

2.4. Other than PHIs, Other Healthcare Payers usually provide payment to Providers according to the terms of the insurance policy or liability scheme. These Other Healthcare Payers usually pay the fee in full, therefore there is less likely to be ‘gap’ exposure for customers. Accordingly, the Applicants’ view is that it is less likely that these Other Healthcare Payers will negotiate contract arrangements with Providers.

3. Consultation

Submissions prior to the draft determination

3.1. The ACCC invited submissions from a wide range of interested parties including hospitals, specialists, peak medical bodies and associations, PHIs, the existing buying groups, and relevant Government departments and regulators.

3.2. The ACCC received submissions from 24 interested parties in response to the Proposed Conduct as originally described, 21 of which opposed the application for authorisation.

3.3. Private Healthcare Australia (**PHA**) supported the application, noting the voluntary nature of the buying group and that each organisation has control of whether to enter into contracts negotiated by the buying group.

3.4. Mater Health supported the application provided it does not involve collective boycotts, all funds should maintain the capability to negotiate with a provider outside of the HH Buying Group arrangement, any information sharing with any overseas parties be avoided and any authorisation only be granted for a three year period.

3.5. The Department of Veterans Affairs provided information about its purchases of health services, but did not express a view on whether the Proposed Conduct should be authorised.

3.6. The 21 interested parties opposing the application included:

- 16 peak bodies for different areas of medical practice (e.g. orthopaedics, dentistry, anaesthesiology)[3]
- two operators of hospitals[4]
- Members Health Fund Alliance (a peak body for 26 health funds)
- Australian Health Service Alliance (one of the two existing buying groups), and
- one individual with expertise in the field of private health insurance in Australia.

3.7. Interested parties raised concerns with a wide range of issues including the structure of the HH Buying Group, market power of the HH Buying Group, the claimed public benefits from the Proposed Conduct, information sharing under the Proposed Conduct; and the length of authorisation sought.

3.8. One issue raised by multiple interested parties was the involvement of Cigna Corporation in the Proposed Conduct as a 50 per cent owner of HH. Several interested parties noted criticisms of and lawsuits against Cigna in the US, relating to issues of rejected health insurance claims and refusals to treat patients with critical conditions. The Applicants submit these issues are not relevant to determining whether the Proposed Conduct will generate public benefits.

Submissions following the draft determination

3.9. The ACCC received around 350 submissions in response to the draft determination; 27 of these were from bodies representing specialists likely to be affected by the Proposed Conduct. A large number of submissions were from individual doctors in a similar format and raising similar issues. The vast majority of interested parties continue to strongly oppose the application for authorisation.

3.10. The key issues raised by interested parties are outlined below. A more detailed summary of submissions is at Annexure A and all public submissions are available on the public register for this matter.

Introduction of US-style managed care in Australia

3.11. Many interested parties have raised concerns that the Proposed Conduct will result in a change to the current Australian healthcare system to a US-style managed care

[3] Australia Acupuncture & Chinese Medicine Association, Australia Orthopaedic Association, Australia Private Hospitals Association, Australian Dental Association, Australian Medical Association, Australian Society of Anaesthetists, Australian Society of Ophthalmologists, Catholic Health Australia, Council of Procedural Specialists, Day Hospitals Australia, Medical Surgical Assistants Society of Australia, Occupational Therapy Australia, Optometry Australia, Private Healthcare Australia Limited, Rehabilitation Medicine Society of Australia and New Zealand, Royal Australian College of Surgeons, Spine Society Australia.

[4] Adventist Health Care Limited and Healthscope.

model. Interested parties submitted that managed care will be introduced under the guise of 'value-based contracting', which interested parties claim is akin to managed care.

3.12. Interested parties submitted concerns about the involvement of Cigna in the HH Buying Group, noting Cigna's involvement in managed care in the US and that as a company with multi-billion dollar turnover, it dwarfs any Australian PHI.

3.13. Interested parties submitted that a shift to managed care will lead to detriments for consumers including reduced patient choice of healthcare provider, reducing the quality of care provided to patients (because of a reduction of payment for services provided by hospitals and medical practitioners). This detriment will disproportionately affect vulnerable consumers such as the chronically ill, elderly and low-income consumers and consumers with complex illnesses. Interested parties submitted the Proposed Conduct will also affect remote/rural consumers, who already have less choice of health services and this is likely to get worse under the Proposed Conduct.

3.14. Interested parties submitted that the Proposed Conduct will have a significant detrimental impact on some healthcare Providers particularly hospitals and medical practitioners. Healthcare Providers are concerned that the Proposed Conduct will result in:

- The addition of an unnecessary entity that will interfere in medical decisions to such an extent that medical practitioners will be unable to act independently.
- Data obtained by HH Buying Group participants will be misinterpreted due to a lack of clinical training and data linked to hospital re-admission may be incorrectly interpreted to be due to poor care by hospitals and/or medical practitioners
- PHIs will alter existing no gap/known gap treatment arrangements to coerce practitioners into arrangements on a take it or leave it basis and Providers that do not join the buying group will be removed from or be allocated less attractive slots on hospital operating lists. which Providers submitted are an effective boycott.
- An increase in administration workload and therefore costs for healthcare Providers, many of which are small medical practices; doctors will have to negotiate as many payment schedules as there are health insurers even with the introduction of the HH Buying Group. The present situation where a doctor sets their own fee, using a tool such the AMA schedule of fees, is both simpler to administer and more transparent than entering into a MPPA.
- increased stress and pressure on doctors whose practices have already been impacted by COVID-19 and who fear loss of patient flow if they do not sign contracts; medical practitioner anxiety will increase as they become conflicted over concerns about health fund directives and their financial viability, and patient anxiety.

3.15. The Applicants reject interested party submissions that the Proposed Conduct will result in a fundamental change to the underlying framework of the Australian healthcare system by introducing US-style managed care in Australia. The Applicants submitted that interested parties have not articulated the causal link between the creation of a buying group for healthcare services and the introduction of managed care, nor have they provided any reasonable or rational basis to support this claim.

3.16. The Applicants submitted that interested parties' managed care concerns are focused on criticising the current and emerging aspects of the health system that are contrary to their personal interests, rather than being focused on the impact of the HH Buying Group to the public (e.g. value-based contracting including no gap programs which benefit consumers). These features of the current healthcare system will continue to exist and will progress with or without the HH Buying Group.

3.17. The Applicants submitted that insurers having preferred provider networks that influence consumers' selection of their healthcare provider is not managed care.

Preferred provider networks that result in reduced or no gap payments have existed for decades.

3.18. The Applicants also submitted that the use of value-based contracting or any funding model that is linked to performance is not managed care.

3.19. The Applicants submitted that the Proposed Conduct does not remove patient choice and does not interfere with clinical autonomy; the current legal and regulatory controls will continue to prevent this from occurring. Further, the Applicants submitted that the ACCC is not being asked to authorise value-based care; it is already lawful and consistent with Australian and international trends.

3.20. Regarding submissions that the Proposed Conduct will result in a reduction in patient choice and discrimination against particular patients, the Applicants submitted that consumers would retain the ability to choose their medical specialist, private hospital or other Providers and there will be more transparency about the cost and quality of care. It would be unlawful for insurers to amend their health insurance policies to restrict cover to services provided by particular Providers and refused to pay any benefits for other Providers. It would also be unlawful for insurers to discriminate against policyholders.

3.21. The Applicants submitted that all value-based contracts with Providers remain governed by the *Private Health Insurance Act 2007* (Cth) (PHI Act) which ensures that the insurer cannot become involved in the nature of the treatment provided or influence the clinical freedom of the medical provider.

3.22. The Applicants submitted that without the HH Buying Group, the Major PHIs (including nib) will continue to progress with these developments while the smaller funds may be left behind if their current buying groups are not able to keep up.

Lack of regulatory oversight

3.23. Interested parties submit there is a lack of regulatory oversight and this provides sufficient reason for the ACCC to deny authorisation until the responsible health regulators and/or the Government have considered the impact of such a significant change to the Australian healthcare system. Interested parties are concerned that there does not appear to have been sufficient input from the Health Minister or Department of Health on whether the proposal is in the public interest. One interested party submitted that there is now an urgent need for the Federal Government and Commonwealth legislation to 'get ahead' of the introduction of managed care with the creation of an independent private health insurance regulator.

The impact on Medicare

3.24. Interested parties submit that the US-style managed care model erodes confidence in private healthcare and patients dissatisfied with patient care under the managed care model, including reduced patient choice, will turn to the increasingly over-burdened public health system.

Size and composition of the HH Buying Group

3.25. Submissions opposed to the Application raised concerns about the potential market power of the HH Buying Group.

3.26. Prior to the draft determination, the Applicants responded to these concerns by amending their original application so that Major PHIs would not be able to participate in the HH Buying Group in relation to hospital contracting, medical gap schemes and general treatment networks. However, the Applicants proposed that Major PHIs would still be able to participate in medical specialist contracting through the BCPP with a condition that the HH Buying Group not exceed 80 per cent market share in any State or Territory. In its draft determination, the ACCC proposed that this limit be 40 per cent.

3.27. Several interested parties submitted that a cap at 40 per cent was too high and submitted that a cap at 20 or 30 per cent would be required to limit public detriment.

3.28. Interested parties remain concerned that the amended application did not make any changes to the composition of the HH Buying Group in relation to hospital contracting, medical gap schemes and general treatment networks. Interested parties argue that, on any measure, the achievement of the expected level of market penetration would provide the HH Buying Group with substantial market power that would ordinarily be seen as detrimental to competition and would also empower the HH Buying Group to pursue the managed care agenda that stakeholders are concerned about.

Detriments arising for Healthcare Payers

3.29. The AMA submitted that nib stand to benefit from the increased purchasing power the proposed HH buying group might bring, but it may also be the beneficiary of the market disruption that will result from the establishment of the HH buying group, including the potential exit of smaller funds.

3.30. The Council of Procedural Specialists submitted that (at least some) members of other buying groups will join the nib/Honeysuckle buying group, and that the strength of competition from existing buying groups will be diminished.

3.31. Day Hospitals Australia submitted that the viability of the smaller funds would be under more pressure with this arrangement and likely result in their amalgamation with larger insurers or they would be forced out of business. The smaller funds may see amalgamation as the only way that they can survive as they are more vulnerable to cost pressures than the larger insurers. This would not only be a negative situation for these insurers but could then in turn impact their policy holders.

Pre-decision conference

3.32. A pre-decision conference was held on 8 July 2021 via Microsoft Teams after being requested by:

- Australian Society of Ophthalmologists
- Council of Presidents of Medical Colleges
- Council of Procedural Specialists, and
- Royal Australian & New Zealand College of Psychiatrists.

3.33. There were approximately 100 attendees from 44 organisations present at the pre-decision conference. The interested parties attending raised similar issues and concerns to those raised in the written submissions. These were broadly as follows:

- The introduction of US-style managed care in Australia is a likely consequence of the authorisation. Cigna is an American managed care company. Value-based contracting, which is what the HH Buying Group seeks to utilise, is another form of managed care due to its incentivising nature. Section 172-5 of the Private Health Insurance Act appears to deem managed care illegal in Australia. However, there are doubts about this provision's effectiveness.
- The lacking legislation in place to control the behaviour of the HH Buying Group, and the minimal involvement of the Health Minister or the Department of health on the authorisation and in determining whether the stated public benefits exist.
- The number of healthcare insurers contracting through a buying group may cause asymmetry in negotiating power, thus reducing the ability of individual Providers to continue to operate and provide care for patients.
- The likelihood of a gatekeeping bureaucracy resulting from the HH Buying Group, which may lead to the collective boycotting of some Providers. This is already happening in the dental industry, where some insurers boycott Providers, and

remove the rebates of any of their patients, when Providers do not sign contracts with the insurers.

- The benefits of authorisation are speculative and the ACCC has not assessed the significant detriments likely to arise from the introduction of managed care.
- Patients may pay lower out of pocket costs, but will instead pay higher premiums. They may also experience a reduction in choice of their provider and/or medical treatment due to preferred provider arrangements.
- As care will be based on value as opposed to patients' needs, and some treatments will need to be authorised by Providers, efficacy will be reduced overall and patient care generally will worsen. This will particularly impact the most vulnerable patients, such as those in marginalised groups or those suffering from severe mental health conditions

3.34. In summary, representatives for HH and nib submitted in response that:

- The HH Buying Group will deal with HPPAs and MPPAs. HH is undertaking this function for nib now and it seeks authorisation to perform the same function for other healthcare payers.
- HH manages a small number of MPPAs for nib, and the BCPP is the first value-based contracting initiative. It is a small-scale network of surgeons performing hip and knee replacements for nib members. Doctors do not charge out of pocket costs for nib members.
- Interested parties are opposed to value-based contracting, not to HH collective bargaining. The ACCC should consider that a public benefit of the HH Buying Group is effectively driving value-based contracting due to the group's scale. Value-based contracting is the future. It links the funding of healthcare to the quality of patient outcomes.
- HH has no intention of interfering between doctors and patients, nor does nib. nib is providing both doctors and patients with more evidence to help them make better decisions, and trying to remedy information asymmetry and improve transparencies around outcomes.
- The application does not propose to authorise treatment or overrule clinical decisions, as is the case in a managed care scenario. Many other OECD countries are using data-driven care to enhance their healthcare systems, which is what HH and nib are striving towards with the Proposed Conduct.

3.35. The ACCC received 13 submissions following the pre-decision conference, which are summarised at Annexure B. These submissions are available on the public register for this matter, along with a record of the pre-decision conference.

4. ACCC assessment

4.1. The Applicants have sought authorisation in relation to conduct that may constitute a cartel provision within the meaning of Division 1 of Part IV, and may substantially lessen competition within the meaning of sections 45 and s 47 of the Act.[5] Consistent with subsection 90(7) and 90(8) of the Act, the ACCC must not grant authorisation unless it is satisfied, in all the circumstances, that the conduct would result or be likely to result in a benefit to the public, and the benefit would outweigh the detriment to the public that would be likely to result (**authorisation test**).

[5] The Applicants' original application sought authorisation in relation to s 46 of the Act. In a 29 January 2021 letter, the Applicants requested that the paragraph referring to s 46 not be considered as part of the application.

Relevant areas of competition

4.2. To assess the likely effect of the Proposed Conduct, the ACCC identifies the relevant areas of competition likely to be impacted.

4.3. The Applicants submit the relevant markets are:

- a national market for private health insurance
- a national market for international medical and travel insurance
- State-based or localised markets for hospital services
- localised markets for medical specialists for each speciality practice, and
- localised markets for each type of allied health service.

4.4. The Applicants note that nib and Participants in the HH Buying Group who are PHIs compete with each other as purchasers of health services in the last three sets of markets listed above and as suppliers of private health insurance.

4.5. A number of interested parties are concerned that the Proposed Conduct would specifically affect rural and remote communities that only have access to a small number of healthcare facilities. Others submit that the Proposed Conduct will have a more adverse effect for smaller Providers, specifically allied health professionals who operate localised businesses.

4.6. The ACCC considers the relevant areas of competition are likely to include:

- the acquisition of hospital services on a State-based or localised basis
- the acquisition of medical specialist services for each specialty practice on a localised basis
- the acquisition of each type of allied health service on a localised basis
- the supply of private health insurance on a national basis, and
- the supply of international medical and travel insurance on a national basis.

4.7. The ACCC also notes that HH proposes to offer its services (primarily to the non-Major PHIs) in competition with the two existing buying groups, AHSA and ARHG (as well as insurers' own internal contracting capabilities). Accordingly, the ACCC considers that the supply of buying group services to PHIs on a national basis is also a relevant area of competition.

4.8. As noted at paragraph 1.19, all references to 'health services' or 'healthcare services' in the application also include any goods that may be provided as part of the provision of such services (e.g. prostheses or drugs provided during a hospital treatment). Given the limited circumstances in which goods will be part of the Proposed Conduct, the ACCC does not propose to analyse any area(s) of competition for these goods.

Likely future with and without the Proposed Conduct

4.9. In applying the authorisation test, the ACCC compares the likely future with the Proposed Conduct to the likely future in which the Proposed Conduct does not occur.

4.10. In the future with the Proposed Conduct, it is likely that:

- the HH Buying Group would become a new option for health insurers in Australia who prefer to be part of a buying group and/or seek contracting services
- the HH Buying Group will achieve sufficient critical mass (in terms of healthcare payers' participation) to be viable, noting nib's approximately 10 per cent share of national private health insurance policies. However, it is unlikely that insurers will be able to join the HH Buying Group while retaining services from either of the other buying groups, AHSA or ARHG. This is because, as a matter of commercial

reality, participants would not be able to split their contracting services across multiple buying groups in an efficient manner. To achieve the best outcomes from a buying group, it is likely a participant would have to decide on wholly joining one and leaving the other.

- at least some current members of AHSA and possibly some current members of ARHG will join the HH buying Group.

4.11. Without the Proposed Conduct, it is likely that:

- nib will continue to use the contracting services offered by HH and HH may attempt to contract with other healthcare payers individually
- Medibank, Bupa, HCF and HBF WA will continue to undertake contracting services as an internal function[6]
- AHSA will continue to act as a buying group on behalf of 27 (of the 36) health insurers in Australia[7]
- ARHG will continue to act as a buying group on behalf of four health insurers in Australia[8], and
- Providers will continue to negotiate with Medibank, Bupa, HCF and HBF WA and existing buying groups separately.

Public benefits

4.12. The Act does not define what constitutes a public benefit. The ACCC adopts a broad approach. This is consistent with the Australian Competition Tribunal (the **Tribunal**) which has stated that the term should be given its widest possible meaning, and includes:

…anything of value to the community generally, any contribution to the aims pursued by society including as one of its principal elements … the achievement of the economic goals of efficiency and progress. [9]

4.13. The Applicants submitted the Proposed Conduct will result in public benefits including transaction cost savings and increased efficiencies, greater choice of buying group, better health outcomes at lower cost, access to data analytics and information, no gap experience for customers, countervailing hospital bargaining power, reduced healthcare costs and premiums for members, and benefits for Other Healthcare Payers.

4.14. The ACCC has assessed the claimed benefits in the following categories:

- greater choice of buying group and increased competition between them
- improvements in information
- reduced healthcare costs/better services for consumers
- increased no gap experience for customers
- transaction cost savings
- increased input into contracts, and
- better health outcomes at a lower cost as a result of value-based contracting.

---

6 HH's understanding is that HBF contracts directly with hospitals in WA and indirectly through the AHSA for all other states.

7 nib was previously a members of AHSA and withdrew in 2011 when it built its own internal contracting function.

8 Mildura Heath Fund, St Lukes Health, Latrobe Health Services, Hunter Health Insurance.

9 Queensland Co-operative Milling Association Ltd (1976) ATPR 40-012 at 17,242; cited with approval in Re 7-Eleven Stores (1994) ATPR 41-357 at 42,677.

Greater choice of buying groups and increased competition between them

4.15. The Applicants consider that the HH Buying Group would provide health insurers with an alternative buying group to AHSA and therefore provide greater choice. HH believes that ARHG is not a suitable alternative to AHSA due to their lack of scale.

4.16. AHSA notes that HH will need to gain members from AHSA in order to achieve sufficient scale. In this context, AHSA submitted that it is more accurate to describe the claimed benefit of greater choice of buying group as a transfer of the services creating scale efficiencies. AHSA adds that splitting buying groups into three would only dilute the existing public benefits that are achieved through scale efficiencies.

4.17. 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, they submit that the HH Buying Group would provide an alternative and unique opportunity for funds that are currently part of an existing buying group, such that there will not be an overall dilution of benefits.

4.18. The Applicants add that in the long term, the Proposed Conduct will increase competition in the market for buying group services and is likely to drive greater innovation and efficiencies from existing buying groups in response to competition from the HH Buying Group.

4.19. The ACCC considers that the Proposed Conduct is likely to result in a public benefit by introducing a competing buying group offering a differentiated model of contracting and funding. Increased competition between buying groups is likely to foster greater innovation and incentivise the buying groups to compete to provide better value to their member PHIs and this is likely to result in better services for PHI policyholders. The implications of the proposed data analytics services are addressed below under 'Improvements in Information'.

4.20. The ACCC notes that participation in the HH Buying Group is voluntary and non-exclusive such that Participants and Providers will have the option to trial the HH Buying Group's contracting model, while retaining the option to return to the traditional contracting arrangements with Participants if they do not see the benefit in the alternative offering.

Improved access to information for smaller PHIs

4.21. The Applicants submitted the Proposed Conduct will provide Participants, who are likely to be smaller health insurers, with access to data analytics tools and technology, which are currently available to larger health insurers.

4.22. Further, the Applicants state that providing smaller PHIs access to the necessary analytics and data through the Proposed Conduct will assist in reducing information asymmetry for those PHIs and allow them to gain insights from information collected across all Participants, which are typically only available to larger PHIs who have the funds and technology to utilise the relevant data.

4.23. HH also submitted that increased access to data analytics and information sharing would assist in developing efficient networks of medical specialists and extras Providers across a range of speciality groups and geographic networks. HH believes that consumers will be better-informed and more empowered to make choices about their healthcare through Participants having better access to information and data.

4.24. AHSA submitted that health insurers who are part of their buying group already have access to data analytics services; therefore, the claimed benefits already exist in the market and the Proposed Conduct would not reduce information asymmetries for HH Buying Group Participants who are current members of AHSA or ARHG.

4.25. The ACCC's general view is that in situations where some parties to negotiations are likely to be poorly informed about market conditions or the preferences of other parties, they may accept (or offer) inferior terms and conditions than they would if

they had more information. Collective bargaining may improve the amount and quality of relevant information available to the less informed parties and enable more efficient terms and conditions to be agreed.

4.26. The ACCC notes AHSA's submission that this claimed benefit is already available in the market through AHSA's existing buying group.

4.27. However, the ACCC also notes the Applicants' submissions that HH is a health data science company with significant capability in data science, analytics and forecasting, and the HH Buying Group will have access to sophisticated data analytics, which the Applicants consider are superior to existing offerings. The Applicants state that HH's data analytics undertaken as part of its Contracting Services will use claims and Hospital Casemix Protocol data of all Participants.

4.28. The ACCC accepts that the HH Buying Group is likely to provide Participants with improved access to information through the option to utilise a particular type of data analytics, based on aggregated data of all members of the buying group, which would not be available in the likely future without the Proposed Conduct. As such, the ACCC considers that the Proposed Conduct is likely to result in a public benefit in the form of improved access to information for smaller PHIs and this is likely to result in better services for policyholders.

Reduced healthcare costs/better services for consumers

4.29. The Applicants submitted that the various claimed public benefits have the combined effect of increasing the value of the benefits paid by healthcare payers for health services and reducing healthcare costs for healthcare payers, particularly for smaller health insurers who likely have limited access to capital. The Applicants submitted that the Proposed Conduct would ease current pressures on health insurers to deal with escalating healthcare costs and inflation, as well as regulatory compliance costs.

4.30. The Applicants submitted that reduced healthcare costs will further reduce pressure for Participants to increase premiums on their policies, therefore extending benefits to customers through lower premiums and encouraging participation in private health insurance.

4.31. AHSA submitted that members of AHSA funds already benefit from reduced healthcare costs and premiums, including in relation to hospital benefits.

4.32. The Australian Society of Anaesthetists (**ASA**), the Australian Private Hospitals Association (**APHA**), Adventist Health Care Limited (**AHCL**) and AHSA submitted there is no evidence that any reduced transaction or administrative costs will reduce premiums or result in better health outcomes. ASA adds that any benefit would be business benefits to the Applicants and that any cost savings would not be passed on to consumers.

4.33. Healthscope and Catholic Health Australia raise concerns that reducing the price of healthcare services could cause reduced funding for investment by Providers in the elements of healthcare separate to medical services (e.g. equipment, maintenance of facilities and innovation). It is not clear to the ACCC this is a likely outcome of the Proposed Conduct.

4.34. The ACCC considers that any public benefits in the form of reduced healthcare costs/better services for consumers are already captured. As outlined above, the ACCC considers the main public benefits likely to result from the Proposed Conduct are a greater choice of buying group for healthcare payers and increased competition between buying groups, and improved access to information for smaller PHIs. The ACCC considers the combination of these outcomes are likely to provide incentives for the Applicants to create benefits for their payer members and for competition between PHIs to provide incentives for them to, in turn, pass on part of the benefits to their customers in the form of lower premiums (or lower increases in premiums) and/or better services to members

Increased availability of no gap experience for customers

4.35. The Applicants submitted that uncertainty about the size of gap payments that consumers face in private healthcare is a major concern for Customers in Australia.

4.36. The Applicants submitted that nib developed its Clinical Partners program, which provides a no gap experience to consumers for knee and hip replacements, in response to this concern. Under the program, nib has entered into MPPAs with orthopaedic surgeons, anaesthetists and assistant surgeons where these 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 to under nib's medical gap scheme and agree to 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.

4.37. Under the Proposed Conduct, the Applicants propose to broaden access to the BCPP by negotiating with the medical specialists participating in the program to add customers of new Participants of the HH Buying Group to the program.[10]

4.38. The Applicants submitted the broadening of access to the BCPP will provide HH with a larger customer base which will ultimately facilitate the engagement with a broader group of medical specialists so that the program can be expanded to cover additional types of treatment, and more geographical areas.

4.39. AHSA submitted that it already addresses the uncertainty highlighted by the Applicants through its Access Gap Cover scheme, which is currently utilised by over 37,000 medical specialists across a range of services. AHSA claims that there would be no public benefit if any of its current funds began to offer the nib Medigap[11] scheme as it currently stands to their members. Instead, AHSA says that it would actually be detrimental because there are a large number of specialists who do not have agreements in place with nib, and it may be inferred that nib members would receive gap bills for these services.

4.40. AHCL submitted that this claimed public benefit is inconsistent with nib's actual current approach. AHCL believes nib has one of the poorest coverages on no gap arrangements of any fund. AHCL states that it has successfully negotiated with other insurers for medical services including radiology, pathology, ultrasound and obstetrics to be provided at no gap to the consumer. AHCL offered to introduce such initiatives with nib who declined.

4.41. The ASA acknowledges the benefits to Australian consumers of a no gap scheme whereby consumers clearly understand the costs involved with their medical treatment. Under the current system, close to 90per cent of medical services in the private healthcare sector already involve no out-of-pocket expense to patients. A further 4-5 per cent are provided under a 'known gap' arrangement, in which there are specific limitations placed on the level of out-of-pocket expenses. Therefore, the argument that out-of-pocket expenses are a significant issue across the sector is false.

---

[10] The expansion of the BCPP does not require any change to the terms and conditions of the new participants' health insurance policies. Under health insurance policies, members are generally entitled to benefits for in-hospital medical services at 25 per cent of the MBS fee (with the other 75 per cent of the MBS fee payable by Medicare). As medical specialists generally charge above the MBS fee, any further benefits paid by health insurers to cover these amounts are dependent on agreements between the health insurers and medical specialists (either under a medical gap scheme or MPPAs).

[11] nib's no gap scheme where doctors choose on a case by case basis if they will eliminate out of pocket expenses for their fees.

4.42. Notwithstanding the submission by ASA, the ACCC notes that complaints about hospital and medical 'gap's represent a significant proportion of complaints[12] and considers that uncertainty about the extent of gaps that patients face in the private healthcare system is one of the major concerns or causes of dissatisfaction for consumers.

4.43. The ACCC recognises that in order to address this concern, many PHIs make gap cover agreements with certain Providers, such as the arrangements identified by AHSA and AHCL above. The ACCC notes AHSA's views on nib's Medigap scheme and AHCL's previous experience in dealing with nib in relation to no gap arrangements. However, the ACCC also notes that one of the main aims of the Proposed Conduct is expanding HH's BCPP.

4.44. The ACCC accepts that the BCPP delivers benefits to existing nib customers by giving them the certainty of a no gap experience for the suite of services involved in knee and hip replacements with certain medical specialists. To the extent that the program is widened to include new Participants in the HH Buying Group, the ACCC considers this is likely to result in public benefit to consumers by extending an increased no gap experience and certainty of costs to the policyholders of those Participants.

4.45. The ACCC recognises that the magnitude of this public benefit depends on the extent to which the Applicants are able to expand the BCPP, noting that it remains an optional program for medical specialists.

4.46. The ACCC has also considered the risk that Participants in the HH Buying Group subsequently renege on maintaining the type of no gap experience offered under the BCPP. The ACCC has examined nib's template MPPA provided on a confidential basis and considers there is little incentive for nib or another HH Buying Group insurer to decide to opt out of offering the type of no gap experience offered under the BCPP. The ACCC also notes that a patient who believed they were covered for no gap treatment and were left out of pocket could raise a complaint with their insurer or with the Commonwealth Ombudsman.[13]

Transaction cost savings

Private health insurers

4.47. The Applicants submitted that the Proposed Conduct will result in:

- significant transaction and administrative cost savings for Participants. For example, nib alone currently negotiates more than 500 contracts per year and manages over 3,500 agreements, and
- greater efficiencies for Providers through simplified billing processes, consistent funding agreements, and reduced negotiation costs.

4.48. nib states that historically, its health services contracting function costs approximately $5 million per annum to operate, and suggests that any health insurer with national coverage that maintains its own contracting function would likely incur similar costs due to the breadth of the Provider networks.

4.49. The Applicants submitted that these costs are significantly reduced because of the HH Buying Group achieving greater efficiencies and economies of scale. The Applicants propose that the fee for Participants would correlate with transaction costs and any savings will be flow though as reduced fees to Participants.

---

[12] Private Health Insurance Ombudsman, 2020 State of the Health Funds Report, p.9 available: https://www.ombudsman.gov.au/__data/assets/pdf_file/0013/112360/OMB0807-State-of-the-Health-Funds-Report-2020-V4.pdf

[13] In 2015, the functions of the Private Health Ombudsman were merged with the Commonwealth Ombudsman. As a result, the Commonwealth Ombudsman became responsible for protecting the interests of private health insurance consumers, including health fund members, health funds, private hospitals or medical practitioners.

4.50. The ASA, APHA, AHC and AHSA disagree that the Proposed Conduct will result in transaction cost savings and efficiencies.

4.51. APHA submitted that adding another buying group would only lead to increased complexity and costs for hospitals contracting with an increased number of buyers. AHC believes HH would only be able to realise the claimed savings if one of the other buying groups ceased to exist; otherwise, any transaction savings would be limited. Further, AHSA submitted that these claimed benefits already exist through the existing buying groups.

4.52. In principle, the ACCC accepts that there are likely to be transaction cost savings from PHIs collectively negotiating for supply of health services, compared to individual negotiations and that these savings would – through competition between PHIs – likely flow at least in part to consumers. For example, participating health insurers can benefit from reduced negotiation costs while Providers can benefit from simplified back-end billing processes, as insurers would have the same contract, rates and billing rules.

4.53. In this case, however, the ACCC notes that the 31 health insurers who might join the HH Buying Group already participate in one of the two existing buying groups (AHSA or ARHG) and are likely to continue to do so absent the Proposed Conduct. In these circumstances, the ACCC considers that the extent of additional transaction cost savings from the Proposed Conduct, and therefore benefits for consumers, is likely to be limited.

Other Healthcare Payers

4.54. The Applicants submitted that, compared to PHIs, hospital and medical purchasing is on a significantly lower scale for Other Healthcare Payers. The Applicants submitted that Other Healthcare Payers will have the benefit of transaction costs savings as part of the HH Buying Group, as well as the associated benefits of access to data analytics and value-based contracting models.

4.55. The Applicants submitted that schemes such as the Department of Veterans' Affairs hospital cover scheme will be able to pass on greater benefits to veterans or reduce general expenditure when part of the HH Buying Group.

4.56. The Department of Veterans' Affairs did not comment on how government healthcare payers being involved in healthcare buying groups is likely to impact on bargaining processes. However, the Department of Veterans' Affairs noted that if improvements in the health sector lead to fair and reasonable outcomes for purchasers, Providers and consumers of health services, then these outcomes may result in achieving greater efficiencies in fees for the Department.

4.57. AHSA states that it already performs work for a number of other purchasers of private medical services, assisting them in their purchasing and allowing them to be more efficient in their pricing. Examples include the Transport Accident Commission and Worksafe Insurance, who work closely with AHSA on funding model methodologies.

4.58. The ACCC considers that the Proposed Conduct is likely to result in transaction cost savings for Other Healthcare Payers where an individual payer does not already obtain services from a buying group like AHSA.

Increased input into contracts

4.59. The ACCC's general view is that collective bargaining may enable individual members of a group to become more informed and engaged participants in negotiations and improve their input into contracts. This may lead to terms of supply that are more comprehensive and better reflect the circumstances of the group and the target business, resulting in more efficient outcomes.

4.60. In this case, the PHIs that are potential members of the group are currently members of either AHSA and ARHG and are therefore likely to be already receiving some benefits of increased input into contracts.

4.61. The Applicants submitted that the Proposed Conduct will enable the HH Buying Group to improve its bargaining position to countervail the market power of some of the hospital groups, which would lead to more efficient hospital pricing.

4.62. The Applicants submitted that some Providers have much stronger bargaining power in negotiations with healthcare payers, which impedes parties from reaching efficient pricing outcomes for health services. They consider this is particularly the case in the private hospital market where the five largest hospital provider groups account for over 50 per cent of the market. They add that some of the smaller private hospitals can also have a high degree of bargaining power due to their iconic status and reputation or their location in regional and remote communities.

4.63. Healthscope rejects any assertion that its prices are inefficient or exceed competitive levels, and suggests that if private hospitals were able to charge supra-competitive prices, it would be expected that the amounts paid by insurers to hospitals would greatly exceed the costs incurred by hospitals. APHA agrees there is no evidence of 'inefficient' or 'supra normal' hospital pricing.

4.64. APHA notes that the five largest health insurers account for 92 per cent of the market and smaller private hospitals, particularly in regional communities, routinely report they are price takers in negotiations with health funds. Catholic Health Australia agrees that smaller hospitals are typically price takers.

4.65. AHSA submitted that the Applicants' claim that public benefits are generated through countervailing hospital power is based on two incorrect assumptions:

- First, that there are currently insufficient checks on hospital bargaining power. AHSA states it has close to 20 per cent market share for hospital-insured persons, which means it has significant scale across Australia when working with large hospital Providers. This scale has allowed AHSA to achieve efficient pricing outcomes for health services for over 25 years and maintain the competitiveness of the AHSA funds' cost base. AHSA's market share across Australia means that most hospitals, including smaller regional hospitals, work constructively with AHSA.
- Second, that any increase in checks on hospital bargaining power would be a panacea for inefficient pricing. AHSA argues that the Applicants have grossly oversimplified the reasons for why pricing for different procedures, treatments and services varies between hospital groups, and that hospital bargaining power alone is not the sole contributing factor to price differences.

4.66. The ACCC is mindful of interested party submissions in relation to this claimed benefit. In particular, the ACCC notes that Healthscope and APHA reject the premise that their prices are above competitive levels and the ACCC is not in a position to test the veracity of this claim. Further, the ACCC notes that AHSA (as an existing bargaining group) disagrees that having countervailing hospital bargaining power would lead to more efficient hospital pricing and increased output or quality of healthcare services.

4.67. The ACCC notes:

- in the likely future without the Proposed Conduct, PHIs would continue to have the option of being represented by AHSA or ARHG in negotiations with hospitals and nib would likely continue to use HH to negotiate with hospitals
- AHSA's submission that bargaining dynamics in the likely future without the Proposed Conduct are such that AHSA's 20 per cent market share has been sufficient for it to deal with large hospital Providers and achieve efficient pricing

outcomes for health services and maintain the competitiveness of the AHSA funds' cost base, and

- in the likely future with the Proposed Conduct, there is no obligation on hospitals to negotiate with the HH Buying Group (though it may be preferable for them to do so).

4.68. In these circumstances, it is not clear to the ACCC that the Proposed Conduct is likely to increase the bargaining power of Participants in the HH Buying Group or result in more efficient hospital pricing and accordingly considers there is insufficient information for it to conclude that this is likely to be a public benefit.

Better health outcomes at a lower cost through 'value-based' contracting

4.69. HH submitted that health systems that have moved to value-based contracting have seen both improvements in health outcomes and lower costs. Value-based contracting is described in paragraphs 1.37 to 1.42.

4.70. The Applicants stated nib's BCPP, which provides a no gap experience to consumers for the suite of services involved in knee and hip replacements with certain medical specialists, is an example of value-based contracting.

4.71. The Applicants submitted that current approaches to contracting generally focus 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.

4.72. A large number of interested parties raised concerns that authorisation of the Proposed Conduct, which includes value-based contracting, will introduce a US-style managed care model of service in Australia (see paragraphs 3.11 to 3.14). Interested parties submitted that this is a flawed model of healthcare and will be detrimental to doctors and patients. Interested parties submitted that managed care places an unnecessary third party, motivated by profit, between doctors and patients; doctors will be unable to act independently and only doctors that have contracts with managed care companies will be able to see insured patients.

4.73. The Applicants responded to these concerns and a summary of their response is set out above in paragraphs 3.15 to 3.22.

4.74. The ACCC understands there is no specific regulatory oversight or limitation on how parties contract with each other in the medical supply chain, and any such limitation (for example, to prevent value-based contracting) would be a matter for Government, through the Commonwealth Department of Health, to determine.

4.75. The ACCC notes that the Applicants propose to introduce a different model of contracting with Providers but it is not clear how different this is likely to be. Even if the Applicants' model does prove to be significantly different, the ACCC considers it is only likely to be implemented broadly if the Applicants can gain the agreement of Providers and there is also support from consumers for this approach. That is, if 'value-based contracting' leads to reduced practitioner or procedure choice or worse health outcomes, consumers have the ability to move and HH participants will lose members to other insurers. This suggests that any effects on health outcomes and costs are unlikely to be harmful and may be beneficial.

4.76. ACCC conclusion on public benefits

4.77. The ACCC considers the Proposed Conduct is likely to result in the following public benefits:

- a greater choice of buying group for smaller PHIs and increased competition between buying groups, and

- improved access to information for smaller PHIs, through the option to utilise a particular type of data analytics based on aggregated data of all members of the buying group, which would not otherwise be available to those PHIs.

4.78. The ACCC considers these outcomes are in turn likely to mean that smaller PHIs can compete more effectively with the Major PHIs to attract customers by offering reduced costs or better services for the benefit of PHI policyholders.

4.79. The ACCC also considers that the Proposed Conduct is likely to result in some public benefits in the form of an increased no gap experience for PHI policyholders via the BCPP, resulting in benefits for consumers and transaction cost savings for Other Healthcare Payers.

Public detriments

4.80. The Act does not define what constitutes a public detriment. The ACCC adopts a broad approach. This is consistent with the Tribunal which has defined it as:

> *…any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency.*[14]

4.81. The ACCC has considered whether the Proposed Conduct is likely to result in the following public detriments:

- an increase in bargaining power resulting in inefficient outcomes in the provision of health services
- an increase in bargaining power resulting in inefficient outcomes in the supply of private health insurance
- bargaining power of Other Healthcare Payers and
- whether authorisation will introduce US-style managed care into Australia and this would be detrimental to Providers and patients.

An increase in bargaining power resulting in inefficient outcomes in the provision of health services

Bargaining power of the HH Buying Group

4.82. The Applicants submitted the potential public detriments from the Proposed Conduct would be minimal (if any) in the markets for the acquisition of health services and would be outweighed by the public benefits set out above. In particular, they noted:

- The 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 acquisition of health services. The key difference being that nib would be a party to the HH Buying Group.
- 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.

4.83. Interested parties are concerned that the Proposed Conduct will result in a major power imbalance between the HH Buying Group and Providers, with the scope of the Application needing limits on the types of insurers eligible to join the buying group.

4.84. In their initial response to submissions, the Applicants stated it is extremely unlikely that the HH Buying Group would represent 100 per cent of all healthcare payers. Further, even if all PHIs other than the four majors joined the group (which the Applicants also consider very unlikely), the HH Buying Group could potentially

[14] Re 7-Eleven Stores (1994) ATPR 41-357 at 42,683.

represent around 40 to 50 per cent of healthcare payers at a national level. If this is narrowed to representing all PHIs except the four Major PHIs, the potential share of healthcare payers nationally falls to around 20 per cent.

4.85. The Applicants also stated it would be reasonable for the ACCC to impose conditions to address this issue, such as requiring HH to notify the ACCC of new Participants to provide the ACCC with an opportunity to raise any concerns it may have.

4.86. Healthscope submitted that the notification condition suggested by the Applicants would be inappropriate as it would impose a heavy administrative burden on the ACCC and detracts from the ACCC's current task of determining whether the present application would result in a net public benefit.

4.87. The ACCC notes that PHIs and the existing buying groups negotiate with Providers to acquire health services from hospitals, medical specialists, general practitioners and allied health professionals. By joining the HH Buying Group in relation to medical specialist contracting services under the BCPP, PHIs would be conducting their procurement of medical specialist health services jointly rather than individually.

4.88. The ACCC agrees that if the HH Buying Group comprised 100 per cent of PHIs, this would be likely to result in significant public detriment due to the bargaining power of the buying group compared to the bargaining power of healthcare Providers.

4.89. However, it is important to note that outside of nib and the Major PHIs (Medibank, Bupa, HCF and HBF WA), all other PHIs are already engaged in collective procurement of health services through their participation in one of the two existing buying groups (AHSA and ARHG) and are likely to continue to do so absent the Proposed Conduct. This means that in the future without the Proposed Conduct, bargaining for the acquisition of health services (other than for medical specialists' services) is likely to continue to be limited to Medibank, Bupa, HCF, HBF WA, nib, AHSA and ARHG.

4.90. The key change brought about by the Proposed Conduct is to introduce the HH Buying Group as a new entity collectively negotiating on behalf of nib and any other healthcare payers who join the group.

4.91. Following the amendments to the application for authorisation mentioned at paragraphs 1.3 to 1.6, the potential parties in the HH Buying Group will vary with the type of contracting involved. Each type of contracting service is considered below.

Hospital contracting

4.92. The Applicants submitted that the HH Buying Group would potentially have a stronger bargaining position than if nib or each Participant negotiated agreements with private hospitals individually.

4.93. The Applicants provided the following market shares of each PHI and buying group based on hospital policies as disclosed in APRA's *Operations of Private Health Insurers Annual Report 2019*.

Table 1: Private Health Insurers' market shares 2019[15]

Contracting Group	NSW & ACT	VIC	QLD	SA	NT	WA	TAS	National
Medibank	22.60%	31.10%	30.70%	19.30%	40.30%	21.50%	26.00%	25.90%
Bupa	22.90%	23.10%	31.40%	46.70%	35.90%	11.10%	31.40%	24.90%
HCF	20.10%	7.50%	8.00%	9.80%	6.70%	5.60%	5.90%	12.30%
nib	15.20%	8.50%	6.80%	4.30%	3.40%	4.20%	3.10%	9.60%
HBF	0.80%	1.10%	0.70%	0.50%	1.50%	48.70%	0.70%	6.70%
AHSA	17.20%	27.00%	21.50%	19.20%	12.20%	8.90%	10.50%	19.00%
ARHG	1.20%	1.70%	0.90%	0.20%	0.10%	0%	22.40%	1.60%

4.94. The Applicants submitted that the increased market share of the HH Buying Group would allow the Participants to respond to the strong bargaining positions of large hospital groups, such as Ramsay and Healthscope, therefore putting pressure on hospital pricing to fall to competitive and efficient levels.

4.95. Interested parties including Healthscope, Catholic Health Australia, the Australian Private Hospitals Association and Adventist Health Care are concerned that an increase in bargaining power for the HH Buying Group would result in a distortion of hospital funding allocations, favouring lower cost treatments, reducing available resources and disadvantaging smaller private hospitals (particularly those in rural and remote areas).

4.96. As noted at paragraphs 1.3 to 1.6, the Applicants have responded to concerns about the potential bargaining power of the HH Buying Group by amending their application to not seek authorisation for Medibank, Bupa, HCF and HBF WA to acquire contracting services from HH in relation to hospital contracting, medical gap schemes or general treatment networks. This means that, at a maximum, the HH Buying Group for hospital contracting could comprise nib and the other 31 PHIs (and the non-Western Australian business of HBF which is currently managed by AHSA), which would require the HH Buying Group to successfully attract all of the existing members of AHSA and ARHG.

4.97. Based on the information available, the ACCC considers the future with the Proposed Conduct is likely to involve a situation where some PHIs find the package of services and model of contracting offered by HH to be commercially attractive and decide to become Participants in the HH Buying Group. Both HH and AHSA agree that, as a matter of commercial reality, it is difficult to split contracting services across a buying group. Consequently, new Participants in the HH Buying Group are likely to leave either AHSA or ARHG.

4.98. The ACCC considers that, at least in the short to medium term and compared to the likely future without the Proposed Conduct, the creation of a third buying group is likely to mean a less concentrated market structure for the acquisition of health services by PHIs.

4.99. As such, the ACCC considers that the Proposed Conduct is unlikely to result in public detriment due to the bargaining power of the HH Buying Group in the acquisition of hospital contracting services.

[15] APRA's *Operations of private health insurers annual report 2019*.

Medical specialist contracting

4.100. The Applicants submitted that the impact of the HH Buying Group would be minimal in the market for medical specialist services because MPPAs are not critical to medical specialists, but are seen as an optional arrangement. If a medical specialist did not wish to enter into an MPPA with the HH Buying Group, they would still have statutory rights to be paid for their services, including benefits paid by Medicare, the insurers, and any out-of-pocket expenses paid by the Customer. For these reasons, the Applicants submitted that insurers do not have strong bargaining power in MPPA negotiations with medical specialists, despite the difference in size of organisations, because specialists are simply agreeing to cap their fees and forgoing their right to charge out-of-pocket expenses.

4.101. The Spine Society of Australia, Australian Society of Anaesthetists and Council of Procedural Specialists all raised concerns about the potential for HH to apply pressure to force medical specialists to agree to contracts under HH's terms, or face the possibility of being blocked from referral systems developed within the HH Buying Group.

4.102. In response, the Applicants reiterated that the Proposed Conduct does not involve collective boycott activities, nor does it serve to restrict employment of different Providers. Further, the Applicants submitted that consumers will retain the ability to choose their medical specialist, and therefore those specialists who do not reach an MPPA with HH will still be able to treat members of the HH Buying Group's Participants, and will still be paid for their professional services through the combination of benefits paid by Medicare (75 per cent of the Medicare Benefits Schedule fee for the service), benefits paid by the insurer (25 per cent 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).

4.103. Unlike the other contracting services, the Applicants have not expressly excluded the Major PHIs from joining the HH Buying Group in relation to medical specialist contracting. As discussed earlier, the Applicants seek authorisation for HH to provide contracting services that relate to HH's BCPP to Medibank, Bupa, HCF and HBF in relation to its contractual arrangements with healthcare Providers in Western Australia

4.104. This means that the HH Buying Group could comprise all PHIs as well as other Healthcare Payers in relation to the BCPP.

4.105. The Applicants submitted that even if the HH Buying Group includes the Major PHIs in the BCPP, this is not likely to result in public detriment because:

- the BCPP is an optional program for medical specialists and therefore, the onus is on HH to persuade medical specialists of the benefits to them of participating in the program
- HH will not have the ability to drive down benefits payable to medical specialists as this would lead to less engagement by specialists in the program. HH must pay a higher level of benefits than under medical gap schemes to compensate specialists for agreeing to a higher standard of quality of services (among other terms and conditions of the MPPA)
- the expansion of the BCPP to Customers of major health insurers will increase the extent of public benefits that can be realised through the HH Buying Group, and
- in addition to broadening this no gap, high quality experience for a larger group of Customers, the BCPP places downward pressure on non-participating surgeons to reduce their out-of-pocket costs in order to compete effectively with surgeons participating in the BCPP.

4.106. Notwithstanding these submissions, the Applicants acknowledged ongoing concerns about the HH Buying Group comprising 100 per cent of PHIs in relation to the provision of medical specialist contracting services.

4.107. In light of this, on 8 April 2021, the Applicants stated they were prepared to place limits on the contracting services offered by the HH Buying Group so that the contracting services that would apply to 100 per cent of PHIs would only relate to the BCPP under which Customers would receive a no gap experience for the whole episode of care for a surgical procedure. The BCPP has already been established, is operational for hip and knee replacements and the Applicants intend to broaden access to the program and make it available to Customers of any interested Participants in the HH Buying Group.

4.108. On 6 May 2021, the Applicants amended their application, so that the HH Buying Group would only be allowed to represent a maximum of 80 per cent of the national private health insurance market (based on the number of hospital policies) in relation to the BCPP.

4.109. Based on discussions with medical specialists through the existing BCPP, the Applicants consider that 20 per cent market share is the minimum level that would make it viable for medical specialists to operate multiple models of funding and medical care based on individual funds. The Applicants consider that once 80 per cent market share is reached, the benefits to medical specialists would no longer increase at the same rate if the market share increased beyond 80 per cent.

4.110. Based on the information available, the ACCC considers that the future with the Proposed Conduct (as set out in the revised application for authorisation dated 6 May 2021) is likely to involve a situation where a number of PHIs, including some of the Major PHIs, join the BCPP.

4.111. Compared to the likely future without the Proposed Conduct where Major PHIs individually engage with medical specialists, the ACCC considers that an implementation of the BCPP that includes Major PHIs is likely to result in public detriment by increasing insurers' bargaining power to such an extent that it leads to inefficient outcomes in the provision of health services by medical specialists.

4.112. The ACCC considers there are two ways in which permitting Major PHIs to participate in the HH buying group for the purposes of the BCPP could reduce efficiency, and therefore result in public detriment, in the provision of health services by medical specialists:

- First, medical specialists would face fewer alternative healthcare payers with whom to negotiate payments than they would absent the Proposed Conduct. As a result, the Applicants will likely have the ability to secure the agreement of medical specialists to participate in the BCPP for a lower payment premium over existing gap scheme payments than absent the Proposed Conduct. This could raise the likelihood of the operation of the BCPP resulting in an inefficient under-provision of medical specialist services.
- Second, the ACCC is mindful that if HH attracted a large enough group of specialists to participate in the BCPP, then HH buying group insurers (including nib) might have incentives to abolish or reduce the generosity of their no and known gap scheme payments. This is because if insurers reduced their gap scheme payments, specialists will be constrained from raising out-of-pocket fees to customers because customers will have access to a large pool of other specialists who are committed to a no gap experience for customers. Those specialists who are not members of the BCPP and are unwilling to join it may raise their gap fees, but perform fewer procedures. Reduced insurer gap scheme payments could thereby result in a contraction in the supply of medical specialists' services, which would likely be a public detriment.

Condition of authorisation

4.113. The ACCC considers that a BCPP that includes some or all of the Major PHIs is likely to result in public detriment by increasing bargaining power of the HH Buying Group regarding the BCPP to such an extent that it results in inefficient outcomes in the acquisition of health services from medical practitioners.

4.114. The ACCC accepts the extent of this likely public detriment is mitigated to a degree by the fact that the Proposed Conduct is voluntary for Participants and does not allow the HH Buying Group to collectively boycott the services of any Provider.

4.115. However, in order to ensure that the likely public detriment does not outweigh the likely public benefits of the Proposed Conduct, the ACCC has decided to impose the condition of authorisation set out at paragraph 5.11.

4.116. In the draft determination, the ACCC proposed to impose a condition that HH must not provide the BCPP services to Major PHIs where this would result in the participants in the program representing more than 40 per cent of private health insurance policies in any State or Territory.

4.117. The Applicants submitted that a 40 per cent cap is too low, as it would likely prevent HH from including any of the Major PHIs in the BCPP on a national basis. The Applicants submitted that a 60 per cent cap is more appropriate.

4.118. Several interested parties submitted that a cap at 40 per cent was too high and submitted that a cap at 20 or 30 per cent would be required to limit public detriment.

4.119. Following the draft determination and pre-decision conference, the ACCC invited the Applicants to provide any further submissions on a condition of authorisation that the Major PHIs must not participate in the buying group. On 27 August 2021, the Applicants submitted that allowing one Major PHI to participate in the BCPP will:

- result in more consumers having access to the benefits of the Program
- will reduce transaction costs for the Major PHI that decides to join the Program
- not result in an imbalance of bargaining power with medical specialists.

4.120. The ACCC considers that a condition to limit the bargaining power of the HH Buying Group in respect of the BCPP is necessary to ensure that the authorisation test is met.

4.121. The ACCC considers the most appropriate condition is to exclude the Major PHIs from authorisation in relation to the BCPP, rather than imposing a cap based on the proportion of policy numbers. The Major PHIs are capable of implementing their own programs that provide a no gap experience for policyholders and the ACCC notes that HCF already done so in relation to obstetrics and joint replacement. This condition is likely to promote further competition between PHIs for policyholders. The smaller insurers would be unlikely to have the size and scale to do this on their own, and therefore may be attracted to joining the HH Buying Group.

4.122. The ACCC notes that excluding the Major PHIs from participating in the BCPP reduces the magnitude of likely public detriment that may result from the Proposed Conduct. Small PHIs would be free to join the HH Buying Group and participate in the BCPP and in doing so they would be shifting from one buying group to another.

Medical gap schemes and general treatment networks

4.123. The Applicants submitted that the Proposed Conduct will have minimal, if any, impact on medical gap schemes and general treatment networks because the HH Buying Group would not be negotiating agreements with Providers. Instead, and because of the large number of individual health Providers in the industry (around 50,000), HH will be managing schemes based on a standard schedule of rates and terms and conditions.

4.124. 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.

4.125. The only agreements negotiated in this area relate to the operation of an insurer's branded optical or dental centre, 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.

4.126. The ACCC notes the Proposed Conduct does not include the Applicants providing any contracting services to Major PHIs in relation to medical gap schemes and general treatment works.

4.127. The ACCC also notes that the HH Buying Group will not be facilitating any collective negotiation between PHIs and Providers in this area.

4.128. Accordingly, the ACCC considers that the Proposed Conduct is not likely to result in any public detriment by increasing bargaining power in the acquisition of health services in relation to medical gap schemes and general treatment networks.

Reduced competition in the supply of private health insurance

4.129. The Applicants submitted 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. Accordingly, 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.

4.130. The Applicants added that 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.

4.131. The ACCC has considered whether the Proposed Conduct is likely to reduce competition in the supply of private health insurance to consumers through:

- nib's 50 per cent stake in HH,
- information sharing under the Proposed Conduct, and/or
- reduced incentives for PHIs to innovate.

nib's ownership interest in HH

4.132. Interested parties are concerned that the Proposed Conduct will allow nib, through its ownership interest in HH, to have direct knowledge of the commercially sensitive contracting and strategic information of all of its competitors who join the HH Buying Group.

4.133. More specifically, AHSA submitted:

- nib's 50 per cent interest in HH means HH will in fact be competing with its own customers in the markets for the supply of private health insurance and the acquisition of healthcare buying services.
- HH and nib share a managing director and board members which raises a conflict of duty and the possibility that HH could preference nib's interests over other Participants of the HH Buying Group when it negotiates agreements with Providers. For example, nib has a younger membership based than most other healthcare funds, and is therefore exposed to different risks for the type and volume of hospital episodes under contract. Therefore, AHSA suggests that a contract structure which favours nib could disadvantage other HH Buying Group

Participants, who have different customer demographics (likely older age cohorts with associated hospital episodes). There is hence a potential for HH's decision making to be influenced to favour nib's customer demographics when negotiating contracts for the HH Buying Group.

4.134. In response to these concerns, the Applicants submitted the following:

- nib will have access to the same Participant information as any other Participant, and will balance the needs of all Participants in order to make the HH Buying Group an effective and successful business. To achieve this balance, HH will ascertain each Participant's requirements prior to negotiations with Providers to ensure everyone's needs and requirements are addressed. Where conflicts between these interests arise, the Applicants submitted that it will engage with the relevant Participants to ensure an appropriate balance is met for both parties. When a balance is unable to be achieved, HH will give the relevant Participant the opportunity to withdraw from the particular negotiation, or even withdraw from the HH Buying Group.
- nib will not have access to the personal information of Participants' customers, and will not receive greater access to information than other Participants due to its partial ownership stake in HH.
- The directors of HH, and AHSA alike, are required to act in accordance with their fiduciary and statutory duties to act in the best interests of their respective buying groups, regardless of the ownership structure of the company. The Applicants submitted that any suggestion that its directors would be likely to breach their legal duties by preferencing nib's interests over the other Participants is without any basis.

4.135. More generally, the Applicants submitted it is critical to the HH Buying Group business model that HH handles the information of Participants strictly in accordance with its governance and security frameworks, in order to drive participation in the HH Buying Group. The Applicants submitted that it would be completely contrary to HH's commercial interests for HH to disclose commercially sensitive information of Participants to nib.

4.136. The ACCC acknowledges the concerns of interested parties that nib's ownership stake in HH when it is also a Participant in the HH Buying Group at least creates an impression of a potential conflict of interest in relation to other Participants in the group.

4.137. However, the ACCC notes the Applicants' submissions setting out the various legal obligations on nib and HH, including the fiduciary and statutory duties on directors of HH to act in the best interests of HH, regardless of the ownership structure of that company. The ACCC does not have any information that suggests that nib and HH will not comply with those legal obligations.

4.138. The ACCC is persuaded by the Applicants' submission that it would be contrary to HH's commercial interests to disclose commercially sensitive information of Participants to nib, when the objective of the Proposed Conduct is to increase participation in the HH Buying Group.

4.139. Based on the information available, the ACCC considers that the Proposed Conduct is not likely to result in public detriment by reducing competition in the supply of private health insurance through nib's ownership stake in HH.

Information sharing and privacy under the Proposed Conduct

4.140. Interested parties are concerned that increased information exchange between the Participants and HH to perform data analytics and help deliver the value-based contracting model will lead to a softening of competition or a concerted practice

between participating private health funds, which could hinder or reduce competition for consumers and result in increased premiums or less inclusions for the same price.

4.141. More specifically, Mater, AHSA, ASA, Council of Procedural Specialists, Adventist Health Care and Healthscope queried how information collected would be shared and what privacy protocols would be established.

4.142. The Applicants stated that they recognise the importance of data sharing parameters, both commercially and legally, and they will continue to adopt a best practice approach to both privacy and data governance through HH's Risk Management Framework and Information Security Management System.

4.143. The Applicants submitted that no personally identifiable information will be shared with Cigna. All personally identifiable information will be held by HH and will be stored in accordance with HH's Privacy Policy, Data Governance Policy and Information Security Management Policies.

4.144. The Applicants submitted that HH operates independently of its joint venture partners, nib and Cigna.

4.145. The Applicants submitted that the disclosure of member data to HH will be undertaken on a de-identified basis for the purpose of data analytics and will only be identified if necessary for HH to perform its functions. Participants will obtain privacy consent for this use and disclosure of members' personal information. The personal information of each Participant's members will not be shared between Participants and it will not be shared with international organisations.

4.146. Generally, the ACCC considers that information sharing in collective bargaining arrangements is of concern if it allows the parties to co-ordinate their conduct beyond that for which authorisation is granted, for example, if it facilitates collusion or provides a focal point for competitors to align their behaviours in related markets such as the downstream supply of services to consumers.

4.147. In this case, the Applicants have not sought authorisation to share customer information or marketing strategies with Participants. Further, the Applicants submitted that, to the extent that nib is a Participant of the HH Buying Group, it will receive the same level of information as any other Participant and will not benefit by virtue of its equity investment in HH. Sharing such information between Participants would not be covered under the authorisation, and any such information sharing would be subject to the operation of the Act.

4.148. The ACCC also notes that any potential softening of competition or concerted practice resulting from information exchange between the Participants and HH is likely to be mitigated by the fact that the Major PHIs are prevented from participating in the HH Buying Group,

4.149. The ACCC considers it unlikely that there will be a reduction in competition in the supply of private health insurance to consumers as a result of information sharing under the Proposed Conduct. On the information available, the ACCC considers that there are sufficient protections in place to protect policyholder's data and it is unlikely that public detriment would arise from any privacy implications of information sharing under the Proposed Conduct.

Reduced incentives for PHIs to innovate

4.150. The ACCC notes the ability for Major PHIs to join the BCPP is likely to reduce or remove their incentive to continue or develop their own competing programs offering a no gap experience for the entire episode of treatment, or some other type of innovation. As noted by the Applicants, HCF currently offers a similar program in relation to obstetric services and in recent weeks, joint replacement therapy.

4.151. However, the ACCC considers that the exclusion of the Major PHIs from the bargaining group addresses this potential public detriment.

Bargaining power of other healthcare payers

4.152. The Applicants submitted there will no public detriments from the Proposed Conduct in relation to Other Healthcare Payers. The Applicants further submitted:

- travel and medical insurers make up a small percentage of the healthcare payer market so if they join the HH Buying Group, this will not materially alter the competitive position of Providers, and
- government and semi-government healthcare payers form a large part of the healthcare payer market but are less likely to join the HH Buying Group because these schemes invest in and create their own Provider networks, and are subject to extensive public policy constraints when tendering and making agreements.

4.153. The Department of Veterans' Affairs submitted that it was unable to comment on how providing government health payers in healthcare buying groups is likely to impact on bargaining processes, and did not provide a position on whether it was likely to participate in the HH Buying Group.

4.154. The ACCC has received limited information about the nature or extent of any likely increase in bargaining power of Other Healthcare Payers in the acquisition of health services due to the Proposed Conduct. To the extent that some or any of these payers join the HH Buying Group, there is the potential for some increase in bargaining power for the acquisition of health services. However, based on the information available, the ACCC does not consider this is a likely result from the Proposed Conduct.

Authorisation will introduce US-style managed care into Australia and this would be detrimental to Providers and patients

4.155. The concerns of interested parties and the responses from the Applicants are set out in detail at paragraphs 3.111 to 3.222 above. In short, interested parties are concerned authorisation will allow the Applicants to introduce US-style managed care in Australia under the guise of 'value-based contracting' and this would be detrimental to Providers and patients. The Applicants strongly refute these claims. Their responses include:

- interested parties have not articulated the causal link between the creation of a buying group for healthcare services and the introduction of managed care, nor have they provided any reasonable or rational basis to support this claim;
- value-based contracting is not managed care; and
- the Proposed Conduct does not remove patient choice or interfere with clinical autonomy be the current legal and regulatory controls will continue to prevent this from occurring.

4.156. The ACCC notes the divergent views of interested parties and the Applicants on whether the Proposed Conduct is likely to result in the introduction of US –style managed care and the detriments identified by interested parties. There does not appear to be an accepted definition of managed care.

4.157. Authorisation by the ACCC exempts the Applicants from specific sections of the *Competition and Consumer Act 2010* and does not alter any existing legal restrictions or policy settings regarding healthcare in Australia.

4.158. The ACCC has carefully considered how interested party concerns about managed care factor into the net public benefit test that must be satisfied to grant authorisation.

4.159. The ACCC recognises that a buying group with sufficient market power and which uses inducements or threats to influence the nature of treatment that medical practitioners and hospitals provide patients or offers strong financial incentives to patients regarding their choice of practitioner might be very difficult for many of its

Providers and members' customers to resist. This may in turn lead to pressure for others to follow suit and embolden other insurers to do the same.

4.160. However, the ACCC does not have sufficient evidence to demonstrate that the HH Buying Group is likely to have this type of market power or that its value-based contracting approach will necessarily interfere with clinical autonomy or patient choice as described above.

4.161. The ACCC notes the *Private Health Insurance Act 2007* (**PHI Act**), administered by the Commonwealth Department of Health, prevents PHIs from limiting the professional freedom of medical practitioners. Further, the obligation (noted above) on insurers under the PHI Act to pay at least 25 per cent of the applicable MBS fee prevents PHIs from altogether refusing to fund legitimate treatments by legitimate Providers. The ACCC considers that the PHI Act should preserve medical practitioners' clinical autonomy and patients' choices. Medical practitioners concerned that their autonomy is compromised should seek assistance from the Commonwealth Ombudsman or the Commonwealth Department of Health.

4.162. The ACCC acknowledges the submissions by interested parties but notes these concerns are not new – the same arguments were raised by medical practitioner groups opposing legislation permitting the introduction of MPPAs in the mid-1990s.

4.163. Overall, the ACCC considers the Applicants' implementation of value-based contracting is unlikely to result in a change from the current Australian healthcare system to a US-style managed care model. Some insurers are already implementing value-based contracting and it appears likely that this will continue. The future without the Proposed Conduct is likely to be one where value based contracting continues to exist.

Other conditions proposed by the Applicants and interested parties

4.164. Interested parties proposed a range of other conditions of authorisation to address public detriments that they considered likely to arise from the Proposed Conduct.

4.165. As explained in paragraphs 4.113 to 4.122, the ACCC considers that a condition to exclude the Major PHIs from participation in the BCPP is necessary to meet the authorisation test.

Excluding unreliable data

4.166. Healthscope agrees that there is a public benefit associated with the ability of insurers to make informed choices as to their negotiations with healthcare Providers on the basis of factually correct information on quality, efficiency, access and reliability. However, this public benefit does not arise if the information shared is either factually incorrect or in dispute. For example, while the HH Buying Group may believe that the healthcare provider has breached a contract or fraudulently made claims, this allegation may be disputed (and successfully so) by the healthcare provider. It would be problematic and counterproductive if the discovery of apparent breaches or fraud were shared with participants prior to those breaches or fraud being proven or agreed.

4.167. Accordingly, Healthscope requested that the final determination include a condition requiring all information and data analytics engaged in by HH Buying Group to exclude disputed or unproven data. At the very least, the Applicants should be required to disclose to participates which data relied upon has been disputed by the relevant healthcare provider.[16]

4.168. The ACCC considers that a condition requiring HH to exclude and/or disclose disputed data is not necessary to meet the authorisation test. Assessment of data to

[16] Healthscope submission 11 June 2021

identify whether it can be relied upon is a subjective process and unsuitable for a condition of authorisation.

Authorisation monitoring and review

4.169. Adventist Healthcare Limited submitted that there should be a monitoring process throughout the authorisation period.[17]

4.170. The Australian Society of Ophthalmologists submits that there should be a formally agreed review 12 months after the Proposed Conduct commences before authorisation can continue.[18]

4.171. The Australian Private Hospitals Association (APHA) submitted that it is concerned that the ownership structure of HH could change whereby Cigna takes 100 per cent ownership of HH. To alleviate these concerns, the ACCC should impose an additional condition of authorisation where a change in ownership structure of HH would automatically trigger a review of the ongoing authorisation.[19]

4.172. The APHA also noted the Applicants submission of 30 June 2021, which indicated that they have no intention to drive other buying groups out of the market. Accordingly, the ACCC should include a condition that the authorisation will be revoked if either AHSA or AHRG exit the market for health fund buying groups.[20]

4.173. The APHA submitted that should there be any changes to any of the legal and regulatory protections relied on by the applicants, including but not limited to the Health Insurance Act, the CCA, State and Federal Discrimination laws or default benefit arrangements, the authorisation would be immediately reviewed to determine if there is increased public benefit.[21]

4.174. The ACCC considers that a shorter authorisation period provides an opportunity to review the public benefits and public detriment that have occurred before considering whether to re-authorise the Proposed Conduct.

4.175. The ACCC also notes that the Act provides for ACCC to commence a review of an authorisation and that depending on the outcome of the review may decide to revoke the authorisation. A significant change to the ownership structure of HH may be grounds for a review of the authorisation.

Reporting condition

4.176. The Council of Procedural Specialists noted that the Applicants had submitted that they would accept a condition requiring the Applicants to notify the ACCC of new Participants so the ACCC could raise any concerns. COPS submitted that the ACCC has not imposed such a condition.[22]

4.177. The ACCC considers that a reporting condition is not required to ensure the authorisation test is met. The Proposed Conduct indicates that the Applicants will advise the ACCC of any additional Participants (healthcare payers) and the ACCC can request information from the Applicants about Participants.

Removing small businesses from the Proposed Conduct

4.178. The Australian Dental Association submitted that nib is significantly larger than the average dental practice, which creates a significant bargaining power imbalance. The

---

17 Adventist Healthcare Limited submission 10 June 2021.

18 Australian Society of Ophthalmologists submission 14 June 2021

19 Australian Private Hospitals Association submission, 11 June 2021

20 Australian Private Hospitals Association submission, 22 July 2021

21 Australian Private Hospitals Association submission, 22 July 2021

22 Council of Procedural Specialists submission 9 June 2021.

ADA submitted that if authorisation is granted all businesses under $10 million per year could be excluded from negotiation with the HH Buying Group.[23]

4.179. The ACCC notes that the Proposed Conduct is voluntary for both payers and Providers and if small businesses wish to opt out, they are free to do so. Further, HH would have no way to reliably assess the turnover of counterparties to negotiation.

Clinical choice and patient autonomy

4.180. The Applicants submitted that they were prepared to accept additional conditions for:

- Clinical autonomy - that HH must not facilitate the entry by a member fund into any MPPA that would limit the professional freedom of the medical practitioner, within the scope of accepted practice, to identify and provide appropriate treatment.
- Patient choice - that HH will not, and will not require its member funds to, limit the freedom of policyholders to choose their preferred medical specialist, private hospital or other Providers.

4.181. The APHA submitted that the Applicants are willing to accept conditions to protect patient choice and clinical autonomy. APHA submitted that the conditions are so limited in scope as to not provide any genuine protection in relation to patient choice and clinical autonomy that the Applicant will not offer any financial inducement, benefit, or penalty to any provider that may have the effect of influencing the choice of provider, venue of treatment, treatment type or pathway.[24]

4.182. The Australian Medical Association submitted that in order to satisfy the authorisation test, the ACCC should impose conditions that limit HH's potential market share and specifically preclude authorisation of any contractual, funding, or other arrangement that limits patient choice and/or seeks to interfere with clinician autonomy.[25]

4.183. The ACCC considers that maintaining clinical autonomy falls within the bounds of health policy and is already regulated by the PHI Act. The ACCC notes that PHIs currently provide patient choice of medical specialist and the ACCC accepts the Applicants submissions that the Proposed Conduct will not limit patient choice. Further, based on the assessment in this section, such a condition is not required to ensure the authorisation test is met.

Reducing the size of the hospital and medical specialist network

4.184. The APHA submitted that the Applicants have stated that they have no intention of reducing the size of nib's current hospital network, which would limit a patient's choice of hospital and treatment. Accordingly, the ACCC should impose a condition that the Applicants not reduce the size of nib's current hospital network.[26]

4.185. The APHA submitted that the ACCC should impose a condition to ensure the Applicants do not contract with fewer medical specialists than is currently the case.[27]

4.186. The ACCC does not consider it appropriate to impose such a condition of authorisation, and it is not required to ensure the authorisation test is met. The ACCC considers there may be many reasons why insurers might decide to reduce the size of their hospital and medical practitioner networks and exercising its discretion to do so would not be appropriate.

---

[23] Australian Dental Association submission, 22 July 2021

[24] Australian Private Hospitals Association submission, 22 July 2021

[25] Australian Medical Association submission 21 July 2021

[26] Australian Private Hospitals Association submission, 22 July 2021

[27] Australian Private Hospitals Association submission, 22 July 2021

ACCC conclusion on public detriment

4.187. The ACCC considers that if the Proposed Conduct enabled small and Major PHIs to join the BCPP up to the point where they represented 80 per cent of hospital policies, this would be likely to result in public detriment by creating an imbalance in bargaining power between PHIs and medical specialists, leading to inefficient outcomes in the provision of health services by medical specialists, and this public detriment is likely to outweigh the likely benefits of the Proposed Conduct.

4.188. In order to address this concern, and to ensure the net public benefit test is met, the ACCC has imposed the condition of authorisation at paragraph 5.6 that prohibits HH from supplying BCPP services to Major PHIs. The ACCC considers that this would not compromise the public benefits of the Proposed Conduct because Major PHIs have the scale to develop similar no gap experience programs and can do so without the need to join the BCPP.

Balance of public benefit and detriment

4.189. For the reasons outlined in this determination, the ACCC considers that, on balance and with the condition of authorisation, the Proposed Conduct as described in paragraphs 5.6 and 5.7 of the 'Determination' section below is likely to result in a public benefit and that this public benefit would outweigh the likely detriment to the public from the Proposed Conduct.

Length of authorisation

4.190. The Applicants sought authorisation for a period of 10 years, on the basis that the majority of agreements with private hospitals and medical practitioners have a two to three term and, in some instances, up to five years. The Applicants submitted that the authorisation should cover at least two contract cycles to realise the public benefits of the Proposed Conduct.

4.191. Further, the Applicants anticipate that the transition for Participants from their current contracting arrangement to the HH Buying Group will require planning, analysis and communication with members and Providers, which could potentially last for up to two years.

4.192. Interested parties who oppose the Proposed Conduct submitted that the length of the authorisation period sought is not necessary to understand the impact of the Proposed Conduct. Some interested parties submitted that if authorisation is granted, three to five years would be sufficient.

4.193. In light of the assessment set out above, the ACCC considers it appropriate to authorise the Proposed Conduct for a shorter period than the Applicants have requested. This will give the ACCC an earlier opportunity to re-assess any public benefits or detriments that have resulted from the Proposed Conduct if the Applicants decide to apply for re-authorisation in the future.

4.194. The ACCC understands that the majority of agreements with private hospitals and medical practitioners have a two to three year term and HH is likely to require time to establish the HH Buying Group and put in place arrangements with Providers. In these circumstances, the ACCC has granted authorisation with a condition for five years.

5. Determination

The application

5.1. On 24 December 2020, HH and nib lodged application AA1000542 with the ACCC, seeking authorisation under subsection 88(1) of the Act.

5.2. HH and nib sought authorisation for the Proposed Conduct defined at paragraph 1.18.

The authorisation test

5.3. Under subsections 90(7) and 90(8) of the Act, the ACCC must not grant authorisation unless it is satisfied in all the circumstances that the Proposed Conduct is likely to result in a benefit to the public and the benefit would outweigh the detriment to the public that would be likely to result from the Proposed Conduct.

5.4. For the reasons outlined in this determination, the ACCC is satisfied, in all the circumstances, that the Proposed Conduct, as described in paragraphs 5.6 and 5.7, with the condition set out in paragraph 5.11, is likely to result in a benefit to the public and the benefit to the public would outweigh the detriment to the public that is likely to result from the conduct.

5.5. Accordingly, the ACCC has decided to grant authorisation with a condition.

Conduct authorised

5.6. The ACCC grants authorisation AA1000542 to the following entities:

(a) Honeysuckle Health Pty Ltd and nib Health Funds Ltd (collectively, the **Applicants**);

(b) PHIs registered under the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) except for the following specified entities, and any related body corporate (within the meaning of s4A of the Act), acquirer or successor entity of any of these specified entities:

- Medibank Private Limited,
- Bupa HI Pty Ltd,
- Hospitals Contribution Fund of Australia Limited, and
- HBF Health Limited, with respect to its operations within Western Australia (for clarity, HBF Health Limited is authorised with respect to its operations outside of Western Australia),

(collectively, **Excluded Entities**);

(c) international medical and travel insurance companies;

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

(e) any other payer of health services or goods other than an Excluded Entity, as notified by HH to the ACCC,

(collectively, **Authorised Entities**).

5.7. Authorisation AA1000542 applies in relation to the following conduct:

(a) the formation and operation of the HH Buying Group by HH, including the BCPP, involving the provision of services to Authorised Entities; and

(b) the acquisition of contracting services by Authorised Entities from HH.

5.8. Authorisation is granted in relation to Division 1 of Part IV of the Act, and sections 45 and 47 of the Act.

5.9. The ACCC grants authorisation with the following condition until 13 October 2026.

Condition of authorisation

5.10. The ACCC may specify conditions in an authorisation.[28] The legal protection provided by the authorisation does not apply if any of the conditions are not complied with.[29]

5.11. The ACCC grants this authorisation with the condition that the Applicants must not supply services to any Excluded Entity.

6. Date authorisation comes into effect

6.1. This determination is made on 21 September 2021. If no application for review of the determination is made to the Australian Competition Tribunal, this authorisation will come into force on 13 October 2021.

[28] Section 88(3) of the Act.

[29] Section 88(3) of the Act.

Appendix A

7. Summary of interested party submissions

7.1. The ACCC received over 350 submission in response to the draft determination. Of these, 27 are from associations/bodies that represent specialists likely to be affected by the Proposed Conduct. A large number of submissions are from individual doctors in a very similar format.

Interested parties

7.2. The views of interested parties in response to the ACCC's draft determination are summarised below and considered in the assessment section of this determination.

Submissions from individual doctors

7.3. The ACCC received a significant number of submissions from individual doctors regarding the Proposed Conduct. The vast majority of these submissions were identical or raised the same issues, including concerns for the power and influence of large health insurance companies, the introduction of managed care into Australia, and the consequences of this for autonomy for both medical specialists and patients.

7.4. A number of submissions in this category also included anecdotal evidence of experiences with PHIs, both in Australia and overseas. Others included references and excerpts from relevant research, articles and reports.

National Association of Practising Psychiatrists (NAPP)

7.5. NAPP raised concerns about the Proposed Conduct leading in the introduction of US-style managed care into Australia, resulting in restrictions for patients' choices of medical provider and available treatment. Notably, concern was raised for the Proposed Conduct interfering with medical decisions in order to reduce costs, and ultimately remove patients' choice of doctor.

7.6. NAPP also discussed the possibility that the size of the HH Buying Group will distort the market, creating difficulties for private hospitals and professional services to operate independently without influence from PHIs.

Australian Hand Surgery Society

7.7. The Australian Hand Surgery Society predominantly raised concerns for nib merging with Cigna to purchase health services from the private sector, and the loss of choice for patients, which may result from the Proposed Conduct.

Australian Society of Plastic Surgeons (ASPS)

7.8. ASPS raised concerns about the Applicants' intentions to introduce "value based contracting," similar to the US model introduced by Cigna in 2008 in the US. ASPS believes the Applicants' proposed model will reduce costs regardless of patient need and choice, dictating decisions based on financial considerations rather than medical needs.

National Association of Specialist Obstetricians and Gynaecologists (NASOG)

7.9. NASOG raised concerns about the Proposed Conduct resulting in PHIs placing profitability ahead of patient rights, preferences, and clinician expertise. NASOG contends that the existing attempts at 'no gap' maternity programs has not experienced the expected uptake and profitability, resulting in a movement in the area to the public sector. NASOG also queries the value of adding further administration to our healthcare system, where HH will be drawing an income from the contracting and management arrangements.

Australian and New Zealand Society for Vascular Surgery (ANZSVS)

7.10. ANZSVS submitted that it is extremely concerning that Cigna is attempting to step into the Australian healthcare sector, merging with nib to purchase health services from the private sector and potentially transform and destabilise the Australian healthcare system. ANZSVS raised concerns over the evidence of restriction of treatment choices based on commercial grounds by PHIs.

Interventional Radiology Society of Australasia (IRSA)

7.11. IRSA raised concerns that the Proposed Conduct would lead to a US style managed care system being introduced into Australia, resulting in reductions in patient choice of provider and treatment, and eroding confidence in both the public and private healthcare sectors in Australia.

Council of Procedural Specialists (COPS)

7.12. COPS submission indicated that evidence has shown that Pay for Performance may be detrimental, especially in disadvantaged and high risk populations, with a number of ethical and practical concerns and risks of misuse of financial incentives. COPS contends it is unclear how the Proposed conduct will affect the GP-specialist referral system, and that there is potential to disrupt established pathways between patients, GPs and specialists.

7.13. COPS suggests that the Applicants' proposed value based contracting model will allow insurers to move towards a full risk-rated private health insurance system, which policy makers have, up until now, considered to be contrary to the public interest.

7.14. COPS suggests that the ACCC's draft determination fails to clarify the legality of paying or providing contracted doctors or other health professionals "incentives" to treat patients according to health fund protocols. COPS also highlights that there is no prohibition on the applicants using significant financial resources and advertising budgets to 'position' doctors who have not signed value-based contracts as being 'not preferred' as Providers of medical specialist services. Further, it is suggested that there is no guarantee that existing no gap and known-gap arrangements will not be altered to provide significant disincentives designed to drive doctors towards value-based contracts as being the only option for their survival.

Australian Medical Association (AMA)

7.15. AMA submitted that authorisation will result in less choice for patients, no premium relief, and less competitive market. ACCC has not given enough weight to stakeholder concerns about the potential for the authorisation to lead to a managed care style healthcare system. AMA believes the Applicants are seeking to take control of decisions that should be made by patients/doctors. HH Buying Group power will be substantial and detrimental.

7.16. Further, AMA suggests nib will be able to significantly improve its position in the private health insurance market, and nib may be the beneficiary of the resulting market disruption and the exit of smaller funds. The HH Buying Group will compete for membership with the two existing buying groups (both of which are more vulnerable).

7.17. AMA believes the outcome of authorisation will be one of the following: HH Buying Group fails to recruit members; HH Buying Group recruits some members, largely splitting the existing market between three buying groups; HH Buying Group achieves monopoly status.

Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS)

7.18. ASOHNS submitted that the amendments made to the Application and the conditions put forward in the draft determination do not go far enough to address the many concerns raised in initial submissions. ASOHNS believes there is a reasonable

expectation that the Proposed Conduct would create a US-like system which is far removed from the current world-class Australian healthcare system. They suggest that introducing an intermediate entity (the insurer) into the decision-making position as to what healthcare patients will receive is highly undesirable.

Day Hospitals Australia (DHA)

7.19. DHA raised concerns that the condition proposed in the ACCC's draft determination does not go far enough, and that these four health insurers can still participate in the HH Buying Group in negotiating contracts with medical specialists for their services provided for in hospital care.

7.20. DHA suggests that the Proposed Conduct will impact all consumers of healthcare and particularly those residing in rural areas. Further, DHA believes that the ACCC has not gone far enough in reigning in the aggressive activities of Honeysuckle Health with the merger of the US company Cigna and Nib health.

Adventist Healthcare

7.21. On HPPA contracting, Adventist Healthcare believes allowing HH to contract for AHSA, ARHG and smaller funds would give a potential dominant market power to HH if they were successful in enlisting these other groups. AHCL submits that HBF and DVA should be excluded from the authorisation.

7.22. On the BCPP, Adventist Healthcare believes there is little public benefit in having another party with a "known out of pocket for medical gaps" cover. AHCL believes the 40 per cent market share is far too high and believes it should be limited to 30 per cent. They submit that there should be a monitoring process throughout the authorisation period, and the period should be limited to four years.

Spine Society of Australia (SSA)

7.23. SSA submits that the ACCC is approving a framework where the workings of that structure have not been defined and clearly are not understood by the decision makers at the ACCC. SSA maintains that value based contracting combined with the proposed data analytics through performance and quality targets will result in an overall public detriment, which would outweigh any minor benefits from the Proposed Conduct.

7.24. SSA raised concern for therapeutic decision making ending up in the hands of PHIs, and resulting in a standard of care determined by a monolith insurer group, rather than by health professionals and the laws of Australia.

Royal Australian College of Surgeons (RACS)

7.25. RACS submitted that the Proposed Conduct will introduce a United States style of 'managed care', under the guise of 'managed agreements', into the Australian healthcare sector. RACS suggests that patients will not be able to choose their own primary care regime, and instead a third party or administration will decide for them.

7.26. RACS believes that the Application provides for data and analytics in absence of any risk adjustments for geography, patients with existing medical conditions, complexity, and with no assurance regarding the governance of this data.

7.27. Further, RACS submits that, despite the assurances of no boycotts against non-contracted hospitals or doctors, this no gap program will be heavily marketed, forcing other major funds to follow suit, and effectively boycotting hospitals and practitioners who fail to participate in the contracts.

Department of Anaesthesia & Pain Medicine St John of God Hospital (St Johns)

7.28. St Johns submits that the Proposed Conduct is a step towards US-style managed care with nib as a 'for-profit' health fund which has shareholders as a major consideration. St Johns raised concerns about the lack of choice that this will lead to for patients, who will be limited to a subset of doctors within a closed and controlled

network. They also raised concern for the removal of freedom around clinical decision making for clinicians working within such arrangements, and that private health insurance companies will be in a position to dictate how and where patients are treated.

Healthscope

7.29. On the BCPP, Healthscope believes there should be symmetry between hospital and medical specialist contracting, and this cannot be achieved with the current proposed 40 per cent condition on the HH Buying Group.

7.30. Healthscope suggests that involvement of major funds in BCPP will implicate hospital contracting, where Major PHIs would have the incentive to demand certain conditions which aligned it with the terms reached as part of the BCPP (e.g. PHI reducing amount payed to hospital operators for charges like accommodation or operating theatre fees).

7.31. Further, Healthscope submitted that the HH Buying Group is too uncertain/complex to ensure public benefits will result. Healthcare Providers will not know how many insurers they deal with when negotiating through HH. Insurers will be able to see contractual terms and prices negotiated by competitors through the sharing of information in the HH Buying Group.

Australian Society of Anaesthetists (ASA)

7.32. ASA submitted that the Application will not enhance the welfare of Australians through the promotion of competition and fair trading or provide consumer protection. It will result in sig increase in market power for nib and public detriment by way of lower quality health care. ASA suggests that independent doctors do not encourage the creation of a powerful managed care provider. If authorisation is granted, there will be separate and more burdensome administrative requirements for doctors for each health fund. ASA believes the Applicants only want coercive market power.

7.33. ASA believes the Proposed Conduct will restrict the terms upon which Providers are able to enter agreements, and that doctors will not be able to determine their own fees. They further suggest that there is no evidence that value-based contracting provides benefits for patients or Providers, and that the Proposed Conduct will lead to 'managed care' model of service, thus reducing patient choice and outcomes while increasing their costs.

7.34. ASA does not believe that out of pocket expenses are a significant issue across the sector as most policy holders rarely change health fund Providers. HH Buying Group managing SMEs could reduce transparency for consumers who use comparator sites. Consideration of premiums in isolation is not sufficient as it does not take into account excesses that may be imposed prior to receipt of any benefits.

Australian and New Zealand College of Anaesthetists (ANZCA)

7.35. ANZCA raised a number of key concerns in relation to the Proposed Conduct, including limiting care for patients with complex co-morbidities associated with complications and increased costs, and reduced choice for consumers in selecting preferred specialists.

7.36. ANZCA submits that the Proposed Conduct may put choice of provider into the hands of health insurers rather than the patient, highlighting the insurer's obligations to maximise profits for shareholders over maximising health outcomes for consumers. ANZCA contends that the proposed arrangements under the BCPP do not add any certainty compared to the status quo, while severely restricting access and choice in certain markets, and that another outcome of the Proposed Conduct will be to severely limit patient choice in some regional markets. ANZCA submits that decisions about appropriate healthcare should be made by individual patients, their GPs and their chosen specialists, rather than private insurance companies making decisions based on commercial interest.

Australian Private Hospitals Association (APHA)

7.37. APHA submitted that if the HH Buying Group gains sufficient size, hospitals will deal with them so they receive contract rates and the hospital continues to be viable. Providers will have no choice but to contract with them if they gain great market share – will be on a take it or leave it basis.

7.38. APHA believes that if the ACCC is not in a position to test veracity of claims re value-based contracting, then it can't accept any of them as they are all contested. ANZCA believes that any public benefits from HH Buying Group will be offset by a decrease in efficiency for existing buying groups as they lose market share.

Australian and New Zealand Association of Oral and Maxillofacial Surgeons (ANZAOMS)

7.39. ANZAOMS raised concerns that the HH Buying Group will create uncompetitive health sector detrimental to patients through limiting choice and constraining clinician decisions in the best interests of the patient. Will introduce US-style managed care. They believe the draft determination does not note differences between Australian and US health systems, as the Application relies on US data to support claims made. ANZAOMS submits that Cigna is too large and will distort the market through its involvement in the buying group, and the group is an unnecessary entity to place between doctor and patient.

7.40. Further, they contend that savings will be passed to shareholders not patients, they are the true beneficiaries of reduced costs, and more contracts will increase the administrative burden associated with the buying group.

Australian Dental Association (ADA)

7.41. ADA expressed concern that authorisation would have the effect of significantly impacting many of the small business' represented by the ADA if a buying group of large health insurers (BUPA, Medibank, HCF and NIB) were to pose the same conditions as is currently being applied by BUPA. They submit that there is already a marked imbalance of market power between health insurers and small community-based health practices. Extending the ability for health insurers to collectively use (or misuse) this very significant imbalance of market power is unconscionable.

Neuromodulation Society of Australia and New Zealand (NSANZ)

7.42. NSANZ submitted that a value-based healthcare system will greatly worsen these statistics and further burden the public healthcare system and our greater Australian community. With poorer access to chronic pain specialists, and treatment of chronic pain, the use of opioids in Australia will rise exponentially and the USA opioid public health crisis and epidemic will be mirrored in Australia. NSANZ believes the patient must be put front and centre when it comes to healthcare in Australia. The patient's rights, expectations, and needs as well as their treating medical practitioners must be considered by the ACCC.

Australian Doctor's Federation (ADF)

7.43. ADF calls on the ACCC to refer the application to the Federal Department of Health for a public inquiry into the proposed benefits and detriments of such a significant change to Australia's healthcare delivery system and its impact on the future confidence of the Australian public and medical profession in Private Health Insurance and private sector healthcare.

7.44. The ADF also maintains that it is in the public interest for the ACCC to consider the behaviour of any of the applicants in relation to consumer behaviour in any jurisdiction, both in Australia and overseas, as to assessing potential adverse impacts on Australians.

7.45. The ADF contends that all data related to medical practice is patient related. Given that patient related data is the subject of cybersecurity concerns, both in Australia and

overseas, the ADF urges the ACCC to reassess the potential public detriments and national interest concerns resulting from the proposed conduct.

7.46. The ADF believes there is nothing to stop health funds altering existing rules of no gap and known gap products in order to drive medical practitioners into proposed contract arrangements by making it extremely difficult, to the point of non-viability, not to participate on take it or leave it conditions.

Catholic Health Australia (CHA)

7.47. CHA submits that a five year length of authorisation important to give sufficient timeframe for several rounds of contracting, also provides Commission and market participants opportunity to assess claimed public benefits and detriments. They believe conditions and exclusion of major health funds from certain services are essential to mitigate potential for significant public detriment arising from the HH Buying Group potentially comprising 100 per cent of PHIs.

Australian Pain Society (APS)

7.48. APS submitted that the HH Buying Group will limit patient choice, concentrate allied health services and create de facto panels of approved Providers, limit ability to refer to specialised allied health Providers, create a vertically integrated managed care arrangement, and result in penalties imposed on Providers/hospitals who are deemed to not have met predetermined outcomes.

Australian Orthopaedic Association (AOA)

7.49. AOA believes the Proposed Conduct will introduce a system of managed care to Australia similar to the USA system and that is a system that does not benefit significant numbers of Americans and will not benefit Australian patients. They suggest there will be discrimination against certain groups of patients, including the elderly, the socially isolated, those for whom English is a second language, rural populations, the chronically unwell and those in the lower socioeconomic strata of the general population. AOA also believes there will be an increased burden on the public hospital system, which is already under - resourced and increasingly unable to cope with ever-increasing utilisation numbers.

Australian Society of Ophthalmologists (ASO)

7.50. ASO's primary concern is the prospect of an average 30 per cent market share across total hospital policies, purchase of health services and total hospital and extras cover and the ACCC's proposed condition adds further concern (with its cap up to 40 per cent). ASO maintains the position that the principal measurement of public benefit in health care needs, relate to the delivery of the optimum medical service for the patient and the patient's condition and therefore this must rest with the patient, and the doctors. A position obviously supported more broadly across different areas of medical practice given the 16 submissions lodged by 16 peak bodies during the consultation period.

7.51. The ASO reiterated concerns previously raised that it claims the ACCC did not address in its draft determination, including patient confidentiality concerns, comparison of Providers leading to a failure in public benefit, and the CPI used as the index to increase payments.

Psychiatrists for Racial Equality in Mental Health Australia (PREMHA)

7.52. PREMHA believes the Proposed Conduct is an e attempt at introducing managed care into Australia, rebranded as 'value-based care contracting', as a subversive attempt at colonisation of the Australian health care system by Nib Health Funds Ltd and Cigna Corporation, an American multinational insurance company.

7.53. PREMHA questions whether managed care insurers 'diversity and inclusion' portfolios, underlaid by competitive business / advantage models, can be genuinely ethical, humanising and promoting of equity, or whether this is a politically correct

marketing and advertising campaign concealing a capitalist system designed to extract maximum profit and which has clear parallels with historical practices of colonialization and slavery.

Margaret Faux

7.54. Margaret Faux provided a detail submission. She submitted that a central focus of this application is to control out-of-pocket medical costs (OOPs). Historically, all similar attempts have failed (including MPPAs), and have in fact had the opposite effect. Australian OOPs are now some of the highest in the world. This is attributable to the labyrinthine complexity of Australia's health financing arrangements and the constitutional protection of medical practitioners.

7.55. Ms Faux indicted that the draft determination appears to be largely based on a mistaken belief that statutory benefits cannot be denied. For those with no experience in the murky world of Australian medical billing, this is understandable, but mistaken. The PHIs can and already do block legitimate statutory benefits.

7.56. Ms Faux indicates a significant finding from her PhD is that Australia's health financing arrangements are profoundly complex and beyond the comprehension of anyone. With respect, any suggestion that this application with simplify and streamline fee arrangements for medical specialists is laughable. NIB's proposed MPPA contract rates will add more complexity, not less. NIB will still have its gapcover fee list, as will all of the other PHIs, and the MPPAs will add another layer to the current morass of rules and rates. There are already over 30 different payment rules and rates for every single MBS item number, as well as over two million medical billing rules.

Mater Health

7.57. Mater Health suggests that there should be strict and transparent guidelines around how it might operate in a manner that avoids cartel like behaviour or collective boycotts when one or more of their stakeholder funders do not agree a proposal from a provider. They believe any information sharing with any overseas parties be avoided (in line with current Australian Privacy Principles and legislation), and authorisation should only be granted for a three year period to allow the industry to better assess the impact of the Proposed Conduct.

Council of Presidents of Medical Colleges

7.58. CPMC submits that there is limited public benefit likely to result from the proposed conduct, which aims to diversify and dominate the market, which will reduce competition. They indicate that medical specialists are concerned about the introduction of third parties in the doctor-patient relationship thereby putting at risk clinical autonomy, which will put at risk the safety of the Australian public in seeking access to medical services.

Appendix B

8. Summary of pre-decision conference interested party submissions

8.1. The ACCC received 14 submissions following the pre-decision conference from the following interested parties, summarised below.

Adventist Healthcare

8.2. Adventist Healthcare reiterated their concerns from their previous written submissions, claiming that there is a clear dispute on facts and impact on consumers between doctors, learned colleges and hospital providers on one side and the Applicants on the other. Adventist Healthcare suggested that monitoring of authorisation should have regard to the fact that most HPPAs generally have strict confidentiality provisions that protect their contents.

Australian Hand Surgery Society (AHSS)

8.3. AHSS submitted that authorisation will significantly negatively impact health insurance industry, and that the benefits identified by ACCC are marginal at best and the likely detriments are very significant. AHSS submits that there is a misplaced use of exemption power in that the ACCC should not permit a buying group with over 20 per cent of any state/territory markets as this creates too dominant of an entity. Even if the market share is authorised specifically, it could still grow as the years go on.

8.4. AHSS also believes there is a lack of clarity in Application meaning it is unclear what the scope of services included/excluded from will be, and that the Application is disingenuous as there has been contradicting information in the submissions provided by the Applicant and the draft determination. AHSS submits that there will be a sharing of data within the HH Buying Group that will encourage insurers to act in concert and limit market competition.

Australian Medical Association (AMA)

8.5. The AMA reiterated the points made in earlier submissions, raising serious concerns about detrimental impact of proposed authorisation, and that the Application is anti-competitive as it gives HH too much market power. The AMA submits that the proposed condition on market share caps are well above benchmarks that would concern regulators generally. The AMA believes significant public detriment will arise from HH's proposed market power through their ability unilaterally dictate terms and conditions to Providers. Most of these Providers are small and have no bargaining power, could not form bargaining groups to counter this.

8.6. The AMA is concerned with Cigna's involvement in the Proposed Conduct because it is a managed care organisation, which means it is more likely to pursue this agenda through the HH Buying Group.

Australian Private Hospitals Association (APHA)

8.7. APHA submits that the Applicants and other PHIs engage in managed care through provisions in contracts with Providers that are subject to confidentiality. Therefore, they submit that the Department of Health has no visibility over contracts between funds and Providers, and thus cannot scrutinise arrangements.

8.8. APHA also submits that private health funds will and are lessening competition by refusing to pay benefits for patients to access services that may compete with those that they own. APHA believes granting authorisation could put more members into nib

service, which reduces choice for patients, financially advantaging nib, restricting competition in the provision of out of hospital services

Australian Dental Association (ADA)

8.9. The ADA submit that dental treatment is not covered by rules related to Medicare, so are therefore not protected from anti-boycotting provisions submitted by the Applicants. They submit that practitioner boycotts already occur at several levels in Australia, with some being unilaterally excluded from giving their patients rebates. ADA submits that Providers are often met with threats of being derecognised if they do not pay insurers more money.

8.10. ADA further argues that PHIs are only concerned about power imbalances where the benefits rest with Providers, despite Private Healthcare Australia seeking policy change to address bargaining power imbalances where large market shares are concerned.

Healthscope

8.11. Healthscope submit that the ACCC's proposed 40 per cent condition is too high, and that the condition should exclude Major PHIs or reduce the cap to 30 per cent. They submit that there is still a considerable amount of uncertainty surrounding the contracts and the sharing of information/data use. Healthscope believes the ACCC should impose a condition requiring all information sharing and data analytics engaged in by the HH Buying Group to exclude disputed or unproven data, or the Applicant should be required to disclose to participants which data relied upon has been disputed by the relevant healthcare provider. Further, Healthscope submits that the Applicants' proposed contracting approach should not be considered to result in a likely public benefit for the purposes of the ACCC's assessment due to its uncertainty.

Catholic Health Australia (CHA)

8.12. CHA says concerns remain regarding the 40 per cent market share cap condition. CHA submits that the main benefits claimed from the establishment of a new buying group will not necessarily materialise, and AHSA have some of the highest fees and premium indexations in the industry.

8.13. CHA has further concerns about managed care in Australia through the Proposed Conduct, particularly threatening the autonomy of medical professionals. However, CHA concedes that value-based healthcare does offer opportunities for improved models of service delivery that are currently being implemented across health networks. Although CHA contends that already successful examples of value-based models that are rejected by health funds when the value to consumers exceeds the value to the health fund. CHA questions how the ACCC will monitor the buying group's progress to ensure the public benefits and detriments are adequately accounted for.

Dr Gary Galambos

8.14. Dr Galambos submits that collective bargaining for PHIs will reduce healthcare choices for Providers and consumers, affect Medicare, increase out-of-pocket costs, and lead to poorer health outcomes. He believes that for-profit PHIs prioritise return to shareholders, their employees' salaries and bonuses, and that there are only a few PHIs left that are mutual and prioritise their members. Providers are seen by PHIs as blocking their profits.

8.15. Dr Galambos submits that PHIs try to force contracts with private hospital health services to dominate the healthcare environment, and that PHIs need to be tightly regulated in order to protect the quality of healthcare. Current Medicare and PHI funder subsidisation affords Providers/patients an independent space to conduct healthcare business. Dr Galambos believes giving PHIs more power to influence

healthcare processes will be anticompetitive, as the power will be used to negatively disrupt the industry and cause worse health outcomes.

National Association of Practising Psychiatrists (NAPP)

8.16. NAPP submits that it does not believe that patients, consumer groups and the public have been adequately consulted re this application, and highlights nib's intention for a "strong alignment" and drawing from Cigna's experience and expertise. NAPP contends that the concentration of power by the HH Buying Group would exert a very asymmetric force upon Providers, who would have limited bargaining capacity should they decline a contract – resulting in a gateway to managed care under the name of value based contracting.

8.17. NAPP submits that it is imperative that the ACCC considers the sociocultural and historical impact of managed care from which the HH application emerges in making its assessment of the potential detriments of approving the application. NAPP further submits that it would be negligent of the ACCC to approve an application that multiple different health and legal professional parties have declared on record will result in net detrimental impact, and with the full knowledge that there is "no specific regulatory oversight or limitation on how parties contract with each other in the medical supply chain" in place as part of due diligence to protect Australians' safety.

8.18. NAPP calls on the ACCC to consult broadly with the public and mental health consumer groups regarding consumers' responses and anticipated experiences as to the impact it would have to discover that one's psychiatrist was signed up into an incentivising/disincentivising, unregulated, commercial third-party contract of which the details were confidential. NAPP asserts that it would be negligent for the ACCC to knowingly approve the HH application without the relevant oversight and regulatory legislation being in place to protect Australians. NAPP also holds significant concerns re the intention of HH to "mine customer data".

Dr Shirley Prager

8.19. Dr Prager submits that the ACCC is not the appropriate decision maker to predict the levels of benefit/detriment to physical and mental health of Australian community resulting from authorisation. Dr Prager questions whether, due to nib and Cigna's relationship with China, there may be data analytics used that could be a risk to Australia's security. Dr Prager also questions whether there has been adequate evidence provided by HH that guarantees that the Australian public will never be exposed to US-style managed care, given nib and Cigna have detrimental ambitions/practices generally.

Margaret Faux

8.20. Ms Faux submits that there is a major lack of knowledge from consumers about how fees are negotiated/pain between PHIs and practitioners. There is also a misunderstanding of what Medicare claims actually cover, and the billing of 'non-related' services, such as booking fees. She believes the Application seems likely to lead to collective boycotts of Providers if, for example, the HHBG makes a unilateral finding of criminal fraud by a provider, and circulates that decision among group participants.

8.21. Ms Faux submits that, at best, the HHBG will have no impact on OOPs, but at worst, it may increase consumer OOPs quickly and significantly, as doctors shift the cost burden to their patients.

8.22. Ms Faux provided some potential future triggers for revocation if authorisation is granted, and submitted that if the ACCC authorise the conduct, it should only be for three years and the BCPP condition should only be for 20 per cent of the market. Ms Faux also submits that authorisation should require written confirmation that the BCPP will be made equally available to all policy holders not just gold policy holders.

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

8.23. RANZCP considers that the ACCC has given insufficient consideration to the negative consequences for the Australian community, and maintains that the HH Buying Group is a gateway to managed care in Australia. RANZCP believes value based contracting will lead to reduced access to care and treatment, and that no inappropriate interference should be introduced in the doctor-patient relationship, nor the clinical decision-making. RANZCP submits that the fluctuating nature of mental illness should be recognised, as well as the fact that outcomes very and costs are difficult to align. Further, the Application fails to acknowledge that the public and private health systems work together, and fails to detail how cost would be adjusted accordingly for this. RANCP opposes the 60 per cent market share condition that the Applicants are seeking.

Medical Surgical Assistants Society of Australia (MSASA)

8.24. MSAS submits that there are the following five key detriments:

- Loss of choice for surgeons, assistance, anaesthetists, and patients.
- Erosion or total loss of the independence of the Medical Surgical Assistant role, which will increase perioperative risks for patients.
- A large increase in administrative costs due to extensive contracting which often needs renewal.
- Introduction of managed care in Australia.

Council of Procedural Specialists (COPS)

8.25. While PHA contends that managed care is illegal, COPS argues the purpose of the Application is to introduce contracts that provide financial incentives for medical professionals to cost-cut. COPS believes value-based contracting is a flawed concept that has not been introduced into Australia for valid reasons.

8.26. COPS submits that authorisation will create a huge imbalance in market power, and that a wide definition of detriments be designed to protect the public and should be used in this case. COPS believes comparing the HH Application with other buying groups is erroneous because existing buying groups are not seeking to offer value based contracts, nor do they comprise larger health funds.

8.27. COPS submits that the PHI Act does not protect Australia from managed care/doesn't apply in this situation, and that the ACCC's proposed 40 per cent condition will not protect against abuse of market power. Further, COPS believes there will be increased cybersecurity risks from the Proposed Conduct

Applicant's response to interested party submissions

8.28. The Applicants deny the major issues raised by the Interested Parties and respond to these issues individually.

8.29. *Economic coercion of medical practitioners to sign MPPAs:* Specialists that do not participate will be paid benefits under current medical gap schemes. Offering different rates to those agreed upon is not economic coercion. Medical specialists joining the BCPP will not change their financial position, but will no longer be able to determine their own fees/gaps. This decision is voluntary and specialists can leave the BCPP at any time.

8.30. *Economic influence on medical practitioners to provide certain treatment*: As per the PHI Act and Health Practitioner Regulation National Law, it is illegal to provide financial benefits to practitioners for referring patients to specialists. Currently, consumers are influenced economically when deciding on specialists for hospital treatment. This is not coercion. Without the current gap scheme, there would be no

control over gaps. The BCPP is similar because it provides an additional layer of choice for consumers where gaps are further controlled for the whole episode of care.

8.31. *Forty per cent cap for BCPP:* The more appropriate cap is 60 per cent to allow at least one other Major PHI to participate in all States and Territories. This will not create bargaining imbalance as the BCPP is optional. A higher market share of the HH Buying Group will allow HH to engage with more medical specialists and enhance public benefits.

8.32. *Collective boycotts*: There is no proposal to enter into MPPAs with dentists/allied health professionals as part of the Proposed Conduct. Nib has a network of recognised Providers, which will be retained. Providers would only be derecognised if they engaged in fraud. The HH Buying Group will provide greater commercial incentive to have larger network of allied health Providers.

8.33. *Uncertainty for Providers*: Uncertainty is a necessary element of a buying group that does not collectively boycott.

8.34. *Push consumers to purchase gold policies:* The Proposed Conduct does not involve provision of any comparison services between products offered by Participants and other health insurers.

8.35. Introduction *of new criteria for approved treatments*: Health insurers are legally required to pay minimum benefits for hospital treatment under PHI Act. If insurers impose new criteria, this is to determine whether a higher level of benefits is payable under the HPPA. For the HH Buying Group to negotiate new criteria for HPPAs, the changes would need to be agreed by hospitals.

8.36. HH intends to develop contracts in mental health after consultations with hospitals and psychiatrists.

8.37. HH is willing to use a different measurement of standards if there is one that is better than ICHOM.