MinterEllison

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Dear Michael

Response to submissions following the pre-decision conference

We refer to the pre-decision conference held on Thursday, 8 July 2021 by the ACCC (**conference**) in relation 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 since the conference.

We have set out below the Applicants' response to the submissions of interested parties made during the conference and the submissions that were uploaded to the public register up to and including 28 July 2021 (**conference submissions**). Our response focuses on any new issues raised in the conference submissions that have not been addressed in our previous responses. Capitalised terms used in this letter are defined in the Application unless defined in this letter.

1. Economic coercion of medical practitioners to sign MPPAs

1.1 Concerns have been raised that the proposed HH Buying Group will use economic coercion to compel practitioners to sign up to MPPAs as they will not willingly do so.[1] The Australian Society of Anaesthetists claims that this will restrict the ability of practitioners to determine their own fees and conditions due to the Applicants applying pressure on doctors to participate in the scheme.[2] We have assumed that they are referring to doctors' participation in the Broad CPP.

1.2 The Applicants refute that practitioners will be coerced financially to join the Broad CPP. Medical specialists that do not participate will be paid benefits under the current medical gap schemes. Although the rate of benefits payable under the Broad CPP will be higher, this comes with additional obligations such as providing data, being assessed on performance and giving up the discretion to charge gaps. This is not an option that will appeal to all medical specialists despite being paid a higher level of benefits. The higher payment under the Broad CPP is approximately equivalent to the Provider charging a known gap of $500 which is permitted under other funds' schemes. Further, the Applicants fail to see how offering a differential in rates that have been commercially agreed with the medical specialist to cover their additional costs and to secure certainty for consumers over gaps, could constitute economic coercion. There will be no change to the current rates under the medical gap scheme and therefore, the Applicants submit that there cannot be economic coercion to join the Broad CPP as the current financial position of medical specialists will not change. The Broad CPP simply provides an option to earn additional benefits without the Provider needing to charge an out of pocket cost to the patient.

[1] Australian Society of Anaesthetists, 11 June 2021 submission page 2; reiterated at conference.
[2] Australian Society of Anaesthetists, 11 June 2021 submission page 3; reiterated at conference.

1.3 With respect to the limitation in determining fees, the Applicants accept that medical specialists that join the Broad CPP give up their freedom to determine their own fees and gaps in connection with treatment provided to members of the Participants. This is a positive outcome for consumers and one of the public benefits of the HH Buying Group. The decision to give up this freedom is voluntary and only if they decide to join the Broad CPP. There will be no financial pressure imposed on medical specialists, as explained above. Medical specialists may also elect to cease participating in the Broad CPP at any time.

2. Economic influence on medical practitioners to provide certain treatment

2.1 The Australian Private Hospitals Association argues that financial incentives will be provided to specialists to refer patients to particular programs, such as the nib rehabilitation service rather than in-hospital rehabilitation, which will reduce choice and competition in the provision of out-of-hospital services.[3] Some interested parties allege that nib requires specialists to direct a certain proportion of their patients to at-home rehabilitation.

2.2 We refer to the template MPPA provided with our letter dated 29 July 2021 in which it is clear that nib pays the same fee to orthopaedic surgeons regardless of the patient's clinical pathway. There is no economic incentive for the surgeons to refer patients to at-home rehabilitation and there is no obligation on the surgeons to meet a target percentage of patients who must be referred to home rehabilitation. Rather, it is an option for the surgeon and patient to consider, as explained in our 29 July 2021 letter.

2.3 The Applicants wish to clarify that nib does not provide its own or operate any home rehabilitation programs. It engages quality third party providers to provide this service on an arm's length basis. nib and HH do not have any financial interest in home rehabilitation businesses. In contrast, private hospitals do have a direct financial interest in influencing care towards inpatient rehabilitation and removing the choice for consumers of undertaking rehabilitation at home. This is contrary to consumers' interests as inpatient rehabilitation has shown to be low value care (with sometimes worse outcomes for patients) delivered at a high cost which drives up the premiums for health insurance.

3. Economic influence over consumer choice of doctor

3.1 Concerns have been raised that the HH Buying Group will influence choice of practitioner and treatments by providing financial benefits to practitioners to encourage them to refer patients into preferred providers.[4] These concerns suggest that patients will be targeted into nib sponsored services over other, potentially more appropriate programs, when they present to their medical practitioner and patient choice will consequently be compromised. A number of submissions claim that the HH Buying Group will engage in economic coercion via the payment, or non-payment, of rebates which affects the ability of consumers to choose their preferred provider and most appropriate treatment. Consumers undergoing the same procedure with different medical specialists could receive different rebates for the same service and are likely to choose (or be required to choose) the greater rebate and not their preferred medical specialist.[5]

3.2 The Applicants strongly deny that the HH Buying Group will be providing any financial benefits to practitioners such as GPs to encourage them to refer patients to medical specialists in the Broad CPP. They also will not be providing financial benefits to medical specialists to refer patients to hospitals in the HH network. nib and HH do not currently engage in this conduct and this is not part of HH's plans going forward. More importantly, this conduct is unlawful as HH would be interfering with the clinical freedom of medical practitioners which is prohibited under the *Private Health Insurance Act 2007* (Cth) (**PHI Act**). nib and HH could also be at risk of inciting unprofessional conduct by medical specialists if it provides them with financial benefits for referring patients to the Broad CPP or network hospitals. Unprofessional conduct is prohibited under the Health Practitioner Regulation National Law (**National Law**) and includes accepting a benefit as inducement to refer a patient to a specific health service provider.[6]

3.3 In relation to influencing consumer choice, the Applicants submit that under the current medical gap schemes, consumers are already subject to economic influence when deciding on a medical specialist for hospital treatment. Consumers are currently influenced by whether a medical

[3] Australian Private Hospitals Association, 22 July 2021 page 2.
[4] Catholic Health Australia, 23 July 2021 page 2.
[5] Australian Society of Anaesthetists, 11 June 2021 submission page 8; reiterated at conference.
[6] National Law, section 136(1).

specialist charges a gap amount determined by the specialist or whether they agree to participate in the medical gap scheme. The existence of the current medical gap scheme cannot be characterised as health insurers economically coercing consumers, but rather they are providing more options to consumers where gaps are controlled for medical specialist services. Without the current medical gap scheme, there would be no control over gaps. The Broad CPP can be characterised in the same way as it provides an additional layer of choice for consumers where gaps are further controlled for the whole episode of care.

3.4 Consumers' choice will be influenced by their gap experience rather than the dollar amount of benefits paid by health insurers to medical specialists as they have no visibility over this amount and does not have any impact on them financially. Under hospital cover, there are no annual limits (they are prohibited under the PHI Act) so the payment of higher benefits to a medical specialist has no impact on consumer choice. The Applicants refute the claim that the HH Buying Group will be influencing consumers not to choose their preferred medical specialist based on the benefits they pay.

3.5 Consumers' decision as to who is their preferred medical specialist will depend on a range of factors such as their GP recommendation and gap payments. The Proposed Conduct will influence consumer choice because consumers will have an additional no gap option to consider with their GP. This is part of the public benefits that will be derived from the Proposed Conduct.

3.6 Consumers will often not become aware of a medical specialist's gap until the first consultation, as their GP will generally not have information about gaps on hand when recommending a specialist to their patients. After the first consultation, consumers are then reluctant to switch specialists even if the gap payments will be large. The Applicants submit that there is greater potential for economic coercion of consumers in the current state. Under the Broad CPP, GPs will be armed with information about the no gap program and can give consumers a no gap option when they are choosing their medical specialist.

4. 40% cap for Broad CPP

4.1 A number of submissions express concerns that the 40% market cap condition remains too high and that the HH Buying Group would achieve a significant imbalance in bargaining power in negotiations with medical specialists, should the condition be granted.[7] The Council of Procedural Specialists claims that the 40% cap is not an appropriate use of a condition for authorisation as it does not ensure a net public benefit.[8] Further, they claim that economic literature recognises that buyer power is more insidious at lower market shares than supplier power.[9]

4.2 The Applicants submitted in their letter dated 30 June 2021 that a more appropriate market cap for the Broad CPP is 60% to enable at least one other major health insurer to participate in all States and Territories. The Applicants do not consider that this will create a significant imbalance in the bargaining positions of medical specialists as the Broad CPP is an optional program for medical specialists and as stated above, there will be no financial pressure for medical specialists to join as there will be no change to the other funding options available to them.

4.3 The increased market share of the HH Buying Group will enable HH to engage with a broader group of medical specialists as it requires an investment of time and resources by the medical specialists to participate. This will further enhance the public benefits associated with the Broad CPP, namely better quality care with a no gap experience for consumers.

5. Dental and allied health – collective boycotts

5.1 The Australian Dental Association has expressed concern that the HH Buying Group would gain too much influence and be able to implement effective boycotts by derecognising practitioners who do not accept the relevant MPPA terms.[10] They suggest that the HH Buying Group will derecognise practitioners and then provide consumers with a list of preferred providers to direct them away from practitioners that are not engaged via the MPPA. A number of submissions have raised concerns that despite the Applicants' assurances surrounding collective boycotts, the HH Buying Group will have the ability to impose effective boycotts via preferential and punitive

[7] Australian Dental Association, 22 July 2021 page 1; Healthscope, 23 July 2021 page 1; reiterated at conference.
[8] The Council of Procedural Specialists, 28 July 2021 page 10.
[9] The Council of Procedural Specialists, 28 July 2021 page 10.
[10] Australian Dental Association, 22 July 2021 page 1.

payment arrangements with certain providers to direct their patients elsewhere.[11] The Australian Dental Association notes that dental practitioners are particularly vulnerable to boycotts as they are not covered by the rules related to Medicare.[12] They state that dental practitioners are currently subject to boycotts via insurers adopting preferential patient arrangements which directly exert control over the market and in some cases, making unilateral decisions to exclude a practitioner's patients from all rebates.

5.2 The Applicants wish to clarify that it is not proposing to enter into MPPAs with dentists or allied health professionals as part of the Proposed Conduct. nib's current network of recognised providers and preferred providers for dental and allied health services will be retained and offered to new Participants of the HH Buying Group.

5.3 nib currently recognises all dental providers that are registered practitioners under the National Law. nib would only derecognise dentists if they engaged in fraud through their claiming behaviour or have been deregistered under the National Law. A similar approach is taken with other allied health providers. Under the Proposed Conduct, this approach will not change and there are no plans to derecognise certain practitioners and provide a narrow list of preferred providers.

5.4 The Applicants acknowledge that health insurers are not legally required to pay benefits to allied health providers and that they are not entitled to receive Medicare benefits. Allied health providers do not have the benefit of a price floor in the market unlike medical practitioners and hospitals. This is the nature of the current health system and if the ACCC does not authorise the Proposed Conduct, this will continue to be the case.

5.5 The Applicants submit that the existence of the HH Buying Group will actually provide a greater commercial incentive to have a larger network of allied health providers than is currently the case with nib alone. This is because health insurers have a critical commercial need to have a broad network of allied health providers to ensure that their members who have cover for services like dental can actually use that cover by visiting a local dentist and receiving benefits. Competition among health insurers drives insurers to provide a good service to its members through a comprehensive allied health provider network. A large and geographically diverse membership base of the HH Buying Group creates a greater commercial need to have a large network of recognised allied health providers that provide services in all the areas in which members are situated.

6. Uncertainty for providers when negotiating with HH

6.1 Healthscope has expressed concern surrounding the complexity and uncertainty with respect to the application of any negotiated agreement with the HH Buying Group.[13] They note that healthcare providers will not know the number or nature of the insurers they are dealing with when negotiating through HH, including because insurers can also opt out. Uncertainty about the value of costs and benefits attributable to the terms under negotiation would remain.

6.2 The uncertainty described by Healthscope is a necessary element of having a buying group that does not collectively boycott. HH cannot provide Healthscope with certainty about the number of health insurers that will enter into a HPPA through the HH Buying Group unless HH had an agreement with the Participants under which they commit to entering into an HPPA with Healthscope on certain terms. If Healthscope refused to enter into a HPPA on those terms, the Participants and HH would be collectively boycotting Healthscope. The Applicants are not seeking authorisation for this conduct. HH will not, under its agreement with each Participant, be compelling them to enter into HPPAs negotiated by HH.

6.3 Healthscope will be aware of the identity of each Participant and HPPA negotiations will take place on the expectation that all of the Participants will enter into the HPPA. If this occurs, Participants' right to opt out of the HPPA would be limited by the terms of the HPPA. The extent to which a Participant can terminate an HPPA will be a matter that is agreed by the parties and largely in Healthscope's control, given their size and bargaining power in HPPA negotiations.

[11] Margaret Faux, 26 July 2021 and Australian Dental Association, 22 July 2021.
[12] Australian Dental Association, 22 July 2021 page 1.
[13] Healthscope, 23 July 2021 page 2.

7. Push consumers to purchase gold policies

7.1 Concerns have been raised that the Applicants will engage in conduct to push consumers to purchase more expensive 'gold policies' to participate in the Broad CPP.[14] Margaret Faux notes the risk that the Applicants may engage third-party price comparison services, such as iSelect and Compare the Market, as a means to encourage consumers to upgrade their coverage beyond their means.

7.2 The Proposed Conduct does not involve the provision of any comparison services between products offered by the Participants and other health insurers. Further, the Applicants submit that the Broad CPP will not influence consumers to purchase gold tiered policies. If consumer wish to be covered for joint replacements (regardless of their gap experience), they will need to purchase a product with joint replacement cover. Due to the legislated product tiers, this will generally be a gold or silver plus tiered product. If the consumer chooses an orthopaedic surgeon in the Broad CPP, they will have a no gap experience for the joint replacement. This does not require the consumer to upgrade their cover or make any changes to their cover.

8. Introduction of new criteria for approved treatments

8.1 Adventist HealthCare submit that the proposed HPPA contracts will negatively impact consumers by introducing new certificates or criteria which are inconsistent with agreed national standards.[15] These submissions suggest that new criteria will be employed as a means of restricting the treatment available to consumers.

8.2 Health insurers are legally required to pay a minimum level of benefits for hospital treatment under the PHI Act. The PHI Act allows insurers to request certificates from hospitals for certain treatment. For example, Type C procedures normally do not require hospitalisation and if a hospital claims benefits for these procedures, they must produce a Type C certificate.

8.3 If health insurers impose additional certificates or criteria, this is to determine whether a higher level of benefits is payable under the HPPA. For example, a higher rate is payable for ICU if certain criteria are met that indicate a complex ICU admission. In this case, a hospital must provide a certificate from an ICU physician that certifies that the criteria were met for the payment of higher benefits.

8.4 The Applicants submit that the existence of the HH Buying Group to negotiate HPPAs will not impact on the requirements for certificates or the imposition of new criteria. These changes would need to be agreed to by the hospitals as part of HPPA negotiations. The HH Buying Group's bargaining power in HPPA negotiations (which would exclude any other major health insurer) will countervail the bargaining power of some hospital groups (whether due to the size of the hospital group or their significance to members in particular geographical areas).

9. Appropriateness of value-based contracting for mental health

9.1 Several submissions raise concerns that value-based contracting is not sufficiently developed to link payments to short term outcomes within mental health, due to the episodic nature and ongoing treatment of mental health problems.[16] They note that many patients require ongoing treatment over a period of years and that linking contractual terms to outcomes may further create a financial disincentive for psychiatrists to see complex patients with treatment-resistant conditions.[17] Further, even where a diagnosis is achievable, Dr Gary Galambos' submission notes that this is not a good predictor of the need or duration of an admission.[18]

9.2 The Applicants appreciate the complexity of introducing value-based contracting for mental health hospitalisations compared to say, joint replacements. HH does intend to develop value-based contracts in mental health. The contracts will be developed in consultation with hospitals and psychiatrists. They will be based on clinical best practice, respect the primacy of the

[14] Margaret Faux, 26 July 2021 page 6.
[15] Adventist HealthCare, 15 July 2021 page 1.
[16] The Royal Australia & New Zealand College of Psychiatrists, 26 July 2021 page 2 and the National Association of Practising Psychiatrists, 23 July 2021 page 2.
[17] National Association of Practising Psychiatrists, 23 July 2021 page 2.
[18] Dr Gary Galambos, 23 July 2021 page 12.

specialist/patient relationship and look to address the existing gaps in care that are created by existing funding models.

10. ICHOM standards

10.1 The National Association of Practising Psychiatrists has raised concerns over the use of the International Consortium for Health Outcomes Measurement (**ICHOM**) to determine the value of care under the Broad CPP.[19] Specifically, they suggest that ICHOM is not internationally recognised by the broad scientific community as a standard set of values and therefore question the appropriateness of its use in the Broad CPP. Further, they raise concerns that the concepts of ICHOM are inconsistent with the realities of psychiatric practice.

10.2 ICHOM's primary activity is the development of condition-specific global outcome sets that focus on what matters to patients. To develop these sets, ICHOM brings together patients, international registry leaders, outcomes researchers, and leading providers to agree on a minimum set of outcomes they recommend that all providers track.

10.3 ICHOM released their Psychotic Disorder Standard Set on 20 May 2020. Leading mental health researchers, practitioners and service user representatives from across Europe, the Americas, Asia and Australia joined forces to establish and launch the first international standard for measuring treatment outcomes for adults and adolescents with psychotic disorders aged 12 and above.

10.4 Honeysuckle Health is not aware of a better set of standards for measuring outcomes from psychiatric treatment that matter to patients. The Applicants note that, at present, care is provided without any benchmarking or transparency for consumers on outcomes.

10.5 The above withstanding, the Applicants are open to working with each medical specialty college to determine if better measurement systems exist for their specific craft group if ICHOM is deemed as not appropriate.

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

Yours faithfully
MinterEllison

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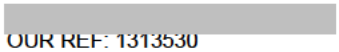
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[19] National Association of Practising Psychiatrists, 23 July 2021 page 7.