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Lodgment and Details

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File Title:	RMSANZ APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
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Important information

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Commonwealth of Australia

Competition and Consumer Act 2010 (Cth)

In the Australian Competition Tribunal

File Number:	ACT 4 of 2021
File Title:	APPLICATION FOR REVIEW OF AUTHORISATION A1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Applicant:	National Association of Practising Psychiatrists

AND

File Number:	ACT 5 of 2021
File Title:	APPLICATION FOR REVIEW OF AUTHORISATION A1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Applicant:	Rehabilitation Medicine Society of Australia and New Zealand Ltd

Submissions of the Rehabilitation Medicine Society of Australia and New Zealand

Filed on behalf of Rehabilitation Medicine Society of Australia and New Zealand, Applicant

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A. INTRODUCTION

1. Pursuant to s 101(1) of the *Competition and Consumer Act 2010* (Cth) (the **CCA**), the Rehabilitation Medicine Society of Australia and New Zealand (**RMSANZ**) seeks review of the Australian Competition and Consumer Commission (**ACCC**)'s decision to authorise Honeysuckle Health Pty Ltd (**HH**) and nib health funds limited (together, the **Authorisation Applicants**) to form and operate a buying group (**HH Buying Group**) to collectively negotiate and manage contracts with healthcare providers (including hospitals and medical specialists) (**Healthcare Providers**) on behalf of private health insurers (**PHIs**), medical insurance providers and other payers of healthcare services for a period of five years until 13 October 2026 (the **Proposed Conduct**).[1] A condition of the authorisation was that the Authorisation Applicants not supply services to Medibank, Bupa, HCF and HBF (in Western Australia) (**Major PHIs**).[2] The Authorisation Applicants now contend that the Tribunal should affirm the ACCC's decision to grant authorisation and otherwise amend the authorisation such that the period of authorisation is extended from five to ten years and the condition preventing Major PHIs from joining the HH Buying Group is removed in respect of medical specialist contracting.[3]

2. RMSANZ does not specifically seek review of the authorisation insofar as it applies to the HH Buying Group providing services to hospitals. That said, it is for the Authorisation Applicants to satisfy the Tribunal that the entirety of the Proposed Conduct meets the criteria in s 90(7)(b).

3. RMSANZ submits that authorisation should not be granted for the provision of services to rehabilitation medicine physicians (referred to in these submissions as **rehabilitation specialists**).

4. If authorisation is to be granted by the Tribunal (an outcome which is not supported by RMSANZ) in respect of rehabilitation specialists, RMSANZ contends that conditions should be imposed that, among other things, safeguard their clinical independence and the clinical independence of those clinicians who refer to them.[4]

5. Accordingly, RMSANZ submits the Tribunal should:

   a) set aside the ACCC's authorisation; or alternatively

   b) vary the ACCC's authorisation so to exclude the Authorisation Applicants from providing services to rehabilitation specialists; or alternatively

   c) vary the ACCC's authorisation so to impose further conditions on the provision of services to medical specialists that, among other things, safeguard their clinical independence.

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[1] ACCC Determination at page 1 (**CB105**)**.** A similar review application has been brought by the National Association of Practicing Psychiatrists (**NAPP**) (ACT 4). NAPP represents Australian psychiatrists, clinicians who hold specialist expertise in assessment, formulation, diagnosis and treatment of patients with mental illness.
[2] ACCC Determination at [4.113]-[4.122] (**CB133**).
[3] Authorisation Applicants Statement of Facts, Issues and Contentions (**AA SOFIC**), [85]-[91] (exclusion of major PHIs); [92]-[94] (Authorisation Period) (**CB336-339**).
[4] Categories of the conditions that RMSANZ proposes be imposed in the event of the Tribunal authorising the Proposed Conduct in respect of rehabilitation specialists are listed at paragraph [163] of RMSANZ's Statement of Facts, Issues and Contentions. (**CB311-312**).

6. The focus of this application is the operation of the HH Buying Group as it relates to the negotiation of agreements between PHIs and medical specialists. The imposition of 'value based' contracts on specialists as part of the Authorisation Applicants' Broad Clinical Partners Program (**BCPP**) poses serious detriments, particularly in relation to clinical independence, which are not outweighed by the alleged benefits. As part of the BCPP, PHI participants in the HH Buying Group will enter into agreements with medical specialists that impose certain 'price' and 'non-price' terms on specialists in relation to the provision of care. The Authorisation Applicants have provided the ACCC with a template specialist agreement, which will form the basis for contracting under the BCPP (**Template MPPA**).

7. The public benefits alleged by the Authorisation Applicants in this case are: (1) better health outcomes at a lower cost; (2) access to data analytics and information; (3) an expanded 'no gap' experience for private health insurance policyholders; (4) the provision of an alternative to existing buying groups; (5) transaction costs savings and increased efficiencies; and (6) countervailing hospital bargaining power.

8. The Authorisation Applicants have failed to demonstrate how the Proposed Conduct would be likely to generate any of these alleged public benefits, beyond the incremental benefits that may accrue to PHIs who shift from an existing buying group to the HH Buying Group. Significantly, the Authorisation Applicants have not substantiated their contention that the Proposed Conduct is likely to generate better health outcomes – despite the centrality of this claim to nearly all of their alleged public benefits.

9. Moreover, the Proposed Conduct, and in particular, the BCPP, is likely to produce a number of significant public detriments, namely (1) the model of health care and contracting that the Authorisation Applicants seek to impose through the Proposed Conduct; (2) the non-price terms imposed by the Template MPPA; (3) the ways in which the proposed medical specialist contracting model overrides independent clinical decision making and the resulting harm to patient safety, experience and outcomes; and (4) the increase in PHI bargaining power (relative to medical specialists) that will result in the inefficient provision of health care. The Tribunal cannot be satisfied, having regard to the Template MPPA and other evidence relied on by the Authorisation Applicants, that these significant and serious detriments are outweighed by the alleged benefits.

10. Lastly given the reasons below, and the concerns expressed by the ACCC in respect of Major PHI involvement in the BCPP,[5] there is no basis for the Tribunal to amend the authorisation such that the condition preventing Major PHIs from joining the HH Buying Group is removed in respect of medical specialist contracting. For the reasons provided by the ACCC,[6] nor is there any basis for the length of the authorisation to be extended.

[5] ACCC Determination at [4.113]-[4.122] (**CB133**).
[6] ACCC Determination at [4.190]-[4.194] (**CB141**).

B. OUTLINE OF SUBMISSIONS

11. These submissions are set out as follows:

    a) Part C sets out an overview of the parties and Proposed Conduct;

    b) Part D sets out the background to this hearing;

    c) Part E sets out a brief overview of the private healthcare and insurance markets;

    d) Part F sets out the legal framework;

    e) Part G sets out the alleged benefits; and

    f) Part H sets out the public detriments.

C. THE PARTIES AND THE CONDUCT THE SUBJECT OF THE AUTHORISATION

Overview of the Proposed Conduct

12. RMSANZ is the professional representative body for rehabilitation medicine physicians and trainees in Australia and New Zealand. Its objectives include promoting the speciality of rehabilitation medicine and advocating on behalf of rehabilitation specialists and recipients of rehabilitation services.

13. The HH Buying Group is comprised of nib and HH. nib is a PHI which has an approximately 9.7% share of the Australian private health insurance market.[7] HH is a health services and data science company founded as an equal joint venture between nib and Cigna Corporation (**Cigna**), an American multinational managed healthcare and insurance company.

14. The conduct the subject of the application for authorisation is the proposed collective bargaining conduct which encompasses:

    a) the Authorisation Applicants forming and operating the HH Buying Group to negotiate contracts with Healthcare Providers on behalf of Participants; and

    b) the provision of a range of contract management and data analytics services to Participants including data analytics, contract administration and management services, dispute resolution services (in relation to contractual arrangements), management of customer complaints, and performance and compliance assessment of Healthcare Providers (**Contracting Services**).[8]

15. The identity of the members of the HH Buying Group is yet to be determined, but in this review, authorisation is sought for the Participants to include:

    a) PHIs, comprising the Major PHIs and all other PHIs;

[7] AA SOFIC at [5] (**CB315**).
[8] Affidavit of David Malcolm Du Plessis affirmed 13 June 2022 (**Du Plessis Affidavit**) at [178] (**CB1262**).

b) international medical and travel insurance companies;

c) government and semi-government payers of healthcare services; and

d) any other payer of healthcare services notified by HH to the ACCC.

16. The Authorisation Applicants do not seek authorisation for HH to provide any Contracting Services to the Major PHIs, except for Contracting Services related to medical specialists. This includes the provision of Contracting Services that relate to HH's BCPP. The BCPP consists of agreements between PHIs and individual medical specialists that impose certain 'price' and 'non-price' terms on specialists in relation to the provision of care.

17. The Authorisation Applicants presently operate the BCPP in respect of medical specialists who provide services for hip and knee joint replacement surgery to nib customers (**nib BCPP**).[9] The Authorisation Applicants propose to expand the nib BCPP model to all Participants in the HH Buying Group, and to additional medical specialities and procedures.[10] The Template MPPA is a template medical purchaser provider agreement (**MPPA**) that will form the basis for contracting under the expanded BCPP model.[11] The different arrangements by which PHIs pay Healthcare Providers are explained below at paragraphs 31 to 34.

D. BACKGROUND TO THE PRESENT HEARING

18. On 24 December 2020, the Authorisation Applicants lodged an application for authorisation (AA1000542) with the ACCC under s 88(1) of the CCA. The Authorisation Applicants sought authorisation for 10 years for HH to form and operate the HH Buying Group, with no limits in respect of the PHIs that could become Participants.

19. On 8 April 2021, the Authorisation Applicants amended their application to exclude the provision of Contracting Services to Major PHIs, other than with respect to the BCPP (**Revised Application**).

20. On 6 May 2021, the Authorisation Applicants amended their application to indicate that they were open to a condition which limited the Contracting Services proposed to be provided to Major PHIs in relation to the BCPP (**Further Amended Application**). The effect of the condition was to restrict the HH Buying Group from providing Contracting Services to more than 80% of the national private health insurance market (based on the number of hospital policies) in relation to the BCPP.

21. On 21 May 2021, the ACCC published a draft determination under which it proposed to grant authorisation for the Proposed Conduct on the condition that the HH Buying Group did not provide Contracting Services to more than 40% of the national private health insurance market (based on the number of hospital policies) in relation to the BCPP. The ACCC received over 350 submissions from

[9] Du Plessis Affidavit at [84] (**CB1237**).
[10] Du Plessis Affidavit at [226] (**CB1273**).
[11] Du Plessis Affidavit at [183] (**CB1263**).

interested parties in response to the draft determination – including from bodies representing medical specialists likely to be affected and concerned individual practitioners.[12]

22. On 21 September 2021, the ACCC published its Determination in which it gave authorisation for the Proposed Conduct on the condition that the HH Buying Group did not supply any services to a major PHI.[13] The authorisation applied to the Proposed Conduct for a period of 5 years.[14]

E. THE PRIVATE HEALTHCARE AND INSURANCE MARKETS

Overview of private healthcare in Australia

23. Consumers of health care services in Australia can opt to receive healthcare and services from the public Medicare system or the private healthcare system.[15] The public system provides free hospital treatment in public hospitals, as well as subsidised access to other healthcare services.[16]

24. Consumers can also opt to receive health care in the private system. This enables patients to be able to choose their doctor, obtain timely medical interventions (especially for elective surgery), choose their preferred hospital and to have continuity of care with a specialist doctor and treatment team.[17]

25. Private health care services are funded by a combination of government subsidies, payments by PHIs and/or consumer contributions.[18] The Medicare Benefits Schedule (**MBS**) sets out medical services that are subsidised by the Australian Government.[19] The MBS allocates a unique item number to each service, provides a description of the service, and sets out the fee payable for the service (the **Schedule Fee**).[20] The MBS does not cover services provided by hospitals.[21]

26. In Australia, private health insurance operates to cover policyholders in respect of hospital treatment and general treatment (also known as 'extras' cover) in the private healthcare system.[22]

27. Hospital treatment cover provides cover for patients' in-patient and day-care in hospitals, with the precise scope of the cover depending on the level of private cover taken out by the policyholder.[23] Each PHI pays an amount in respect of a patient's in-patient or day-hospital costs (both hospital charges and those of the treating specialist) up to an agreed amount, on a fee for service basis.

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[12] ACCC Determination at [7.1] (Appendix A) (**CB144**). A summary of certain interested party submissions is contained at [7.2]-[8.37] of the ACCC Determination (**CB144-155**).
[13] ACCC Determination at [5.6]-[5.11] (**CB142-143**).
[14] ACCC Determination at [5.9] (**CB143**).
[15] Statement of Dr Omar Khorshid dated 14 June 2022 (**Khorshid Statement**) at [30]-[32] (**CB3112**).
[16] Khorshid Statement at [31] (**CB3112**).
[17] Khorshid Statement at [33] (**CB3112**).
[18] Khorshid Statement at [15]-[20], [31]-[32] (**CB3109-3110,3112**).
[19] Khorshid Statement at [15] (**CB3109**).
[20] Khorshid Statement at [15] (**CB3109**).
[21] Du Plessis Affidavit at [60] (**CB1231**).
[22] Du Plessis Affidavit at [19] (**CB1222**).
[23] Khorshid Statement at [32]-[33] (**CB3112**).

28. Under the MBS, the Australian Government reimburses each patient who holds private health insurance for 75% of the Schedule Fee for each in-patient or applicable day-patient service provided to them by a specialist.[24] PHIs are required to reimburse the patient for the remaining 25% of the Schedule fee.[25]

29. In practice, the patient assigns their right to the Medicare component to the specialist and the PHI pays the balance to the specialist.[26]

30. The Schedule Fee is often substantially lower than the prevailing market fees for the services provided by specialists.[27] The extent of the difference between the Schedule Fee and the actual fee charged by the specialist – for which the patient is liable – is known as the 'out of pocket' or 'gap' amount.[28]

Arrangements between PHIs, hospitals, and medical specialists

31. PHIs are permitted to enter into hospital purchaser provider agreements (**HPPAs**) with private hospitals. Under HPPAs, hospitals agree with healthcare payers the rates and terms and other conditions and agree not to charge out-of-pocket costs to customers of healthcare payers.[29]

32. In respect of services provided by a medical specialist, PHIs are able to:

    a) pay the specialist the Schedule Fee owed in accordance with the MBS Schedule. Under this arrangement the specialist's patient is liable to pay the 'gap' amount;[30]

    b) pay the specialist in excess of the Schedule Fee pursuant to a MPPA in return for the specialist agreeing to charge their patient no extra fees (a **'no gap**' arrangement) or a fixed extra fee (a **'known gap'** arrangement);[31] or

    c) pay the specialist, pursuant to the PHI's gap cover scheme that the specialist has chosen to register for, on either a no gap or known gap basis.[32]

33. Even if a medical specialist has entered into an MPPA with a PHI or registered for a PHI's gap cover scheme, they are normally permitted to opt out from providing services under those arrangements on a case-by-case basis.[33]

34. HH proposes to offer the Contracting Services to Participants in relation to HPPAs, MPPAs with medical specialists (including those entered into under the BCPP), gap cover schemes and general treatment networks.[34]

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[24] Khorshid Statement at [16] (**CB3109-3110**).
[25] Khorshid Statement at [16] (**CB3109-3110**).
[26] Khorshid Statement at [34] (**CB3112**).
[27] Khorshid Statement at [35], [45], [Table 1] (**CB3112-3113,3114**); Du Plessis Affidavit at [62] (**CB1231-1232**).
[28] Khorshid Statement at [35] (**CB3112-3113**).
[29] Du Plessis Affidavit at [92] (**CB1238-1239**).
[30] Du Plessis Affidavit at [62], [71] (**CB1231-1233**).
[31] Khorshid Statement at [37]-[39] (**CB3113**).
[32] Du Plessis Affidavit at [67]-[68] (**CB1233**).
[33] Khorshid Statement at [43] (**CB3114**); Du Plessis Statement at [67] (**CB1233**).
[34] Du Plessis Affidavit at [182] (**CB1262**).

PHI Contracting Services and Buying Groups

35. There are currently 34 PHIs in Australia, and the four largest health insurers (Medibank, Bupa, HCF and HBF) account for approximately 70 per cent of health insurance policies nationally.[35] The four largest PHIs each have an internal contracting function and negotiate directly with Healthcare Providers.[36]

36. The remaining PHIs engage in collective bargaining with Healthcare Providers through one of 2 buying groups: the Australian Health Services Alliance (**AHSA**) and the Australian Regional Health Group (**ARHG**).[37] AHSA represents 27 PHIs and ARHG represents 4 PHIs.[38]

37. The Authorisation Applicants anticipate that those PHIs that are presently members of AHSA or ARHG are likely to join the HH Buying Group, and that the Major PHIs may join the HH Buying Group in relation to medical specialist contracting.[39]

Provision of rehabilitation medicine in the private healthcare system

38. Rehabilitation specialists provide care with the primary clinical purpose of improving the functioning of patients with impairments, activity limitations or restrictions due to a health condition.[40] In practice, at least a third of all referrals for consultations by a rehabilitation physician come from orthopaedic surgeons or their teams.[41] Together, rehabilitation specialists and orthopaedic surgeons manage a number of complex conditions, including joint replacements.[42]

F. LEGAL FRAMEWORK

39. A person dissatisfied with a determination of the ACCC under Division 1 of Part VII may apply to the Tribunal for a review of the determination under s 101(1) of the CCA. Per s 101(2), a review by the Tribunal is a rehearing of the matter. Section 102(1) provides that the Tribunal may make a determination affirming, setting aside or varying the determination of the ACCC, and for the purposes of the review, may perform all the functions and exercise all the powers of the ACCC.

40. The review is a *de novo* review whereby the Tribunal conducts a fresh hearing and determination of the matter.[43] The role of the Tribunal is not to review the determination of the ACCC in the sense of deciding whether it is 'right or wrong'.[44] The Tribunal must 'make its own findings of fact and reach its own decision as to whether authorisation should be granted or not and, if so, any conditions to which it is to be subject.'[45] To that end, s 102(7) of the CCA expressly permits the Tribunal to have regard to any

[35] Du Plessis Affidavit at [29] (**CB1225**).
[36] ACCC Determination at [2.1] (**CB113**).
[37] ACCC Determination at [2.1] (**CB113**).
[38] Du Plessis Affidavit at [104] (**CB1241**).
[39] Du Plessis Affidavit at [177] (**CB1261-1262**).
[40] Statement of Dr Zoe Adey-Wakeling Statement dated 16 May 2022 (**Adey-Wakeling Statement**) at [8] (**CB1117**).
[41] Adey-Wakeling Statement at [22] (**CB1119**).
[42] Adey-Wakeling Statement at [23] (**CB1119**).
[43] *Application by Port of Newcastle Operations Pty Limited (No 2)* [2022] A CompT 1 (***Port of Newcastle***) at [20].
[44] *Application by Medicines Australia Inc* [2007] A CompT 4 (***Medicines Australia***) at [138] (French J, Mr G Latta and Prof C Walsh).
[45] *Medicines Australia* at [135].

information furnished, documents produced or evidence given to the ACCC in connection with the making of the determination.

41. In order to make a determination granting an authorisation, the ACCC was required by s 90(7) of the CCA to be satisfied in all the circumstances that:

    a) the conduct would not have the effect, or would not be likely to have the effect, of substantially lessening competition: s 90(7)(a); or

    b) 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 result, or be likely to result, from the conduct: s 90(7)(b).

42. Section 90(8) of the CCA relevantly provides that s 90(7)(a) does not apply if Division 1 of Part IV (cartel conduct) applies to the conduct for which authorisation is sought.

43. The Authorisation Applicants sought authorisation on the basis that the Proposed Conduct could constitute a cartel provision within the meaning of Division 1 of Part IV of the CCA and could substantially lessen competition within the meaning of ss 45 and 47 of the CCA.

44. The applicable statutory precondition for the grant of authorisation is therefore outlined in s 90(7)(b), namely that the Proposed 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 result, or be likely to result, from the conduct.

45. In *Medicines Australia*, the Tribunal outlined the general principles in respect of the public benefits test, then contained in the *Trade Practices Act 1974* (Cth). In respect of public benefits, the Tribunal said:

> The words 'public benefit' which lie at the heart of the authorisation process encompass '… the widest possible conception of public benefit … anything of value to the community generally, any contribution to the aims pursued by the society, including as one of its principal elements (in the context of trade practices legislation) the achievement of the economic goals of efficiency and progress'. The term 'public' refers to the Australian public. The range of public benefits which may be considered is limited, in the context of authorisation, by the requirement that the benefit be the result or the likely result of the conduct which is the subject of authorisation Thus the public benefit which may be considered under s 90 is confined to the extent that it must be related to classes of conduct amenable to authorisation and causally related to the conduct authorised. Subject to those constraints the range of matters that may be brought to account as benefits is not limited. While economic efficiency will loom large in many authorisation applications, the Act and its objects do not limit it to such matters.[46]

46. As to public detriments, the Tribunal said

> Sections 90(6) and 90(7) of the TPA require consideration of the risk of 'detriment to the public', a concept extending to '… 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 …' Although 'detriment' covers a wider field than anti-competitive effects in many cases the important detriments will have that character. The relevant detriment will flow from the anti-competitive effect of the conduct to which authorisation is sought. This does not exclude

[46] *Medicines Australia* at [107] (citations omitted).

> consideration of other detriments which may be incidental to and therefore detract from, a claimed public benefit. To that extent such detriment will be relevant in weighing the benefit.[47]

47. Accordingly, it is clear that the Tribunal is required under the statute to consider 'any detriment to the public', 'any impairment to the community generally' and 'any harm or damage to the aims pursued by the society'.

48. In the *Qantas Airways Limited*,[48] the Tribunal explained what is required for benefits and detriments to be considered:

> ... for a benefit or detriment to be taken into account, we must be satisfied that there is a real chance, and not a mere possibility, of the benefit or detriment eventuating. It is not enough that the benefit or detriment is speculative or a theoretical possibility. There must be a commercial likelihood that the applicants will, following the implementation of the relevant agreements, act in a manner that delivers or brings about the public benefit or the lessening of competition giving rise to the public detriment. We must be satisfied that the benefit or detriment is such that it will, in a tangible and commercially practical way, be a consequence of the relevant agreements if carried into effect and must be sufficiently capable of exposition (but not necessarily quantitatively so) rather than 'ephemeral or illusory', to use the words of the Tribunal in Re Rural Co-operative (WA) Ltd.[49]

49. In *Port of Newcastle*, the Tribunal stated 'numeric quantification of benefits is not essential, but there must be a factual basis for concluding that the public benefits are likely to result from the proposed conduct'.[50]

50. The s 90(7)(b) test requires a 'comparison of a future in which the conduct, the subject of the authorisation application, occurs with a future in which that conduct does not occur. That comparison is required in order to assess whether the conduct the subject of the authorisation would or would be likely to result in a net public benefit'.[51] The Tribunal can only be concerned with the 'foreseeable future as it appears on the basis of evidence and argument relating to the particular application'.[52]

51. These submissions now turn to analyse the alleged public benefits and public detriments.

G. ALLEGED PUBLIC BENEFITS

No factual basis for allegation that value-based contracting will result in better health outcomes at a lower cost

52. The Authorisation Applicants submit that they intend to work collaboratively with Participants to implement a more efficient 'value-based' contracting model with Healthcare Providers.[53] Put at its highest, value based care is achieving 'the best care possible for each patient while maintaining an

[47] *Medicines Australia* at [108] (citations omitted).
[48] *Re Qantas Airways Ltd* [2004] ACompT 9 (Goldberg J, Mr G Latta and Professor Round) (***Qantas***).
[49] *Qantas* at [156] (citations omitted).
[50] *Port of Newcastle* at [37].
[51] *Port of Newcastle* at [50].
[52] *Re Queensland Co-operative Milling Association Ltd* (1976) 8 ALR 481 at 508 (Woodward J, Shipton and Brunt).
[53] Du Plessis Affidavit at [212] (**CB1270**); AA SOFIC at [59]-[62] (**CB328-329**).

efficient use of resources'.[54] The Authorisation Applicants contend that their model of value based care will deliver better health outcomes at a lower cost.[55]

53. RMSANZ does not agree that the model of value based contracting proposed by the Authorisation Applicants will improve patient health outcomes, or (in the long run) reduce expenditure on health care. Nor does it agree that the provision of value based contracting models to smaller PHIs through the HH Buying Group represents a public benefit.

54. The Authorisation Applicants have proceeded on the basis that their proposed model of care will be beneficial for patients.[56] They have not sought to substantiate these contended benefits, as opposed to merely asserting their existence.[57] In fact, RMSANZ contends that a number of detriments arise in respect of patient welfare from the proposed contracting model – see the discussion below at paragraphs 90 to 106.

55. To the extent that the Authorisation Applicants' proposed model of care does reduce costs, these savings are likely to be short term and captured by the Participants rather than being passed on to consumers of private health insurance. The long-term economic detriments of the Proposed Conduct are discussed below at paragraph 94.

56. The Authorisation Applicants rely on the evidence of David Du Plessis,[58] as well as the expert report of Greg Houston (**Houston Report**),[59] in order to substantiate the claim that savings from their proposed contracting model will be passed onto consumers in the form of lower premiums.

57. RMSANZ accepts Mr Du Plessis's evidence that premium increases require ministerial approval under the *Private Health Insurance Act 2007* (Cth) (**PHI Act**),[60] and that there are no legislative barriers to consumers switching between PHIs.[61] These matters are uncontroversial. However, the basis upon which Mr Du Plessis opines that reduced PHI costs result in reduced premiums is undisclosed,[62] as is the "experience" Mr Du Plessis purports to rely in giving the opinion.[63] His evidence on these matters should accordingly be given little weight.

58. At paragraph [138] of the Houston Report, Mr Houston states that it is 'complex' to determine the extent to which lower cost or higher quality health provider contracting services will be passed on to consumers in the private insurance market. He states that 'it would be very unusual for there to be no pass-through

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[54] Du Plessis Affidavit [118] (**CB1243**)**.** See also Reply Statement of Dr Philip Morris dated 28 June 2022 (**Morris Reply Statement**) at [10] (**CB415**); Reply Statement of Dr Zoe Adey-Wakeling (**Adey-Wakeling Reply Statement**) at [14] (**CB1150**).
[55] AA SOFIC at [59]-[62] (**CB328-329**). Expert Report of Greg Houston (**Houston Report**) at [136] to [143] (**CB3161-3163**).
[56] See for example, Du Plessis Affidavit at [254]: 'It is fundamentally inconsistent with value based contracting to achieve worse health outcomes for patients' (**CB1281**).
[57] See for example, Du Plessis Affidavit at [127] (**CB1246**).
[58] Du Plessis Affidavit at [49], [120], [131]-[132] and [215] (**CB1229, 1243, 1248, 1271**).
[59] Houston Report at [136]-[140] (**CB3161-3162**).
[60] Du Plessis Affidavit at [48] (**CB1228**).
[61] Du Plessis Affidavit at [36]-[40] (**CB1226-1227**).
[62] See for example, Du Plessis Affidavit at [120], [131]-[132] and [215] (**CB1243, 1248, 1271**).
[63] Du Plessis Affidavit at [131] (**CB1248**).

to consumers at all'.[64] Mr Houston's 'presumption' that reduced costs will be passed on to consumers is based on three matters:[65] (1) the structure of the private health insurance market implying that competition is effective; (2) the predominant form of cost savings for PHIs from the Proposed Conduct being in respect of marginal costs, which are more likely to be passed on than fixed cost savings; and (3) the degree to which the market for private health insurance is regulated.

59. In respect of the first matter supporting Mr Houston's presumption, RMSANZ does not accept that there is presently effective competition in the market for private health insurance. This is because:

    a) some of the 34 PHIs presently operating in Australia are related entities of one another – for example, nib owns GU Health;[66]

    b) the major PHIs and nib together have a 72% share of the Australian private health insurance market;[67] and

    c) there is a great degree of variance in private health insurance market concentration at the State and Territory regional level,[68] such that generalisations about competitive dynamics at the national level should be approached with caution.

60. Further, RMSANZ submits that the Proposed Conduct is likely to lessen competition in the market for the supply of private health insurance to consumers for the reasons in the expert report of George Siolis (**Siolis Report**),[69] namely that the Proposed Conduct is likely to have the following economic effects:

    a) permitting Participants to share information amongst themselves in a way that might lead to or facilitate coordinated behaviour;[70] and

    b) standardising PHI input costs (i.e., collectively negotiated medical specialist and hospital fees) such that competition amongst PHIs is reduced, and the incentives for PHIs to reduce marginal costs (through innovation, for example) are reduced.[71]

61. Mr Houston opines that even if competition in the private health insurance industry cannot be presumed to be effective, savings will be passed on because 'even a monopolist can be expected to reduce its prices somewhat in response to a reduction in its marginal cost.'[72] However, any 'pass-through' of costs to consumers in these circumstances would be extremely limited.[73]

62. In the above circumstances, there is not a sufficient factual basis for concluding that any savings that accrue to PHIs from the Proposed Conduct are likely to be passed onto consumers. For the reasons

[64] Houston Report at [138] (**CB3161**).
[65] Houston Report at [139] (**CB3161**).
[66] See for example, Du Plessis Affidavit at [108] (**CB1241**).
[67] Expert Report of George Siolis (**Siolis Report**) at [12, Table 1] (**CB3238**).
[68] Siolis Report at [12, Table 1] and [76] (**CB3238, 3251)**.
[69] Siolis Report at [37]-[42] (**CB3243**).
[70] Siolis Report at [39] (**CB3243**).
[71] Siolis Report at [40]-[41] (**CB3243**).
[72] Houston Report at [140] (**CB3162**).
[73] Siolis Report at [31]-[32] (**CB3241**).

outlined below, nor is there a satisfactory basis to conclude that the Proposed Conduct will lead to better outcomes. The evidence relied on by the Authorisation Applicants to establish this public benefit has not risen above contestable 'general statements'.[74]

63. For the avoidance of doubt, RMSANZ accepts that a reduction in costs per se – even if not passed on to consumers – can be a form of efficiency capable of constituting a public benefit. However, the extent of any such benefit in the present case is unquantified, remains speculative and is outweighed by the public detriments identified below. Further, RMSANZ contends that the economic benefit of any such savings is diluted – or possibly even extinguished – if those costs are simply shifted to another party.

Access to data analytics and information does not necessarily result in public benefit

64. The Authorisation Applicants contend that the HH Buying Group will provide Participants with access to data analytics services that are superior to those offered by the existing buying groups or managed internally by PHIs.[75] The improvements are said to arise from HH's capability in data science, analytics and forecasting, as well as from the collection of a large volume of patient and provider data from across the buying group. In order to establish this public benefit, however, the Authorisation Applicants have largely relied on assertions that the analytics capabilities of HH and Cigna exceed those presently available in the market.[76]

65. RMSANZ accepts, in principle, that access to data and analytics services may generate some public benefit. Any benefit, however, is attenuated by reason that members of the AHSA buying group and some major PHIs already have access to similar data analytics services. The public benefit to be assessed is the incremental improvement that HH's data analytics services represents, as compared to the current data analytics capabilities of AHSA and some major PHIs. The Authorisation Applicants have provided limited evidence of the difference between the HH data analytics services and services already available in the market.[77] RMSANZ again notes the submission of AHSA to the ACCC which provides a comprehensive outline of the buying group's data analytics capabilities and offering to the market.[78]

66. The extent of any public benefit is also limited by the extent to which the data is used by HH to develop inappropriate models of care. The Authorisation Applicants propose to use data from Participants with HH's data analytics to perform benchmarking,[79] identifying 'low value or no value care',[80] assess the efficacy of care,[81] and adjust funding to Healthcare Providers to incentivise the provision of certain types of care.[82] The public detriments likely to flow from these aspects of the Proposed Conduct are outlined below at paragraphs 90 to 112.

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[74] See *Port of Newcastle* at [37].
[75] Du Plessis Affidavit at [216] to [225] (**CB1271-1273**); AA SOFIC [49]-[53] (**CB326-327**).
[76] See for example, Du Plessis Affidavit at [10] and [216] (**CB1220,1271**).
[77] Du Plessis Affidavit at [222] (**CB1272**).
[78] AHSA submission to the ACCC dated 12 February 2021 **(AHSA Submission)** at [39]-[42] (**CB3289**).
[79] Du Plessis Affidavit at [273] to [276] (**CB1284**).
[80] Du Plessis Affidavit at [151] (**CB1254-1255**).
[81] Du Plessis Affidavit at [154] (**CB1255-1256**).
[82] Du Plessis Affidavit at [154]-[155] (**CB1255-1256**).

67. Given the above, the Authorisation Applicants have not substantiated their claim that the Proposed Conduct will result in the benefit of PHIs having access to superior data analytics services.

Alleged public benefit of 'no gap' experience for Customers from BCPP is speculative or theoretical

68. The Authorisation Applicants state that the establishment of the HH Buying Group will extend the 'no gap' experience of the BCPP to more customers.[83] The expanded BCPP is proposed to provide a 'complete' no gap experience that does not permit, unlike existing gap cover schemes, specialists to charge a 'known gap' fee or choose to provide services on a case by case basis according to the scheme.[84]

69. RMSANZ accepts that the introduction of a no gap experience for policyholders is a public benefit. However, it notes that the size of any such benefit conferred by the Proposed Conduct depends on the range of specialities, medical specialists, and geographical areas the BCPP is expanded to cover. The Authorisation Applicants' evidence does no more than identify 'opportunities to expand' the BCPP.[85] The extent to which the BCPP will be expanded remains unknown. Accordingly, this benefit amounts to no more than a 'speculative or theoretical possibility'.[86]

70. In any event, the size of any public benefit must be assessed having regard to the future without the Proposed Conduct. Almost all private rehabilitation specialists provide in-patient services on a no gap basis.[87] More widely, approximately 89% of all private medical services are already provided on a no-gap basis.[88] A further 4 to 5% are provided under a 'known gap' arrangement.[89] AHSA, in its submission to the ACCC, outlined the steps already taken by its members and the major PHIs to address consumer concerns about gap cover uncertainty.[90] This being the case, it does not appear likely that the Proposed Conduct will introduce any benefit not already being enjoyed by a large number of private health insurance policyholders.

Transaction costs savings and increased efficiencies not substantiated from Proposed Conduct

71. The Authorisation Applicants contend that collective bargaining will result in significant transactional and administrative cost savings for Participants.[91] These savings are alleged to arrive from: (1) Participants not having to negotiate individually with medical specialists; (2) reducing administrative costs for specialists; and (3) the efficient establishment of new models of care.[92]

72. In its determination, the ACCC accepted in principle that 'there are likely to be transaction cost savings from PHIs collectively negotiating for supply of health services, compared to individual negotiations and that these savings would – through competition between PHIs – likely flow at least in part to

[83] Du Plessis Affidavit at [226] to [231] (**CB1273-1274**); AA SOFIC [54]-[58] (**CB327-328**).
[84] Du Plessis Affidavit at [227]-[228] (**CB1273-1274**).
[85] Du Plessis Affidavit at [85] (**CB1237**).
[86] *Qantas* at [156].
[87] Statement of Dr Gary Galambos dated 16 May 2022 at [28] (**CB378**); Statement of Dr John Estell Statement dated 16 May 2022 at [29] (**CB480**).
[88] Khorshid Statement at [45, Table 1] (**CB3114-3115**); Siolis Report at [63] (**CB3247**).
[89] Khorshid Statement at [45, Table 1] (**CB3114-3115**).
[90] AHSA Submission at [50]-[52] (**CB3291-3292**).
[91] Du Plessis Affidavit at [232] to [236] (**CB1274-1275**); AA SOFIC at [63]-[66] (**CB329-330**).
[92] Du Plessis Affidavit at [232] (**CB1274**).

consumers'.[93] However, the ACCC also concluded that in the present case, 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, and therefore benefits for consumers, is likely to be limited'.[94]

73. RMSANZ adopts the ACCC's conclusion – the future without the Proposed Conduct does not include PHIs (most of which are members of the existing buying groups) negotiating individually with specialists.[95] Further, the Authorisation Applicants do not expect major PHIs to join the HH Buying Group, except in limited respects.[96] The public benefit relevant to the Tribunal is any incremental improvement offered by the HH Buying Group vis a vis the two existing buying groups.

74. The Authorisation Applicants contend that there are efficiency gains for PHIs that switch from the existing buying groups to the HH Buying Group – in the form of competitive fees and a broader scope of contracting services on offer.[97] The onus rests with the Authorisation Applicants to establish that these incremental benefits will eventuate from the Proposed Conduct. Insufficient evidence has been provided to date.

75. In any case, the extent to which the Proposed Conduct includes a scope of services beyond those already offered by the market remains unclear. RMSANZ notes the AHSA submission to the ACCC,[98] which outlines in detail the equivalent differential contracts and innovative funding models based on quality and data analytics services including outcomes analytics which AHSA currently provides.

76. The Authorisation Applicants assert that savings from the Proposed Conduct are also attributable to specialists who opt into the BCPP because of simplified billing procedures and 'consistent funding arrangements with several contracts rather than individual contracts with different rates and terms across different PHIs'.[99] However, this does not describe the addition of any additional public benefits, as they are already realised through the existing buying groups.[100] Further, the experience of RMSANZ is that MPPAs are already provided to specialists on a pro-forma basis for negotiation.

77. The Authorisation Applicants also contend that the Proposed Conduct will lead to the faster roll-out of new models of care because MPPAs will no longer be customised to match the 'care model delivery of the individual specialist'.[101] The Authorisation Applicants have not established how this supposed benefit is not already provided by the existing buying groups.

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[93] ACCC Determination at [4.52] (**CB125**).
[94] ACCC Determination at [4.53] (**CB125**).
[95] See also Siolis Report at [61] (**CB3247**).
[96] Du Plessis Affidavit at [177] (**CB1261-1262**). To the extent major PHIs join the HH Buying Group in a limited fashion, but also retain their internal contracting functions, this will involve an ***increase*** in their outlay on the relevant transaction costs.
[97] Du Plessis Affidavit at [234] (**CB1275**).
[98] AHSA Submission at [38] to [49] (**CB3288-3291**).
[99] Du Plessis Affidavit at [235] (**CB1275**).
[100] See AHSA Submission at [32] (**CB3287**).
[101] Du Plessis Affidavit at [236] (**CB1275-1276**).

78. RMSANZ says further:

a) the Authorisation Applicants have not established the extent to which the reduced transaction costs are attributable to negotiations with hospitals (which understandably require significant resources, separate complex negotiations, and specific contracts), as opposed to the negotiations with specialists;

b) the Authorisation Applicants' evidence does not provide meaningful insight as to any transaction cost benefits arising from collective negotiations with specialists; and

c) in any event, it does not accept that any cost savings realised by PHIs as a result of the Proposed Conduct will be passed on to consumers – see paragraphs 56 to 62 above.

79. Given the above, the Tribunal cannot be satisfied that the Proposed Conduct will result in transaction and administrative cost savings for PHIs. Any public benefit that might be realised is largely contained to PHIs who already realise scale efficiencies through existing buying groups. Further, the contended benefit is contingent on the Authorisation Applicants substantiating their claim that the services offered by HH extend beyond what is already available.

Addition of HH Buying Group to existing buying groups does not create meaningful public benefit beyond competitive tension that currently exists and may reduce competitive pressures

80. The Authorisation Applicants contend that the HH Buying Group will offer an alternative to the two existing buying groups in four main respects by offering: (1) a contracting model that is voluntary (for PHIs), non-exclusive and free from interference by nib or HH; (2) value based contracting; (3) a greater range of medical specialist contracting; and (4) data analytics services.[102]

81. RMSANZ also does not concede that the introduction of a further buying group generates any meaningful public benefit beyond the competitive tension that already exists in the market. In this respect, RMSANZ adopts the analysis of Mr Siolis:

> The PHI market is characterised by a small number of large players (that negotiate independently with healthcare providers) and many smaller PHIs that negotiate as part of established buying groups - 27 are part of AHSA; 4 as part of ARHG. In these circumstances, it is possible that the introduction of an additional buying group will have the perverse effect of reducing rather than increasing the competitive pressures faced by the Major PHIs.[103]

82. In addition, the public benefits realised by existing buying groups are likely to be diminished if participating PHIs leave those groups. In this respect, RMSANZ adopts the submission of AHSA to the ACCC that 'the claimed benefit of greater choice of buying groups [is more accurately described] as a transfer of the services creating scale efficiencies',[104] and that 'splitting buying groups into three would only dilute the existing benefits achieved through [those] scale efficiencies'.[105]

[102] Du Plessis Affidavit at [198] (**CB1267**); AA SOFIC [44] to [48] (**CB325-326**).
[103] Siolis Report at [62] (**CB3247**).
[104] AHSA Submission at [35] (**CB3288**).
[105] AHSA Submission at [37] (**CB3288**).

83. To the extent that the Proposed Conduct encompasses value based contracting and data analytics services, these contended benefits are discussed at paragraphs 64 to 66 and 90 to 106.

No countervailing hospital bargaining power

84. The Authorisation Applicants submit that the Proposed Conduct will allow Participants in the HH Buying Group to countervail the market power of some major hospitals.[106]

85. As stated above, RMSANZ does not object to the Tribunal granting authorisation sought by the Authorisation Applicants insofar as the authorisation applies to hospital Contracting Services. However, it adopts the finding of the ACCC in its determination that the Proposed Conduct was not likely to increase the bargaining power of Participants or result in more efficient hospital pricing.[107]

H. PUBLIC DETRIMENTS

86. The Authorisation Applicants contend that they 'do not require authorisation to engage in value based contracting or otherwise to include non-price terms with medical specialists' as 'that conduct is lawful and an existing feature of contracting in the market'.[108]

87. This contention misrepresents the task of the Tribunal, which is to weigh those detriments which 'flow from the anti-competitive effect of the conduct to which authorisation is sought' as well as 'other detriments which may be incidental to and therefore detract from, a claimed public benefit'.[109]

88. The relevant detriments for the Tribunal's consideration include the: (1) model of health care and contracting that the Authorisation Applicants seek to impose through the Proposed Conduct; (2) the non-price terms imposed by the Template MPPA; (3) the ways in which the proposed medical specialist contracting model overrides independent clinical decision making in the best interests of patients; and (4) the increase in PHI bargaining power (relative to medical specialists) that will result in the inefficient provision of health care.

89. The Tribunal is plainly required by statute to consider each of these alleged detriments, which are outlined below, as they represent likely 'impairment to the community' and 'harm or damage' to the aims pursued by our society.[110]

Imposition of the Authorisation Applicant's model of value based care

90. As stated above, the Authorisation Applicants propose to adopt a value based contracting model in respect of medical specialists.[111] This will entail HH:[112]

    a) obtaining data from Participants;

[106] Du Plessis Affidavit [238] to [240] (**CB1276-1277**); AA SOFIC [67]-[69] (**CB330**).
[107] ACCC Determination at [4.61] to [4.68] (**CB126-127**).
[108] AA SOFIC at [71] (**CB331**).
[109] *Qantas* at [10].
[110] *Medicines Australia* at [108].
[111] AA SOFIC at [26] (**CB319**).
[112] Du Plessis Affidavit at [154]-[155], [183], [193] (**CB1255-1256, 1263, 1266**).

b) aggregating and analysing the data to establish benchmarks and outcome measures;

c) comparing specialists against their peers in respect of those benchmarks and outcome measures; and

d) adjusting the price or structure of fees paid by Participants to specialists according to the deemed value of the specialist and the services they provide.[113]

91. The Authorisation Applicants have provided evidence of the financial incentives that will be applied to complex systems of care,[114] without detailing the infrastructure necessary to ensure the successful delivery or review of value based care models.[115] By way of example:

a) only limited evidence has been provided of the commissioning stages that are planned to be undertaken as the BCPP is expanded into new areas of medicine; of how consumers and clinicians will be involved in the development of the model; and how the model will be continually evaluated;[116]

b) it remains unclear which recognised outcome measures will be used by HH as the BCPP model is expanded to new areas of medicine – particularly as there are no properly established value based measures available as yet for sub-acute areas of medicine (including rehabilitation medicine) and psychiatry;[117] and

c) it has not been disclosed which evidence-based guidelines or standards of care will be followed in determining what is and is not 'high value' care.[118]

92. The Authorisation Applicants contend that value based care models are being trialled across the Australian public health system.[119] RMSANZ does not cavil with this proposition. However, these models of care are materially different to what is proposed by the Authorisation Applicants.[120]

93. Given the dearth of evidence about the establishment of the Authorisation Applicants' value based contracting model, it can be inferred that the Authorisation Applicants have adopted a narrow interpretation of value based healthcare to reduce costs through inducements and financial penalties rather than one that encompasses healthcare outcomes that are important to patients and specialists.[121]

94. A model of value based care driven primarily by reduction of costs has the potential to: (1) deny insured patients the most appropriate healthcare;[122] (2) increase treatment costs in the long-run (by, for example

[113] Du Plessis Affidavit at [154]-[155] (**CB1255-1256**).
[114] See for example, Du Plessis Affidavit at [155] and [156] (**CB1256**).
[115] Adey-Wakeling Reply Statement at [21] (**CB1151**).
[116] See Adey-Wakeling Reply Statement at [14]-[21] (**CB1150-1151**).
[117] Adey-Wakeling Reply Statement at [22] (**CB1151-1152**); Morris Reply Statement at [11] (**CB415-416**).
[118] Adey-Wakeling Reply Statement at [23] (**CB1152**).
[119] See for example, Du Plessis Affidavit at [135] (**CB1249**).
[120] Adey-Wakeling Reply Statement at [14]-[24] (**CB1150-1153**); Morris Reply Statement at [11] (**CB415-416**).
[121] Adey-Wakeling Reply Statement at [24] (**CB1153**); Morris Reply Statement at [24] (**CB418-419**).
[122] Adey-Wakeling Reply Statement at [24], [31] and [58] (**CB1153,1155,1162**); Morris Reply Statement at [8], [16] and [20] (**CB414-417**).

exposing patients to a greater likelihood of relapse in the future);[123] and (3) shift healthcare costs from the PHI to the patient (e.g. for outpatient treatment) or to the public healthcare system.[124] These risks represent likely impairment to the community and society's aims.

Non-price terms imposed by the Template MPPA

95. The Authorisation Applicants contend that the nib BCPP is an example of a value based contracting model.[125] HH proposes to extend the nib BCPP model to Participants and other specialities and procedures, using a form of MPPA similar to the Template MPPA.[126] The extent to which the objects of the nib BCPP and the Template MPPA have been driven by HH's data analytics capabilities has not been explained by the Authorisation Applicants.

96. The key features of the Template MPPA are:

    a) [redacted];[127]

    b) terms which require specialists to follow nominated clinical guidelines.[128]

97. RMSANZ agrees with the Authorisation Applicants that clinical targets are commonly imposed on hospitals and medical specialists.[129] However, such targets:

    a) are not commonly accompanied by financial incentives or penalties;

    b) are mainly used for the purpose of hospital accreditation and benchmarking, rather than being used to influence the clinical decision-making of specialists;

    c) are most often related to specific clinician behaviours (e.g., handwashing); and

    d) rarely require clinical decisions to be made by specialists in respect of patient populations without regard to the individual characteristics of patients.[130]

98. The clinical targets contained in the Template MPPA appear to be arbitrary,[131] unjustified by a proper medical evidence base, and chosen by the Authorisation Applicants with the primary purpose of reducing the incidence of referral to inpatient rehabilitation following joint replacement surgery.[132] It can also be inferred that the targets have been driven by the need to reduce expenditure on this form of care.[133]

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[123] Morris Reply Statement at [20] (**CB417**).
[124] Annexure PM-1 to the Morris Reply Statement: Baggaley, 'Value-based healthcare in mental health services', *BJPsych Advances* (2020) at 199 (**CB422**).
[125] Du Plessis Affidavit at [133] (**CB1248**).
[126] Du Plessis Affidavit at [183], [263] (**CB1263,1282**).
[127] Template MPPA, subclauses 7.1(e) and (g): Annexure DD-62 to the Du Plessis Affidavit (**CB2986**).
[128] Template MPPA, clause 10.3: Annexure DD-62 to the Du Plessis Affidavit (**CB2988**).
[129] Du Plessis Affidavit at [262] (**CB1282**); Adey-Wakeling Reply Statement at [39] (**CB1158**).
[130] Adey-Wakeling Reply Statement at [40] (**CB1158**).
[131] Adey-Wakeling Reply Statement at [41]-[47] (**CB1158-1159**).
[132] Adey-Wakeling Reply Statement at [45] (**CB1159**)
[133] Adey-Wakeling Reply Statement at [38] (**CB1157**).

99. The effect of the targets is to restrict the decision making of clinicians (in the case of the nib BCPP, orthopaedic surgeons) in respect of their referral options. By limiting patient access to clinically appropriate care, such targets may risk patient outcomes and safety.[134] This represents a significant impairment of the social of good of providing proper and safe healthcare.

100. The Authorisation Applicants have contended that inpatient rehabilitation is a form of 'low value' care,[135] and that by incentivising referral of joint replacement patients to rehabilitation in the home, they are achieving better value care.[136] In support of this position, Mr Du Plessis (who is not medically trained) has not referred the Tribunal to any material that amounts to a determination by a properly constituted academic institute or better value health consortium.[137] Instead, in his affidavit, he has relied on a single a study that is the subject of medical and academic controversy.[138] This undermines the Authorisation Applicants' claim that the Proposed Conduct is concerned with improving patient outcomes.

101. RMSANZ also agrees with the Authorisation Applicants that clinical guidelines are a feature of medical practice.[139] However, standard guidelines are independently developed, supported by research, do not bind medical practitioners to certain courses of action, and are never applied in a 'one size fits all' manner.[140] The Template MPPA potentially requires specialists to adhere to guidelines that do not possess some or all of these characteristics. This also risks undermining the important social good involved in the provision of healthcare.

Interference with clinical independence

102. The inclusion of mandatory clinical targets and guidelines in the Template MPPA is unprecedented and threatens to severely curtail the clinical independence of specialists, notwithstanding legislative and contractual safeguards, as well as specialist obligations to act in the best interests of patients.

103. The Authorisation Applicants contend that the clinical independence of specialists is preserved by:[141]

    a) section 172-5(1) of the PHI Act, which requires that agreements between PHIs and medical practitioners do not limit medical practitioner clinical autonomy and independence; and

    b) terms of the Template MPPA which purport to preserve the ability of a specialist who is party to the agreement to act in accordance with their clinical judgement.

104. The Authorisation Applicants, beyond pointing to the existence of these formal limits on PHI interference with independence, have not engaged with how the Proposed Conduct, in substance, may 'influence practitioners to make decisions that are not in the best interests of their patients'.[142] Further, there is no obligation on Participants to maintain existing MPPAs and gap cover schemes following the expansion

[134] Adey-Wakeling Reply Statement at [46] (**CB1159**).
[135] Du Plessis Affidavit at [121]-[122] (**CB1244**).
[136] Du Plessis Affidavit at [133] (**CB1248**).
[137] Adey-Wakeling Reply Statement at [34] (**CB1155**)
[138] Annexure DD-29 to the DuPlessis Affidavit (**CB1681**). Adey-Wakeling Reply Statement at [34]-[36] (**CB1155-1156**).
[139] Adey-Wakeling Reply Statement at [49] (**CB1159**); Morris Reply Statement at [8.4] (**CB414**).
[140] Adey-Wakeling Reply Statement at [50] (**CB1159-1160**).
[141] Du Plessis Affidavit at [113]-[116] and [252]-[256] (**CB1242-1243,1280-1281**).
[142] Adey-Wakeling Reply Statement at [58] (**CB1162**).

of the BCPP. This may mean that specialists are forced to decide between charging patients out of pocket fees or joining the BCPP.[143]

105. The nib BCPP and Template MPPA contain the following features:

a) a specialist's remuneration for providing services pursuant to the Template MPPA is greater than if those services were provided pursuant to other funding arrangements (i.e., under another MPPA, a gap cover scheme or out of pocket arrangement);[144]

b) specialists who do not comply with the terms of the Template MPPA (including mandatory clinical targets and guidelines) will receive less remuneration than those who do;[145]

c) once a specialist has entered into the Template MPPA, they cannot opt to treat a Participant's policyholder pursuant to other funding arrangements; [146] and

d) the failure of a specialist to comply with clinical targets in the Template MPPA will lead to the termination of the agreement.[147]

106. The BCPP model also has attractive features for patients, provides certainty of income for specialists in respect of each service they provide and offers practitioners (particularly doctors without established practices) a large potential client base.[148]

107. Given the above matters, specialists are encouraged by the BCPP contracting model to adapt their clinical decision-making to comply with mandatory terms and guidelines in the agreement.[149] The Tribunal should be concerned to inquire into the *substantive effect* of the Proposed Conduct by looking at the above features of the Template MPPA that incentivise specialists and PHIs to breach statutory and contractual obligations.

Increased bargaining power resulting in inefficient outcomes in provision of health services

108. RMSANZ submits, for the reasons explained in the Siolis Report,[150] that the Proposed Conduct will likely result in more concentrated demand for medical specialist services (at both a national and State and Territory level). RMSANZ adopts Mr Siolis' conclusion that the inefficiencies generated by an increase in PHI market power are likely to 'push the market to a sub-optimal equilibrium where the price of medical specialist services is artificially low causing medical services to be under-provided and greater pressure placed on the public system'.[151]

109. Further, the risk of inappropriate models of care being instituted and the risk of interference with clinical independence are increased if the Proposed Conduct results in PHIs obtaining greater bargaining power

[143] Adey-Wakeling Reply Statement at [55] (**CB1161**).
[144] Du Plessis Affidavit at [260] (**CB1282**).
[145] Du Plessis Affidavit at [156] (**CB1256**).
[146] Khorshid statement at [43] (**CB3114**); Du Plessis Affidavit at [56] (**CB1230**).
[147] Du Plessis Affidavit at [260] (**CB1282**).
[148] Adey-Wakeling Reply Statement at [55] (**CB1161**).
[149] Adey-Wakeling Reply Statement at [58] (**CB1162**).
[150] Siolis Report at [30]-[36] (**CB3241-3242**).
[151] Siolis Report at [35] (**CB3242**).

over medical specialists. If the HH Buying Group obtains sufficient market power, its use of financial inducements or threats (referred to as 'levers'[152] by the Authorisation Applicants) to influence the nature of treatment that specialists provide may be difficult for many specialists and patients to resist – notwithstanding the formal obligations in place to preserve clinical independence.

110. This is particularly so given that the Authorisation Applicants seek authorisation for major PHIs to join the HH Buying Group in respect of the BCPP – in a future with the Proposed Conduct, medical specialists may have to negotiate with a buying group that consists of 100 per cent of PHIs. Concerns that the HH Buying Group might comprise 100 percent of PHIs in relation to medical specialist contracting were acknowledged by the Authorisation Applicants before the ACCC – see paragraphs 19 and 20 above in respect of the Revised Application and the Further Amended Application.[153]

111. A greater concentration in demand for medical specialist services may also embolden and/or increase pressure on other PHIs and buying groups to adopt the same levers. This possibility was acknowledged by the ACCC in its determination.[154]

112. Contrary to the conclusion of the ACCC,[155] the obligation on insurers under the PHI Act to pay at least 25 per cent of the applicable Schedule Fee to specialists is **not** an effective constraint on the market power of buying groups, nor does it increase specialists' relative market power. This is because as explained by Mr Siolis in his Report, this obligation "does not give providers any credible threats that could be leveraged when negotiating with PHIs… [as] charging MBS fees represents a loss (or foregone profit) for providers".[156] As outlined above at paragraph 30, most medical specialists charge a fee which is above the Schedule Fee.

DATE: 8 JULY 2022

P P Thiagarajan

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[152] See for example, Du Plessis Affidavit at [127] (**CB1246**).
[153] See also ACCC Determination at [4.106]-[4.108] (**CB132**).
[154] ACCC Determination at [4.159] (**CB137-138**).
[155] ACCC Determination at [4.161] (**CB137**).
[156] Siolis Report at [36] (**CB3242**).