Draft Determination

Application for authorisation
lodged by
Honeysuckle Health Pty Ltd and
nib health funds limited
in respect of
the Honeysuckle Health Buying Group
Authorisation number: AA1000542

21 May 2021

Commissioners:	Keogh
	Brakey
	Court
	Ridgeway

Summary

The ACCC proposes to grant authorisation to enable Honeysuckle Health (HH) and nib (together, the Applicants) to form and operate a buying group to collectively negotiate and manage contracts with healthcare providers (Providers) on behalf of health and medical insurance providers and other payers of healthcare services.

The application for authorisation

HH provides services to healthcare payers in Australia and New Zealand. These services currently include health analytics (e.g. measurement of impact of health interventions, population risk classification and Provider benchmarking), health management programs (e.g. phone programs to support patients' transition from hospital and manage chronic diseases) and contract negotiation and management services for nib. The Applicants seek authorisation for HH to provide the contracting services to additional healthcare payers and form a joint buying group.

Participation in the buying group and HH's contracting services would be available to most private health insurers in Australia, international medical and travel insurance companies, government and semi-government payers of healthcare services and any other healthcare payer notified by HH to the ACCC.

The Applicants have not sought authorisation for the HH Buying Group to engage in the collective boycott of any services of a Provider. This means that no Provider would be obliged to deal with the HH Buying Group and the HH Buying Group would not be permitted to boycott any Providers that refuse to deal with the group.

Consultation and amendments to the application for authorisation

The ACCC received a significant number of submissions from market participants opposing the application for authorisation. In response to these concerns, as well as issues identified by the ACCC, the Applicants have amended their original application.

Following the amendments, under the proposed authorisation it would *not* be open to Medibank, Bupa, HCF, or HBF in Western Australia to be part of the general buying group and acquire contracting services from HH in relation to hospital contracting, medical gap schemes and general treatment networks.

However, it *would* still be open to Medibank, Bupa, HCF and HBF in Western Australia to acquire HH's contracting services relating to HH's Broad Clinical Partners Program. This is a program under which HH enters into agreements with medical specialists to ensure that customers are not charged out-of-pocket costs for medical services provided during an episode of hospital treatment (currently only for joint replacement surgery, but it is proposed to apply to other services in the future).

Public benefits

The HH Buying Group would be a new option for those health insurers who prefer to be part of a collective acquisition of health services and/or seek contracting services.

The ACCC considers the main public benefits likely to result from the Proposed Conduct are a greater choice of buying group for healthcare payers and more competition between buying groups. The ACCC also considers the Proposed Conduct is likely to result in some public benefits in the form of better input into contracts, better information for participants in the HH Buying Group and some transaction cost savings, mainly for healthcare payers other than private health insurers.

Public detriments

Based on the information available, the ACCC considers it is likely that some private health insurers, including major insurers, will join HH's Broad Clinical Partners Program. The ACCC considers, if all private health insurers are able to join the Broad Clinical Partners Program, this potentially uncapped aggregation is likely to result in public detriment by reducing competition between acquirers of medical specialist services.

Proposed condition

In order to address this public detriment, the ACCC proposes to impose a condition of authorisation that HH not provide the Broad Clinical Partners Program services to major private health insurers where this would result in the participants in the program representing more than 40% of the private health insurer market in any State or Territory.

Balance of public benefits and detriments

On balance, and with the proposed condition of authorisation, the ACCC considers that the Proposed Conduct is likely to result in a public benefit and that this public benefit would outweigh any likely detriment to the public from the Proposed Conduct.

Length of authorisation

The Applicants sought authorisation for 10 years. The ACCC understands that the majority of agreements with private hospitals and medical practitioners have a two to three year term and HH is likely to require time to establish the HH Buying Group and put in place arrangements with Providers. In these circumstances, the ACCC proposes to grant authorisation with the proposed condition for 5 years.

Next steps

The ACCC invites submissions in relation to this draft determination by 11 June 2021 before it makes its final decision.

1. The application for authorisation

1.1. On 24 December 2020, Honeysuckle Health Pty Ltd (**HH**) and nib health funds limited (**nib**) (together, the **Applicants**) lodged an application for authorisation AA1000542 with the Australian Competition and Consumer Commission (the **ACCC**). HH and nib are seeking authorisation for 10 years for HH to form and operate a buying group (the **HH Buying Group**) to collectively negotiate and manage contracts with healthcare providers. This application for authorisation AA1000542 was made under subsection 88(1) of the *Competition and Consumer Act 2010* (Cth) (the **Act**).

1.2. In response to concerns raised by the ACCC and interested parties, the Applicants have made a number of amendments to the application.

1.3. On 8 April 2021, the Applicants amended their application to exclude Medibank Private Limited (**Medibank**), Bupa HI Pty Limited (**Bupa**), the Hospitals Contribution Fund of Australia Limited (**HCF**) and HBF Health Limited (**HBF**) in relation to its contractual arrangements with healthcare providers in Western Australia (**HBF WA**)[1] (each, **a Major PHI**) from the Proposed Conduct in relation to in relation to hospital contracting, medical gap schemes and general treatment networks.

[1] The non-Western Australian business of HBF is currently managed by the Australian Health Services Alliance.

1.4. On 21 April 2021, the Applicants further amended their application to limit the medical specialist contracting services offered by the HH Buying Group to the Broad Clinical Partners Program (under which customers would receive a no gap experience for the whole episode of care for a surgical procedure).

1.5. In this further amended application, the Applicants stated they were open to the imposition of a condition that would only allow the HH Buying Group to represent a maximum of 80% of the national private health insurance market (based on the number of hospital policies) in relation to the Broad Clinical Partners Program.

1.6. The ACCC may grant authorisation, which provides businesses with protection from legal action under the competition provisions in Part IV of the Act for arrangements that may otherwise risk breaching those provisions, but are not harmful to competition and/or are likely to result in overall public benefits.

The Applicants

1.7. HH is a health services and specialist data science company that provides services including health analytics and health management programs. In December 2019, HH was established as a joint venture between nib and Cigna (with each owning 50% of HH). The Applicants state that HH operates independently of nib and Cigna. From 1 October 2020, nib appointed HH to act as its agent to provide data analytics, contract negotiation, procurement and administration services in relation to nib's contracts with hospitals, medical specialists, general practitioners and allied health professionals.

1.8. nib is an Australian health insurer supplying approximately 10% of national private health insurance policies[2], providing insurance to Australian residents, international workers and international students. nib is also Australia's third largest travel insurance provider, and also underwrites GU Health, Suncorp and Qantas health insurance.

1.9. Cigna is a global health services company. It provides a suite of health services (medical, dental, pharmacy, vision), as well as related products including group life, accident and disability insurance.

Parties to the Proposed Conduct

1.10. The Applicants have sought authorisation for and on behalf of:

(a) private health insurers registered under the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) except for certain private health insurers in the circumstances specified below at paragraph 1.12.

(b) international medical and travel insurance companies

(c) government and semi-government payers of healthcare services such as workers' compensation and transport accident scheme operators, and the Department of Veterans Affairs scheme (DVA), and

(d) any other payer of health services or goods as notified by HH to the ACCC

(**Participants**).

1.11. Together, the healthcare payers described in paragraph 1.10(b) to (d) are referred to as **Other Healthcare Payers** in this draft determination.

The Proposed Conduct

1.12. The Applicants seek authorisation for the following conduct:

[2] Based on total of Hospital and Extras Policies from APRA's Operations of private health insurers annual report 2019.

- as regards Medibank, Bupa, HCF and HBF WA (each a '**Major PHI**'):
    - HH to operate the Broad Clinical Partners Program involving the provision of services to any Major PHI
    - each Major PHI to acquire contracting services from HH, but only in relation to the Broad Clinical Partners Program, and
- as regards all other private health insurers (including HBF's arrangements with healthcare providers outside Western Australia), Other Healthcare Payers and any other healthcare payer notified by HH to the ACCC (**Other Participants**):
    - HH to form and operate the HH Buying Group, including the Broad Clinical Partners Program, involving the provision of services to Other Participants, and
    - Other Participants to acquire contracting services from HH.

  (collectively, the **Proposed Conduct**).

1.13. The key features of the Proposed Conduct are:

- The Applicants seek authorisation for HH to provide contracting services to additional healthcare payers (HH already provides these services to nib) and form a joint buying group.
- Under the proposed authorisation, it would not be open to Medibank, Bupa, HCF, or HBF in Western Australia to be part of the general buying group and acquire contracting services from HH in relation to hospital contracting, medical gap schemes and general treatment networks.
- However, it would still be open to Medibank, Bupa, HCF and HBF in Western Australia to acquire HH's contracting services relating to HH's Broad Clinical Partners Program. This is a program under which HH enters into agreements with medical specialists to ensure that customers are not charged out-of-pocket costs for medical services provided during an episode of hospital treatment (currently only for joint replacement surgery, but it is proposed to apply to other services in the future).

1.14. All references to 'health services' or 'healthcare services' in the application also include any goods that may be provided as part of the provision of such services.

Conduct voluntary, and no collective boycott

1.15. HH intends to negotiate a bilateral participation agreement with each Participant to undertake the contracting services in relation to some or all of the Providers. Participants will be able to opt to purchase some or all of the different categories of contracting services.

1.16. The Applicants have not sought authorisation for the HH Buying Group to engage in the collective boycott of any services of a Provider. This means that no Provider would be obliged to deal with the HH Buying Group, and the HH Buying Group is not permitted to boycott any Providers that refuse to deal with the group.

The Proposed Conduct will involve four categories of contracts

1.17. The four broad categories of contracting intended to be covered by the HH Buying Group are:

(a) *hospital contracting* – Hospital purchaser provider agreements (**HPPAs**), where hospitals agree not to charge out-of-pocket costs to customers of healthcare payers (**Customers**), and are used by health insurers to provide financial certainty to its customers

(b) *medical specialist contracting* – Medical purchaser provider agreements (**MPPAs**), used by health insurers to provide financial certainty to Customers in relation to potential out-of-pocket costs for specialist services (e.g. radiologists, pathologists, surgeons)

(c) *medical gap schemes* – where health insurers pay a set fee for each type of professional service they provide to Customers in hospital, and medical specialists agree not to charge Customers an out-of-pocket amount or agree to limit the amount the Customer is charged at a fixed amount (e.g. $500), and

(d) *general treatment networks* – arrangements with Providers for services that are not provided in hospital (e.g. physiotherapists, dentists, optometrists) that are covered under the 'extras' component of private health insurance products.

Nature of the Proposed Conduct in relation to the four types of contracts

1.18. For the various types of contracts, the Proposed Conduct will involve HH engaging in the activities outlined below.

For hospital and medical specialist contracting - data analytics and contract negotiations

1.19. Initially, HH proposes to engage in collective negotiations with Providers that currently have HPPAs and MPPAs with nib in order to agree to new contracts with Participants based on the Provider's existing agreement with nib.

1.20. HH intends to negotiate new HPPAs and MPPAs on an ongoing basis on behalf of nib and Participants as the nib-based contracts expire or enter into contracts with new Providers. HH intends to act as the lead agent in the negotiations after consultation with the Participants. This will involve:

- aggregation of Participant claims data for the Provider and undertaking data analytics to establish benchmarks relating to quality of service, price and application of services
- conducting collective commercial negotiations on behalf of Participants, and
- once HH receives instructions that a Participant wishes to enter into an HPPA or MPPA on the negotiated terms and conditions, coordinate the execution of the HPPA or MPPA between the Participant and the Provider (or execute the contract if HH has signing authority).

1.21. The HH Buying Group will be voluntary and Participants will unilaterally decide whether to enter into an HPPA or MPPA based on the terms and conditions negotiated by HH.

1.22. If they choose to do so, Participants will execute an agreement with the Provider. HH will not be party to the agreement. HH will then undertake contract administration services for that agreement.

1.23. If a Participant does not wish to enter into an agreement on the negotiated terms, the Applicants submit that Participants can negotiate directly with Providers and enter into agreements independently of the HH Buying Group on their own terms and conditions.

1.24. The Proposed Conduct will not prevent Providers from offering services to other insurers, buying groups or healthcare payers that are not part of the HH Buying Group. Further, it will not restrict the terms and conditions upon which Providers are entitled to enter those agreements. Similarly to Participants, Providers will be able to contract with Participants individually or with a different set of Participants than those proposed by the HH Buying Group.

For the medical gap scheme and general treatment networks – management and administration of the schemes

1.25. HH intends to engage with Providers registered in nib's existing medical gap schemes and general treatment network to notify them of the extension of these schemes to Participants.

1.26. On an ongoing basis, HH will manage the medical gap scheme and general treatment networks, review the schedules of rates and terms and conditions, and actively manage the registered Providers of the schemes and networks. This includes ensuring adherence to requirements around registration, qualification and other terms and conditions of the schemes and networks.

For all types of contracts – contract management and dispute resolution

1.27. HH intends to provide contract administration and management services, and dispute resolution services to Participants for the contracting services that they have engaged HH to undertake.

For all types of contracts – data analytics

1.28. HH will provide the Participants with data analytic services as part of contract negotiations but also on an ongoing basis to assess the performance of each Provider and benchmark their performance for each Participant against the aggregated data for the HH Buying Group. This would include an assessment of the following:

- provider quality
- provider compliance
- benefits paid to the Provider by Participants
- access to the Provider's services, and
- efficiency and value of treatment provided by the Provider.

1.29. Subject to confidentiality and privacy obligations, HH would also share information concerning one Participant with the HH Buying Group to the extent the information is related to agreements facilitated by HH or services provided by HH to the Participants. This could include information such as contract breaches by a Provider, or the discovery of fraudulent claims made by a Provider in relation to an agreement with one Participant, which would therefore be relevant to other Participants who contract with that Provider.

The Proposed Conduct involves 'value-based' contracting

1.30. The Proposed Conduct involves a value-based contracting model, which HH describes as comparing health outcomes with the costs of providing services to determine the value of the service from the healthcare payer's perspective.

1.31. Under this model, HH would initially compare the value of services from a particular Provider against peers in the local region, State or Territory and nationally. Based on the outcomes and quality of care achieved by the Provider, the cost of the services would be adjusted (either through price or structure) to match the value being delivered by the Provider.

1.32. Information sharing and data analytics between members of the HH Buying Group will provide the necessary information to assess the performance of Providers and benchmark their performance for each Participant against the aggregated data for the HH Buying Group.

1.33. The Applicants state the Broad Clinical Partners Program, which provides a no gap experience to consumers for the suite of services involved in knee and hip replacements with certain medical specialists, is an example of value-based contracting.

1.34. The Applicants submit that current approaches to contracting generally focus on cost of care of the services and most funds, and buying groups such as the AHSA and ARHG, have historically focused on cost of care to determine payment structure and price of services.

1.35. A large number of interested parties raised concerns about the Applicants' value-based contracting model. These include the following:

- The Australian Orthopaedic Association, Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) and Australian Dental Association are concerned that the Proposed Conduct will prevent parties from being able to choose their source of primary care.
- Occupational Therapy Australia is concerned that the Proposed Conduct will lead to the concentration of allied health services and create 'de facto' panels of approved providers, and that may also lead to the termination of longstanding clinical relationships and reduce customer choice.
- The Australian Medical Association submits that the Proposed Conduct will create a vertically integrated managed care arrangement, resulting in poor health outcomes and increased costs.
- Catholic Health Australia submits there is no basis for concluding that value-based contracting will lead to better health outcomes – in many ways, these terms can be arbitrary and impose penalties on hospitals without a corresponding health outcome.
- The Medical Surgical Assistants' Society of Australia submits there is no evidence of a benefit to patients of value-based contracting. The fact a health insurer has shifted to a different funding mechanism is only proof that the new mechanism is more profitable for the insurer.
- AHSA submits that the Applicants provide insufficient detail on how value-based contracting would assist patient outcomes, and have not substantiated the claim that value-based arrangements have been a key component of Cigna's success.

1.36. In response, the Applicants submit their conception of value-based contracting aligns the amount of funding for the healthcare services to be proportionate to the quality of care delivered and the outcomes for the patient.

1.37. The Applicants also state that the implementation of value-based contracting by Providers requires a degree of investment and engagement, which in nib's experience, has been more difficult to achieve as a stand-alone insurer. This is because value-based contracting is complex and difficult to implement. The existence of the HH Buying Group provides the scale required to engage with Providers – both in terms of data collection and wide participation to ensure a standardised approach to value-based contracting.

1.38. A number of interested parties are also concerned that the Proposed Conduct will lead to the implementation of a US-style 'managed care' model of service, reducing patient choice and patient outcomes while increasing costs.

1.39. The Applicants recognise that it is critical to ensure that Providers retain clinical autonomy and submit that they are not seeking to introduce the US model of managed care to the Australian health system, nor do they consider it appropriate to do so.

1.40. The ACCC notes there is significant disagreement between the Applicants and interested parties about 'value-based contracting' including fundamental issues such as what the term actually means.

1.41. The ACCC understands there is no specific regulatory oversight or limitation on how parties contract with each other in the medical supply chain, and any such limitation (for example, to prevent value-based contracting) would be a matter for Government, through the Commonwealth Department of Health, to determine.

1.42. At this stage, the ACCC notes that the Applicants propose to introduce a different model of contracting with Providers but it is not clear how different this is likely to be. Even if the Applicants' model does prove to be significantly different, the ACCC considers it is only likely to be implemented broadly if the Applicants can gain the agreement of Providers and there is also support from consumers. That is, if 'value-based contracting' leads to reduced practitioner or procedure choice or worse health outcomes, consumers have the ability to move and HH participants will lose members to other insurers.

2. Background

2.1. There are currently 36 private health insurers in Australia, with the four largest health insurers (excluding nib) accounting for approximately 70% of health insurance policies nationally. The four largest health insurers manage their contracting services internally. The remaining private health insurers engage in collective bargaining through one of the two existing buying groups - 27 health insurers are part of the Australian Health Services Alliance (**AHSA**) and four health insurers are part of the Australian Regional Health Group (**ARHG**). nib was previously a member of AHSA and withdrew in 2011 when it built its own internal contracting function.

2.2. Healthcare payers pay benefits to healthcare providers for health services (provided to individuals) under health insurance policies issued to individuals. Customers generally make claims for benefits on-the-spot with a Provider at the time they are receiving treatment (e.g. through electronic claiming system or at a private hospital). The Provider receives benefits directly from the insurer and may collect any additional amounts from the Customer (known as 'gaps').

2.3. Under some agreements between health insurers and Providers, Providers agree not to charge a 'gap' to the customer and the health insurer agrees to pay more in benefits to the Provider. This arrangement creates a network of Providers that healthcare payers can promote as being health services where their customers can potentially receive a no gap experience. Providers therefore receive higher benefits from healthcare payers for providing a little to no gap experience to customers of that healthcare payer.

2.4. Other than private health insurers, healthcare payers such as international medical, travel and life insurance companies, as well as government and semi-government payers of healthcare services (**Other Healthcare Payers**), usually provide payment to Providers according to the terms of the insurance policy or liability scheme. These Other Healthcare Payers usually pay the fee in full, therefore there is less likely to be 'gap' exposure for customers. Accordingly, the Applicants' view is that it is less likely that these Other Healthcare Payers will negotiate contract arrangements with Providers.

3. Consultation

3.1. We received submissions from 24 interested parties, 21 of which opposed authorisation of the Proposed Conduct, at least as originally proposed.

3.2. Private Healthcare Australia (**PHA**) supports the application, noting the voluntary nature of the buying group and that each organisation has control of whether to enter into contracts negotiated by the buying group.

3.3. Mater Health supports the application on the basis that: it does not involve collective boycotts, all funds should maintain the capability to negotiate with a provider outside of the HH arrangement, any information sharing with any overseas parties be avoided and any authorisation only be granted for a three year period.

3.4. The Department of Veterans Affairs provided information about its purchases of health services, but did not express a view on whether the Proposed Conduct should be authorised.

3.5. The remaining 21 interested parties oppose the application. The parties include:

- 16 peak bodies for different areas of medical practice (e.g. orthopaedics, dentistry, anaesthesiology)[3]
- two operators of hospitals[4]
- Members Health Fund Alliance (a peak body for 26 health funds)
- Australian Health Service Alliance (one of the two existing buying groups), and
- one individual with expertise in the field of private health insurance in Australia.

3.6. Interested parties raised concerns with a wide range of issues including the structure of the HH Buying Group, market power of the HH Buying Group, the claimed public benefits from the Proposed Conduct, information sharing under the Proposed Conduct; and the length of authorisation sought. The ACCC has considered these issues in its assessment of the Proposed Conduct in section 4.

3.7. The ACCC notes that all submissions were made before all or some of the Applicants' subsequent amendments to their application, as described in paragraphs 1.2 to 1.5, which were intended to address a number of the concerns raised. The ACCC invites these interested parties to make submissions in response to this draft determination, including commenting on whether these amendments address their earlier concerns.

3.8. One issue raised by multiple interested parties was the involvement of Cigna Corporation in the Proposed Conduct as a 50% owner of HH. Several interested parties noted criticisms of and lawsuits against Cigna in the US, relating to issues of rejected health insurance claims and refusals to treat patients with critical conditions. The Applicants submit these issues are not relevant to determining whether the Proposed Conduct will generate public benefits.

3.9. The ACCC notes the concerns about rejected health insurance claims and refusals to treat patients with critical conditions in the US. At this stage, there is no information for the ACCC to conclude that such issues are likely to result from the Proposed Conduct in Australia but the ACCC notes that some of these could constitute a public detriment and the ACCC would consider this in any reauthorisation process.

3.10. Public submissions are on the public register page for this matter.

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[3] Australia Acupuncture & Chinese Medicine Association, Australia Orthopaedic Association, Australia Private Hospitals Association, Australian Dental Association, Australian Medical Association, Australian Society of Anaesthetists, Australian Society of Ophthalmologists, Catholic Health Australia, Council of Procedural Specialists, Day Hospitals Australia, Medical Surgical Assistants Society of Australia, Occupational Therapy Australia, Optometry Australia, Private Healthcare Australia Limited, Rehabilitation Medicine Society of Australia and New Zealand, Royal Australian College of Surgeons, Spine Society Australia.

[4] Adventist Health Care Limited and Healthscope.

4. ACCC assessment

4.1. The Applicants have sought authorisation in relation to Division 1 of Part IV, s 45 and s 47 of the Act.[5] Consistent with subsection 90(7) and 90(8) of the Act, the ACCC must not grant authorisation unless it is satisfied, in all the circumstances, that the conduct would result or be likely to result in a benefit to the public, and the benefit would outweigh the detriment to the public that would be likely to result (**authorisation test**).

Relevant areas of competition

4.2. To assess the likely effect of the Proposed Conduct, the ACCC identifies the relevant areas of competition likely to be impacted.

4.3. The Applicants submit the relevant markets are:

- a national market for private health insurance
- a national market for international medical and travel insurance
- State-based or localised markets for hospital services
- localised markets for medical specialists for each speciality practice, and
- localised markets for each type of allied health service.

4.4. The Applicants note that nib and Participants in the HH Buying Group who are private health insurers compete with each other as purchasers of health services in the last three sets of markets listed above and as suppliers of private health insurance.

4.5. A number of interested parties are concerned that the Proposed Conduct would specifically affect rural and remote communities that only have access to a small number of healthcare facilities. Others submit that the Proposed Conduct will have a more adverse effect for smaller Providers, specifically allied health professionals who operate localised businesses.

4.6. The ACCC agrees that the Proposed Conduct is likely to have varying impacts at different areas of competition (i.e. national, State, and local), as well as on different sectors (hospital-based, medical specialists, allied health services).

4.7. The ACCC considers the relevant areas of competition are likely to include:

- the acquisition of hospital services on a State-based or localised basis
- the acquisition of medical specialist services for each specialty practice on a localised basis
- the acquisition of each type of allied health service on a localised basis
- the supply of private health insurance on a national basis, and
- the supply of international medical and travel insurance on a national basis.

4.8. The ACCC also notes that HH proposes to offer its services (primarily to the non-major private health insurers) in competition with the two existing buying groups, AHSA and ARHG (as well as insurers' own internal contracting capabilities). Accordingly, the ACCC considers that the supply of buying group services to private health insurers on a national basis is also a relevant area of competition.

4.9. As noted at paragraph 1.13, all references to 'health services' or 'healthcare services' in the application also include any goods that may be provided as part of the provision

[5] The Applicants' original application sought authorisation in relation to s 46 of the Act. In a 29 January 2021 letter, the Applicants requested that the paragraph referring to s 46 not be considered as part of the application.

of such services (e.g. prostheses or drugs provided during a hospital treatment). Given the limited circumstances in which goods will be part of the Proposed Conduct, the ACCC does not propose to analyse any area(s) of competition for these goods.

Likely future with and without the Proposed Conduct

4.10. In applying the authorisation test, the ACCC compares the likely future with the Proposed Conduct to the likely future in which the Proposed Conduct does not occur.

4.11. In the future with the Proposed Conduct, it is likely that:

- the HH Buying Group would become a new option for health insurers in Australia who prefer to be part of a buying group and/or seek contracting services
- Medibank, Bupa, HCF and the HBF WA may participate in the HH Buying Group in relation to medical specialist contracting services as part of the proposed Broad Clinical Partners Program, but are likely to continue handling other contracting tasks in-house, and
- the HH Buying Group will achieve sufficient critical mass (in terms of healthcare payers' participation) to be viable, noting nib's approximately 10% share of national private health insurance policies. However, it is unlikely that insurers will be able to join the HH Buying Group while retaining services from either of the other buying groups, AHSA or ARHG. This is because, as a matter of commercial reality, participants would not be able to split their contracting services across multiple buying groups in an efficient manner. To achieve the best outcomes from a buying group, it is likely a participant would have to decide on wholly joining one and leaving the other.

4.12. Without the Proposed Conduct, it is likely that:

- nib will continue to use the contracting services offered by HH and HH may attempt to contact with other healthcare payers individually
- Medibank, Bupa, HCF and HBF WA will continue to undertake the contracting services as an internal function[6]
- AHSA will continue to act as a buying group on behalf of 27 (of the 36) health insurers in Australia[7]
- ARHG will continue to act as a buying group on behalf of four health insurers in Australia[8], and
- health services providers will continue to negotiate with Medibank, Bupa, HCF and HBF WA or existing buying groups.

Public benefits

4.13. The Act does not define what constitutes a public benefit. The ACCC adopts a broad approach. This is consistent with the Australian Competition Tribunal (the **Tribunal**) which has stated that the term should be given its widest possible meaning, and includes:

[6] HH's understanding is that HBF contracts directly with hospitals in WA and indirectly through the AHSA for all other states.

[7] nib was previously a members of AHSA and withdrew in 2011 when it built its own internal contracting function.

[8] Mildura Heath Fund, St Lukes Health, Latrobe Health Services, Hunter Health Insurance.

…anything of value to the community generally, any contribution to the aims pursued by society including as one of its principal elements … the achievement of the economic goals of efficiency and progress. [9]

4.14. The Applicants submit the Proposed Conduct will result in public benefits including transaction cost savings and increased efficiencies, greater choice of buying group, access to data analytics and information, no gap experience for customers, countervailing hospital bargaining power, reduced healthcare costs and premiums for members, and benefits for Other Healthcare Payers.

4.15. The ACCC notes the Applicants also claimed the Proposed Conduct is likely to result in better health outcomes at a lower cost through value-based contracting. The ACCC has discussed this issue at paragraphs 1.30 to 1.42 above.

4.16. The ACCC has assessed the claimed benefits in the following categories:

- greater choice of buying group and increased competition between them
- increased input into contracts
- improvements in information, and
- transaction cost savings.

Greater choice of buying groups and increased competition between them

4.17. The Applicants consider that the HH Buying Group would provide health insurers with an alternative buying group to AHSA and provide greater choice. HH believes that ARHG is not a suitable alternative to AHSA due to their lack of scale.

4.18. AHSA notes that HH will need to gain members from AHSA in order to achieve sufficient scale. In this context, AHSA submits that it is more accurate to describe the claimed benefit of greater choice of buying group as a transfer of the services creating scale efficiencies. AHSA adds that splitting buying groups into three would only dilute the existing public benefits that achieved through scale efficiencies.

4.19. The Applicants accept that the public benefits being realised by existing buying groups may reduce in the short term if participating funds leave those groups. However, they submit that the HH Buying Group would provide an alternative and unique opportunity for funds that are currently part of an existing buying group, such that there will not be an overall dilution of benefits.

4.20. The Applicants add that in the long term, the Proposed Conduct will increase competition in the market for buying group services and is likely to drive greater innovation and efficiencies from existing buying groups in response to competition from the HH Buying Group.

4.21. The ACCC considers that the Proposed Conduct is likely to result in a public benefit by introducing a competing buying group offering a differentiated model of funding. Increased competition between buying groups is likely to foster greater innovation and incentivise the buying groups to provide better value to their participants – including through their data analytics services (see below under Improvements in information).

4.22. The ACCC notes that participation in the HH Buying Group is voluntary and non-exclusive such that Participants and Providers will have the option to trial the HH Buying Group's contracting model, while retaining the option to return to the

[9] Queensland Co-operative Milling Association Ltd (1976) ATPR 40-012 at 17,242; cited with approval in Re 7-Eleven Stores (1994) ATPR 41-357 at 42,677.

traditional contracting arrangements if they do not see the benefit in the alternative offering.

Increased input into contracts

4.23. The ACCC's general view is that collective bargaining may enable individual members of the group to become more informed and engaged participants in negotiations and improve their input into contracts. This may lead to terms of supply that are more comprehensive and better reflect the circumstances of the group and the target business, resulting in more efficient outcomes.

4.24. The ACCC considers that the following claimed benefits can be assessed as potential outcomes from HH Buying Group members having increased input into contracts.

Increased no gap experience for customers

4.25. The Applicants submit that uncertainty about the size of gaps that consumers face in private healthcare is a major concern for Customers in Australia.

4.26. nib submits that it developed its Broad Clinical Partners Program, which provides a no gap experience to consumers for knee and hip replacements, in response to this concern. Under the program, nib has entered into MPPAs with orthopaedic surgeons, anaesthetists and assistant surgeons where these medical specialists agree on fees paid by nib for their services and agree not to charge Customers any gap for their professional services. The medical specialists are paid a higher fee than what they would otherwise be entitled to under nib's medical gap scheme and agree to data sharing and quality target requirements. Unlike nib's medical gap scheme, Broad Clinical Partners Providers cannot choose to opt-out of the program on a patient-by-patient basis. This provides certainty that all nib customers will have a no gap experience with these medical specialists.

4.27. Under the Proposed Conduct, the Applicants propose to broaden access to the Broad Clinical Partners Program by negotiating with the medical specialists participating in the program to add customers of new Participants of the HH Buying Group to the program.[10]

4.28. The Applicants submit the broadening of access to the Broad Clinical Partners Program will provide HH with a larger customer base which will ultimately facilitate the engagement with a broader group of medical specialists so that the program can be expanded to cover additional types of treatment, and more geographical areas.

4.29. AHSA submits that it already addresses the uncertainty highlighted by the Applicants through its Access Gap Cover scheme, which is currently utilised by over 37,000 medical specialists across a range of services. AHSA claims that there would be no public benefit if any of its current funds began to offer the nib Medigap[11] scheme as it currently stands to their members. Instead, AHSA says that it would actually be detrimental because there are a large number of specialists who do not have agreements in place with nib, and it may be inferred that nib members would receive gap bills for these services.

4.30. Adventist Health Care Limited (AHCL) submits that this claimed public benefit is inconsistent with nib's actual current approach. AHCL believes nib has one of the poorest coverages on no gap arrangements of any fund. AHCL states that it has

[10] The expansion of the Broad Clinical Partners Program does not require any change to the terms and conditions of the new participants' health insurance policies. Under health insurance policies, members are generally entitled to benefits for in-hospital medical services at 25% of the MBS fee. 75% of the MBS fee is payable by Medicare. As medical specialists generally charge above the MBS fee, any further benefits paid by health insurers to cover these amounts are dependent on agreements between the health insurers and medical specialists (either under a medical gap scheme or MPPAs).

[11] nib's no gap scheme where doctors choose on a case by case basis if they will eliminate out of pocket expenses for their fees.

successfully negotiated with other insurers for medical services including radiology, pathology, ultrasound and obstetrics to be provided at no gap to the consumer. AHCL offered to introduce such initiatives with nib who declined.

4.31. The Australian Society of Anaesthetists (ASA) acknowledges the benefits to Australian consumers of a no gap scheme whereby consumers clearly understand the costs involved with their medical treatment. Under the current system, close to 90% of medical services in the private healthcare sector already involve no out-of-pocket expense to patients. A further 4-5% are provided under a 'known gap' arrangement, in which there are specific limitations placed on the level of out-of-pocket expenses. Therefore, the argument that out-of-pocket expenses are a significant issue across the sector is false.

4.32. Notwithstanding the submission by ASA, the ACCC considers that uncertainty about the extent of gaps that patients face in the private healthcare system is one of the major concerns or causes of dissatisfaction for consumers.

4.33. The ACCC recognises that in order to address this concern, many private health insurers make gap cover agreements with certain Providers, such as the arrangements identified by AHSA and AHCL above. The ACCC notes AHSA's views on nib's Medigap scheme and AHCL's previous experience in dealing with nib in relation to no gap arrangements. However, the ACCC also notes that the focus of the Proposed Conduct is on HH's Broad Clinical Partners Program.

4.34. The ACCC accepts that the Broad Clinical Partners Program delivers benefits to existing nib customers by giving them the certainty of a no gap experience for the suite of services involved in knee and hip replacements with certain medical specialists. To the extent that the program is widened to include of new Participants in the HH Buying Group, the ACCC considers this is likely to result in public benefit by extending an increased no gap experience and certainty of costs to customers of those Participants.

Countervailing hospital bargaining power

4.35. The Applicants submit that some Providers have much stronger bargaining power in negotiations with healthcare payers, which impedes parties from reaching efficient pricing outcomes for health services. They consider this is particularly the case in the private hospital market where the five largest hospital provider groups account for over 50% of the market. They add that some of the smaller private hospitals can also have a high degree of bargaining power due to their iconic status and reputation or their location in regional and remote communities.

4.36. The Applicants submit that the Proposed Conduct will allow Participants to improve their bargaining positions to countervail the market power of some of the hospital groups, leading to more efficient hospital pricing.

4.37. Healthscope rejects any assertion that its prices are inefficient or exceed competitive levels, and suggests that if private hospitals were able to charge supra-competitive prices, it would be expected that the amounts paid by insurers to hospitals would greatly exceed the costs incurred by hospitals. The Australian Private Hospitals Association (APHA) agrees there is no evidence of 'inefficient' or 'supra normal' hospital pricing.

4.38. APHA notes that the five largest health insurers account for 92% of the market and smaller private hospitals, particularly in regional communities, routinely report they are price takers in negotiations with health funds. Catholic Health Australia agrees that smaller hospitals are typically price takers.

4.39. AHSA submits that the Applicants' claim that public benefits are generated through countervailing hospital power is based on two incorrect assumptions:

- First, that there are currently insufficient checks on hospital bargaining power. AHSA states it has close to 20% market share for hospital-insured persons, which means it has significant scale across Australia when working with large hospital providers. 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 smaller regional hospitals, work constructively with AHSA.
- Second, that any increase in checks on hospital bargaining power would be a panacea for inefficient pricing. AHSA argues that the Applicants have grossly oversimplified the reasons for why pricing for different procedures, treatments and services varies between hospital groups, and that hospital bargaining power alone is not the sole contributing factor to price differences.

4.40. The ACCC is mindful of interested party submissions in relation to this claimed benefit. In particular, the ACCC notes that Healthscope and APHA reject the premise that their prices are above competitive levels and the ACCC is not in a position to test the veracity of this claim. Further, the ACCC notes that AHSA (as an existing bargaining group) disagrees that having countervailing hospital bargaining power would lead to more efficient hospital pricing and increased output or quality of healthcare services.

4.41. The ACCC notes:

- in the likely future without the Proposed Conduct, private health insurers would continue to have the option of being represented by AHSA or ARHG in negotiations with hospitals and nib would likely continue to use HH to negotiate with hospitals
- AHSA's submission that bargaining dynamics in the likely future without the Proposed Conduct are such that AHSA's 20% market share has been sufficient for it to deal with large hospital providers and achieve efficient pricing outcomes for health services and maintain the competitiveness of the AHSA funds' cost base, and
- in the likely future with the Proposed Conduct, there is no obligation on hospitals to negotiate with the HH Buying Group.

4.42. In these circumstances, it is not clear to the ACCC that the Proposed Conduct is likely to increase the bargaining power of Participants in the HH Buying Group or result in more efficient hospital pricing.

ACCC conclusion on increased input into contracts

4.43. The ACCC considers that the Proposed Conduct is likely to result in increased input into contracts. One of the ways this is likely to manifest is increased coverage of the Broad Clinical Partners Program and the benefit of an increased no gap experience for customers of new Participants in the HH Buying Group.

Improvements in information

4.44. The Applicants submit the Proposed Conduct will provide Participants, who are likely to be smaller health insurers, with access to data analytics tools and technology, which are currently available to larger health insurers.

4.45. Further, the Applicants state that providing smaller health insurers access to the necessary analytics and data through the Proposed Conduct will assist in reducing information asymmetry and allowing them to gain insights from information collected across all Participants, which is typically only available to larger health insurers who have the funds and technology to utilise the relevant data.

4.46. HH also submits that increased access to data analytics and information sharing would assist in developing efficient networks of medical specialists and extras providers across a range of speciality groups and geographic networks. HH believes that consumers will be better informed and more empowered to make choices about their healthcare through Participants having access to increased information and data.

4.47. AHSA submits that health insurers who are part of their buying group already have access to data analytics services; therefore, the claimed benefits already exist in the market and the Proposed Conduct would not reduce information asymmetries for HH Buying Group Participants who are likely current members of AHSA or ARHG.

4.48. The ACCC's general view is that in situations where some parties to the negotiations are likely to be less well informed about market conditions or the preferences of other parties, they may accept (or offer) lesser terms than they would if they had more information. Collective bargaining may improve the amount and quality of relevant information available to the less informed parties and enable more efficient terms and conditions to be negotiated.

4.49. The ACCC notes AHSA's submission that this claimed benefit is already available in the market through AHSA's existing buying group.

4.50. However, the ACCC also notes the Applicants' submissions that HH is a health data science company with significant capability in data science, analytics and forecasting, and the HH Buying Group will have access to sophisticated data analytics, which the Applicants consider are superior to existing offerings. The Applicants state that HH's data analytics undertaken as part of its Contracting Services will use claims and Hospital Casemix Protocol data of all Participants.

4.51. The ACCC accepts that the HH Buying Group is likely to provide Participants with improved information through the option to utilise a particular type of data analytics, based on aggregated data of all members of the buying group, which would not be available in the likely future without the Proposed Conduct. As such, the ACCC considers that the Proposed Conduct is likely to result in some public benefit in the form of improved access to information.

Transaction cost savings

Private health insurers

4.52. The Applicants submit that the Proposed Conduct will result in:

- significant transaction and administrative cost savings for Participants. For example, nib alone currently negotiates more than 500 contracts per year and manages over 3,500 agreements, and
- greater efficiencies for Providers through simplified billing processes, consistent funding agreements, and reduced negotiation costs.

4.53. nib states that historically, its health services contracting function costs approximately $5 million per annum to operate, and suggests that any health insurer with national coverage that maintains its own contracting function would likely incur similar costs due to the breadth of the Provider networks.

4.54. The Applicants submit that these costs are significantly reduced because of the HH Buying Group achieving greater efficiencies and economies of scale. The Applicants propose that the fee for Participants would correlate with transaction costs and any savings will be flow though as reduced fees to Participants.

4.55. The Australian Society of Anaesthetists (**ASA**), APHA, Adventist Health Care (**AHC**) and AHSA disagree that the Proposed Conduct will result in transaction cost savings and efficiencies.

4.56. APHA submits that adding another buying group would only lead to increased complexity and costs for hospitals contracting with an increased number of buyers. AHC believes HH would only be able to realise the claimed savings if one of the other buying groups ceased to exist; otherwise, any transaction savings would be limited. Further, AHSA submits that these claimed benefits already exist through the existing buying groups.

4.57. In principle, the ACCC accepts that there are likely to be transaction cost savings from private health insurers collectively purchasing health services, compared to individual negotiations. For example, participating health insurers can benefit from reduced negotiation costs while healthcare providers can benefit from simplified back-end billing processes, as insurers would have the same contract, rates and billing rules.

4.58. In this case, however, the ACCC notes that the 31 health insurers who might join the HH Buying Group already participate in one of the two existing buying groups (AHSA or ARHG) and are likely to continue to do so absent the Proposed Conduct. In these circumstances, the ACCC considers that the extent of additional transaction cost savings from the Proposed Conduct is likely to be limited.

Other Healthcare Payers

4.59. The Applicants submit that, compared to private health insurers, hospital and medical purchasing is on a significantly lower scale for Other Healthcare Payers. The Applicants submit that Other Healthcare Payers will have the benefit of transaction costs savings as part of the HH Buying Group, as well as the associated benefits of access to data analytics and value-based contracting models.

4.60. The Applicants submit that schemes such as the Department of Veterans' Affairs hospital cover scheme will be able to pass on greater benefits to veterans or reduce general expenditure when part of the HH Buying Group.

4.61. The Department of Veterans' Affairs did not comment on how government healthcare payers being involved in healthcare buying groups is likely to impact on bargaining processes. However, the Department of Veterans' Affairs noted that if improvements in the health sector lead to fair and reasonable outcomes for purchasers, providers and consumers of health services, then these outcomes may result in achieving greater efficiencies in fees for the Department.

4.62. AHSA states that it 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. Examples include the Transport Accident Commission and Worksafe Insurance, who work closely with AHSA on funding model methodologies.

4.63. The ACCC considers that the Proposed Conduct is likely to result in transaction cost savings for Other Healthcare Payers where an individual payer does not already obtain services from a buying group like AHSA.

Reduced healthcare costs and premiums for members

4.64. The Applicants submit that the various claimed public benefits have the combined effect of increasing the value of the benefits paid by healthcare payers for health services and reducing healthcare costs for healthcare payers, particularly for smaller health insurers who likely have limited access to capital. The Applicants submit that the Proposed Conduct would ease current pressures on health insurers to deal with escalating healthcare costs and inflation, as well as regulatory compliance costs.

4.65. The Applicants submit that reduced healthcare costs will further reduce pressure for Participants to increase premiums on their policies, therefore extending benefits to customers through lower premiums and encouraging participation in private health insurance.

4.66. AHSA submits that members of AHSA funds already benefit from reduced healthcare costs and premiums, including in relation to hospital benefits.

4.67. ASA, APHA, AHC and AHSA submit there is no evidence that any reduced transaction or administrative costs will reduce premiums or result in better health outcomes. ASA adds that any benefit would be business benefits to the Applicants and that any cost savings would not be passed on to consumers.

4.68. Healthscope and Catholic Health Australia raise concerns that reducing the price of healthcare services could cause reduced funding for investment by Providers in the elements of healthcare separate to medical services (e.g. equipment, maintenance of facilities and innovation). It is not clear to the ACCC this is a likely outcome of the Proposed Conduct.

4.69. The ACCC notes the interested party submissions that there is no evidence the Proposed Conduct will reduce healthcare costs and premiums for members.

4.70. As outlined above, the ACCC considers the main public benefits likely to result from the Proposed Conduct are a greater choice of buying group for healthcare payers and increased competition between buying groups. The ACCC considers competition between health insurers would provide an incentive for members of the buying group to pass on part of the savings to them (arising from their participation in the buying group) in the form of lower premiums (or lower increases in premiums) and/or better services to members, although the overall effect is unlikely to be large.

ACCC conclusion on public benefits

4.71. The ACCC considers that the main public benefits likely to result from the Proposed Conduct are a greater choice of buying group for healthcare payers and increased competition between buying groups.

4.72. The ACCC also considers that the Proposed Conduct is likely to result in some public benefits in the form of increased input into contracts and improvements in information for participants in the HH Buying Group and some transaction cost savings, mainly for Other Healthcare Payers.

Public detriments

4.73. The Act does not define what constitutes a public detriment. The ACCC adopts a broad approach. This is consistent with the Tribunal which has defined it as:

> *…any impairment to the community generally, any harm or damage to the aims pursued by the society including as one of its principal elements the achievement of the goal of economic efficiency.*[12]

[12] Re 7-Eleven Stores (1994) ATPR 41-357 at 42,683.

4.74. The ACCC has considered whether the Proposed Conduct is likely to result in the following public detriments:

- reduced competition in the acquisition of health services, and
- reduced competition in the supply of private health insurance.

Reduced competition in the acquisition of health services

Competition between private health insurers

4.75. The Applicants submit the potential public detriments from the Proposed Conduct would be minimal (if any) in the markets for the acquisition of health services and would be outweighed by the public benefits set out above. The 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 acquisition of health services. The key difference being that nib would be a party to the HH Buying Group.

4.76. The Applicants state that the other key reason that potential public detriments would be minimal is that the Providers have statutory rights (assigned from members) to be paid benefits from insurers and Medicare and do not rely wholly on agreements with health insurers.

4.77. Interested parties are concerned that the Proposed Conduct will result in a major power imbalance between the HH Buying Group and Providers, with the scope of the Application needing limits on the types of insurers eligible to join the buying group.

4.78. In their initial response to submissions, the Applicants stated it is extremely unlikely that the HH Buying Group would represent 100% of all healthcare payers. Further, even if all private health insurers other than the four majors joined the group (which the Applicants also consider very unlikely), the HH Buying Group could potentially represent around 40 to 50% of healthcare payers at a national level. If this is narrowed to representing all private health insurers except the four major private health insurers, the potential share of healthcare payers nationally falls to around 20%.

4.79. In their initial response to submissions, the Applicants stated it would be reasonable for the ACCC to impose conditions to address this issue, such as requiring HH to notify the ACCC of new Participants to provide the ACCC with an opportunity to raise any concerns it may have.

4.80. Healthscope submits that the notification process suggested by the Applicants would be inappropriate as it would impose a heavy administrative burden on the ACCC and detracts from the ACCC's current task of determining whether the present application would result in a net public benefit.

4.81. In further responses to concerns about the bargaining power of the HH Buying Group, the Applicants amended their application to exclude Medibank, Bupa, HCF and HBF WA in relation to hospital contracting, medical gap schemes and general treatment networks.

4.82. However, HH will still be able to provide contracting services to Medibank, Bupa, HCF and HBF WA in relation to the Broad Clinical Partners Program. This means that the HH Buying Group could include all healthcare payers in Australia in relation to medical specialist contracting.

4.83. The ACCC notes that private health insurers compete to acquire health services from hospitals, medical specialists, general practitioners and allied health professionals. By joining the HH Buying Group, private health insurers would be conducting their procurement of health services jointly rather than individually. This means the

Proposed Conduct has the potential to reduce competition for the acquisition of health services at local, State and national levels.

4.84. The ACCC agrees that if the HH Buying Group comprised 100% of private health insurers, this would be likely to result in significant public detriment through its effect on competition between insurer healthcare acquirers and the bargaining position of small healthcare providers, and the potential reduction in the quantity and quality of health services. More specifically, it is likely that small healthcare providers would face strong incentives to accept the terms and conditions offered by the group. The risk of losing Customers because they are not part of the Participants' schemes would also be significant if the HH Buying Group were very large.

4.85. However, it is important to note that outside of nib and the major insurers (Medibank, Bupa, HCF and HBF), all other private health insurers are already engaged in collective procurement of health services through their participation in one of the two existing buying groups (AHSA and ARHG) and are likely to continue to do so absent the Proposed Conduct. This means that in the future without the Proposed Conduct, competition in the acquisition of health services (other than for medical specialists' services) is likely to continue to be limited to Medibank, Bupa, HCF, HBF, nib, AHSA and ARHG.

4.86. The key outcome of the Proposed Conduct is to introduce the HH Buying Group as a new acquirer of health services collectively negotiating on behalf of nib and any other healthcare payers who join the group.

4.87. Following the amendments to the application for authorisation mentioned at paragraph 1.4-1.5 above, the potential parties in the HH Buying Group will vary with the type of contracting involved. Each type of contracting service is considered below.

Hospital contracting

4.88. The Applicants submit that the HH Buying Group would potentially have a stronger bargaining position than if nib or each Participant negotiated agreements with private hospitals individually.

4.89. The Applicants provided the following market shares of each private health insurer and buying group based on hospital policies as disclosed in APRA's Operations of private health insurers annual report 2019.

Table 1: Private Health Insurers' market shares 2019[13]

Contracting Group	NSW & ACT	VIC	QLD	SA	NT	WA	TAS	National
Medibank	22.6%	31.1%	30.7%	19.4%	40.9%	21.4%	26.0%	26.1%
Bupa	22.9%	23.1%	31.4%	47.8%	36.2%	10.9%	32.7%	25.1%
HCF	20.1%	7.5%	8.0%	8.9%	5.9%	4.7%	4.8%	11.7%
nib	15.2%	8.5%	6.8%	4.1%	3.2%	3.9%	3.0%	9.5%
HBF	0.8%	1.1%	0.7%	0.5%	1.7%	49.7%	0.7%	6.9%
AHSA	17.2%	27.0%	21.5%	18.4%	11.6%	5.3%	31.3%	19.2%
ARHG	1.2%	1.7%	0.9%	0.7%	0.3%	3.9%	0.6%	1.6%

4.90. The Applicants submit that the increased market share of the HH Buying Group would allow the Participants to countervail the strong bargaining positions of large hospital groups, such as Ramsay and Healthscope, therefore putting pressure on hospital pricing to fall to competitive and efficient levels.

4.91. Interested parties including Healthscope, Catholic Health Australia, the Australian Private Hospitals Association and Adventist Health Care are concerned that an increase in bargaining power for the HH Buying Group would result in a distortion of hospital funding allocations, favouring lower cost treatments, reducing available resources and disadvantaging smaller private hospitals (particularly those in rural and remote areas).

4.92. As noted at paragraphs 1.4 to 1.6, the Applicants have responded to concerns about the potential bargaining power of the HH Buying Group by amending their application to not seek authorisation for Medibank, Bupa, HCF and HBF WA to acquire contracting services from HH in relation to hospital contracting, medical gap schemes or general treatment networks. This means that, at a maximum, the HH Buying Group for hospital contracting could comprise nib and the other 31 private health insurers (and the non-Western Australian business of HBF which is currently managed by AHSA), which would involve the HH Buying Group successfully attracting all of the existing members of AHSA and ARHG.

4.93. Based on the information available, the ACCC considers the future with the Proposed Conduct is likely to involve a situation where some private health insurers find the package of services and model of contracting offered by HH to be commercially attractive and decide to become Participants in the HH Buying Group. Both HH and AHSA agree that, as a matter of commercial reality, it is difficult to split contracting services across buying group. Consequently, new Participants in the HH Buying Group are likely to leave either AHSA or ARHG.

4.94. The ACCC considers that, at least in the short to medium term and compared to the likely future without the Proposed Conduct, the creation of a third buying group is likely to mean a less concentrated market structure and more competition in the acquisition of health services by private health insurers. Even in the long term, if the Proposed Conduct led to the elimination of AHSA and ARHG (i.e. if the HH Buying Group effectively replaced them), the increase in concentration would be relatively modest.

[13] APRA's Operations of private health insurers annual report 2019

4.95. As such, at this stage, the ACCC considers that the Proposed Conduct is unlikely to result in public detriment by reducing competition in the acquisition of hospital contracting services.

Medical specialist contracting

4.96. The Applicants submit that the impact of the HH Buying Group would be minimal in the market for medical specialist services because MPPAs are not critical to medical specialists, but are seen as an optional arrangement. If a medical specialist did not wish to enter into an MPPA with the HH Buying Group, they would still have statutory rights to be paid for their services, including benefits paid by Medicare, the insurers, and any out-of-pocket expenses paid by the Customer. For these reasons, the Applicants submit that insurers do not have strong bargaining power in MPPA negotiations with medical specialists, despite the difference in size of organisations, because specialists are simply agreeing to cap their fees and relinquish their right to charge out-of-pocket expenses.

4.97. SSA, Australian Society of Anaesthetists and Council of Procedural Specialists all raise concerns about the potential for HH to apply pressure to force medical specialists to agree to contracts under HH's terms, or face the possibility of being blocked from referral systems developed within the HH Buying Group.

4.98. In response, the Applicants reiterated that the Proposed Conduct does not involve collective boycott activities, nor does it serve to restrict employment of different providers. Further, the Applicants submit that consumers will retain the ability to choose their medical specialist, and therefore those specialists who do not reach an MPPA with HH will still be able to treat members of the HH Buying Group's Participants, and will be remunerated through either Medicare or existing gap schemes.

4.99. Unlike the other contracting services, the Applicants have not expressly excluded HBF, Medibank, Bupa and HCF from joining the HH Buying Group in relation to medical specialist contracting. As discussed earlier at paragraph 1.12, the Applicants seek authorisation for HH to provide contracting services that relate to HH's Broad Clinical Partners Program to Medibank, Bupa, HCF and HBF in relation to its contractual arrangements with healthcare providers in Western Australia

4.100. This means that the HH Buying Group could comprise all private health insurers in relation to the Broad Clinical Partners Program.

4.101. The Applicants submit that even if the HH Buying Group includes the major insurers, this is not likely to result in public detriment because:

- the Broad Clinical Partners Program is an optional program for medical specialists and therefore, the onus is on HH to persuade medical specialists of the benefits to them of participating in the program
- HH will not have the ability to drive down benefits payable to medical specialists as this would lead to less engagement by specialists in the program. HH must pay a higher level of benefits than under medical gap schemes to compensate specialists for agreeing to a higher standard of quality of services (among other terms and conditions of the MPPA)
- the expansion of the Broad Clinical Partners Program to Customers of major health insurers will increase the extent of public benefits that can be realised through the HH Buying Group, and
- in addition to broadening this no gap, high quality experience for a larger group of Customers, the Broad Clinical Partners Program places downward pressure on non-participating surgeons to reduce their out-of-pocket costs in order to

compete effectively with surgeons participating in the Broad Clinical Partners Program.

4.102. Notwithstanding these submissions, the Applicants acknowledge ongoing concerns about the HH Buying Group comprising 100% of private health insurers in relation to the provision of medical specialist contracting services. In light of this, the Applicants state they are prepared to place the following limits on the medical specialist contracting services offered by the HH Buying Group:

- the services would only relate to the Broad Clinical Partners Program under which Customers would receive a no gap experience for the whole episode of care for a surgical procedure. The Broad Clinical Partners Program has already been established, is operational and the Applicants intend to broaden access to the program and make it available to Customers of any interested Participants in the HH Buying Group, and
- the HH Buying Group would only be allowed to represent a maximum of 80% of the national private health insurance market (based on the number of hospital policies) in relation to the Broad Clinical Partners Program.

Based on discussions with medical specialists through the existing Broad Clinical Partners Program, the Applicants consider that 20% market share is the minimum level that would make it viable for medical specialists to operate multiple models of funding and medical care based on individual funds. The Applicants consider that once 80% market share is reached, the benefits to medical specialists would no longer increase at the same rate if the market share increased beyond 80%.

4.103. Based on the information available, the ACCC considers that the future with the Proposed Conduct is likely to involve a situation where a number of private health insurers, including major insurers, join the Broad Clinical Partners Program.

4.104. Compared to the likely future without the Proposed Conduct, where major insurers individually engage with medical specialists, the ACCC considers that a Broad Clinical Partners Program including major insurers is likely to result in public detriment by reducing competition between acquirers of medical specialist services.

4.105. In particular, the ACCC notes the ability for major insurers to join the Broad Clinical Partners Program is likely to reduce or remove their incentive to continue or develop their own competing programs offering a no gap experience for the entire episode of treatment, or some other type of innovation. As noted by the Applicants, HCF currently offers a similar program in relation to obstetric services and in recent weeks, joint replacement therapy.

4.106. The ACCC is also mindful that if HH attracted a large enough group of specialists to participate in the Broad Clinical Partners Program, then in a scenario whereby 80% of insurers are included in the HH buying group, those insurers (including nib) might have incentives to abolish or reduce the generosity of their no and known gap scheme payments. This is because if insurers reduced their gap scheme payments, specialists will be constrained from raising out-of-pocket fees to customers because customers will have access to a large pool of other specialists who are committed to a no gap experience for customers. Those specialists who are not members of the Broad Clinical Partners Program and are unwilling to join it may raise their gap fees, but perform fewer procedures. Reduced insurer gap scheme payments could thereby result in a contraction in the supply of medical specialists' services, which would likely be a public detriment.

Condition of authorisation

4.107. The ACCC considers that a Broad Clinical Partners Program including major insurers is likely to result in public detriment by reducing competition between acquirers of medical specialist services.

4.108. The ACCC accepts the extent of this public detriment is mitigated to a degree by the fact that the Proposed Conduct is voluntary for Participants and does not allow the HH Buying Group to collectively boycott the services of any Provider.

4.109. However, in order to ensure that the likely public detriment does not outweigh the likely public benefits of the Proposed Conduct, the ACCC proposes to impose the condition of authorisation set out at paragraph 5.7.

4.110. Under the proposed condition, HH must not provide the Broad Clinical Partners Program services to major private health insurers where this would result in the participants in the program representing more than 40% of private health insurance policies in any State or Territory.[14]

4.111. The ACCC considers this proposed condition addresses the key concern that the inclusion of major private health insurers in the Broad Clinical Partners Program could result in a major power imbalance.

4.112. The ACCC notes the acquisition of services from medical specialists occurs at a local level and therefore, proposes that the market share cap is measured at a State or Territory level.

4.113. The ACCC proposes 40% as the appropriate market share cap noting that it:

- falls within the range identified by the Applicants to achieve sufficient engagement from medical specialists in the program; and
- corresponds to the Applicants' own upper estimates of the potential private insurer market share of the HH Buying Group in relation to services other than the Broad Clinical Partners Program (including hospital contracting) – the ACCC considers this provides a useful benchmark for the insurer market share cap on participation in the Broad Clinical Partners Program.

4.114. The ACCC notes the Applicants were open to a condition of authorisation that HH not provide the Broad Clinical Partners Program services to more than 80% of the national private health insurer market.

4.115. The ACCC notes this is at the upper limit of the 20%-80% range that the Applicants say is required to achieve sufficient engagement from medical specialists in the program and enable the realisation of public benefits. The ACCC is not persuaded by the Applicants' submissions that an 80% limit is justified by administrative efficiencies, the need for one-to-one conversations between HH and medical specialists and better information for patients. As mentioned above, the ACCC considers that the acquisition of services from medical specialists occurs at a local level and, therefore, it would be more appropriate for the market share cap to be less than the national level suggested by the Applicants.

Medical gap schemes and general treatment networks

4.116. The Applicants submit that the Proposed Conduct will have minimal, if any, impact on medical gap schemes and general treatment networks because the HH Buying Group would not be negotiating agreements with Providers. Instead, and because of the

[14] Based on the latest private health insurance statistics published by the Australian Prudential Regulation Authority (APRA) or equivalent.

large number of individual health providers in the industry (around 50,000), HH will be managing schemes based on a standard schedule of rates and terms and conditions.

4.117. These schemes are voluntary and Providers have the option to register to be part of these networks and receive additional benefits for agreeing to 'no gap' arrangements and other terms and conditions.

4.118. The only agreements negotiated in this area relate to the operation of an insurer's branded optical or dental centre, or potentially agreements with networks of Providers, such as dentists, that may be bespoke and negotiated. HH's involvement in the negotiation and management of such contracts would be undertaken on an individual basis for the relevant insurers.

4.119. The ACCC notes the Proposed Conduct does not include the Applicants providing any contracting services to Medibank, Bupa, HCF and HBF WA in relation to medical gap schemes and general treatment works.

4.120. The ACCC also notes that the HH Buying Group will not be facilitating any collective acquisition by competing private health insurers from Providers in this area.

4.121. Accordingly, the ACCC considers that the Proposed Conduct is not likely to result in any public detriment by reducing competition in the acquisition of health services in relation to medical gap schemes and general treatment networks.

Competition between Other Healthcare Payers

4.122. The Applicants submit there will no public detriments from the Proposed Conduct in relation to Other Healthcare Payers. The Applicants further submit:

- travel and medical insurers make up a small percentage of the healthcare payer market so if they join the HH Buying Group, this will not materially alter the competitive position of Providers, and
- government and semi-government healthcare payers form a large part of the healthcare payer market but are less likely to join the HH Buying Group because these schemes invest in and create their own Provider networks, and are subject to extensive public policy constraints when tendering and making agreements.

4.123. The Department of Veterans' Affairs submitted that it was unable to comment on how providing government health payers in healthcare buying groups is likely to impact on bargaining processes, and did not provide a position on whether it was likely to participate in the HH Buying Group.

4.124. The ACCC has received limited information about the nature or extent of competition between Other Healthcare Payers in the acquisition of health services. To the extent that some or any of these payers join the HH Buying Group, there is the potential for some reduction in competition for the acquisition of health services. However, based on the information available, the ACCC does not consider this is a likely result from the Proposed Conduct.

Reduced competition in the supply of private health insurance

4.125. The Applicants submit the Proposed Conduct will not impact the way healthcare payers compete with one another in relation to the setting of premiums, the products they provide, or their sales strategy, rather it will only impact the way that healthcare payers engage with suppliers of health services. Accordingly, the Proposed Conduct will have very little impact on the way private health insurance is supplied to consumers other than easing the pressure on premium increases due to cost reductions.

4.126. The Applicants add that this position is supported by the fact that buying groups in respect of health services already exist and have not impacted or acted as a detriment to competition in the supply of private health insurance.

4.127. The ACCC has considered whether the Proposed Conduct is likely to reduce competition in the supply of private health insurance through:

- nib's 50% stake in HH, and/or
- information sharing under the Proposed Conduct.

nib's ownership interest in HH

4.128. Interested parties are concerned that the Proposed Conduct will allow nib, through its ownership interest in HH, to have direct knowledge of the commercially sensitive contracting and strategic information of all of its competitors who join the HH Buying Group.

4.129. More specifically, AHSA submits:

- nib's 50 per cent interest in HH means HH will in fact be competing with its own customers in the markets for the supply of private health insurance and the acquisition of healthcare buying services.
- HH and nib share a managing director and board members which raises a conflict of duty and the possibility that HH could preference nib's interests over other Participants of the HH Buying Group when it negotiates agreements with Providers. For example, nib has a younger membership based than most other healthcare funds, and is therefore exposed to different risks for the type and volume of hospital episodes under contract. Therefore, AHSA suggests that a contract structure which favours nib could disadvantage other HH Buying Group Participants, who have different customer demographics (likely older age cohorts with associated hospital episodes). There is hence a potential for HH's decision making to be influenced to favour nib's customer demographics when negotiating contracts for the HH Buying Group.

4.130. In response to these concerns, the Applicants submit the following:

- nib will have access to the same Participant information as any other Participant, and will balance the needs of all Participants in order to make the HH Buying Group an effective and successful business. To achieve this balance, HH will ascertain each Participant's requirements prior to negotiations with Providers to ensure everyone's needs are requirements are addressed. Where conflicts between these interests arise, the Applicants submit that it will engage with the relevant Participants to ensure an appropriate balance is met for both parties. When a balance is unable to be achieved, HH will give the relevant Participant the opportunity to withdraw from the particular negotiation, or even withdraw from the HH Buying Group.
- nib will not have access to the personal information of Participants' customers, and will not receive greater access to information than other Participants due to its partial ownership stake in HH.
- The directors of HH, and AHSA alike, are required to act in accordance with their fiduciary and statutory duties to act in the best interests of their respective buying groups, regardless of the ownership structure of the company. The Applicants submit that any suggestion that its directors would be likely to breach their legal duties by preferencing nib's interests over the other Participants is without any basis.

4.131. More generally, the Applicants submit it is critical to the HH Buying Group business model that HH handles the information of Participants strictly in accordance with its governance and security frameworks, in order to drive participation in the HH Buying Group. The Applicants submit that it would be completely contrary to HH's commercial interests for HH to disclose commercially sensitive information of Participants to nib.

4.132. The ACCC acknowledges the concerns of interested parties that nib's ownership stake in HH when it is also a Participant in the HH Buying Group at least creates an impression of a potential conflict of interest in relation to other Participants in the group.

4.133. However, the ACCC notes the Applicants' submissions setting out the various legal obligations on nib and HH, including the fiduciary and statutory duties on directors of HH to act in the best interests of HH, regardless of the ownership structure of that company. The ACCC does not have any information that suggests that nib and HH will not comply with those legal obligations.

4.134. The ACCC is persuaded by the Applicants' submission that it would be contrary to HH's commercial interests to disclose commercially sensitive information of Participants to nib, when the objective of the Proposed Conduct is to increase participation in the HH Buying Group.

4.135. Based on the information available, the ACCC considers that the Proposed Conduct is not likely to result in public detriment by reducing competition in the supply of private health insurance through nib's ownership stake in HH.

Information sharing and privacy under the Proposed Conduct

4.136. Interested parties are concerned that increased information exchange between the Participants and HH to perform data analytics and help deliver the value-based contracting model will lead to a softening of competition between participating private health funds and result in increased premiums.

4.137. More specifically, Mater, AHSA, ASA, Council of Procedural Specialists, Adventist Health Care and Healthscope query how information collected would be shared and what privacy protocols would be established.

4.138. The Applicants state that they recognise the importance of data sharing parameters, both commercially and legally, and they will continue to adopt a best practice approach to both privacy and data governance through HH's Risk Management Framework and Information Security Management System.

4.139. The Applicants submit that the disclosure of member data to HH will be undertaken on a de-identified basis for the purpose of data analytics and will only be identified if necessary for HH to perform its functions. Participants will obtain privacy consent for this use and disclosure of members' personal information. The personal information of each Participant's members will not be shared between Participants and it will not be shared with international organisations.

4.140. Generally, the ACCC considers that information sharing in collective bargaining arrangements is of concern if it allows the parties to co-ordinate their conduct beyond that for which authorisation is granted, for example, if it facilitates collusion or provides a focal point for competitors to align their behaviours in related markets such as the downstream supply of services to consumers.

4.141. In this case, the Applicants have not sought authorisation to share customer information or marketing strategies with Participants. Further, the Applicants submit that, to the extent that nib is a Participant of the HH Buying Group, it will receive the same level of information as any other Participant and will not benefit by virtue of its

equity investment in HH. Sharing such information between Participants would not be covered under the authorisation, and any such information sharing would be subject to the operation of the Act.

4.142. The ACCC considers it unlikely that there will be a reduction in competition in the supply of private health insurance as a result of information sharing under the Proposed Conduct. On the information available, the ACCC considers it unlikely that public detriment would arise from any privacy implications of information sharing under the Proposed Conduct.

ACCC conclusion on public detriment

4.143. The ACCC considers that the Proposed Conduct is likely to result in public detriment by reducing competition in the acquisition of medical specialist contracting services.

4.144. The extent of this public detriment is mitigated to a degree by the fact that the Proposed Conduct is voluntary for Participants and does not allow the HH Buying Group to collectively boycott the services of any Provider.

4.145. However, in order to ensure that the likely public detriment does not outweigh the likely public benefits of the Proposed Conduct, the ACCC proposes to impose the condition of authorisation set out at paragraph 5.7.

Balance of public benefit and detriment

4.146. For the reasons outlined in this draft determination, the ACCC considers that, on balance and with the proposed condition of authorisation, the Proposed Conduct is likely to result in a public benefit and that this public benefit would outweigh any likely detriment to the public from the Proposed Conduct.

Length of authorisation

4.147. The Applicants seek authorisation for a period of 10 years, on the basis that the majority of agreements with private hospitals and medical practitioners have a two to three term and, in some instances, up to five years. The Applicants submit that the authorisation should cover at least two contract cycles to realise the public benefits of the Proposed Conduct.

4.148. Further, the Applicants anticipate that the transition for Participants from their current contracting arrangement to the HH Buying Group will require planning, analysis and communication with members and Providers, which could potentially last for up to two years.

4.149. Interested parties who oppose the Proposed Conduct submit that the length of the authorisation period sought is not necessary to understand the impact of the Proposed Conduct. Some interested parties submit that if authorisation is granted, three to five years would be sufficient.

4.150. In light of the assessment set out above, the ACCC considers it appropriate to authorise the Proposed Conduct for a shorter period than the Applicants have requested in order to assess any public benefits or detriments that have resulted from the Proposed Conduct.

4.151. The ACCC notes the majority of agreements with private hospitals and medical practitioners have a two to three year term and HH is likely to require time to establish the HH Buying Group and put in place arrangements with Providers.

4.152. In these circumstances, the ACCC proposes to grant authorisation for five years.

5. Draft determination

The application

5.1. On 24 December 2020, HH and nib lodged application AA1000542 with the ACCC, seeking authorisation under subsection 88(1) of the Act.

5.2. HH and nib seek authorisation for the Proposed Conduct defined at paragraphs 1.12 – 1.33. Subsection 90A(1) of the Act requires that before determining an application for authorisation, the ACCC shall prepare a draft determination.

The authorisation test

5.3. Under subsections 90(7) and 90(8) of the Act, the ACCC must not grant authorisation unless it is satisfied in all the circumstances that the Proposed Conduct is likely to result in a benefit to the public and the benefit would outweigh the detriment to the public that would be likely to result from the Proposed Conduct.

5.4. For the reasons outlined in this draft determination, the ACCC considers, in all the circumstances, that the conduct described at paragraph 5.6 with the proposed condition, would be likely to result in a benefit to the public and the benefit to the public would outweigh the detriment to the public that would result or be likely to result from the conduct, including any lessening of competition.

5.5. Accordingly, the ACCC proposes to grant authorisation.

Conduct which the ACCC proposes to authorise

5.6. The ACCC proposes to grant authorisation AA1000542 in relation to the following conduct:

- as regards Medibank, Bupa, HCF and HBF WA (each a '**Major PHI**'), the ACCC proposes to authorise:
  - HH to operate the Broad Clinical Partners Program involving the provision of services to any Major PHI, on the condition specified in paragraph 5.7; and
  - each Major PHI to acquire contracting services from HH, but only in relation to the Broad Clinical Partners Program, and
- as regards all other PHIs (including HBF's arrangements with healthcare providers outside Western Australia), Other Healthcare Payers and any other healthcare payer notified by HH to the ACCC, the ACCC proposes to authorise:
  - HH to form and operate the HH Buying Group, including the Broad Clinical Partners Program, involving the provision of services to Other Participants; and
  - Other Participants to acquire contracting services from HH.

5.7. The proposed grant of authorisation in paragraph 5.6 is proposed to be made on condition that HH must not supply services to any Major PHI as part of the Broad Clinical Partners Program if that supply would mean that HH is supplying services under the Broad Clinical Partners Program to PHIs in a State or Territory that collectively account for more than 40% of private health insurance policies in that State or Territory, based on the latest private health insurance statistics published by the Australian Prudential Regulation Authority (APRA) or equivalent.

5.8. Authorisation is proposed to be granted in relation to Division 1 of Part IV of the Act and sections 45 and 47 of the Act.

5.9. The ACCC proposes to grant authorisation AA1000542 for five years.

5.10. This draft determination is made on 21 May 2021.

6. Next steps

The ACCC now invites submissions in response to this draft determination by 11 June 2021. In addition, consistent with section 90A of the Act, the Applicants or an interested party may request that the ACCC hold a conference to discuss the draft determination.