Australian Health Service Alliance

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Mr M Pappa
Competition Exemptions Branch
Australian Competition and Consumer Commission
By email: exemptions@accc.gov.au

Dear Michael

Honeysuckle Health and nib application for Authorisation AA1000542 – interested party consultation

1. We refer to the ACCC's invitation to provide submissions in response to the application submitted by Honeysuckle Health Pty Ltd (Honeysuckle Health) on behalf of itself and nib health funds limited (nib) (together, the Applicants).

Introduction

2. AHSA makes this submission to correct a number of assertions made by the Applicants in their attempt to justify why they need authorisation, and to identify the gaps in the Applicants' submission that, in our view, are likely to prevent the ACCC from being able to properly assess the benefits and risks of the proposed conduct.

3. As this submission explains, the benefits the Applicants identify as reasons for authorisation are already embedded in the sector and enjoyed by those funds in AHSA and, for that reason, cannot be justifications for authorisation. These benefits may be new to nib but have long been enjoyed by the majority of the private health insurance market. In reading the Applicants' submission, it is obvious that nib is an outlier and is seeking to catch up with the innovation bought to the private health insurance market by Medibank, Bupa, and AHSA over the past 5 years.

4. nib's knowledge of developments in the marketplace is naturally limited as they are one insurer (with a relatively smaller market scale compared to Medibank, BUPA, HCF and AHSA) and have only their own experience in the Australian market to call on in seeking to justify authorisation. As a consequence, the Applicants make a number of incorrect assertions and assumptions and fail to recognise that the 27 funds with AHSA already enjoy the competitive benefits they purport to deliver through Honeysuckle Health.

Conduct is vague and scope is uncertain

5. Furthermore, more information is required before the ACCC can meaningfully assess the potential public detriment and benefits. The exact scope of the conduct described in the application is vague and unclear, both overall and as they relate to defined markets. Accordingly, the ACCC cannot undertake a proper assessment of likely benefits and detriments which flow from the proposed conduct.

6. The ACCC's assessment of the public detriments and benefits will obviously vary depending on the size and number of the health insurers who may become members of the buying group. Leaving to one side the medium to long term problems with the Applicants' suggestion that current AHSA members would join the Honeysuckle Health group (see paragraph 37 below), the Applicants' submissions on the potential scope of its membership are vague. On the one hand, in paragraph 5.7 of their submission, the Applicants state that their market share modelling is based on an assumption that all of AHSA's member funds would join Honeysuckle Health (which, in our view, is a

commercially unrealistic and speculative possibility), and note in paragraph 1.5 that the four largest health insurers are "unlikely" to join the Honeysuckle Health buying group. On the other hand, in paragraph 1.5, the Applicants note that "the major health insurers… may be interested in purchasing bespoke parts of [Honeysuckle Health's] contracting services to supplement their internal contracting function" . It is unclear how likely the Applicants consider this possibility to be, or what they envision the scope and scale of these "bespoke" services to be. But it is patently clear that any public detriments and benefits, including impacts on the market structure of an industry as vital as private health, would vary greatly depending on whether Honeysuckle Health customers were limited to a handful of small to medium health insurers, or included larger funds such as Medibank or BUPA.

7. Further the mere fact of the creation of a buying group does not automatically generate benefits as asserted by the application. There are many alternate intermediary steps for a buying group to undertake to realise the benefits of collective negotiations. The Applicant has failed to specify any such intermediary steps which means the ACCC must give little if any weight to the theoretical and speculative claimed benefits without further elaboration of the conduct.

8. Therefore, the proposed conduct must be specified in significantly greater detail before any meaningful assessment of the claimed benefits and likely detriments of the conduct can occur.

The relevant legal principles

9. Section 90(7) of the *Competition and Consumer Act 2010* (Cth) provides that the ACCC must not make a determination granting authorisation under section 88 unless it is satisfied that the conduct would result, or be likely to result, in public benefit which outweighs any public detriment.

10. Two well-established principles are relevant to the ACCC's determination in the present application.

Principle 1: Authorisation must not be granted on the basis of benefits that are merely speculative

11. The ACCC must not grant authorisation on the basis of benefits that are merely speculative.[1] As the Australian Competition Tribunal (the **Tribunal**) has explained:[2]

> *… for a benefit or detriment to be taken into account, we must be satisfied that there is a real chance, and not a mere possibility, of the benefit or detriment eventuating. It is not enough that the benefit or detriment is speculative or a theoretical possibility. There must be a commercial likelihood that the applicants will, following the implementation of the relevant agreements, act in a manner that delivers or brings about the public benefit or the lessening of competition giving rise to the public detriment. We must be satisfied that the benefit or detriment is such that it will, in a tangible and commercially practical way, be a consequence of the relevant agreements if carried into effect and must be sufficiently capable of exposition (but not necessarily quantitatively so) rather than "ephemeral or illusory", to use the words of the Tribunal in* Re Rural Co-operative (WA) Ltd *at 263.* (citations omitted)

[1] *Qantas Airways Limited* [2004] ACompT 9 (*Qantas*) at [156].
[2] *Qantas Airways Limited* [2004] ACompT 9 at [156].

12. Establishing the asserted benefits requires the party seeking authorisation to identify some evidence that they will come to pass. In *QCMA*,[3] the Tribunal observed:[4]

> *We are to be concerned with probable effects rather than with possible or speculative effects. Yet we accept the view that the probabilities with which we are concerned are commercial or economic likelihoods which may not be susceptible of formal proof. We are required to look into the future, but* ***we can be concerned only with the foreseeable future as it appears on the basis of evidence and argument relating to the particular application****.* (emphasis added)

13. These principles are recognised in the ACCC's Authorisation Guidelines. Whilst acknowledging that the assessment of benefits will not always be susceptible to a precise mathematical exercise, the Guidelines state that:[5]

> *… there* ***must be a sufficient basis*** *for concluding that the benefits and detriments are likely to result from the proposed conduct.* (emphasis added)

14. Relevantly, the Guidelines also note[6] that "the number and identity of the likely beneficiaries" will be "[o]f particular relevance" in assessing the weight that society attaches to the asserted public benefits.

15. Similarly:[7]

> *… where possible, and particularly with complex applications, the ACCC encourages applicants to quantify the size of claimed benefits and detriments.*

16. It follows that, where an applicant claims a public benefit will flow from authorisation, that claim must be substantiated and grounded in the realities of the relevant market.

Principle 2: Public benefits that would exist in a future without the authorisation lack the required causal nexus with authorisation

17. In identifying and weighing the public benefits and detriments associated with authorised conduct, the ACCC must compare the 'future with' the authorised conduct (the factual), and the 'future without' the authorised conduct (the counterfactual). As the Tribunal has explained:[8]

> *The test is not to compare the present situation with the future situation, were the acquisition to take place: a 'before and after' test. Rather the test is to appraise the future, were the acquisition to take place, in light of the alternative outcome, were the acquisition not to take place: the 'future with-and-without' test.*

18. It necessarily follows that public benefits that would exist in a future without the authorisation do not "follow from" the authorisation. As the Tribunal explained in *Re Sea Swift*:[9]

> ***A public benefit arises from a proposed acquisition if the benefit would not exist without the acquisition*** *or if the acquisition removes or mitigates a public detriment which would otherwise exist.* ***If a claimed public benefit***

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[3] (1976) 8 ALR 481.
[4] At 508.
[5] ACCC Guidelines for Authorisation of Conduct (non-merger) dated March 2019 (**Guidelines**) at [8.14].
[6] Guidelines at [8.7].
[7] Guidelines at [8.12].
[8] *Re QIW Ltd* (1995) 132 ALR 225 at 226, cited with approval in *Qantas* at [151].
[9] ACompT [2016] 9 at [42].

> ***exists, in part, in a future without the proposal, the weight accorded to the benefit may be reduced appropriately***. *Public benefit is a wide concept and may include anything of value to the community generally so long as there is a causal link between the proposed acquisition and the benefit.* (citations omitted)

19. That passage builds upon the Tribunal's earlier decision in *Medicines Australia*.[10] At [118]-[119], the Tribunal reasoned:

> *… The* ***words "likely to result" in each case require consideration of a hypothetical future in which the subject proposal is in effect***. *Consideration of that future allows assessment of the nature and scale of relevant benefits and detriments and the likelihood of their occurrence.*
>
> *Consideration of a future without the proposal in effect assists the public benefit and anti-competitive detriment assessment in at least three ways:*
>
> > *(i) If the claimed public benefits are unlikely to exist without the proposal they can be described as benefits flowing from the proposal.*
> >
> > ***(ii) If the claimed public benefits exist, in part, in a future without the proposal the weight accorded to them may be reduced appropriately.***
> >
> > *(iii) If, in a future without the proposal, there are public detriments which are removed or mitigated in the future with the proposal that may be considered as an element of the claimed public benefit flowing from the proposal.* (emphasis added)

20. Paragraph [119] of the *Medicines Australia* decision is cited in the ACCC's Authorisation Guidelines.[11] Consistently, the Guidelines state:[12]

> *This approach enables the ACCC to focus its assessment on the impact of the conduct* ***rather than other effects that would occur irrespective of whether the conduct occurs***. (emphasis added)

21. In short, the Applicants must be able to identify a causal nexus between the authorisation and the public benefits. That requirement will not be satisfied if the claimed benefits would exist in the future without the authorisation.

22. Two relevant conclusions follow from these principles:

    i. Authorisation must not be granted if there is insufficient clarity or certainty as to the public benefits and public detriments that would result from the proposed conduct.

    ii. The weight given to asserted public benefits must be reduced if they would exist in a future without authorisation.

23. As explained below, the Applicants' submission does not provide sufficient information for the ACCC to form a view as to the public benefits and detriments that would result from the proposed conduct.

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[10] [2007] ACompT 4.
[11] At 6.12.
[12] Guidelines at [6.11].

The asserted public benefits would not flow from authorisation

24. A fundamental assumption underpinning the Applicants' rhetoric is that the public benefits they state would flow from authorisation are not currently available due to the absence of economies of scale and scope. This assumption is erroneous. Through the efforts of AHSA and other healthcare buying groups, private health insurers (and, where relevant, consumers and other healthcare providers) already have the benefit of:

    - transaction cost savings and efficiencies;
    - choice of buying group;
    - better health outcomes at a lower cost;
    - access to data analytics and information;
    - no gap experiences;
    - countervailing bargaining power in hospital negotiations; and
    - reduced healthcare costs and premiums.

25. Critically, this means that on the evidence put forward by the Applicants, authorisation would not generate any additional public benefit but would simply permit a potential commercial redistribution of activity, as the public benefits cited exist in the future without authorisation. As explained in paragraphs 17 to 21 above, this compels the conclusion that the Applicants have not satisfied the counterfactual test the ACCC must apply in its determination.

26. We discuss each of the public benefits cited by the Applicants in turn.

Transaction costs savings and increased efficiencies

27. The Applicants' description of public benefits that may accrue – especially to insurers and, by extension, policyholders – largely arise from the benefit of economies of scale and scope made available by the Applicants' structure and the scope and approach to its services. As detailed below, the advantages arising from economies of scale and scope that the Applicants suggest would be unavailable to insurers if not for the advent of Honeysuckle Health are in fact currently available to and utilised by insurers.

28. The Applicants refer to the "significant transactional and administrative cost savings" that would flow from the conduct (see paragraph 4.3 of their submission). The assertion that authorisation would create economies of scale might be true for Honeysuckle Health as an individual entity, but this proposition cannot be extrapolated to suggest, as the Applicants do, that economies of scale are already absent in the market for the acquisition of healthcare services. Other healthcare buying groups and the four large private health insurers with internal contracting functions, including Medibank, BUPA, HBF and HCF, are already able to provide the transaction cost savings and increased efficiencies that the Applicants claim would result "from" authorisation. The Applicants' submission equates nib's own experiences in negotiating HPPAs with the experiences of other health insurers, when this is simply not the case.

29. The Applicants note in paragraph 4.3 that nib's current network of providers requires nib to negotiate over 500 contracts per year and manage over 3,500 agreements. In contrast, AHSA already performs the services proposed by the Applicants on behalf of 27 funds and currently manages and administers:

    a. 546 Hospital Agreements nationally;
    b. 14 broader Health Cover Agreements nationally;
    c. 6 Optical Agreements;

d. 38,682 doctors across 98,221 practice locations;

e. 64 MPPAs; and

f. 3 HPPA/MPPAs.

30. The Applicants also refer in paragraph 4.4 of their submission to the "time consuming and… protracted" process of negotiating HPPAs, which can take up to 16 months. Yet AHSA's members already benefit from the systems AHSA has in place that avoid or mitigate the lengthy and inefficient procedures the Applicants describe. For example, many of AHSA's processes and systems have been automated through development of internal systems to ensure efficiency and cost savings for AHSA participating funds. AHSA works closely with providers to continually improve and enhance contracts, and also provides services to its funds around training, contract compliance, and dispute resolution.

31. Additionally, the Applicants state in paragraph 4.5 that "[a]ny health insurer that has national coverage and maintains its own health services contracting function would need to support a function of similar size to nib's (of approximately 25 staff and cost of approximately $5 million per annum), due to the breadth of the provider networks. Those expenses are a function of nib's decision to conduct its own health services contracting. They are not reflective of the experience of other Australian health insurance funds. AHSA performs these services at a budget of approximately [redacted], a figure that covers all of AHSA's work for 27 different funding bodies (including PHI and third party players). The scale efficiencies already achieved by AHSA confirm that it has and continues to eliminate duplication of the resources and processes involved in the contracting services and reduce costs for participants.

32. Indeed, AHSA member funds and providers already receive each of the benefits identified by the Applicants in paragraph 4.9 of their submission, and benefit from the continual improvement over 25 years of AHSA's systems and processes that have been developed to this end.

33. The savings and efficiency benefits to providers that the Applicants describe in paragraph 4.9 of their submission rest on flawed logic:

a. Paragraph 4.9(a) asserts that providers will have simplified backend billing processes because the participants in Honeysuckle Health will have the same contract, rate and billing rules. However, as acknowledged in the opening sentence of the same paragraph, the listed benefits will be limited if the participants come from AHSA or ARHG – which the Applicants' introduction states is the anticipated participant base. It follows that paragraph 4.9(a) does not describe any generation of additional public benefits, but a simple change in the entity providing benefits that already exist.

b. Paragraph 4.9(b) contains suppositions only. It does not provide sufficient detail for the ACCC to assess how this asserted benefit would come to pass.

c. Paragraph 4.9(c) is erroneous in three ways. First, as explained in paragraph 37 below, the number of buying groups and/or in house contractors in the private health insurance market would not change with the entry of Honeysuckle Health. Second, the frequency of negotiations is as much a function of the costs and resources that providers need to apply as it is a function of the number of buying groups and/or in house contractors. The assertion that providers would experience a reduction in costs through reduced negotiation frequency rests on a misunderstanding of the negotiation process.

> Third, if nib is currently taking an average of 6-8 months (and up to 16 months) to negotiate agreements with providers, as stated in paragraph 4.4 of the Applicants' submission, it is likely that providers would only face increased costs for negotiations if Honeysuckle Health acquired members from AHSA due to significant decreases in the efficiency of negotiations.

34. As discussed in paragraphs 11 to 16 above, the benefits flowing from the conduct must not be theoretical or speculative. Relevantly, the ACCC must be satisfied that the Applicants are "commercially likely to act in a way which brings about the benefit".[13] It is difficult to understand how Honeysuckle Health and its 50% shareholder (nib, as an ASX-listed for profit entity) would ensure the fees for participants would correlate with transactional cost savings generated from economies of scale.

35. Critically, it appears that the Applicants' modelling on the efficiencies that would be realised are contingent upon health insurers that are already part of the AHSA or ARHG buying groups switching to Honeysuckle Health (see paragraph 4.8). Further, as the Applicants identify at 5.2 of their submission, "[t]he health insurers that are most likely to be Participants are members of existing buying groups. As insurers would be switching from one buying group to another, it would not substantially change the current market dynamics in the market for health services." For these reasons, the claimed benefits, if any, would not arise solely from authorisation. Any effect the authorisation would have would merely involve a transfer of the services creating those benefits from one entity to another. The only circumstance in which authorisation could conceivably generate additional public benefits arising from scale efficiencies would be if one of the four major private health insurers joined the Honeysuckle Health buying group – in which case, the Applicants' submission does not sufficiently grapple with the implications authorisation would have for market dynamics.

36. On either view, the Applicants' submission on this point does not justify authorisation: either there would be simply no expansion from the existing supply and, consequently, public benefits would not "flow from" authorisation; or the Applicants have not provided sufficient disclosure and explanation of their long term plans for Honeysuckle Health for the ACCC to make a determination.

Greater choice of buying group

37. The Applicants assert in paragraph 4.10 of their submission that Honeysuckle Health would provide health insurers with greater choice as to buying group, on the basis that ARHG is not a viable alternative to AHSA due to a lack of scale. Whether or not ARHG is a viable alternative to AHSA, the submission ignores a fundamental difficulty. As discussed above in paragraph 35, the Applicants' submission implicitly acknowledges that Honeysuckle Health will need to acquire members from AHSA in order to achieve sufficient scale. It follows that it is unlikely that both the Honeysuckle Health buying group and AHSA could, in the medium to long term, have sufficient scale to be competitive and act as a constraint upon the other participants in the market. Once again, the asserted benefit of 'greater choice of buying group' is more accurately described as, at best, a transfer of the services creating those benefits. At worst, splitting buying groups into three would only dilute the existing public benefits that have been achieved through scale efficiencies. Any increase in the number of available buying groups would be marginal and non-enduring. The Applicants' submission has failed "to distinguish between one-off benefits and those of a more lasting nature"[14], despite this distinction being fundamental to the benefits assessment.

38. Finally, as discussed in further detail below, it is far from clear that any additional public benefits would flow from the "differentiated model of funding such as value-based

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[13] *Re Sea Swift* [2016] ACompT 9 at [45].

[14] *Re Sea Swift* [2016] ACompT 9 at [46].

contracting" authorised by the ACCC, as suggested by the Applicants in paragraph 4.11 of their submission. In any event, AHSA has been providing differential contracts and innovative funding models based on quality to AHSA funds for over 25 years. AHSA continues to apply best practice in its advancement of its contracting, and has at all times operated successfully in accordance with the competition and consumer laws. Once again, the asserted public benefits already exist. They would not flow from authorisation in the requisite sense because they are already available to the stakeholders the Applicants identify as beneficiaries.

Access to data analytics and Information

39. The Applicants claim in paragraph 4.24 of their submission that, at present, only larger health insurers have access to the body of information and data analytics required to support the development of value-based contracting. The submission states that authorisation would provide participants, who the Applicants claim are likely to be smaller health insurers, with access to data analytics tools and technology to, among other things, reduce information asymmetry.

40. However, it is not correct to say that these benefits would "flow from" authorisation. Health insurers already have access to these services. AHSA's data warehouse captures the data of 27 health funds and provides advanced analytic capabilities. AHSA has a dedicated team of staff who specialise in the tasks referred to in paragraphs 4.18 and 4.19 of the Applicants' submission, as well as platforms and systems available to ensure that it fully maximises its data analytics strength. To that end, AHSA currently performs:

    a. provider benchmarking and compliance/integrity (including financial);

    b. outcomes analytics including Patient Reported Outcome Measures (**PROMs**) and Patient Reported Experience Measures (**PREMs**);

    c. advanced data analytics;

    d. data management, including for regulatory purposes; and

    e. data warehousing and analytics services for AHSA funds, which include small and medium funds.

41. These services demonstrate that AHSA has already achieved, and is continuing to invest in, the "mature and sophisticated data science capabilities" that the Applicants suggest are missing from the Australian market.

42. AHSA has also built reliable and efficient networks over 25 years across all areas of its business, including hospital contracting, general treatment contracts, medical agreements, and schemes and data management, and various specialty groups and geographic networks. AHSA member funds already benefit from the improved standards of care and information transparency referred to in paragraph 4.25 of the Applicants' submission. Authorisation would not reduce information asymmetry for AHSA's member funds which, by the Applicants' own submission, are the same funds it proposes would become member funds of Honeysuckle Health.

Better health outcomes at a lower cost

43. The Applicants' assertion that authorisation would lead to better health outcomes at a lower cost rests on a number of false and unsubstantiated premises.

44. First, the Applicants have provided insufficient detail as to how the proposed performance based contracting described in paragraphs 2.37, 4.2 and 4.12 would assist patient outcomes. Critically, despite references to performance metrics such as benchmarking and compliance with contractual terms, nowhere do the Applicants refer

to Patient Reported Outcome Measures (PROMs). This omission is important because, in the current Australian private health insurance context, outcomes are not communicated to funders, hospitals, or even the specialists themselves in any systematic way, as patients are often transitioned back to GPs with little to no relationship with funders or hospitals after treatment.

45. Second, in paragraph 4.12, the Applicants refer to a "transition" from fee-for-service to value-based contracting relationships that would occur following authorisation, implying that value-based contracting is not already present in the Australian market. However, AHSA has already begun implementing a value based contract system on behalf of participating funds through a national, Australia-specific platform based on quantifiable outcomes on a National basis.

46. AHSA's data analytics capabilities (described above in paragraph 40) are already used in contracting and add significant value to AHSA and its member funds, including smaller insurers (see paragraph 4.17 in the Applicants' submission). In particular, the PROMs and PREMs utilised by AHSA are critical aspects of any value-based contracting approach. AHSA has held close to 15-20% of the market share for PHI data for over 25 years, and has a national footprint to make informed decisions in contracting with providers. AHSA has introduced a number of unique and innovative payment models since nib left AHSA eleven years ago. To take recent examples:

    a. The Rehabilitation AN-SNAP model (RAM) adjusts funding for inpatient rehabilitation care according to the patient's main condition(s) and the severity of the functional impairment of the patient. In so doing, more funding is put towards inpatient rehabilitation care for patients with more complex conditions and more severe functional impairment. This is distinct from the historical approach to funding inpatient rehabilitation, which did not scale funding according to the complexity of inpatient rehabilitation required by the patient.

    b. After substantial work and engagement with both funds and hospital groups, AHSA has significantly advanced the development of an acute contemporary wholly episodic payment model with performance and value elements.

    Under these models, providers are already taking on the greater involvement in the lifecycle of the contracting process that the Applicants suggest, in paragraph 4.20, would be encouraged by authorisation.

47. The contention by the Applicants that only larger funds have meaningful access to complex analytics and data science (in paragraph 4.16) is also factually incorrect and another example of the Applicants erroneously conflating nib's own experiences with those of other health insurers. The benefits identified in paragraph 4.21 of the Applicants' submissions are already available to AHSA's members – including the smaller insurers that the Applicants claim are unable to secure "modern and effective health procurement funding models". The benefits enjoyed by AHSA member funds may be contrasted with nib's own experiences.

48. In AHSA's experience, the duration of its relationships with providers has been critical to obtaining innovative outcomes for its member funds. The long term contracting relationship has given providers sufficient certainty that AHSA member funds can provide the necessary volume of care to validate and justify investments in quality of care, which the Applicants recognise in paragraph 4.22 is critical to the value-based model it proposes. The Applicants have not adequately specified how Honeysuckle Health, which does not enjoy such long term relationships and trust, can give providers the certainty they need.

49. Third, the Applicants have not substantiated the claim in paragraph 4.13 of their submission that value-based reimbursement arrangements "have been a key component" of Cigna's success, or provided any clarity on how the "better quality scores" referred to in paragraph 4.14 are assessed, or by whom. This omission is significant. The reported benefits on medical cost trends referred to in paragraph 4.13 of the Applicants' submission are financial in nature, and 'quality scores' are undefined. The Applicants' submission cites sector embedded metrics such as rate of hospital acquired complication, length of hospital stay, unplanned readmission to theatre and conversion to ICU. These metrics are not patient-based outcomes as normally defined, and do not establish either potential or actual improved patient outcomes at a lower cost. As noted in paragraphs 11 to 16 above, the ACCC cannot meaningfully assess the strength of an asserted 'public benefit' without a reasonable degree of clarity as to the nature and scope of the benefits.

No gap experience for Customers

50. AHSA agrees with the Applicants that uncertainty around the extent of gaps is a major concern and cause of dissatisfaction for private health consumers. Once again, however, no public benefit would flow from authorisation. The Applicants' submission ignores the steps already taken by AHSA and the four major insurers to address these consumer concerns. For example, AHSA has maintained its Access Gap Cover (**AGC**) scheme for nearly 20 years, which is currently utilised by over 37,000 medical specialists across a range of services. AHSA also has agreements in place with a number of doctor owned and small day hospitals where it has negotiated that doctors will not charge gaps at the facility. Similarly, BUPA has a network of no gap hospital facilities. Annexure A demonstrates that member gaps are currently significantly lower in quantum for all other insurers when compared to nib. We would not want to see these gaps increase in the sector. AHSA is also an active participant in several industry department and government forums, through which it works with doctors to improve value and address out of pockets.

51. AHSA ensures private health consumers receive clear information regarding any out of pocket expenses. AHSA funds utilise Healthshare to provide consumers with more information about medical specialists that potentially charge gaps. These services continue to assist in mitigating any uncertainty consumers may face around gaps.

52. There would be no public benefit if any of AHSA's current funds made the decision to offer the nib Medigap scheme as it currently stands to their members. In fact, such a switch would likely constitute a detrimental change and insurers would be required to notify all their members of this change (as they would for MPPAs no longer offered). A change to the nib Medigap scheme could be seen as a detrimental change for the following reasons:

    a. Overall, nib Medigap schedule rates are lower than AGC. It may be inferred that a higher proportion of nib's contracted services would have gaps, and that those gaps would likely be higher.

    b. nib's Medigap scheme does not allow specialists to charge a gap. Therefore, many specialists do not use it at all and this, by current APRA reporting, is immediately obvious. This means that gaps are likely to be higher for those members. Where a doctor does not participate in the nib Medigap scheme, benefits would be payable up to the government schedule fee only and fund member contribution would likely increase significantly.

    c. The Applicant's submission states that nib has a network of 21,764 medical specialists. In contrast, AHSA's coverage includes over 37,000 medical specialists on AGC, practising at almost 90,000 locations. As well as medical specialists, AHSA offers a large number

of no gap medical agreements to its funds. For AHSA funds nationally, for example, 99 per cent of all pathology services and 83% of all radiology services are paid under agreement with no gap to members, and 95% of all radiology services are covered as either no or known gap for AHSA funds. The websites of a number of major pathology and radiology providers, including Sonic Healthcare, Healius (ex-Primary), and Clinical Labs, show that these companies do not unanimously have agreements in place with nib. It may be inferred that nib members would receive gap bills for these services.

d. Annexure A and Annexure B highlight recent average gap statistics for a number of funds. Annexure A shows that the nib average gap is significantly higher than those of AHSA funds. Annexure B shows that nib performs significantly worse than AHSA funds on the percentage of services with no gap or a known gap.

Countervailing hospital bargaining power

53. The Applicants claim in paragraph 4.31 of their submission that authorisation is necessary if hospital bargaining power is to be countervailed. This is a misrepresentation of the current bargaining dynamics in the market, and overlooks the fact that hospitals need to reach agreement just as much as health funds do. AHSA already has close to 20% per cent market share for hospital insured persons, which means that it has significant scale across Australia when working with large hospital providers, as one in five private health insurance patients come from an AHSA fund. 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 the smaller regional hospitals referred to in paragraph 4.32 of the Applicants' submission, work constructively with AHSA. AHSA has appropriately ensured the preservation of key hospitals in regional markets to the benefit of private health insurance consumers. AHSA has funds who reside in every state in Australia, and is as important to the regional hospitals as they are to us. In contrast, nib has a handful of regional strongholds, such as the Hunter and Newcastle regions, but small member concentrations in a number of other regions.

54. Even more significantly, the Applicants' submission that countervailing hospital bargaining power would, without more, lead to more efficient hospital pricing demonstrates a fundamental misunderstanding of the drivers of differential pricing. It is correct that pricing for specific procedures, treatments, and services varies between hospital groups. But paragraph 4.33 of the Applicants' submission is a gross oversimplification of why this occurs. For one, the quantum of funding is a factor of volume of services and/or patients and variances in the case mix between providers. Other factors that are overlooked are differences in additional conditions places for a specific procedure, treatment or service, such as bundled add-ons or specific penalty clauses, and the history of differences in price points across providers. Examining unit price point differences neglects a large variety of other contributory factors and cannot be said to be a result of hospital bargaining power alone. Every buyer of private health services experiences these pricing differentials, including ARHG, Medibank, Bupa, HCF, and HBF. Any assertion that Honeysuckle Health would be able to achieve a different outcome is speculation without regard to commercial reality. AHSA also notes that it is difficult to reconcile the proposed focus on narrowing variances in unit price with the Applicants' assertions about the primacy Honeysuckle Health will give to value based contracting.

55. Consequently, the Applicants' submission on why authorisation would generate public benefits through countervailing hospital power are based on two incorrect assumptions: that there are currently insufficient checks on hospital bargaining power, and that any increase in those checks would be a panacea for inefficient pricing.

Reduced healthcare costs and premiums for members

56. Members of AHSA funds are already benefiting from the reduced healthcare costs and premiums that the Applicants claim will follow from authorisation, including in relation to hospital benefits. AHSA has achieved significant cost efficiencies, as described in paragraphs 28 to 32 above. Because of the work already undertaken by AHSA, its 27 member funds have a competitive cost base against their larger competitors (such as Medibank and Bupa), and are already able to offer competitive prices to their members.

57. Furthermore, the Applicant has failed to substantiate how the proposed conduct will likely result in reduced healthcare costs and premiums for members. Such statements are merely unsubstantiated assertions that can be given no weight. AHSA reiterates the points made in paragraph 37 above that authorisation would simply lead to a dilution or transfer of public benefits that already exist. The only beneficiaries would be the Applicants and their commercial interests.

Public benefits for other healthcare providers

58. Finally, we note that other healthcare providers already receive the benefits the Applicants describe in paragraphs 4.39 to 4.41 of their submission. AHSA 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. These providers have utilised AHSA's industry knowledge and advanced data analytics capabilities. Examples include the Transport Accident Commission and Worksafe Insurance, who work closely with AHSA on funding model methodologies.

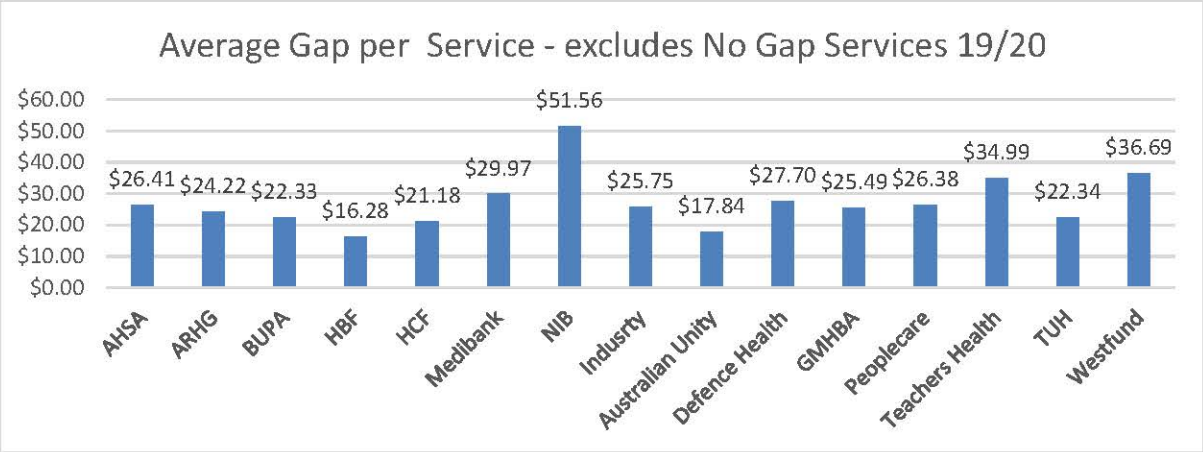
Thank you for the opportunity to comment on this matter.

Yours sincerely

Andrew Sando
Chief Executive Officer

Annexure A

Average Medical Gaps (APRA data 19/20 - Services above MBS fee and excluding no gap services)



Annexure B

Percentage of services with no gap/known gap (data from the most recent Private Health Insurance Ombudsman State of the Health Funds Report utilising APRA Data 18/19)

APRA Data from the State of the Health Funds Report 18/19 (most current report available)

Table 4A—Medical services with no gap

Fund name (Abbreviated)	% of Services with no gap							
	ACT	NSW	VIC	QLD	SA	WA	TAS	NT
Open membership funds								
Australian Unity	83.90%	91.20%	91.70%	91.70%	92.00%	87.30%	91.90%	85.80%
BUPA	81.30%	87.00%	86.10%	87.90%	86.10%	83.10%	86.70%	84.00%
CBHS Corporate	83.30%	85.00%	88.00%	86.30%	87.00%	85.90%	66.00%	N/A
CDH	57.10%	87.90%	75.60%	74.40%	66.70%	50.00%	42.30%	N/A
CUA Health	81.20%	91.50%	90.60%	94.50%	86.70%	86.60%	93.20%	89.80%
GMHBA	47.70%	72.90%	79.50%	81.00%	80.80%	72.30%	75.70%	74.40%
GU Health Corporate	85.30%	78.80%	82.40%	84.00%	87.60%	78.80%	93.50%	88.60%
HBF	73.40%	76.80%	66.70%	70.00%	67.70%	91.80%	79.70%	72.70%
HCF	81.30%	91.10%	89.10%	91.20%	87.90%	86.90%	90.50%	84.70%
HCI	82.90%	89.60%	90.80%	91.90%	79.40%	90.30%	91.70%	N/A
Health.com.au	70.10%	86.10%	85.30%	88.20%	84.40%	83.50%	86.00%	94.70%
Health Partners	74.70%	88.10%	86.80%	92.40%	93.00%	86.50%	91.50%	93.80%
HIF	65.70%	86.70%	88.90%	89.40%	87.20%	87.30%	88.60%	67.70%
Latrobe	60.40%	77.70%	76.70%	83.50%	88.90%	68.90%	72.80%	74.20%
MDHF	45.20%	85.10%	80.90%	79.70%	82.00%	74.40%	75.50%	58.80%
Medibank	78.30%	87.70%	84.60%	87.10%	86.70%	73.70%	91.10%	84.90%
MO Health	68.60%	82.20%	86.00%	87.90%	79.60%	81.00%	72.00%	70.60%
NIB	66.00%	92.80%	91.50%	87.30%	93.30%	87.20%	83.90%	78.70%
Onemedifund	89.10%	89.30%	90.40%	93.60%	90.90%	86.50%	88.00%	N/A
Peoplecare	80.40%	93.00%	90.50%	92.00%	89.20%	83.50%	89.90%	92.10%
Phoenix	63.40%	92.00%	89.70%	92.70%	92.30%	88.00%	91.90%	85.70%
QCH	64.40%	93.90%	91.30%	91.70%	95.70%	87.30%	88.30%	84.90%
St Lukes	80.40%	86.00%	82.10%	78.00%	90.30%	69.50%	89.60%	82.40%
Transport Health	87.30%	88.60%	92.50%	92.40%	77.10%	77.50%	80.00%	N/A
Westfund	73.50%	92.40%	90.00%	90.10%	89.20%	79.40%	85.40%	75.00%
Restricted membership funds								
ACA	86.80%	92.10%	93.30%	92.90%	90.00%	90.90%	93.10%	N/A
CBHS	82.40%	89.40%	90.20%	92.40%	91.10%	86.70%	91.00%	81.20%
Defence Health	80.30%	89.60%	90.60%	92.60%	90.80%	85.70%	91.30%	86.50%
Doctors' Health	90.40%	92.00%	92.50%	93.50%	91.90%	88.20%	87.60%	86.10%
Emergency Services	76.70%	90.70%	87.50%	88.70%	91.80%	80.80%	100.00%	62.10%
Navy Health	80.30%	90.40%	91.00%	92.30%	91.50%	88.20%	91.90%	89.30%
Nurses and Midwives	78.40%	90.40%	84.90%	91.60%	90.90%	83.30%	77.70%	96.80%
Police Health	71.30%	87.60%	85.00%	89.10%	89.80%	82.80%	88.10%	87.60%
Reserve Bank	87.50%	90.20%	92.80%	94.20%	96.40%	93.90%	89.20%	N/A
RT Health Fund	83.40%	93.80%	91.60%	93.40%	92.00%	87.00%	91.20%	82.30%
Teachers Health	83.40%	90.50%	90.10%	93.20%	90.10%	85.00%	91.10%	92.20%
TUH	81.90%	91.20%	91.50%	93.00%	93.80%	91.00%	96.10%	92.80%

Table 4B—Medical services with no gap or where known gap payment made

Fund name (Abbreviated)	% of Services with no gap or where known gap payment made							
	ACT	NSW	VIC	QLD	SA	WA	TAS	NT
Open membership funds								
Australian Unity	93.70%	96.70%	97.90%	96.50%	98.30%	96.80%	98.50%	91.10%
BUPA	90.20%	91.90%	91.60%	91.60%	91.70%	90.10%	92.30%	91.10%
CBHS Corporate	83.30%	91.40%	96.60%	92.20%	90.20%	95.50%	93.60%	N/A
CDH	100.00%	97.40%	94.60%	94.40%	98.70%	50.00%	92.30%	N/A
CUA Health	93.90%	97.20%	98.50%	98.40%	97.80%	98.00%	98.90%	96.30%
GMHBA	74.70%	89.20%	91.10%	94.00%	97.00%	86.30%	90.30%	90.70%
GU Health Corporate	94.00%	91.90%	97.20%	94.10%	96.70%	95.00%	98.20%	93.20%
HBF	99.30%	99.40%	99.80%	99.60%	99.90%	99.80%	99.80%	98.80%
HCF	96.00%	98.70%	99.50%	99.20%	99.80%	98.30%	99.60%	98.50%
HCI	92.30%	97.20%	98.60%	97.40%	99.30%	97.20%	99.20%	N/A
Health.com.au	90.50%	95.60%	97.80%	96.60%	97.00%	95.30%	97.70%	98.40%
Health Partners	90.80%	96.20%	97.50%	96.90%	99.70%	93.60%	99.40%	100.00%
HIF	89.70%	96.10%	98.30%	97.30%	98.80%	97.50%	98.20%	88.70%
Latrobe	98.40%	98.00%	99.90%	99.50%	99.90%	99.60%	99.20%	100.00%
MDHF	88.10%	98.80%	98.90%	94.20%	95.80%	86.70%	92.60%	96.10%
Medibank	93.30%	96.40%	94.40%	95.50%	99.20%	89.20%	98.30%	95.70%
MO Health	92.00%	93.80%	97.20%	95.80%	97.80%	95.40%	89.30%	100.00%
NIB	66.00%	92.80%	91.50%	87.30%	93.30%	87.20%	83.90%	78.70%
Onemedifund	100.00%	97.10%	98.50%	98.80%	99.50%	97.10%	99.40%	N/A
Peoplecare	95.30%	97.90%	98.80%	97.80%	99.10%	97.70%	97.70%	100.00%
Phoenix	84.40%	98.10%	98.80%	98.00%	99.40%	98.00%	99.60%	95.20%
QCH	94.90%	98.70%	98.50%	98.00%	98.30%	98.00%	98.50%	95.40%
St Lukes	87.70%	93.30%	90.30%	90.40%	96.70%	85.50%	98.50%	100.00%
Transport Health	95.20%	96.50%	99.00%	98.30%	100.00%	100.00%	90.00%	N/A
Westfund	82.70%	97.80%	98.60%	97.40%	98.40%	96.50%	92.80%	96.30%
Restricted membership funds								
ACA	99.30%	97.70%	99.10%	98.10%	98.40%	97.50%	99.60%	N/A
CBHS	94.40%	96.70%	98.30%	97.30%	98.70%	96.60%	98.20%	90.80%
Defence Health	94.50%	97.00%	98.90%	98.10%	99.50%	97.20%	98.60%	97.00%
Doctors' Health	97.80%	98.40%	98.80%	98.70%	99.40%	98.40%	98.30%	99.30%
Emergency Services	86.70%	96.50%	97.80%	96.20%	98.70%	89.50%	100.00%	89.70%
Navy Health	94.80%	97.10%	98.60%	97.90%	99.30%	97.50%	99.30%	96.40%
Nurses and Midwives	94.60%	97.60%	97.30%	96.30%	99.50%	96.30%	87.30%	96.80%
Police Health	86.40%	96.50%	97.60%	97.30%	99.30%	95.90%	98.20%	97.50%
Reserve Bank	94.90%	96.90%	98.80%	98.30%	99.60%	98.30%	97.60%	N/A
RT Health Fund	93.60%	98.40%	98.90%	98.40%	98.90%	97.90%	98.80%	96.80%
Teachers Health	95.70%	97.50%	98.80%	98.20%	99.40%	97.30%	99.10%	97.70%
TUH	96.60%	97.90%	99.00%	98.30%	99.00%	97.30%	99.80%	98.20%