Conference record

Application for authorisation AA1000542

Lodged by Honeysuckle Health and nib

9:30AM AEST

8 July 2021

Microsoft Teams

The information and submissions contained in this conference record are not intended to be a verbatim record of the conference, but a summary of the matters raised.

Attendees

Australian Competition & Consumer Commission (ACCC)

- Stephen Ridgeway, Commissioner (Chair of Conference)
- Delia Rickard, Deputy Chair
- Mick Keogh, Deputy Chair
- Anna Brakey, Commissioner
- Peter Crone, Commissioner
- Tom Leuner, Executive General Manager – Mergers, Exemptions, and Digital
- David Jones, General Manager – Competition Exemptions
- Darrell Channing, Director – Competition Exemptions
- Simon Bell, Assistant Director – Competition Exemptions
- Rajat Sood, Principal Economist
- Anthony Haly, Principal Lawyer
- Claudia Crause, Lawyer
- Andrew Mahony, Analyst – Competition Exemptions
- Michael Pappa, Analyst – Competition Exemptions
- Cristina Trafficante, Project Officer – Competition Exemptions

The Applicants

Honeysuckle Health

- Rhod McKensey, CEO
- David Du Plessis, Head of Health Service Contracting

MinterEllison (representing Honeysuckle Health)

- Noelia Boscana, Partner
- Alix Friedman, Lawyer
- Dylan Gaymer, Lawyer

nib

- Mark Fitzgibbon, CEO
- Jordan French, Senior Corporate Counsel

Interested parties

Adventist HealthCare

- Brett Goods, CEO

- Philip West, CFO & Services Executive

APRA

- Karl Niemann, Manager, Private Health Insurance

Australian and New Zealand Association of Oral & Maxillofacial Surgeons

- Belinda Mellowes, Executive Officer

Australian Chiropractors Association

- Glynis Grace, Professional Services Manager

Australian Dental Association

- Dr Chris Sanzaro, Federal Executive Councillor
- Damian Mitsch, CEO

Australian Hand Surgery Society

- Jeff Ecker, President

Australian Health Service Alliance

- Simon McCarthy, General Manager, Corporate Services

Australian Orthopaedic Association

- Dr Michael Gillespie, President
- Dr Annette Holian, Vice President
- Dr Chris Morrey, Second Vice President
- Adrian Cosenza, CEO
- Kathy Hill, Advocacy & Governance Manager

Australian Pain Society

- Trudy Maunsell, President

Australian Physiotherapy Association

- Dan Miles, Deputy GM, Policy & Government Relations

Australian Private Hospitals Association

- Michael Roff, CEO

Australian Society of Anaesthetists

- Mark Charmichael, CEO

Australian Society of Ophthalmologists

- Kerry Gallagher, CEO
- Associate Professor Ashish Agar, President
- Belinda Castellano, General Manager, Strategy & Policy

Australian Society of Otolaryngology, Head, and Neck Surgery

- Professor Suren Krishnan OAM, President
- Dr Guy Rees

Australian Society of Plastic Surgeons

- Kim Hanna, COO

Bupa

- Richard Fox, General Manager, Strategy, Commercial & Healthcare Models

Catholic Health Australia

- Cathy Ryan
- Judith Day
- Angela Souter
- Alison Jeanne
- Philip Maloney
- Peter Kahn
- Stephanie Panchision
- James Kemp

CBHS Health Fund

- Anna Lowe, Chief Strategy Officer
- Nicole Nott, Group General Counsel & Company Secretary

Consumers Health Forum of Australia

- Jo Root, Policy Director

Council of Presidents of Medical Colleges

- Dr Kym Jenkins, Chair
- Angela Magarry, Chief Executive

Council of Procedural Specialists

- Stephen Milgate, CEO, Council of Procedural Specialists
- Dr Nigel Munday, President, Medical Surgical Assistants Society of Australia
- Dr Peter Waterhouse, Chairman of the Professional Issues Advisory Committee, Australian Society of Anaesthetists
- Dr Shirley Prager, National Association of Practising Psychiatrists
- Dr Melinda Hill, National Association of Practising Psychiatrists
- Dr Ashish Agar, President, Australian Society of Ophthalmologists
- Belinda Mellowes, EO, Australian and New Zealand Association of Oral & Maxillofacial Surgeons

- Dr Gary Galambos, Section of Private Practice Psychiatrists (SPPP) of the Royal Australian and NZ College of Psychiatrists

Day Hospitals Australia

- Jane Griffiths, CEO

Department of Health

- Mehak Vohra, Acting Assistant Secretary of the Private Health Insurance Branch
- Pierre Nijssen, Director, Engagement and Compliance Section, Private Health Industry Branch
- Yvette Long
- Sandra Pantic
- Michele Nelson, Assistant Director, Engagement and Compliance Section, Private Health Industry Branch

General Surgeons Australia

- Sarah Benson, Executive General Manager

GMHBA

- Adam Shar, Head of Strategy

HBF

- Lynne Walker, Head of Health Strategy

Healthscope

- Michelle Anglin, Deputy General Counsel
- Paul Haratsis, National Manager, Partnerships
- Meke Kamp, Corporate Affairs Manager, Industry & Government
- James Somerville, Senior Associate, Allens

Hunter Pain Specialists

- Kay Gray, Director

Latrobe Health Services

- Ian Whitehead, CEO

Mater Health

- Michelle Somlyay, Regional Executive Director
- Kirsten Beyer, Director of Revenue

Medibank

- Maki Takken, Senior Legal Executive

National Association of Practising Psychiatrists

- Dr Shirley Prager
- Dr Melinda Hill

Neuromodulation Society of Australia and New Zealand

- Dr Nick Christelis, President

Nexus Hospitals

- Scott Bell, COO

Private Healthcare Australia (PHA)

- Dr Rachel David, CEO
- Ben Harris, Director of Policy & Research

Robina Procedure Centre

- David Harris, CEO

Royal Australasian College of Surgeons (RACS)

- Chesney O'Donnell, Manager of the Policy & Advocacy Team
- Etienne Scheepers, Executive, General Manager of Fellowship Engagement Division

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

- Dr Elizabeth Moore, President-Elect
- Associate Professor Jeffrey Looi
- Nicola Wright, Manager, Bi-national Policy

St John of God Health Care

- Peter Kahn, General Manager, Health Funding, Strategy & Performance

Synapse Medical

- Margaret Faux, Solicitor, Founder & CEO

Conference summary

Conference Chair's introduction

Commissioner Stephen Ridgeway introduced himself and the ACCC staff present, welcomed everyone to the conference and declared the conference open.

Commissioner Ridgeway noted that the ACCC process is focused on whether Honeysuckle Health should be granted an exemption from specific competition laws in relation to its provision of certain contracting and other services to private health insurers in addition to nib. The ACCC does not have a role in how parties contract with each other in the medical supply chain, and any policy and other regulation regarding the relationships between doctors, patients, hospitals and private health insurers are a matter for Government, particularly through the Commonwealth Department of Health.

Opening statements from parties requesting the conference

Royal Australian & New Zealand College of Psychiatrists (RANZCP)

Dr Elizabeth Moore (RANZCP, President-Elect) said that:

- RANZCP is concerned the application will lead to participants entering into agreements with specialists, including price schedules and performance indicators, which will lead to changes in the patient-psychiatrist relationship, with no improvement in outcomes.
- The key issues for RANZCP are that this will lead to selective choice of providers, create cost caps, create limits to services, and create a gatekeeping bureaucracy.
- Private practice psychiatrists provide care based on individual need, in order to provide optimal care. There should be no third-party input into care and treatment.
- Psychiatrists provide care across a range of mental health services. Some patients require ongoing treatment over years. Limits or gatekeeping to treatment may limit collaborative care planning.
- Requiring people with mental illness to seek authorisation to access treatment will introduce delays, which may cause patients to leave the private health system, with implications for the wider health system.
- The private health system is important for various people, helping prevent people presenting to the public health system.
- RANZCP has concerns around the potential changes in practice, incentives and affordability of healthcare.

Associate Professor Jeffrey Looi (RANZCP, Section of Private Practice Psychiatry; ANU Medical School) said that:

- RANZCP opposes the formation of a buying group and exemption from competition laws on the following bases, which are characteristics of managed care:
    - Selective contracting creates issues for the community in terms of access and choice.
    - Financial incentives for providers to improve efficiency can be risky. Authorisation and approval of care can restrict the provision of care.

    - Utilisation management (managing healthcare costs by influencing patient decision-making) is not appropriate in the doctor-patient relationship.
- RANZCP is concerned that the number of healthcare insurers buying through a buying group would potentially cause asymmetry in negotiating power and, therefore, reduced ability for individual providers to provide valuable care to patients.
- RANZCP does not agree that managed care is a solution to unaffordability of psychiatric care.
- Professor Looi noted that psychiatry had not flourished under managed care in the US. Many managed care providers in the US subcontract to behavioural care organisations, which have issues with staff turnover and quality of service.

Council of Procedural Specialists (COPS), Council of Presidents of Medical Colleges (CPMC) and Australian Society of Ophthalmologists

Stephen Milgate (CEO, COPS) said that:

- COPS remains opposed to the application because there would be significant detriments to healthcare, which outweigh the speculative benefits proposed in the application. COPS maintains that what is described in the application is managed care and uses the Productivity Commission's definition as its guide.
- COPS believes section 172-5 of the Private Health Insurance Act is not sufficient protection. It does not cover third party payers; it covers insurers. Most importantly, the legislation does not say anything about preferred provider networks, which the buying group intends to use. The buying group can use contract terms and conditions to shape practitioner behaviours.
- What COPS is talking about as managed care is controlling patient flows and managed contracts; it is managed care through the backdoor, with clinical advisors making sure things are being managed per objectives.
- COPS considers nib's disclosures to the ASX need to be taken into account. nib says it is going to provide guidance about how individual risk can be managed, mitigated and treated, and deliver procedures to those disease risk profiles. nib says it is their ambition to provide a leap in healthcare and wants to minimise avoidable hospital admissions.
- COPS says the extent of this intervention needs to be fully understood and made public. nib CEO Mark Fitzgibbon said nib wants to get as much data from participants as it can and run it through algorithms to identify members' greatest health risks. These are up-front statements from the joint venture about the extent of intervention.
- COPS believes doctors will be coerced into these contracts.
- COPS considers the ACCC has been very helpful in the draft determination when it says that value-based contracting has not been seen before and is unregulated. It could lead to worse health outcomes. Most of us are currently locked down because the government is protecting us from worse health outcomes. COPS believes the applicants should withdraw the application until value-based contracting is fully evaluated and discussed publicly.
- Cigna's role in this application is being ignored. Currently, Australia has a community-rated system in Australia. COPS noted comments from health fund CEOs that they would like to move to a risk-rated system.
- Lower costs for patients is an illusion. There will be no out of pocket costs upfront, but doctors will be paid a higher incentive payment, as is now the case with nib's

clinical partners program. The out of pocket situation will be no different to patients because they will be paying the “gap” through higher premiums.

- COPS does not want a system where doctors treating difficult patients are eliminated or valued less in a market sense, and therefore discouraged from practising in that particular area.
- COPS’s contention is this application is about big corporations getting more power to contract and coerce small businesses into joining part of their business strategy.
- To COPS’s knowledge, the alternative buying group is not seeking to push doctors into unseen contracts.
- This particular application is asking the ACCC to aid and abet the corporate control of Australian medicine, and no one in government or big business should control the doctor-patient relationship.
- COPS is here to make sure the clinical doctor-patient relationship is preserved, which has worked and achieved high standards through the pandemic.
- COPS does not want to shift risky patients out of the health system. Doctors do not want a system that encourages them to do that.
- The 40% cap [on participation in the Broad Clinical Partners Program] is far too high for any protection. COPS thinks the application itself should be removed by the applicants or removed by ACCC.
- COPS believes this application should be rejected.

Dr Kim Jenkins (Chair, Council of Presidents of Medical Colleges (CPMC) said that:

- Across all disciplines in medicine, it is recognised that Australia has one of the best health services in the world. The CPMC is not naïve enough to think it is perfect; it is all too aware of areas in need of revision and quality improvement. However, the CPMC strongly believes the introduction of the Honeysuckle Health buying group will be of no benefit in leading us in that direction.
- Patients in the community value the health system we have and do not want to see anything that could erode Medicare being universally available.
- Currently, people have a private vs public choice. If they are choosing private care, then they are making a choice of how they want to be treated and by whom.
- Misleading advertising can affect choice and that can impact informed consent. Not necessarily about procedures, but also the environment and situation in which healthcare is being delivered – and this can affect a patient’s right to autonomy. CPMC questions how patients and doctors and hospitals will know what is good quality care from Honeysuckle Health and nib.
- The doctor-patient relationship has been discussed. The presence of a third party will be detrimental to that therapeutic relationship, and will lead to a loss of mutual respect and regard between doctor and patient. If there is no trust, there is no care.
- If a doctor or healthcare professional is perceived to be working on behalf of a third party, or even having what they can do be clinically determined by a third party, this trust will be eroded. This trust is the cornerstone of sound ethical medical practice. We will also see the erosion of patient- or person-centred care that is so important and becoming increasingly recognised across all medical disciplines and the whole of healthcare. The focus should be on care that is appropriate to the individual, not a doctor’s own interests. Any introduction of a third party reduces the quality of care.

- Discharge from hospital requires a lot of considerations, including factors in the patient's life, family and home situation; the patient's views are paramount here. Discharge planning cannot and should not be determined by a pre-set algorithm based on time, economics, and value for money or number of bed days spent in hospital.
- Dr Jenkins concurred with Professor Looi and Mr Milgate that we cannot let the Honeysuckle Health buying group proceed.

Dr Peter Waterhouse (Chairman, Professional Issues Advisory Committee, Australian Society of Anaesthetists) said that:

- A buying group with the goal of introducing preferred provider networks is simply reducing patient choice. While there might be patient choice in theory, actually there is economic coercion brought to bear, due to favourable and unfavourable rebating. We have universal providers broken into preferred provider stables.
- The cost of this division of the workforce into preferred provider networks spirals upwards as in the US example. With preferred provider networks, there will be, from an administrative point of view, as many payment schedules and contract obligations as there are health insurers, which will introduce an upward spiral in cost. This includes data collection. The burden of assembling the data set will fall on practitioners, leading to an upward spiral in cost.
- The days of individual practitioners treating individual patients will be over – this will lead to practitioners banding together to cover increasing administration costs.

Dr Gary Galambos (Psychiatrist, Co-Joint Senior Lecturer at UNSW) said that:

- The private health system provides choice, which is facilitated by the universal Medicare system subsidising private healthcare. It gives specialists wide parameters within which to practice. Flexibility is what allows us to offer person-centred care.
- The way to preserve the choice that enables collaborative healthcare to take place is not to allow private health insurers to have collective bargaining power. That will ultimately interfere with healthcare processes.
- Those of us who have spent their careers working in these areas feel the ACCC is making a life or death choice. If the ACCC gives the applicants what they want, they will destroy Medicare. It is an absolute turning point in whether the healthcare system degrades. It will be a totalitarian takeover.
- Medicare had enabled Dr Galambos to work in a variety of settings, including now as part of the Young Adult Unit in Sydney, which requires a long-term investment view.
- Health funds do not understand healthcare and economic imperatives are the priority. Health funders are looking after shareholders, the fund and their bonuses.
- Health funds have legal obligations to increase profits and the only thing they can do to achieve that is reduce healthcare costs.

Dr Ashish Agar (President, Australian Society of Ophthalmologists) said that:

- Australia has a healthcare culture based on the doctor-patient relationship. The Hippocratic Oath reinforces the independence of the medical profession, and spells out duties and obligations to patients. We are concerned about managed care because it limits choice. When treatment is determined by an unrevealed contract, this violates the doctor-patient relationship. To include a third party breaches the fundamental trust upon which medicine is based.

- Evidence-based medicine already measures patient outcomes. Patient data transfer must be transparent and authorised by the Department of Health. This is an unprecedented event. This conference turn-out speaks to the gravity of what we are facing. Having every specialist society in Australia be present at this meeting and speak in a unified voice about a single issue is completely historic. They are clearly worried about something.
- We launched a campaign to see what the public would think about this matter. 95% of respondents saw this as a clear threat to their care. 4.9% agreed with the application and 0.1% supported it. The patients and the profession understand. Some patients said they wanted a medical-licensed person to direct care, not an insurance-licenced person.
- These are matters of health policy. This decision will make health policy by default. The Department of Health should handle this issue and give their opinion on it.

Dr Melinda Hill (Consultant Psychiatrist & Psychoanalytic Psychotherapist, National Association of Practising Psychiatrists) said that:

- As a psychotherapist, Dr Hill assesses and develops formulation histories. Only when these dynamic factors are gathered is it possible to understand the patient and their symptoms and develop individualised and appropriate treatment and risk responsivity.
- Similarly, the Honeysuckle Health application should be carefully examined, along with the sociocultural and historical context from which it emerges. Only then can a truly nuanced and informed assessment of detriments, harms and risks flowing from the approval of the application be formed. This is important because nib has made clear there is a strong alignment in how it and Cigna see healthcare evolving. Psychiatrists know that we must look at the past along with the present, in order to make informed decisions that will impact the future.
- To consider the cultural and historical impacts of managed care, we look to the US. In an American Health Law article regarding the upwards trajectory in health plan disputes involving the coverage of mental health benefits, Cigna was one of the 5 major health insurers against whom litigation was discussed. Media reports from 2014-2016 have reported them discriminating and improperly limiting mental health coverage, or placing undue burdens on mental health coverage. Legislation was introduced, but designation of treatment as not medically necessary reportedly happens twice as often for mental health.
- It is known as moral injury when we perpetrate or fail to prevent an act which goes against our moral beliefs. Our oath is to put the patients first. As clinicians, we are forced to consider demands of other stakeholders, including insurers. Putting their needs before the needs of the patients produces a healthcare system that over time becomes unsafe for patients - re-traumatising - and also for practitioners - with increasing levels of vicarious traumatisation and moral injury. The solution is to have a healthcare system that prioritises healing over profit. Dr Hill asserts that this is the true definition of value rather than that asserted by for-profit insurers and managed care corporations.
- The intrusion of a third party incorporating confidential incentives and disincentives is not in keeping with patients' rights to protection from cruel, inhuman, and degrading treatment. Dr Hill said that she would like to put on record that she wants to hear mental health consumers' responses as to the impact that it would have to discover that their psychiatrist was signed onto an incentivising/disincentivising, unregulated, commercial third party contract, of which the details were confidential. Dr Hill said it was her sense this would result in fear, at best call into question the trustworthiness

of the psychiatrist and at worst, irreparably damage the therapeutic relationship. The proposed conduct does not capture the devastating impact that such ruptures can have.

Opening statements from Honeysuckle Health and nib

Rhod McKensey (CEO, Honeysuckle Health) said that:

- The Honeysuckle buying group focuses on hospital purchaser provider agreements (HPPAs) and medical purchaser provider agreements (MPPAs). Honeysuckle Health is undertaking this function for nib. The application seeks authorisation to perform the same thing for other funders. Honeysuckle Health will negotiate terms and conditions of HPPAs with hospitals and each participant of the buying group will be free to enter into contracts or negotiate independently. The buying group cannot collectively boycott hospitals or groups.
- Honeysuckle Health manages a small number of MPPAs for nib and the Clinical Partners Program (CPP) is the first value-based contracting initiative. It is a small-scale network of surgeons performing hip and knee replacement for nib members. Doctors do not charge costs for nib members. There will be no interference from Honeysuckle Health. Honeysuckle Health will not dictate any clinical pathway for a patient. Submissions allege that the introduction of the buying group will lead to US-style managed care, undermining patient choice and clinical autonomy of doctors. These fears are unfounded. These principles are protected under proposed conditions and private health insurance law.
- Interested parties are opposed to value-based contracting, not to Honeysuckle Health collectively bargaining. ACCC needs to consider that a public benefit of the Honeysuckle Health buying group is effectively driving value-based contracting due to the group's scale. Value-based contracting is the future. It links the funding of healthcare to the quality of patient outcomes. Currently health funding is based on a fee-for-service model and does not consider performance, so value-based contracting rewards providers for better outcomes.
- [Honeysuckle Health provided an example of localised prostate cancer and the resulting measurable outcomes]. Defining outcomes is more complex for mental health and Honeysuckle Health will work with providers to better understand this. Honeysuckle Health uses objectively established outcome measures such as standardised ones developed by the International Consortium for Health Outcomes Measurement (ICHOM).
- Honeysuckle Health has no intention of interfering between doctors and patients. Neither Honeysuckle Health nor nib dictate how the surgeon provides care. Surgeons do not charge a gap to members, thus lessening the gaps other surgeons will charge. Specialists who choose not to participate can access the nib gap scheme or set their own fee and charge out-of-pocket costs. Honeysuckle Health is not removing those options.

Mark Fitzgibbon (CEO and Managing Director, nib), said that:

- nib is not interfering with doctor-patient relationships. nib is providing both doctors and patients with more evidence to help them make better decisions, and trying to remedy information asymmetry and improve transparencies around outcomes. Collective bargaining is just one part of making healthcare as much about disease prevention and management as it is about treatment. It improves people's ability to predict underlying health risks and better prevent, manage, and treat disease.

- The application does not propose to authorise treatment or overrule clinical decisions i.e. a managed care scenario. Americans have made great progress in this area. In Europe, their healthcare systems are moving towards data-driven care, similarly to most OECD countries. We should be a part of that and we should be proud that we are sourcing a partner in the form of Cigna.
- Doctors will benefit as data science will help them diagnose/treat their patients. They will have access to a range of services that support their patients, including digital programs. We will launch a health program, and they will be rewarded for outcomes. It is difficult measuring outcomes, but we do it because it is hard but worthwhile and in the interests of the healthcare system. We will reward doctors for outcomes, especially for those treating severe illnesses.
- When Medibank (precursor to Medicare) was launched, there were 10 working Australians to one retired. Now, there are 50 to every one. We need to make the healthcare system more sustainable. Preventing, managing, and treating diseases is part of the quest, and our application to negotiate provider relationships with doctors is part of that too.

General discussion

Dr Omar Khorshid (President, Australian Medical Association (AMA)) said that:

- The AMA does not believe the healthcare system is truly competitive – price setting exists, government intervenes in fees, Medicare fixes prices, AMA fees signal prices also. Public detriment is measured in healthcare quality and quantity, not financial terms. This model will create a larger buying group with more market power to drive price down, not quality up. This might drive efficiency, but will impact other buying groups and hospitals. Main concerns come from very small providers, individuals, or groups representing the doctors who have to recognise the size of the market the insurer represents. It is a poor commercial decision to not sign up to the only buying group in the market. Others will move so products do not become too expensive.
- There is a lack of trust as seen from the comments made today. No trust that a for-profit insurer with nib's history will act in the patients' interest. Value-based contracting is a reasonable concept but Medicare is not value-based, it is service-based. Applying a new philosophy is not going to provide value-based contracting in the AMA's view.
- The ACCC cannot intervene around contracting, but the contracting delivers the patient detriment. No reassurance is meaningful unless contracts are open. The AMA is interested in future contracts rather than current. Once a certain amount of market power is in this space, it will be easier for insurers to exert control. Use of value-based contracting should be open/transparent/regulated, although the ACCC is not the appropriate regulator.
- Honeysuckle Health's model of data collection brings concerns around privacy and misuse of information. The AMA is concerned about using this data to predict a patient's healthcare needs and what that means for future choice for patients with their health insurer. The AMA wants more reassurance. Honeysuckle Health/nib needs to take people with them on a journey to more sustainable healthcare. There is almost universal opposition to this authorisation. You cannot bring in change without trust – trust must be built first.

Michael Roff (CEO, Australian Private Hospitals Association) said that:

- The applicants have not demonstrated public benefits outweigh detriments. The application should be rejected. However, if authorised, APHA proposes some conditions. The market share cap on CPP should not be increased to 60%. It should be reduced to 30%. At 40% it could include all healthcare payers, not just health insurers. The cap could also apply regionally, defined by LGAs or local health districts, as doctors only provide services at the local or regional level, so the cap should apply at the level of the market rather than nationally.
- In their submissions, the applicants adopt a limited definition of insurers controlling providers. This constitutes managed care but overlooks things like influencing choice of provider/treatment. The applicants claim they are not allowed to dictate clinical decisions. This is not true. CPP currently offers financial benefits to doctors higher than ordinarily paid by nib, and otherwise charged in the market, paid on condition that doctors reduce referral rates to defined benchmarks and all patients go into nib's program. Clearly influencing choice of provider/treatment. There is no transparency for the patient about why it is happening. If nib refutes this APHA invites them to publicly release those contract terms. APHA submits a condition should specifically state nib will not offer any financial inducement, benefit, or penalty to any provider that may have the effect of influencing the choice of provider, venue of treatment, treatment type, or pathway.
- The applicants are using financial incentives to stream patients into care settings that are in the financial interest of nib, but not in the clinical interest of the patient. There are a number of things in the application which the applicants have no intention of doing, including reducing the size of nib's current hospital network, contracting with fewer medical specialists, and driving other buying groups out of the market. If they have no intention of doing these things, they should have no issue with each of these statements becoming a condition of authorisation.
- The applicants rely on protections afforded by the regulatory regime. There are a number of reviews underway which may change these regulations. Health insurers are advocating for the second tier default benefit to be abolished. APHA proposes that any change in provisions referred to should trigger an automatic review of the grant of authorisation.
- The applicants submit the ACCC is not the right body to determine if value based contracting should be regulated and that authorisation is not the right process for imposing restrictions as these are matters for the Federal Government. On this basis, the ACCC should seek the views of the Federal Government (Department of Health) on these issues and proposed changes to the regulatory protections referred to by the applicants before making a final determination.

Dr Rachel David (CEO, Private Healthcare Australia) said that:

- There is no basis upon which to reject application. Managed care is illegal in Australia. We are not permitted to preauthorise claims. Fund benefits pay for hospital care when a benefit is payable. A third party cannot direct a doctor to act against patients' best interests (Medical Board Regulatory Framework, 2009). The default benefit regime means that a health fund/buying group seeking to narrow networks is not possible. People can always switch funds, giving incentive to keep customers happy. A community health regulator is needed to make this decision.
- Providing information to consumers about no-gap specialists is a fundamental role for health funds. It is part of private practice. Geography impacts out-of-pocket fees. Consumers need to be informed about that. 10% of our members pick their specialists purely based on price, sometimes going interstate to find a cheaper one.

That is what private practice means, not managed care. PHA does not advocate to change Medicare.

- A lot of the issues raised by interested parties happen already. They are part of the things that are regulated by the Federal Government. PHA urges people to understand that PHA are not advocating for unusual changes. There are already buying groups for funds to reduce health fund management expenses. Little funds are trying to contract with individual hospitals, and they do not represent not-for-profit funds. There are a few for-profit funds already, which begs the question of why the new one will be any different.
- There are no plans for funds to insert themselves into the doctor-patient relationship. It should be transparent. Funds continue to address information asymmetry. PHA considers that managed care is not possible in our community. PHA has consumers' best interests at heart.

Dr Michael Gillespie (President, Australian Orthopaedic Association (AOA)) said that:

- AOA supports the position of the AMA, COPS, CPMC and others.
- AOA strongly believes that neither the ACCC nor APRA is tooled up to effectively regulate this area, and believes that an independent regulator is necessary.
- AOA believes the contracts have the potential to clash with doctors' commitments to ethical behaviour.
- Data collection is fraught with concerns about privacy and misuse of information.
- AOA already has a protected data system, with patient recorded outcome measures. AOA is happy to work together with the applicants, but believes that the applicants are going about it the wrong way.

Margaret Faux (solicitor, founder and CEO of Synapse Medical) said that:

- We do have managed care in Australia. Workers compensation schemes are managed care. Look at iCare in NSW; iCare was in trouble because of failures in managed care. There are protections in the Private Health Insurance Act, but it is a federal scheme. There is however managed care creep, with insurers denying and delaying claims.
- There are several inaccuracies in the ACCC's draft determination:
    - Paragraph 2.2 is incorrect, as patients do not make claims on the spot. This only happens with outpatient care. There is no billing on the spot because it cannot be billed until it is coded at the end of the episode of care.
    - Regarding paragraph 1.42, consumers do not understand that a doctor has not been paid for services.
    - Regarding paragraphs 3.8-3.9, Synapse and all doctors could provide evidence of the current incidence of rejected claims. There is a very high rejection rate in Australia already.
- nib's Clinical Partners Program is part of nib's 'gold policy'. Consumers should not be pushed into gold policies. There should be assurances around this.
- Regarding paragraph 5.51 of the applicants' amended application, around 'known gap' and 'no gap', the applicants have not done what it says here. nib remains the only insurer which has not offered a known gap option. nib has never been incentivised to do this.

- Regarding paragraph 3.22 in the applicants' latest response, they now say they are going to offer a known gap scheme. Ms Faux wants clarification on this.
- Private health insurers cannot control out-of-pocket costs out of hospital. nib needs to make it clear how it intends to do this.
- Regarding no boycotting, with the applicants assessing compliance around fraudulent claims, etc., this would lead to a collective boycott if the Honeysuckle Health buying group makes a finding of fraud. How can they make these findings outside of the law? If a specialist believes they have been unfairly judged, they can only challenge this through expensive legal proceedings.

Brett Goods (CEO, Adventist HealthCare) said that:

- He disagrees that HPPA contracting is an element of least contention in the conduct. Product design is a mechanism that can be used to control the care.
- Department of Veterans' Affairs is a very different case mix to the broader Australian public. There will be a direct impact on this small group, and there will be detriment to the consumer to being part of the Honeysuckle Health group.
- HBF is the largest provider in WA, and if they get market share in eastern states, then the risk of their involvement causing market power issues in the buying group increases.
- nib has had a historical disinterest in no gap or known gap schemes.
- In value-based contracting, broadly the value talked about is patient outcomes; it is not an economic model. Its application in the EU is 'how does it benefit the patient with the treatment they received?'
- Regarding public benefits, what is the measure of success going to be to determine how the authorisation has worked? What is success going to look like?
- Regarding data, it is important not to have an additional burden on providers. There is a significant burden on providers to be compliant to HPPAs already.
- The use of some data can be misrepresented, particularly when medical complications arise. Hospitals do not like how private health insurers have used this information to manipulate the quality of outcomes.
- The term of authorisation should be shorter and only for 4 years, allowing one cycle of contracts.

Cathy Ryan (Catholic Health Australia (CHA)) said that:

- Why the existence of buying groups is a public benefit has not been accurately presented. Ms Ryan acknowledged that it is difficult for the ACCC to define.
- Management-expense ratios have been used to rationalise buying groups' existence, however, buying group members have some of the highest ratios and the highest premium indexations, above the industry average.
- The mere presence of existing buying groups is not a reason to allow another one. The analysis of public benefits needs to be explored further.
- The public interest test has not been passed: how is it increasing competition and how is it lowering costs. Are 35 health insurers too many for the Australian population? Buying groups have allowed the ongoing existence of many smaller health insurers, but is this a good thing?

- CHA has a good relationship with the funds it works with. For those within buying groups, 60% of requests for varied arrangements are declined.
- Patients [affordability, natural market forces] should be considered more closely when considering the public benefit test.

Professor Mark Frydenberg (Chair, Health Policy and Advocacy Committee, Royal Australasian College of Surgeons (RACS)) said that:

- Doctors' priority is to their patients.
- RACS is working with the Department of Health about out-of-pocket expenses.
- A 50% [sic] market share cap on the buying group is too much, and will enable the group to coerce hospitals and specialists.
- There has been no independent indication of how value-based contracting will be measured. Quality of care typically trends downwards, which will not result in benefits to the public.
- If private hospitals have a budget for an episode of care, then that pressure on decisions will result in corners being cut and care reduced for patients. It is an invisible influence on doctors' decision-making based on financials.
- There will be a boycott based on the preferred provider network and associated marketing.
- Data collection requires substantive risk adjustment. It should not be used as a punitive measure against hospitals and doctors where their outcomes do not meet the private health insurers' requirements.
- If a hospital does contract with Honeysuckle Health, then it coerces the doctors in that hospital to also contract with Honeysuckle Health, because otherwise it will disrupt the system.

Rhod McKensey (CEO, Honeysuckle Health) said that:

- In relation to interested parties' claim that the CPP requires targets – this is not the case and Honeysuckle Health is prepared to provide contracts to prove it.
- Regarding backdoor influencing of consumers, this has been going on for a long time; Mr McKensey is not sure how the buying group exacerbates this.
- Regarding boycotting providers, there is no intention to boycott.

Mark Fitzgibbon (CEO, nib) said that:

- There are already collective contracting groups, but Honeysuckle Health's will be better. Bringing competition to this area will be a good thing.
- There will be no pre-authorisation, no denial of cover, no interference with clinical decision-making.
- nib is trying to provide data for both doctors and patients, to alleviate some of the information asymmetries.
- There will be no restrictions on patient choice.
- Data is being used worldwide to improve services. Mr Fitzgibbon is certain this will be a good thing for all and create a more sustainable industry.

Jane Griffiths (CEO, Day Hospitals Australia) said that:

- The opportunity for treatment to occur in the most appropriate setting will be threatened.
- Ms Griffiths agrees with comments that negotiations with specialists will flow on to agreements with hospitals, which will threaten the current system.
- The viability of smaller funds will be under threat. Many smaller funds serve rural communities with niche markets. If they go out of business, there will be additional costs for those communities.
- Regarding patient confidentiality, what guarantees are there that the data collected will be kept in Australia?
- Ms Griffiths believes the conduct will diminish choice in Australia.

Damian Mitsch (CEO, Australian Dental Association (ADA)) said that:

- The ADA sits outside Medicare, so does not have access to the benefits that come from Medicare.
- The ADA and its members deal with private health insurers turning over billions each year. nib is significantly larger than the usual member of ADA. The difference in scale buys that company power and influence.
- Yes, there are already buying groups; however, this is a buying group proposing to team up with other larger insurers. Bupa is the closest thing we have seen in Australia to something this large.
- Regarding the benefits of using data and shifting to value-based healthcare, the ADA is already in discussions to determine what is defined as value. One of the ADA's goals is access to better data; however, no insurers have provided access to help determine where the value exists and where it does not.
- HiCaps have an appeal process for boycotts. ADA has had members "de-recognised" and patients directed to preferred providers.
- For those who do not sign contracts, Bupa said that if you treat a Bupa member, you will automatically be contracting with Bupa. If you disagree, the patients do not get any rebates.
- The application should not proceed, but if it does, the percentage cap should be lowered. Remove businesses with more than $10m in contracting. Prevent them from abusing their power with smaller providers.

Dr Chris Sanzaro (Federal Executive Councillor, Australian Dental Association) said that:

- He had witnessed the reduction in choice for patients through preferred provider arrangements.
- The concept that preferred provider arrangements work in long term is incorrect.
- If a group is able to unilaterally impose conditions, and someone disagrees, then you will lose those patients.
- The concept that Ms Faux raised, that consumers are unaware of what is going on with the insurer and provider, is very relevant. Consumers can only find out what is covered once they have been diagnosed, are stuck with an active disease and unlikely to be able to get the cover that they need.
- Preferred provider arrangements particularly do not work in rural areas. When a patient requires care, this may mean they need to travel far from home to be able to get covered care.

- The 60% cap proposed by the applicants is completely unreasonable.

Jo Root (Policy Director, Consumers Health Forum of Australia (CHF)) said that:

- Consumers welcome moves that makes private health insurance more affordable, and things that push down premiums.
- However, consumers have suggested to CHF that they are concerned about this proposal because of the possibility of loss of choice.
- Research shows that people take out private health insurance because of the choice it provides to them. Removal of choice will remove the comfort with private health insurance.
- Ms Root thinks the argument that increased competition will create benefits is loose.
- Ms Root does not think that if some doctors are offering no gaps that it will push other doctors to also provide no gaps. Ms Root does not think the evidence supports this.
- Ms Root said the draft determination needs more evidence about the public benefits.
- For this big group to have such power would require strong and well-evidenced public benefits.

Trudy Maunsell (President, Australian Pain Society) said that:

- Complex complicated patients are often pushed down the priority list. Ms Maunsell does not believe there will be adequate access to care for such patients.
- There is a need to consider the allied health professionals associated with complex care and to consider access to allied health professionals, particularly those involved in pain management.

Conference Chair's closing

Commissioner Ridgeway said that:

- We have heard from a variety of parties on a number of significant issues.
- Some of the issues to be addressed are whether there is already value-based contracting in arrangements with private health insurers, the fact that there are already other buying groups, at least one of which is relatively large and long-standing, and the claims that managed care would be unlawful.
- The Commission will now accept any further written submissions by Friday, 23 July 2021.
- It would be useful for written submissions to explain how authorisation of the buying group itself will lead to the introduction of managed care in Australia, and whether the 40% share of policies for the BCPP condition is an appropriate condition, or another condition would be appropriate.
- The ACCC will prepare a summary of today's proceedings and provide it to all attendees. Then, when the Commission has had an opportunity to consider the matters raised at this conference and any further written submissions it may receive, it will decide whether or not to grant authorisation and on what terms.

The conference concluded at approximately 12:30PM AEST.