MinterEllison

19 February 2021

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Dear Michael

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

We refer to the application for authorisation by nib health funds limited (**nib**) and Honeysuckle Health Ltd (**Applicants**) dated 23 December 2020 (**Application**) and the submissions received from the interested parties listed in the Annexure. We will provide a response to the remaining submissions in separate correspondence.

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

1. Structure of the HH Buying Group

1.1 Several submissions raised concerns relating to the structure of the HH Buying Group, specifically, the concerns relate to:

(a) lack of details about the Participants;[1]

(b) the inclusion of government payers of healthcare services in the HH Buying Group;[2]

(c) the inclusion of travel insurance providers, specifically QBE travel insurance in the HH Buying Group;[3]

(d) the relationship between the Applicants and the risk that nib's interests will be prioritised in negotiations or [4] that the larger members in the HH Buying group will be prioritised over smaller members in contract negotiation stages;[5] and

(e) use of nib contracts as a base in the HH Buying Group's initial negotiations.[6]

Specificity of Participants

1.2 Various submissions requested further information about the specific Participants who would be involved in the Buying Group. At this stage, nib is the only Participant and therefore, the Application could not be more specific about this.

[1] Catholic Health Australia AACMA
[2] Day Hospitals Australia; AACMA, Occupational Therapy Australia, Optometry Australia, Australian Dental Association, Catholic Health Australia
[3] AACMA
[4] Catholic Health Australia
[5] Catholic Health Australia
[6] AMA, Catholic Health Australia,

1.3 As stated in the Application, potential Participants in the HH Buying Group would be any organisations associated with the funding of medical services in Australia. It is likely this will predominantly be private health insurers but may also include government and semi-government organisations.

Government payers of healthcare

1.4 The concerns expressed in some of the submissions relate to Providers being paid less for their services by government payers if they joined the HH Buying Group.[7] Some interested parties referred to the fact that they enjoy higher benefits from government payers than other payers such as private health insurers for the same health services. This supports the proposition in the Application that the benefits currently being paid by government payers for some health services are not market competitive prices.[8] It also recognises that through the HH Buying Group, government payers would be able to access competitive prices for health services and supports the public benefit arguments in the Application.

1.5 The purpose of the HH Buying Group is to create higher value for health services and achieve the best value price and quality that can be sustained in the market. To suggest that the source of funding for those health services should preclude some organisations from participating (i.e. government payers of healthcare) would be at odds with having an effective and competitive market which, ultimately, is the basis for the Proposed Conduct. Furthermore, the reduction in benefits paid by government from paying more efficient prices for health services is in the best interest of taxpayers who ultimately foot the bill.

1.6 The Applicants note that participation in the Buying Group is on a voluntary basis and is non-exclusive. It will be up to the relevant government agency to determine whether to participate in the HH Buying Group for particular services or retain their current pricing and contracting arrangements.

1.7 The Applicants acknowledge that government payers do not pay supra-competitive prices in relation to all health goods or services. In some cases, government payers achieve more competitive pricing than private health insurers. For example, government payers are not subject to regulation that requires health insurers to pay a minimum price for prostheses and therefore, government payers access more market competitive prices for prosthesis devices.

1.8 One of the submissions claims that there would be reduced benefits paid to veterans and reduced occupational therapy services.[9] However, as DVA generally pays claims in full, the amount paid in benefits does not impact on veterans and any reduction would lead to cost savings for government.[10] Participation in the HH Buying Group does not require Participants to exclusively purchase health services through the HH Buying Group so it would not require government payers to change their service offering or narrow the breadth of services that they fund. Therefore, the Applicants submit that there would not be an impact on the range of health services provided by DVA or other government payers if they participated in the HH Buying Group.

Travel insurers

1.9 The submission of the Australian Acupuncture and Chinese Medicine Association raised the issue of allowing travel insurers to be part of the Buying Group, particularly given nib's recent acquisition of QBE's travel insurance business.[11]

1.10 Ownership of a travel insurance business by nib should not preclude the involvement of travel insurers generally in the HH Buying Group and allowing travel insurers to access competitive health prices. Additionally, the Applicants note that insured persons from nib's travel business are already covered under the Australian contracts that nib holds with major health provider groups. There have been no provider concerns on this issue to date.

[7] AACMA; Occupational Therapy Australia; Optometry Australia; Australian Dental Association.
[8] Application for authorisation, 23 December 2020, [1.8].
[9] Occupational Therapy Australia.
[10] Application for authorisation, 23 December 2020, [1.8].
[11] AACMA

1.11 Lastly, the Applicants do not see why this would have significance to the Australian Acupuncture and Chinese Medicine Association. Travel insurance claims for health issues would be very unlikely to include either acupuncture or traditional Chinese medicine.

Balancing Participants' interests

1.12 Some submissions raise concerns about the interests of nib, large participants and/or government payers being prioritised in negotiations with Providers.

1.13 In operating the Buying Group, HH will be balancing the needs of all Participants in the Buying Group to be effective and successful as a business. To achieve this, HH will ascertain all Participants' requirements prior to negotiating and engaging with healthcare providers to ensure that all Participants' needs and requirements are addressed. Where these conflict HH will engage with the relevant Participants to ensure appropriate balance is achieved for both Participants and, where this is not possible, the Participant will remain able to withdraw from the negotiation with a particular Provider or withdraw from the HH Buying Group, and resume the status quo of contracting directly with Providers.

1.14 Furthermore, the Applicants recognise that each potential Participant has a unique member value proposition that may create differences in contracting strategy and approach. A key role for HH will be to manage the different objectives or priorities that may exist across the Participants. In order for the Applicants to successfully attract additional Participants it will need to be able to demonstrate that it has controls and governance structures in place to ensure that the interests of all Participants are pursued with equal prioritisation.

1.15 In any event, this concern does not create any competition concerns in the health services market (or any other market) or diminish the public benefits for health care consumers from the Proposed Conduct. These are commercial matters for the Participants and HH to manage in the operation of the HH Buying Group.

Using nib's existing contracts

1.16 The submissions express concern that the nib contracts are skewed towards nib's members, and are accordingly not appropriate to be used as the base contracts in negotiations on behalf of all types of healthcare payers.[12]

1.17 Under nib's guidance, the HH contracting team have had a deliberate strategy of moving towards partnership-minded relationships with providers as opposed to the traditional adversarial relationships. The current set of nib HPPAs reflect this transition. Some contracts are more advanced down this path than others due to varying levels of receptivity to this new model of engagement from providers. nib's current contracts will only be used as a starting point and the contracts will evolve with new funding models and to adapt to the interests of new Participants as they join the HH Buying Group.

1.18 The Applicants recognise that in order to be able to attract and retain Participants, HH will need to demonstrate that its contracts reflect the needs of all Participants and are not skewed towards nib's members.

2. Impact on relevant markets and competitive effects

2.1 The submissions raised concerns that the Buying Group's market share could reach 100%.[13] It was submitted that this would have the following competitive effects:

(a) financial and reputational consequences for hospitals who fail to reach a HPPA with the Buying Group;[14]

(b) inefficient pricing for healthcare services, limiting their ability (particularly smaller hospitals known as 'price takers') to invest in new technology, maintain wards and other facilities, and engage in innovation;[15]

[12] Australian Medical Association; Catholic Health Australia.
[13] Healthscope, AMA, Catholic Health Australia
[14] Healthscope
[15] Healthscope, Catholic Health Australia

(c) a buying group with 100% market share would produce inefficient pricing. Hospital prices are not supra-competitive;[16]

(d) reliance on comprehensive preferred provider networks will result in reduced competition as customers will be required (or financially encouraged) to go the selected provider or pay full out of pocket expenses;[17] and

(e) smaller healthcare providers being 'squeezed' out of the market, with larger providers with lower cost treatment models being favoured.[18]

Market Share

2.2 The Applicants consider that it is extremely unlikely that the Buying Group would represent 100% of all health care payers. The four largest private health insurers are very unlikely to join the Buying Group due to the significant investment made by those insurers in their in-house contracting function. Even if all other healthcare payers joined the HH Buying Group (which the Applicants also consider very unlikely), the HH Buying Group could potentially represent around 40 to 50% of health care payers at a national level[19]. If this is narrowed to representing all private health insurers except the four major private health insurers, the potential share of health care payers nationally falls to around 20%.[20]

2.3 The Applicants nonetheless appreciate the concern raised and consider that it would be reasonable for the ACCC to impose conditions to address this 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.

Importance of HPPAs and reduced negotiating power for small health care providers

2.4 Healthscope submitted that the significance of entering into a HPPA for Providers should not be overstated as reputational and financial consequences often follow. Furthermore, various providers, particularly allied health providers, raised concerns that smaller independent providers risked being excluded from the market as a result of significantly reduced market power.

2.5 The Applicants acknowledge the value of having an HPPA to healthcare providers and the importance of being able to attract health insurance members to private hospitals. Although having an HPPA with the HH Buying Group may be more important than a single Participant, it will be similar to the current situation that Providers face with large health insurers and the AHSA. If the HH Buying Group represented all health insurers except the four major players (which the Applicants consider unlikely), then the HH Buying Group's share of the private health insurance market would be between 13% and 40% depending on the geographical scope of the market (State, Territory or national)[21]. This is similar to the current market share of Medibank or BUPA which ranges from around 10% to 48% depending on the geographical market[22]. Therefore, negotiating with the HH Buying Group in the unlikely event that it represented all private health insurers except the four largest, would be on par with the Providers' current position negotiating with Medibank or BUPA.

2.6 The Applicants consider that the reputational and financial consequences of not reaching agreement on a HPPA are also detrimental to private health insurers who have the direct relationship with the member. It is a key member offering for health insurers to have a broad network of hospitals and health professionals where members experience nil or reduced out-of-pocket expenses.

[16] Healthscope
[17] Australian Dental Association
[18] Optometry Australia, Australian Dental Association, Catholic Health Australia, Healthscope, AMA,
[19] Private health insurers account for about 67.7% of health care payers nationally. Market share of the four large private health insurers is about 70% so the HH Buying Group could represent about 20% of health care payers plus the remaining 30% of other health care payers which would be a maximum of 50%. As this includes private funding by individuals of 13% which may include some travel insurance funding, the maximum is more likely to be 40 to 50%. Application for authorisation, 23 December 2020, [3.5 to 3.10]
[20] Private health insurers account for about 67.7% of health care payers nationally. Market share of the four large private health insurers is about 70% so the HH Buying Group could represent about 20% of health care payers. Application for authorisation, 23 December 2020, [3.5 to 3.9]
[21] Application for authorisation, 23 December 2020, [5.6]
[22] Application for authorisation, 23 December 2020, [5.6]

2.7 Additionally, the Applicants do not agree that the Proposed Conduct will result in larger providers benefiting disproportionately from negotiations, and smaller providers being excluded from negotiations with the HH Buying Group. Through a focus on value-based contracting, members of Participants will have the option of purchasing from “higher value” Providers. 'Value' involves assessing the quality of the services against the cost to acquire or purchase the services. Where two providers provide equitable quality of service (for example, two hospitals have the same quality and outcomes for patients in relation to Health Care Acquired Complications and other quality metrics) and one is a lower cost, then the hospital with the lower cost would have a higher value and would be favoured by consumers. Conversely, if two hospitals had the same costs for equivalent services, but one had significantly better quality and outcomes for patients then the hospital with higher quality outcomes would represent better value and would be favoured in negotiations.

2.8 This is an important distinction as currently many providers receive equal payments irrespective of the quality of the outcomes for consumers and patients. This means that low quality providers (and accordingly low value providers) are disproportionately favoured as their peers with better quality will likely have a higher cost to deliver the service. This provides an opportunity for Providers of all sizes to benefit as the focus moves towards the delivery of their health care services which, ultimately, benefits all consumers. Not only will this see Providers with better quality and outcomes for patients favoured more in negotiation, but it will also drive all Providers to have a quality focus.

2.9 The HH Buying Group will be indifferent to the underlying scale of the Provider when engaging in value-based contracting. There is no evidence that smaller Providers are lower quality than larger Providers. But there is evidence that smaller Providers are lower cost than larger Providers. Hence, it is reasonable to believe that smaller Providers will actually benefit from a focus on value-based contracting.

2.10 Turning to the impact on allied health markets such as optometry, dentistry and physiotherapy, these networks would be managed for Participants based on the individual needs of their members. The HH Buying Group's negotiations would be very similar to the current negotiations between private health insurers and the allied health industry and should be synergistic in promoting and marketing participating Providers to members, and in return providing discounted rates to the payers of healthcare services and in turn, consumers.

Transactional cost efficiencies overstated

2.11 Some interested parties submitted that the transactional cost savings as a result of the Proposed Conduct are overstated, and that collective negotiations will actually increase the complexity of contract management, and could lead to more contractual interpretation disputes.[23]

2.12 The Applicants do not agree with these submissions. Reducing the number of parties that payers and Providers must negotiate with, and reducing the number of contracts that are entered into, will reduce contract management complexity for all parties. This includes reducing the number of contractual disputes between parties. Additionally, as much as possible, HH will be looking to standardise definitions with the rest of the industry.

2.13 Best practice approaches to contracting would see that contract terms are developed and negotiated in a manner which avoids ambiguity. Ultimately, current practice means that Providers must implement and manage a range of contracts for funding with all associated payers of health care services. Having an identical contract with terms and conditions for multiple payers will be beneficial by reducing the training required for billing teams, reducing administrative costs associated with management and implementation of the contracts as management will occur through a singular entity (also creating an effective contract relationship model for long term engagement). The Applicants fail to see how this would not result in transactional cost savings to Providers, especially medical and hospital providers, who currently manage this overhead.

2.14 For medical specialists, large overheads currently exist to adapt and implement varied models of care based on individual funders needs and the costs associated with this are prohibitive for many speciality groups.

2.15 Further, the Proposed Conduct would be advantageous to small providers in reducing transaction costs in dealing with one entity rather than negotiating and contracting with multiple payers.

[23] Healthscope; Catholic Health Australia.

Ultimately, the formation of the HH Buying Group will be beneficial to these types of Providers as negotiation with multiple small and medium-sized funds can occur in a singular location and format, reducing transactional costs.

Reduced prices will limit scope for investment in equipment, employees and innovation

2.16 Various submissions raised concerns that reducing the price of healthcare services would result in reduced funding for investment in the elements of healthcare separate to medical services, for example equipment, maintenance of facilities, employee incentives and innovation.[24]

2.17 The Applicants do not agree with the proposition that paying more efficient prices for health services through the HH Buying Group will lead to reduced investment by Providers. The key principle underpinning value-based contracting is to make price reflective of the quality of the services and outcomes associated with healthcare service delivered. Where Providers can directly connect how investment in areas such as capital improvements, employee training and innovation with improved outcomes and efficiency in the market, then this would effectively increase their value in the system and would be reflected in increased funding.

2.18 Regarding small hospital operators specifically, in the Applicants' view, smaller hospital operators are well placed to prosper under a value-based contracting model and create opportunities for investment. These providers currently provide care at equitable levels to larger providers and represent “good value” in the current system. Ultimately, these Providers would benefit more from a value-based system which would equate funding to outcomes rather than activity.

2.19 Additionally, the Applicants do not agree with the proposition that Providers should be paid supra-competitive prices by health care payers in order for Providers to invest in their businesses.

Inefficient pricing

2.20 The Applicants do not consider that the HH Buying Group will drive down prices to below market competitive prices or create inefficient prices. It would not be in the interest of HH nor any of the Participants to drive a non-viable price with Providers. HH would fail to engage Providers on new funding models if it offered to pay below market prices and HH would risk losing Providers from its network which would have a detrimental impact on Participants and HH's service offering to Participants. As mentioned in the Application, without an agreement with private health insurers, Providers are still able to access funding from health insurers and Medicare.

2.21 In contrast, the Applicants submit that the Proposed Conduct will lead to an adjustment of supra-competitive prices for some health services. As stated in the Application, currently higher prices are being paid for the same treatment to larger hospital providers without any correlation to the value for consumers of those services.

3. Managed care models

3.1 Some interested parties submitted that the Proposed Conduct will lead to the implementation of a 'managed care' model of service,[25] reducing patient choice and patient outcomes while increasing costs.[26] Specifically, interested parties are concerned that granting the authorisation will:

(a) prevent parties from being able to choose their source of primary care or primary carer;[27]

(b) lead to the concentration of allied health services and create 'de facto' panels of approved service providers rather than promoting freedom choice;[28]

(c) lead to the termination of longstanding clinical relationships and reduce customer choice;[29]

(d) create a vertically integrated managed care arrangement where patient choice is limited, resulting in poor health outcomes and increased costs;[30]

[24] Healthscope; Catholic Health Australia.
[25] Australian Orthopaedic Association, Occupational Therapy Australia, Rehabilitation Medicine Society of Australia and New Zealand (**RMSANZ**)
[26] Australian Orthopaedic Association, Australian Medical Association, Australian Dental Association
[27] Australian Orthopaedic Association; RMSANZ; Australian Dental Association.
[28] Occupational Therapy Australia.
[29] Occupational Therapy Australia.
[30] Australian Medical Association.

3.2 The Applicants agree that the US style system of managed care is not appropriate for Australia. The Applicants believe that the future pathway to achieve a stronger and better health system is to provide evolved funding models to health providers that encourage and reward innovation in care, by recognising and rewarding providers for driving high quality outcomes for patients in an efficient and effective manner.

3.3 To achieve this, HH would be seeking to further engage with all Providers in a partnered/relationship model based on a more scalable version of the current Clinical Partners Program model of care developed and run by HH on behalf of nib.

Patient choice

3.4 The submissions raise concerns that the Proposed Conduct will result in reduced patient choice as patients will be obliged to use negotiated providers rather than their own preferred provider with whom the Buying Group may not have reached an agreement.

3.5 Consumers' freedom of choice of a Provider will always remain a key principle of the HH Buying Group's contracting arrangements. The Participants would not accept that their members would have any limitations placed on that freedom by participating in the HH Buying Group. There are also regulatory barriers to prevent private health insurers from limiting consumer freedom or engaging in any style of managed care. Consumers will retain the ability to choose their medical specialist, private hospital or other Providers and in fact, the Proposed Conduct will lead to a more informed and independent choice.

3.6 The HH Buying Group will retain the existing contractual framework as the base structure and value-based contacting and other innovative funding models will be offered to Providers as an alternative funding proposition. Providers may adopt these new funding models for particular services and then retain the current funding arrangements for other services. There will be flexibility for Providers and will not result in a complete overhaul of contract funding arrangements.

3.7 HH will retain the breadth of Providers in its network as this is critical for Participants. The Proposed Conduct is not designed to narrow the network of healthcare providers available to consumers., but rather to create an additional tier in the network of Providers. Providers that adopt new funding models may be already be part of the network, and others may be new to the network and attracted by the new funding models, as experienced by the Applicants through the Clinical Partners Program. The Proposed Conduct will not limit consumers' choice of Providers, but instead create more choice, and more informed choice, for consumers.

3.8 The Applicants strongly disagree with the submission that consumers will not be able to choose their Provider, whether in primary care or otherwise.

Longstanding patient relationships

3.9 Occupational Therapy Australia submitted that the Proposed Conduct may lead to the forced termination of longstanding patient relationships as a result of the implementation of a vertically integrated model of care.

3.10 The Proposed Conduct will lead to greater options for health consumers in choosing Providers and more information about the quality of Providers. In some circumstances, this informed choice may lead to the consumers terminating Provider relationships and choosing other Providers because they provide better value health care. GPs may also recommend new Providers to consumers based on additional information at hand about Providers through HH's value-based contracting. The Applicants submit that is not a public detriment arising from the Proposed Conduct but a possible outcome from greater consumer empowerment in choosing Providers.

Vertically integrated model of care

3.11 The Applicants fail to see how the Proposed Conduct is seeking to introduce either managed care or a vertically integrated model of care. Importantly, value-based contracting in this context specifically aims to be implemented without creating a managed model of care by facilitating greater transparency and choice. Through the Proposed Conduct, the Applicants are seeking to introduce and evolve value-based contracting in Australia through more modern funding models and mechanisms. For example, by setting up funding models which allow flexibility in how medical specialists apply care and then rewarding them with funding to match the value they generate in the system, the model should produce positive behaviours where medical specialists

are not financially dis-incentivised to apply more complex and costly care as can sometimes be the case currently. The Proposed Conduct will not result in private health insurers dictating to its members which Provider to use or directing Providers to adopt particular models of care or treatment plans.

3.12 Currently, there is already a 'pseudo' vertical integration model because members generally rely on their GP's advice for a referral to a Provider. Consumers do not currently receive enough information on the quality of the health services they are purchasing to make an informed decision as to their choice of Providers. Consumers rely heavily on GP advice and not their private health insurer who does not advise members about which Providers are clinically appropriate. The Proposed Conduct will not alter this.

3.13 The reliance on GPs can be problematic as GPs also lack access to data on the outcomes and value of Providers to whom they are referring patients. Accordingly there is room to improve consumer choice whilst also moving away from a 'pseudo' vertical integration model by improving transparency on outcomes, value and the quality of the services delivered. One of the goals of value-based contracting is to quantify and provide information on the quality, cost and efficiency of care at the point of decision (the medical specialist). In doing so, this will allow GPs and other medical practitioners to make informed choices to get the best medical and financial outcomes for their patient and to improve the cost efficiency of the system. Additionally, the increased transparency will improve patient understanding and choice, resulting in improved health outcomes. It will also reduce out-of-pocket costs to consumers and reduce health system costs for Participants.

3.14 The Applicants recognise that it is critical to ensure that Providers retain clinical autonomy, and are not seeking to introduce the US model of managed care to the Australian health system, nor does it consider it appropriate to do so. Private health insurance legislation expressly prohibits insurers from limiting a medical practitioner's professional freedom to provide appropriate treatment[31].

4. Value-based contracting

4.1 Interested parties submitted that the extent to which value-based contracting will result in public benefit is overstated in the Application. Specifically, interested parties submit that:

(a) the use of US data and case studies to substantiate the public benefits of value-based contracting is inappropriate due to the difference between the Australian and US health system models[32] and there is no basis for belief that value-based contracting results in improved health outcomes;[33] and

(b) the scope of the Proposed Conduct is not necessary to coordinate and implement value-based contracting.[34]

Application of value-based contracting in Australia

4.2 Value-based contracting, fundamentally, aligns the amount of funding for the health care services to be proportionate to the quality of care delivered and the outcomes for the patient. It primarily seeks to reward and recognise care which delivers better outcomes and quality and essentially recognises that this care can be more costly to provide and should be rewarded with a higher level of funding. Conversely, care which provides lower levels of quality and outcomes for patients and which is priced at a similar level is, by definition, poorer value to the health care system, patients and the health care funder. This care at present is funded at equitable amounts and fundamentally should be treated as lower value in the system.

4.3 HH sees this as one of the most fundamental flaws of the current health care system in Australia and this is one of the primary reasons HH is seeking to mature and evolve funding models into value-based care. The Applicants submit that the benefits of value-based contracting do have application to the Australian market and learnings can be drawn from the United States experience.

[31] section 172-5 of the *Private Health Insurance Act 2007* (Cth)
[32] AMA.
[33] Catholic Health Australia
[34] Healthscope

Value-based contracting in the subacute sector

4.4 RMSANZ raised specific concerns relating to the suitability of value-based contracting in the subacute sector, noting that some subacute patients outcomes cannot be measured, and according value cannot be measured by the outcome.

4.5 As mentioned earlier, the Proposed Conduct will not limit choice for consumers. The models of care which may impact on the subacute sector (specifically rehabilitation medicine and mental health) would be targeted to improve outcomes and allow for more innovative funding models for these medical specialists through programs like the Clinical Partners Program. Models such as this should facilitate better partnership between acute and sub-acute specialists and, more specifically, ensure that these areas are funded appropriately and in alignment with the quality outcomes they deliver.

Scope of Proposed Conduct not necessary to implement value-based contracting

4.6 The implementation of value-based contracting by Providers requires a degree of investment and engagement which in nib's experience, has been more difficult to achieve as a stand-alone insurer. This is because value-based contracting is complex and difficult to implement. The existence of the HH Buying Group provides the scale required to engage with Providers.

4.7 From a data and information collection perspective, it is pertinent that data be collected from a wide range of providers and payers in order for it to be useful in accurately assessing and pricing the market. The more comprehensive the data and information that is received by the HH Buying Group, the more effective the implementation of value-based contracting will be, and the greater the public benefit.

4.8 From a practical perspective, wide participation in the HH Buying Group is important to ensure a standardised approach to value-based contracting. Value-based contracting is more attractive to Providers if standard terms and equivalent quality criteria are established across the market. This uniform approach will be more accessible for providers, and facilitate a smoother transition into value-based contracting. Accordingly, comprehensive involvement the HH Buying Group will increase the participation in, and effectiveness of, value-based contracting.

5. Privacy and information sharing

5.1 Some submissions raised concerns relating to the privacy of information collected during the process of negotiations, and the information sharing parameters that would be established. Specifically, it was submitted that:

(a) information sharing parameters and protections were not clearly defined[35] and privacy of hospital and patient confidential information would need to be protected;[36] and

(b) participants' retained the ability to 'opt-out' of the contract after seeing the negotiated terms and use the information in negotiations to secure more favourable terms on a separate basis.[37]

Information sharing and privacy protections

5.2 The Applicants will continue to adopt a best practice approach to both privacy and data governance. HH's Risk Management Framework maintains an Information Security Management System (ISMS), Privacy Governance Framework and Data Governance Framework. Additionally, the HH ISMS was recently certified as ISO27001 compliant.

5.3 HH's Data Governance Framework outlines both how information is used, stored and shared and the controls that HH has in place to ensure compliance with its obligations to, and expectations of, all stakeholders.

5.4 HH's Privacy Management Framework sets out the practices, procedures and systems being implemented by HH to comply with the Australian Privacy Principles and to meet its privacy stance. It also provides a central source of information for staff and contractors about HH's privacy management approach, privacy roles and responsibilities and relevant policies and

[35] Mater
[36] Mater
[37] Healthscope

procedures. Other important information with respect to HH's management of privacy risks are documented within HH's Privacy Management Plan and Privacy Policy.

5.5 Maintaining the privacy of claims data or other personal information of Participants' members is of paramount importance to HH. 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. Privacy consents will be obtained by Participants for this use and disclosure of their 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.

5.6 Any information that is shared with Participants will be high level, de-identified and aggregated information necessary to facilitate effective negotiations and contract administration. In circumstances where personal information is required to be de-identified in order for HH to perform a function for a Participant (for example, in unique contract administration circumstances where a particular member's needs are relevant), it will be with the support of the Participant and with the necessary consents from the consumer.

5.7 Consistent with HH's Data Governance Framework, nib will not have access to the personal information of Participants' members and will not receive greater access to information than other Participants due to its partial ownership stake in HH.

5.8 The Applicants recognise the importance of data sharing parameters both commercially and legally. This is why strong governance protocols have already been put in place between HH and nib to ensure the proper approach to information collection and use is adhered to. nib has an existing and ongoing need to ensure compliance with Prudential Standard CPS 231 on Outsourcing and meet with the standards imposed relating to data and information security.

5.9 Furthermore, it is not in the interests of HH to share greater information with nib (or any other Participant) as this would not facilitate trust and participation in the HH Buying Group. It is in HH's best interests both commercially and legally to ensure information sharing and data protocols are specifically adhered to and relations with nib are kept 'at arm's length'. To the extent that nib is a Participant in the 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.

Participants' ability to use information from Buying Group to separately negotiate

5.10 Participants will be free to contract with Providers outside of the HH Buying Group if they are not satisfied with the HH Buying Group's negotiated position. The Applicants consider that the non-exclusive nature of participation in the HH Buying Group will foster greater competition between health care payers and greater public benefits.

5.11 The Applicants acknowledge that if a Participant does opt to contract outside the HH Buying Group, they will have the advantage of knowing the terms the Provider agreed to with the HH Buying Group. It does not necessarily translate that the Participant will be able to secure more favourable terms but if they are able to, the Participant should not be prevented from doing so. The Applicants reject this argument as a reason the Proposed Conduct should not be authorised.

6. Length of authorisation

6.1 A number of submissions raised concerns about the length of the authorisation period sought by the Applicants in the Application of 10 years.[38] Interested parties submitted that the length of the authorisation period sought was not necessary to understand the impact of the Proposed Conduct, suggesting that three to five years would be sufficient.[39]

6.2 The Applicants submit 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 submit that the authorisation should cover at least two contract cycles to realise the public benefits of the Proposed Conduct.

6.3 Further, there will be an interim period of formation of the Buying Group during which Participants will join the Buying Group, governance structures will be established and value-based contracting structures and other initiatives are developed and agreed upon as each Participant joins the HH

[38] AACMA, AMA, Catholica Health Australia, Mater, Healthscope, Catholic Health Australia
[39] AACMA; Healthscope; Mater; Catholic Health Australia.

Buying Group. The transition for a Participant from their current contracting arrangements to the HH Buying Group will require planning, analysis of the impact and communications with members and Providers. The Applicants anticipate this implementation period could last up to two years which further reduces the period during which public benefits may be realised.

6.4 A five year authorisation period would not see most contracts endure two cycles and for longer term contracts, it would not be sufficient to endure one contract cycle when the implementation period of two years is taken into account.

6.5 We also note that previous authorisations have been granted for a 10 year in respect of arrangements similar to the Proposed Conduct that do not involve collective boycotting,[40] The Applicants submit that the requested ten-year period to be appropriate to observe the public benefits of the Proposed Conduct.

7. Current features of the health system

7.1 Some submissions raised concerns relating to the current structure of the health system and the role of private health insurers, rather than issues that related specifically to the Proposed Conduct. For example:

(a) AACMA expressed concerns with the classification of Chinese Medicine by private health insurers as a natural therapy (as opposed to an allied health service) for which lower benefits are paid. They submit that this may disadvantage Chinese Medicine Providers in negotiations with the buying group as they will receive a lower fee for service (if natural therapy providers are even included as a group with which the Buying Group will negotiate with);[41]

(b) AACMA also submitted that the imposition of fee limits on healthcare providers who take part in preferred provider networks, and the development of standard rates and terms and conditions is illegal and unfair;[42] and

(c) The AMA submitted there is insufficient federal regulation of private health insurance. [43]

7.2 The Applicants do not consider that these submissions relate to the Proposed Conduct, but instead are concerns about the existing structure and regulation of the private health care system. The existence of the Buying Group will not exacerbate or have any impact on the above concerns.

Please let us know if you have any queries.

Yours faithfully
MinterEllison

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[40] See for example the final determination in the application for authorisation lodged by St Vincent's Health Australia Limited (14 August 2014).
[41] Australian Acupuncture and Chinese Medicine Association
[42] AACMA
[43] AMA

Annexure

1. Private Healthcare Australia
2. Day Hospitals Australia
3. Australian Acupuncture and Chinese Medicine Association
4. Australian Orthopaedic Association
5. Occupational Therapy Australia
6. Rehabilitation Medicine Society of Australia and New Zealand
7. Healthscope
8. Australian Medical Association
9. Optometry Australia
10. Australian Dental Association
11. Mater Health
12. Catholic Health Australia