MinterEllison

14 July 2021

Michael Pappa
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Australian Competition & Consumer Commission
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MELBOURNE VIC 3000

Dear Michael

Response to second tranche of submissions on draft determination AA1000542-1

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

We have set out below the Applicants' response to the submissions of interested parties that were uploaded to the public register after Friday, 25 June 2021 (**second tranche of submissions**). We refer to our submission dated 30 June 2021 (**30 June Response**) which responds to the submissions of interested parties uploaded to the public register up to and including Friday 25 June 2021. Capitalised terms used in this letter are defined in the Application unless defined in this letter.

We note that the Applicants will provide their response to the verbal submissions made during the pre-decision conference held on Thursday, 8 July 2021 after written submissions are lodged by the parties in attendance and those submissions are considered by the Applicants.

1. Second tranche of submissions

1.1 The Applicants have now reviewed the second tranche of submissions from the interested parties in response to the draft determination. The Applicants' assessment of these submissions is the same as that articulated in our 30 June Response, specifically that the vast majority of submissions are from individuals – predominantly medical practitioners, who oppose the proposed authorisation of the HH Buying Group on the basis that this will lead to the implementation of a managed care model.

1.2 The Applicants strongly refute these claims. We refer to our 30 June Response, which sets out in detail why the HH Buying Group will not lead to a managed care model and will not detrimentally impact the autonomy of the health provider or patient.

1.3 We have also identified some new issues raised by the interested parties in the second tranche of submissions and set out these new issues and the Applicants' responses to them below.

2. Response to new issues raised

Insurers are not qualified to make medical decisions

2.1 A number of submissions claim that authorising the Proposed Conduct would give broader control to health insurers to make health-related decisions about which patients and what treatment to cover. Some submissions also analogise the current proposed situation with the US private healthcare system; essentially that medical practices have to obtain prior authorisation from

insurers and ascertain what will and will not be covered, before the doctor can decide on treatment options.[1] The interested parties argue that it is inappropriate for insurers to determine medical care rather than qualified doctors, as the insurers do not have the appropriate medical or specialist training and qualifications. Further, they argue that insurers are not the appropriate body to determine value-based care and outcomes; insurance companies should not encroach on the decision-making powers of doctors or interfere in doctor-patient relationships.[2]

2.2 The Applicants strongly refute these claims on the basis that they are factually incorrect. Firstly, the Applicants can categorically say that the Proposed Conduct will not involve the preauthorisation of treatment or medical care. This is illegal in Australia as insurers are prohibited from limiting a medical practitioner's professional freedom to identify and provide appropriate treatments.[3] The Proposed Conduct essentially allows HH to operate a buying group for the purchase of health services and there is no correlation between this conduct and the preauthorisation of treatment. The engagement of value-based contracting by the HH Buying Group aims to reward high value care provided by medical practitioners and private hospitals for hospital treatment but it does not dictate the nature of the treatment provided. Further, the Participants will not, and legally cannot, refuse to pay any benefits for hospital treatment performed by a medical practitioner or a private hospital because it has not been approved by a Participant. In fact, a price floor is set for the treatment provided by the medical practitioner and for hospital accommodation provided by the private hospital under the *Private Health Insurance Act 2007* (Cth).

2.3 Secondly, the Applicants submit that neither HH nor any of the Participants will be determining the meaning of high value care when engaging in value-based contracting. HH is currently using, and will be using under the Proposed Conduct, internationally recognised scientific standard sets of value, calculated by the International Consortium for Health Outcomes Measurement (**ICHOM**). ICHOM's mission is to "*unlock the potential of value-based healthcare by defining global Standard Sets of outcome measures that matter most to patients and driving adoption and reporting of these measures worldwide*". The ICHOM standard sets specify in detail what a good patient outcome means for each condition.

2.4 For example, under the Clinical Partners Program, orthopaedic surgeons' performance under their MPPAs is measured using the ICHOM standard for knee and hip replacements. Example outcome measures for osteoarthritis of the hip (the treatment for which may be a hip replacement) include hip function, pain in hips, quality of life, work status and satisfaction with results.

High risk patients will be excluded

2.5 Several submissions express concerns that high risk patients with complex co-morbidities will be excluded from the healthcare system because they are associated with complications, increased costs, and accordingly, higher out-of-pocked costs for the patient concerned.[4] They suggest that the HH Buying Group will seek to exclude these complex cases that represent 'poor' value to the HH Buying Group, and focus on the quick and simple patients in order to deliver the highest value care to the buying group.[5]

2.6 The Applicants submit that these claims are based on an incorrect understanding of value. The Applicants agree that patients' comorbidities and complexities must be taken into account to determine appropriate and fair patient outcomes and therefore, value of care. Value scores are risk adjusted and normalised for these factors. HH will undertake this analysis in accordance with international accepted standards (including ICHOM), using the data science tools and methodologies that HH has developed and will continue to develop, as well as tools and methodologies accessible through Cigna. Adjustment for risk factors is not a process determined independently by HH.

2.7 The Applicants also note that under the Clinical Partners' Program, medical specialists do not have discretion to refuse to treat an nib member through the no gap arrangement on the basis that they have a higher risk of complications. Medical specialists agree to provide a no gap experience to all nib members and they are assessed on their performance through a risk adjusted assessment of the value of care they provide.

[1] 11 June submission PDF, page 47.
[2] 10 June submission PDF, page 3.
[3] s172-5 *Private Health Insurance Act 2007* (Cth).
[4] Dr James English, 11 June submission PDF page 103.
[5] 11 June submission PDF pages 101 and 103.

Increased administrative costs for small businesses

2.8 A number of submissions argue that the value-based contracting with medical specialists will be significantly administratively burdensome on small specialist medical practices. The submission from The Australian and New Zealand Association of Oral & Maxillofacial Surgeons (ANZAOMS) analogises with the US system; where the cost to negotiate and manage contracts is detrimental to these businesses because of their small size and limited resources. The submissions refute the statement made by the Applicants that administrative efficiencies will flow to doctors, and argue that there will be added administrative requirements for doctors, who have to negotiate many payment schedules.[6]

2.9 In the Australian context, the contracts that are typically costly to negotiate and manage are HPPAs and MPPAs which currently impacts small private hospitals and medical practitioners. The HH Buying Group will not increase transaction and administrative costs in the negotiation and management of these contracts for the small health providers who currently deal separately with the Participants of the HH Buying Group. It may potentially reduce these transaction costs, depending on which and how many Participants switch to the HH Buying Group.

2.10 In relation to MPPAs such as those entered into under the Clinical Partners Program, they would require an additional investment in time and resources, and would introduce additional administrative processes. However, as MPPAs are purely voluntary (due to the medical gap schemes and Medicare entitlements), a medical specialist would only invest the additional resources if they considered it financially viable to do so due to the benefits of the program such as increased patient volume. Because HH will be providing these contracting services on behalf of a collective group of Participants, the Applicants would be able to reduce the administrative costs for medical specialists by allowing them to only deal with HH in relation to a broad group of their patients rather than negotiating with multiple insurers.

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

Yours faithfully
MinterEllison

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OUR REF: 1313530

[6] Australian Society of Anaesthetists.