NOTICE OF LODGMENT

AUSTRALIAN COMPETITION TRIBUNAL

This document was lodged electronically in the AUSTRALIAN COMPETITION TRIBUNAL and has been accepted for lodgment pursuant to the Practice Direction dated 3 April 2019. Filing details follow and important additional information about these are set out below.

Lodgment and Details

Document Lodged:	Application to Intervene
File Number:	ACT 4 of 2021
File Title:	APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Registry:	VICTORIA – AUSTRALIAN COMPETITION TRIBUNAL

REGISTRAR

Dated: 16/05/2022 1:21 PM

Important information

This Notice has been inserted as the first page of the document which has been accepted for electronic filing. It is now taken to be part of that document for the purposes of the proceeding in the Tribunal and contains important information for all parties to that proceeding. It must be included in the document served on each of those parties.

22/01

16 May 2022

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The Honourable Justice O'Bryan
Deputy President
Australian Competition Tribunal

By email: associate.obryanj@fedcourt.gov.au

Dear Justice O'Bryan

Re: Application by National Association of Practising Psychiatrists (NAPP) and Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ) (ACT 4 and 5 of 2021)

Pursuant to the directions made by the Tribunal on 11 May 2022, the AMA formally seeks leave to intervene in the above proceedings.

In support of its application for leave to intervene, the AMA relies upon its letter to the Tribunal of 6 May 2022, together with the submissions attached to this letter.

Yours sincerely

Dr Omar Khorshid
President

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IN THE AUSTRALIAN COMPETITION TRIBUNAL

File No:	ACT 4 of 2021
Re:	Application for Review of Authorisation AA1000542 Determination made on 21 September 2021
Applicant:	National Association of Practising Psychiatrists
AND	
File No:	ACT 5 of 2021
Re:	RMSANZ Application for Review of Authorisation AA1000542 Determination made on 21 September 2021
Applicant:	Rehabilitation Medicine Society of Australia and New Zealand Ltd

Submissions by the Australian Medical Association in support of its application for leave to intervene in the proceedings

Introduction

1. These submissions are made by the Australian Medical Association Ltd (**AMA**) in support of its application to intervene in these proceedings.

2. The AMA opposes the Authorisation Applicants' application for authorisation.

The AMA

3. The AMA is the peak professional body for doctors in Australia, advocating on behalf of doctors and the healthcare needs of patients and communities, as well as working with Federal and State governments to develop and influence health policy to provide the best outcomes for doctors, their patients, and the community.

Relevant legal principles

4. Section 109(2) of the *Competition and Consumer Act 2010* Cth (Act) provides that the "*Tribunal may, upon such conditions as it thinks fit, permit a person to intervene in proceedings before the Tribunal*".

5. Although the Tribunal's discretion in s 109(2) is not constrained by any express limitation,[1] it does not follow that in exercising its discretion, there are no limitations or restrictions on persons who wish to intervene or participate in reviews by the Tribunal.

6. The person wishing to intervene must demonstrate at least a connection with, or interest in, the subject matter of the proceeding.

7. While the person need not demonstrate that its business interests or activities would be affected by the subject matter of the proceeding, its interest must be something more than just that of an "*officious bystander*" whose interests are no more than those "*found in members of the general community*".[2]

8. Finally, the person must be capable of adding to, or supplementing – rather than simply repeating and duplicating – evidence led, and submissions made, by other parties to the proceeding.[3]

Application of the legal principles to the present circumstances

9. The conduct the subject of the authorisation application will, if authorised, have a direct and immediate impact on the commercial arrangements underpinning the provision of inpatient and day patient services by specialist medical practitioners in private and public hospitals in Australia.

10. As the peak lobby body representing the national medical profession, the AMA is best placed to address the potential implications of the proposed conduct across the medical profession.

11. The AMA is intimately familiar with the operation of the private health insurance regime, having been centrally involved in representing the views of its members in in the course of the development and introduction of the *Private Health Insurance Act 2007* (Cth) and the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (Cth), both Acts being central to the issues raised by the application for authorisation.

[1] *Re Fortescue Metals Group Ltd* [2006] ACompT 6 at [30]
[2] *Re Fortescue Metals Group Ltd* [2006] ACompT 6 at [35] and [43] (referred to by the Tribunal in *Application by New South Wales Minerals Council* [2021] ACompT 2 at [69]). In particular, Goldberg J held that it was not necessary for an applicant for intervention to "*go as far as to show that it may be affected in some way*".
[3] *Re Fortescue Metals Group Ltd* [2006] ACompT 6 at [54]; *Application by Independent Contractors Australia* [2015] ACompT 1 at [28]

12. Unlike the applicants, the AMA is also able to address the broader question raised by the authorisation application with respect to the participation of major private health insurers in the conduct sought to authorised.

13. For the reasons set out above, the AMA has an interest greater than that of an "officious bystander" and is able to add to, and supplement, and evidence led by the applicants.

14. This evidence is likely to include material in relation to:

    a. the structure of the differing markets (geographic and functional) likely to be affected by the proposed conduct;

    b. the appropriate weight attributable to the public benefits asserted by the authorisation applicants; and

    c. the role and importance of no gap and known gap arrangements between private health insurers and specialist medical practitioners; and

    d. the impact of major private health insurers participating in the proposed conduct.

15. Further, the applicants in each of the proceedings is unrepresented and, as such, is likely to be constrained in their ability to explore the complex questions of law and economics arising in the proceedings.

16. The AMA's involvement in the proceeding may also assist in defining the key issues for consideration by the Tribunal.

17. In the circumstances, the AMA respectfully requests that the Tribunal grant it permission to intervene in the proceedings.

Dated: 16 May 2022

D Preston

Owen Dixon West Chambers

20/124

6 May 2022

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Dear Justice O'Bryan

Re: Application by National Association of Practising Psychiatrists (NAPP) and Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ) (ACT 4 and 5 of 2021)

This letter is submitted to the Australian Competition Tribunal (**Tribunal**) with respect to the Tribunal's consideration of the two proceedings identified above.

We have provided a copy of this letter to all the parties and consent to it being placed on the Tribunal's website.

1. Why we are writing to you

The Australian Medical Association (**AMA**) is the peak body for medical practitioners in Australia. Our role is to represent all doctors across all practice areas and settings. We actively participated in the authorisation process and have been following the proceedings closely.

The AMA did not previously intervene on the basis that the matter was limited to two speciality groups (psychiatrists and rehabilitation specialists). It is now clear that nib and Honeysuckle Health (**HH**) intend to re-open the determination by the Australian Competition and Consumer Commission (**ACCC**) that:

(1) the authorisation should be limited to five years; and

(2) HH should not be authorised to offer the Broad Clinical Partners (**BCPP**) program to Bupa, Medibank Private, HCF and HBF (in WA) (**Major PHIs**).

The AMA made multiple submissions to the ACCC expressing concern at the level of market power that would flow from including the Major PHIs in the HH buying group and the significant public detriment that would result. We strongly agree with the conclusion reached by the ACCC (in its Final Determination):

> *"The ACCC considers that a BCPP that includes some or all of the Major PHIs is likely to result in public detriment by increasing bargaining power of the HH Buying Group regarding the BCPP to such an extent that it results in inefficient outcomes in the acquisition of health services from medical practitioners."*

Any dilution of the conditions proposed by the ACCC has wide ranging implications for all our members. We are concerned that these issues may not be adequately addressed by

the proceedings given the limited resources available to NAPP and RMSANZ.

The AMA is aware that time frame for intervention has expired. However, we understand that the ACCC and NAPP have both requested that the Tribunal provide an additional opportunity for third parties to intervene. **If this opportunity is made available, the AMA will submit an application to intervene.**

In the interim, this letter contains additional information about the operation of the Australian health care sector. In our view this information is relevant to the Tribunal's consideration of the matters raised in the proceedings. We have also identified some additional limitations that the Tribunal may wish to consider.

The AMA is available to provide further evidence on these matters should the Tribunal decide to give the AMA a further opportunity to intervene.

2. Executive summary

Agreements between medical practitioners and private health insurers (**PHIs**) are a key part of the market in which medical services are provided to patients obtaining treatment in hospitals (**medical services**). For the September 2021 quarter, over 92% of medical services involved a known gap or no gap agreement between the medical practitioner and the PHI.[1]

Under the legislative framework, PHIs must pay a default benefit of 25% of the Medical Benefits Schedule (**MBS**) fee where a covered patient obtains medical services (with the other 75% of the MBS fee paid by the Commonwealth). However, only a minority of medical services (less than 25%) are provided at or below the MBS fee. On average, for no gap and known gap agreements, PHIs pay an amount equal to approximately 64% of the MBS fee (with the 39% over the mandated amount reflecting the higher amounts paid by the PHIs pursuant to their commercial arrangements with specialists). Accordingly, in the AMA's view, these higher amounts – and the contracts underpinning them are important to both doctors and patients.

With the exception of diagnostic imaging and pathology, PHIs dictate to specialists the terms and the applicable fees that they may charge under either or both of no gap and/or known gap agreements. PHIs can change the fees and the terms at any time by publishing new information on their website. As illustrated by the extracts at **Annexure A**, these agreements impose significant obligations on practitioners.

In the AMA's view, any authorisation of the proposed conduct (even subject to conditions excluding the Major PHIs) is likely to increase the share of medical services ultimately contracted by members of the HH Buying Group. This will further increase HH's ability to set prices and contract terms under both no gap schemes (such as Medigap) and the BCPP. The AMA considers that it is likely that HH, on behalf of the Buying Group, will use its market power to limit above-MBS payments (i.e. no gap or known gap arrangements) to those doctors who agree to provide HH with patient data or agree to meet specified clinical outcome targets.

[1] See https://www.apra.gov.au/quarterly-private-health-insurance-statistics All references in this letter to the September 2021 quarter are to statistics derived from data available from this site.

We acknowledge that HH has proposed (at paragraph [95] of its SOFIC) that the authorisation be subject to the following conditions:

a. *nib will continue to offer the HH medical gap scheme to medical specialists who choose not to participate in the BCPP…*

b. *no contract negotiated with, or offered to, individual specialists (whether as part of BCPP or otherwise) will:*

   i. *require patients to be discharged to home treatment where the clinician's reasonable independent assessment is that in-patient treatment is in the patient's best interests;*

   ii. *require any specialist to have regard to any clinical or treatment guidelines formulated by any organisation other than a recognised specialist body representing that area of medical specialisation; or*

   iii. *otherwise, in the clinician's reasonable opinion, have the likely effect of interfering with the clinician's reasonable independent assessment of the ideal treatment of each patient*.

The AMA supports these conditions. However, in the AMA's view they do not go far enough. The AMA submits that nib and HH should also be:

- Prohibited from providing services to the Major PHIs (as per the ACCC Final Determination).

- Prohibited from including targets in any agreements covered by the authorisation;

- Required to explicitly acknowledge clinical autonomy in any agreements covered by the authorisation; and

- Required to continue to offer a no gap (or known gap) scheme that does not include financial or non-financial incentives or involve collection of patient data (beyond that required to verify claims) and at least maintains the real value (in dollar terms) of no gap or known gap schemes to ensure that practitioners are not subject to a form of economic coercion.

We also support the ACCC's original decision to limit the authorisation for five years. The PHI market is changing rapidly and there is likely to be significant changes during this period. HH's proposal (at paragraph [90] of its SOFIC] that the ACCC continue to monitor the situation and revoke the authorisation imposes considerable administrative costs on the ACCC and doctors. The onus should always be on HH and NIB to show why conduct that would otherwise be unlawful should be authorised.

2. Medical Practitioner Provider Agreements (MPPA)

Paragraph 1.24 of the Final Determination identifies four broad categories of contracting intended to be covered by the HH Buying Group. Categories (b) and (c) are:

(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 provided to their 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)

This suggests that there is a legal distinction between MPPAs (referred to in paragraph (b)) and medical gap schemes (referred to in paragraph (c)). This has not been the case since 2007.

MPPAs were first introduced by the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* (Cth). No gap and known gap schemes were introduced by the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (Cth). The 2000 legislation stated that it was intended to cover situations where there were there was no MPPA. However:

- Both arrangements were subject to extensive legislative requirements, including requirements for no gap and known gap schemes to be approved by the Minister.[2]

- Both arrangements were repealed by the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* (Cth). As part of this, the references to "gap cover scheme" and "medical purchaser-provider agreement" were removed from the *National Health Act 1953* (Cth) and the *Health Insurance Act 1973*.

- The only remaining reference to a "Medical-purchaser provider agreement" is in the heading to section 172.5(1) of the *Private Health Insurance Act 2007*. It provides that:

  *"If a private health insurer enters into an agreement with a *medical practitioner for the provision of treatment to persons insured by the insurer, the agreement must not limit the medical practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments."*

In other words, a MPPA is <u>any</u> agreement between a PHI and a medical practitioner, including known gap agreements or no gap agreements. It is not limited to bespoke arrangements such as BCPP. However, any BCPP arrangement is a form of MPPA.

3. Likely future with the Proposed Conduct – reliance on MBS safety net

The ACCC refers multiple times in the Final Determination to the 'safety net' offered by the requirement that PHI pay at least 25% of the MBS Fee, and the submissions by the authorisation applicants in support of this proposition:

> *"[The] obligation on insurers under the PHI Act to pay at least 25 per cent of the applicable MBS fee prevents PHIs from altogether refusing to fund treatments by healthcare providers."* (Page 3 and paragraph 4.161)

> *"[The] Applicants submitted 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 still be paid for their professional services through the combination of benefits paid by Medicare (75 per cent of the MBS fee for the service), benefits paid by the insurer (25 per cent of the MBS fee or more if the medical specialist participates in a*

[2] The legislation as it existed prior to the amendments is available from https://www.legislation.gov.au/Details/C2007C00156

medical gap scheme) and out-of-pocket expenses paid by the Customer (if any)" (paragraph 4.102)

The AMA considers that this conclusion is incorrect, and any submissions to that effect misleading, for two principal reasons.

(a) MBS fees are substantially below market rates. For the September 2021 quarter, only 24% of medical services covered by PHI were charged at or below the MBS rate (i.e., where PHI only paid 25% of the MBS amount). On average, medical fees were 157% of the MBS fee as prescribed in the MBS Schedule.

(b) Most doctors agree to a no gap or known gap arrangement with the PHI. For the September 2021 quarter, 84% of all medical services covered by PHI were provided under a 'no gap' agreement (i.e., the medical practitioner accepted the price set by the PHI). Another 8% involved known gap arrangements (i.e., where the medical practitioner charged no more than $500 above the price set by the PHI). In total, 92% of services were subject to a no or known gap agreement between the practitioner and the patient's PHI. Accordingly, the AMA submits that any suggestion to the effect that the MBS safety net would operate to counter any potential harm, simply fails to recognise the economic realities of the marketplace, which – in essence – require most specialists to provide medical services under an MPPA.

As detailed in **Table 1**, across no gap and known gap agreements, the average amount contributed by PHI is 64% of the MBS fee. Together with the patient contribution (around $12), the practitioner receives around 50% more under an MPPA than they would if they simply obtained the MBS fee.

	No gap and no agreement (5% of services)	No gap agreement (84% of services)	Known gap (8% of services)	All agreements (92% of services)	No agreement and a gap (3% of services)	All services
MBS (75%)	$66	$73	$123	$78	$186	$80
PHI	$22	$62	$116	$67	$70	$65
Patient	$0	$0	$131	$12	$442	$23
Total fee	**$88**	**$135**	**$370**	**$157**	**$698**	**$168**
MBS fee (100%)	$88	$98	$164	$104	$248	$107
Total fee as a percentage of MBS fee	100%	138%	226%	151%	281%	157%
PHI as a percentage of MBS fee	25%	63%	71%	64%	28%	61%

Table 1: Average fee components by agreement type for September quarter

4. Likely future with the Proposed Conduct – Further consolidation of PHIs

Since the ACCC's Final Determination, APRA has released operational data for 2020-21.[3] HCF, Medibank and nib have all increased their market shares. The orange shading in Table 2 indicates markets where one or more PHI controls over a third of the market.

	NSW/ ACT	VIC	QLD	WA	SA	TAS	NT	Total
Medibank	22.77%	31.09%	30.38%	21.86%	19.69%	25.22%	40.25%	**26.06%**
BUPA	21.98%	22.55%	30.26%	10.74%	45.46%	29.81%	34.81%	**24.19%**
HCF	20.69%	8.33%	9.11%	6.09%	10.12%	6.54%	7.22%	**12.56%**
NIB	15.20%	9.01%	7.13%	4.36%	4.53%	3.28%	3.59%	**9.74%**
HBF	0.79%	1.21%	0.79%	48.19%	0.50%	0.80%	1.55%	**6.78%**
Other funds	19.37%	29.02%	23.12%	8.76%	20.20%	35.15%	14.14%	**27.45%**

Table 2: Market share for 2020-21

Where one or more PHIs have a significant share in a geographic market, there is an even stronger economic incentive for practitioners to accept no or known gap agreements with that PHI. For example, our members have told us that it is not feasible to operate in South Australia market without an agreement in place with Bupa. This is evidenced by the very high proportion of known/ no gap services in South Australia (see Table 3):

	NSW	ACT	VIC	QLD	WA	SA	TAS	NT	AUST
No/ known gap agreement	89.3%	89.7%	91.9%	93.8%	95.1%	97.9%	96.5%	91.8%	92.3%
No agreement and a gap	3.3%	3.7%	2.6%	2.8%	2.8%	0.7%	1.4%	3.5%	2.7%

Table 3: Percentage of PHI eligible services provided on each basis in September quarter

Under the likely future with the proposed conduct there is likely to be a further consolidation in the PHI market. The ACCC assumed that at least some current members of AHSA will join the HH buying Group. Similarly, HH has assumed that some members of existing buying groups would joint the HH Buying Group; and that one or more Major PHIs would join the HH Buying Group [41]. It has also noted that it will differentiate itself from existing buying groups by offering "a combination of hospital and medical specialist contracting (whereas other buying groups focus primarily on hospital contracting)" [46].

nib is the only Major PHI that currently does not offer a known gap program.[4] AHSA offers a known gap scheme with a maximum gap of $500 ($800 for obstetrics). If PHIs that currently use the AHSA buying group shift to the HH buying group, this will reduce the number of PHIs that offer known gap schemes.

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3 https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

4 As discussed further below, HBF is phasing out its known gap program in WA. nib has also introduced a GapSure Anaesthetics network (known gap).

Further, the greater the market share of the Buying Group, the greater the potential economic pressure on practitioners to provide services under their MPPA, particularly where the value of no and known gap schemes is deliberately eroded by HH. A failure by the practitioner to sign up would be likely to require the patient to pay a much higher fee, leading to the patient switching practitioner (given that the practitioner would be unlikely to be prepared to accept the MBS schedule fee).

Under a worst-case scenario, HH could control directly (through nib) or indirectly (through buying group arrangements) hospital and practitioner contracts for all non-major PHIs. As illustrated by Table 4, this could amount to a third of the markets in NSW/ ACT, Victoria and Tasmania. In and of itself, this high degree of market concentration is unlikely to be in the best interests of consumers.

	NSW/ ACT	VIC	QLD	WA	SA	TAS	NT
Medibank	22.77%	31.09%	30.38%	21.86%	19.69%	25.22%	40.25%
BUPA	21.98%	22.55%	30.26%	10.74%	45.46%	29.81%	34.81%
HCF	20.69%	8.33%	9.11%	6.09%	10.12%	6.54%	7.22%
NIB plus balance	34.57%	38.03%	30.24%	13.11%	24.73%	38.43%	17.73%
HBF				48.19%			

Table 4: Market shares if the HH buying group increases to the maximum permitted by the Final Determination

5. Likely future with the Proposed Conduct – Power of PHIs to set prices and contract terms

As discussed above, over 90% of medical services funded by PHI are provided under known or no gap agreement between the medical practitioner and the PHI. The terms of these agreements are set by each PHI and can be changed by them at any time. Since 2007 they have not been regulated. Except for diagnostic imaging and pathology[5], PHIs generally apply the same terms and conditions apply across all service types. However, this is entirely controlled by the PHI. For example, on 1 March 2022 nib amended its no gap agreement (MediGap) to expressly exclude anaesthetists who participate in its GapSure Anaesthetics network (known gap).[6]

We have included at Annexure A, links to the "no gap" or "known gap" agreements for AHSA and all Major PHIs. It is apparent that:

- no gap and known gap agreements include significant terms and conditions; and
- PHIs have substantial market power in setting both the prices they pay (under known and no gap arrangements) and the terms and conditions under which they pay.

In some cases, these terms and conditions have clear competition implications. Patients

5 Diagnostic and imaging and pathology providers are typically part of corporate groups. These groups negotiate bespoke agreements with PHIs. In line with this, nib has specifically excluded pathologists from its Medigap agreement (see section 3).

6 We presume that this is so that these doctors cannot opt out for individual patients.

have a statutory right to change health funds without re-serving waiting periods.[7] However, for example, clause 22 of Medibank's standard agreement provides that:

> *"Providers agree they will not encourage or suggest to a Member to change his or her private health insurance and to become a policyholder of another private health insurer."*

Similarly, HCF's standard agreement provides that:

> *"You or any other person associated with You must not directly or indirectly coax, coerce, suggest, require or persuade any HCF Member or any member of another private health insurer to alter, switch or terminate their membership with their current private health insurer"*

HBF's terms contain a similar restriction:

> *"The Practitioner must not and must ensure that its practice manager, staff and other associated personnel do not incite, recommend or encourage patients to change health insurance funds."*

If a doctor breaches these terms (for example, by providing patients with a copy of a brochure issued by the Ombudsman explaining portability[8]), the PHI can terminate their participation in the no gap/ known gap scheme. The following table contains other illustrations of the power of PHIs to dictate contract terms:

PHI	Term
Nib	[nib/ HH] may suspend or cancel a provider's registration with MediGap [if they] determine, acting reasonably, that suspension is required to protect [their] interests or reputation. Providers must consent to their Practitioner Information being published on websites controlled by third parties. This includes publication via online healthcare provider directories. They must also consent to HH and nib sharing Practitioner Information with one another for the purpose of administering and managing the MediGap network Providers must comply with the nib Supplier Code of Conduct.
Medibank	Medibank may terminate a Provider if they have treated a member less favourably than [they treat] a patient who is the policyholder of another insurer, unless the Provider can satisfy Medibank as to the difference in treatment being appropriate in the particular circumstances. Medibank may terminate or suspend a Provider's participation in the GapCover scheme by providing her or him with 30 days' written notice.
Bupa	Bupa may [publish] moderated feedback about Providers on Bupa websites, digital applications ("Apps"), and Bupa approved third party websites or Apps. Bupa can terminate the agreement immediately if in Bupa's reasonable opinion, a provider's conduct "may adversely impact our brand, goodwill, reputation or business". Either you or Bupa may terminate your status as a Registered Scheme Provider at any time, without cause or reason, by giving 60 days' written notice to the other party.
HCF	You … indemnify HCF against any claims or liabilities whatsoever arising out of any negligence or wrongdoing on the part of You, or others acting on Your behalf, arising from or in connection with the provision of Professional Services for which benefits are paid …by HCF.

7 Section 78.1 of *Private Health Insurance Act 2007* (Cth).

8 https://www.ombudsman.gov.au/__data/assets/pdf_file/0020/29423/The-right-to-change_DL_Brochure_2019_digital-A1776084.pdf

PHI	Term
	You [must] notify Us immediately if a Professional Body … notifies You of any potential disciplinary action against You; You must not deal or act differently with HCF Members because they are covered by private health insurance or due to their membership with HCF. This includes, but is not limited to, charging HCF Members more than the standard fee that You set for Your service/s and product/s, or which is actually charged to people who are not HCF Members; You and Your Representatives [must] comply with any HCF policy relating to modern slavery; HCF can cancel or suspend Your registration as a Recognised Provider [if] you have engaged in conduct that is: in HCF's reasonable opinion, unsatisfactory as regards to billing; or adverse to the interests, business or reputation of HCF. Either party may terminate these terms without cause by giving 30 days' notice to the other party.
HBF[9]	This agreement will automatically terminate if in HBF's reasonable opinion, the Practitioner's conduct may adversely impact [HBF Members or] the goodwill, reputation or business of HBF at any time. Either HBF or the Practitioner may terminate this Agreement without cause by giving the other party 90 calendar days written notice. The Practitioner must ensure that HBF Members are treated as favourably as patients of other health funds. The Practitioner must not and must ensure that its practice manager, staff and other associated personnel do not: (i) enter into any conduct or activities that might reasonably be regarded as harming HBF, its name or reputation with patients; (ii) become involved in any situation which will bring HBF into disrepute, contempt, scandal or ridicule.

As discussed further below, unlike the other Major PHIs, HBF does not allow doctors based in WA to opt out of its no gap arrangement (Full Cover) for individual patients.

6. Likely future with the Proposed Conduct – Relevant market – Localised market for each specialty practice

Paragraph 4.6 of the Final Determination acknowledges that there is a localised market for medical specialists for each specialty practice. For example, there is a localised market for psychiatric services and a localised market for rehabilitation specialists. However, beyond this acknowledgement, the ACCC did not consider – or address in the Final Determination – how the authorisation will impact on different specialties or within localised markets.

The ability of different specialties to negotiate with patients and PHIs is evidenced by the contracting arrangements across different specialties and jurisdictions. For example, for the September quarter in the ACT, less than 2% of PHI eligible services for Urology: Subgroup T8.5, items 36500 – 37854 were charged at or below the MBS rate. The majority involved either a known gap agreement (38%) or no PHI agreement and a gap (38%). The

[9] This table is based on the new terms proposed by HBF (available from https://www.hbf.com.au/-/media/files/pdfs/provider-forms/medical/hbf16778-medical-gap-agreement-tcs.pdf). The equivalent provisions of its existing terms (https://www.hbf.com.au/-/media/files/pdfs/hbf14652-medical-gap-arrangement-terms--conditions.pd) are substantially the same.

remainder (22%) were no gap agreements. This suggests that urologists in the ACT have some capacity to negotiate higher rates with both PHIs and patients.

By contrast, the Authorisation Applicants have accepted that rehabilitation physicians and psychiatrists typically use no gap arrangements [33]. According to APRA the September 2021 quarter:

- For 88.4% of specialist, consultant physician, and consultant psychiatric attendances (Groups A3, A4 and A8; items 104-108, 110-131, 300-352) the doctor accepted the no gap amount set by the PHI.
- For 8.1% of these services the doctor charged the MBS fee
- Patients only paid a gap for 3.5% of these services.

The amount received by the doctor under a no gap arrangement varies depending on the PHI. For NIB, the rate for an Attendance by a consultant psychiatrist (MBS item 326) is $226. This is 16.5% above the MBS rate (of $194). The amount paid by other PHIs varies between $218 and $245.

If there is no agreement with the PHI, then the PHI is legally only required to pay default benefits (25% the MBS rate). In this scenario either:

- **Option 1:** the practitioner needs to agree to only charge the MBS rate. Depending on the PHI[10], the patient must pay the full amount and then submit claims to their PHI and MBS. (Under no gap agreements, the PHI handles all the administration.)

- **Option 2:** the patient needs to agree to pay the gap or find another psychiatrist. In some specialties, 'shopping around' is simply not possible due to workforce pressures. Psychiatry would be a good example. As noted in Table 1, the average gap payable by the patient where the PHI does not 'come to the party' is $442. By contrast, patients pay on average only $12 where there is a no gap or known gap agreement.

In other words, the doctor is 'between a rock and a hard place'. Unless they agree to the PHI's terms, either the doctor (Option 1) or the patient (Option 2) will be substantially out of pocket. This places significant economic pressure on providers to enter into no gap agreements with HH, regardless of how objectionable the terms of those agreements might be.

While, theoretically, practitioners could collectively bargain with PHIs, until recently (June 2021) this has required an ACCC authorisation.[11] Moreover, doctors are generally unwilling to 'strike' given the impacts on their patients. This is particularly true for patients who need psychiatric or rehabilitation services.

7. Likely future with the Proposed Conduct – Relevant market – Interaction between PHI, specialties and private hospital markets

[10] For example, Bupa's no gap/ known agreement provides that if a practitioner chooses not *"to accept the Scheme rates [the practitioner must] bill the Bupa customer directly. Bupa will pay the customer 25% of the MBS rate for eligible services."*

[11] https://www.accc.gov.au/public-registers/class-exemptions-register/collective-bargaining-class-exemption-0

It is also important to consider how the authorisation will impact on the interaction between PHIs, private hospitals and different specialties. This was not addressed by the ACCC in the Final Determination.

In 2020-21, around 64% of the PHI benefits for acute patients were paid to private hospitals, day hospital facilities and hospital substitutes. Only around 15.6% was for medical benefits. PHIs and government have been considering ways to reduce the expenditure on private hospital care, including a proposal to expand access to home and community based mental health and rehabilitation services under PHI. HH has emphasised in their submission [at 77 and 79] that:

> *"Rehabilitation in the home under the BCPP is provided as hospital substitution care or as part of a chronic disease management program, not as outpatient care, and accordingly can be fully funded by PHIs.*
>
> *The requirement to follow clinical guidelines in the template MPPA is expressly subject to the Provider's independence; and only for the purpose of nib administering the Fund and the payment of claims under the Fund: see cl 10.3 of the MPPA. This is to ensure that, if a Customer is eligible for a chronic disease management program or hospital substitution program, Providers comply with the clinical guidelines of those programs to enable nib to pay benefits in respect of the services."*

As psychiatry and rehabilitation services are predominately restorative, providers are, to varying extents, reliant upon upstream medical procedures and referrals from in-hospital procedures. For psychiatrists, 15% of all 'initial consultation new patient' items billed to the MBS took place inside the hospital according to AIHW, 'Expenditure on mental health-related services'. Both specialties also have patient populations that may spend days or weeks in hospital as part of their recovery. Accordingly, they are concerned that HH will use its market power to introduce contracts designed to reduce the amount of time spent by patients in private hospitals, including through the application of targets. The AMA does not believe that the current prohibition in section 172.5 of the *Private Health Insurance Act* is sufficiently robust to prevent this.

For psychiatry there is a risk that significant funding comes under the increasing control of insurers in the private system as their market power increases. According to AIHW, "Total spending on specialised mental health private hospital services was $805 million in 2019-20, and the **non-Commonwealth** sourced component of this **revenue was $584m**." Total MBS expenditure for all psychiatric services in and out of hospital of $389m in 2019-20. The Commonwealth component, $221m of mental health private hospital services (including MBS) shows that a significant share of total expenditure on psychiatrists is being directed through PHIs.

Unlike its MediGap program, nib does not publish its benefit schedule or contractual terms for BCPP. While nib has provided a copy of a sample agreement to the Tribunal and the parties, it can change this agreement in the future. For BCPP or any alternative program to be effective, it obviously needs to be more favourable to both parties than the PHI's no gap or known gap scheme. This could involve:

Benefits for providers	Payments above the standard benefits set out in the nib MediGap Schedule Easier administration for providers Promotion of the practitioner to nib's members
Benefits for PHIs	So that all nib can offer a no gap package to all its members, doctors agree to: 1) treat all nib's members under the scheme.[12]. 2) undertake surgeries at Honeysuckle Health's preferred private hospitals; and 3) refer patients to other providers (e.g., anaesthetists, and surgical assistants) who have also agreed to no gap arrangements with Honeysuckle Health.

The downside of point 1) is that if a patient requires more services than average (e.g., a high-risk patient), the doctor can either choose to lose money on that patient or refuse to accept them as a patient. If all the doctors in a geographical area have signed up for the scheme, high risk patients may not receive the benefit of their PHI. This increases profits for the PHI but undermines the value proposition for patients and increases the burden on public hospitals.

Points 2) and 3) may decrease gaps for patients in the short term but in the longer run they increase the market power of HH in both the provider market and the private hospital market. As part of this, HH may seek to reduce the fees paid by it under both no gap schemes and BCPP. This risk was also highlighted by the ACCC[13] in its Final Determination:

> (1) *medical specialists would face fewer alternative healthcare payers with whom to negotiate payments… As a result, [nib and HH] will likely have the ability to secure the agreement of medical specialists to participate in the BCPP for a lower payment premium over existing gap scheme payments than absent the Proposed Conduct…*
>
> (2) *if HH attracted a large enough group of specialists to participate in the BCPP, then HH buying group 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 BCPP and are unwilling to join it may raise their gap fees, but perform fewer procedures…*

The AMA agrees with this assessment and considers that HH will have every incentive to do this given that it operates on a for profit basis. A good example of this is the WA market. As noted in Table 2, WA is dominated by one insurer (HBF). Outside WA (where it has less market power), HBF uses the AHSA arrangement. The AHSA arrangement is a known gap arrangement and allows doctors to opt in and opt out for individual patients.

In WA, HBF currently offers a "Full Cover" (no gap) arrangement and "Opt in/ Opt Out Known Gap Cover".[14] Unlike MediGap (but like BCPP and presumably GapSure), doctors do not have the ability to opt in and opt out of Full Cover for individual patients. HBF is proposing to use its market power in WA to limit its known gap arrangement to existing participants.[15] Under this approach, if new entrants do not sign up to "Full Cover" (no gap)

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12 Currently doctors can opt out of Medigap 'no gap' arrangements on a patient-by-patient basis (Section 1)

13 Paragraph 4.112 of the Final Determination

14 https://www.hbf.com.au/-/media/files/pdfs/hbf14652-medical-gap-arrangement-terms--conditions.pd

15 The proposed new terms are at https://www.hbf.com.au/-/media/files/pdfs/provider-forms/medical/hbf16778-medical-gap-agreement-tcs.pdf

for all their HBF patients, HBF will only pay them 25% of the MBS fee.

8. Likely future with the Proposed Conduct – Additional and more onerous contractual terms: possible conflict with duty to patients

In addition to the risk highlighted above (of HH reducing fees), HH is likely to use its market power to impose additional contractual terms under both no gap schemes and BCPP. The three types of terms that are of particular concern to our members are:

Targets and financial incentives	As noted above, PHIs are focused on reducing the amount of time spend by patients in private hospitals. As part of this, they may include targets in their agreements. These may be combined with positive incentives (e.g., increased referrals, increased promotion to the PHI's members or higher financial benefits) or negative incentives (e.g., decreased referrals or termination of the agreement). For example, HH may agree to provide higher Benefits (as compared with its MediGap Schedule) to orthopaedic surgeons and psychiatrists who agree to contracts that place greater emphasis on recovery at home. Members are legitimately concerned that any such incentives: • are not transparent; • may give rise to an actual, potential or perceived conflict of interest between the financial interests of the doctor and the interests of the patient; and • may be contrary to the spirit of section 172.5 of the PHI Act. In particular, members are concerned that they will be penalised by PHIs for "failing" to achieve the PHI's targets. For example, it may be implicit that the agreement will not be renewed if the PHI's targets are not met. Patients quite rightly expect doctors to make decisions that are in the best decisions of their patients. They do not want their doctors to have regard to targets in private agreements with PHIs.
Third line forcing	PHIs may also seek to reduce costs by requiring (or encouraging) doctors to use third parties who are employed by, or have contracts with, the PHI. These could be other doctors (such anaesthetists or surgical assistants) or they could be other health providers (such as physiotherapists). Again, doctors who do not meet these requirements (including because they do not consider that they are clinically appropriate for a particular patient) may find that their contract is not renewed.
Collection of patient data	As highlighted in Annexure A, PHIs are already including provisions in their no / known gap agreements that allow them to request or require patient data. AHSA highlights in their agreement that doctors are responsible for obtaining patient consent to provision of this data. If HH includes targets in their agreements, it is also likely to require doctors to provide health information about individual patients, particularly where a doctor is not meeting targets. For example, HH will want to know why a doctor determined that none of their patients were suitable for at home care.

One way to reduce the risk of this type of 'term creep' would be to require that, as a condition of being allowed to collectively negotiate on behalf of its competitors, nib and HH be prohibited from including targets in any collective agreements. We also recommend that HH be required to acknowledge clinical autonomy in any collective agreements. This could be along the lines of section 1 of nib's Medigap agreement:

nib acknowledges the right of medical practitioners to exercise clinical independence at all times in

relation to the provision of medical services. nib will not interfere in the clinical relationship between medical practitioners and their patients.

HH has noted [95] that it would not oppose conditions that:

nib will continue to offer the HH medical gap scheme to medical specialists who choose not to participate in the BCPP and HH will continue to offer the HH medical gap scheme to all Participants

We also recommend that HH be required to continue to offer a no gap (or known gap scheme) that does not include targets, incentives or involve collection of patient data (beyond that required to verify claims) and at least maintains the real value (in dollar terms) of no gap or known gap schemes to ensure that practitioners are not subject to a form of economic coercion. As drafted, there is no guarantee that HH's no gap's scheme:

- will pay any minimum amount (beyond $1) above the MBS schedule fee; or
- will not include similar non-price terms to its no gap agreement (subject to the conditions proposed by HH [paragraph 95(b) of its SOFIC].

This could be addressed by requiring that HH offer a no gap scheme that is at least as favourable to doctors as its current no gap scheme. For example, it could be required to offer rates that are at least as high as the current rates (adjusted for inflation). Similarly, the non-price terms could be benchmarked against the current MediGap terms.

9. Additional comments on HH proposal

We also have a number of specific comments on HH's submissions:

Reference	Comment
23, 28, 29, 75ff	This is a description of the "current" MPPA. Subject to the proposed restrictions (in paragraph [95](b) of its SOFIC), HH is not limited by the terms of the MPPA provided to the ACCC.
23(c), 77	The involvement of Rehabilitation Physicians in decisions about the management of a patient's care can be critical for some patients. However, we agree with HH that it is accepted clinical practice for surgeons to determine, in collaboration with their patients, whether rehabilitation is required and whether it should occur in an inpatient setting. As a practical matter, as at 2016, there were only 170 rehabilitation specialists working in private practice across the whole of Australia.[16] During the same period there were 980 orthopaedic surgeons.[17]
59a	HH has described value-based contracting as including "encouraging Providers to provide and refer Customers to services that are proven to improve health outcomes for Customers". As noted above, HH may seek to reduce costs by "encouraging" doctors to

16 https://hwd.health.gov.au/resources/publications/factsheet-mdcl-rehabilitation-2016.pdf

17 https://hwd.health.gov.au/resources/publications/factsheet-mdcl-orthopaedic-surgery-2016.pdf

Reference	Comment
	use third parties who are employed by, or have contracts with, the PHI. These could be other doctors (such anaesthetists or surgical assistants) or they could be other health providers (such as physiotherapists). Doctors who do not meet these requirements (including because they do not consider that they are clinically appropriate for a particular patient) may find that their contract is not renewed.
63c	HH has suggested that the HH Buying Group will create administrative cost savings for Participants and Providers by "enabling Providers to introduce and establish new clinical practices efficiently by ensuring a sufficiently high volume of Customers are funded for the same care pathways". No evidence is provided for this claim, and it is difficult to see how HH could achieve this without impacting on clinical independence and patient choice. In short, HH appear to be saying that care pathways not approved by them will not be funded, whether or not they are established clinical practice.
69	HH has stated that: *"By increasing the level of direct value based contracting with medical specialists, the Proposed Conduct incentivises hospitals with strong bargaining power to compete on price… If hospitals are not price- competitive, they will risk losing medical specialists to better-value hospitals (where, under a value based contracting model, the medical specialists can achieve higher fees for providing better value care)."* It is not clear to us how this incentive would work unless HH is proposing to either: • provide higher fees (via BCPP) to doctors who opt to provide services in HH preferred hospitals; or • require doctors participating in BCPP to only provide services in HH preferred hospitals. In other words, it appears that HH wants to use BCPP to pressure hospitals into agreeing to HH's terms. If hospitals do not agree to HH's terms, they are likely to lose all procedures performed by BCPP contracted doctors. This may mean that patients are forced to go to hospitals that are out of area or do not have the most appropriate facilities for their condition.

Reference	Comment
29e, 30, 76b, 77c	HH has noted that its agreements will have broad no-fault termination rights. HH can use these rights – or simply decide not to renew the contract – to penalise specialists who do not meet targets. HH has expressly noted [at 77b] that "the targets are intended to ensure that the PHI and the relevant medical practitioner are aligned about what, if clinically appropriate, represents good value practice and, as with any contractual condition, PHIs may reconsider whether to continue the MPPA should a medical specialist not comply with the condition".
76b, 77c	HH has emphasised that "the clinical targets do not involve a financial incentive for medical practitioners in that under the current MPPA Providers are paid the same amount regardless of whether targets are met". However, HH has not made any commitment that future MPPAs will not include financial incentives.
78d	Any requirement on doctors to obtain a patient's informed consent to disclosure of their information must acknowledge that a patient may choose not to provide that consent (or may lack the capacity to do so). There may be no penalty to the doctor where this occurs.
80	As discussed above, this argument assumes that the specialist has market power and/or that the medical gap scheme pays a reasonable amount above the Schedule fee.
80d	As discussed above, Bupa does not provide any processing services where a doctor does not participate in their no gap or known gap scheme. It is up to the patient to submit claims to MBS and the PHI.
89ff	In our view, it is simply not possible for HH to demonstrate that the public benefits will continue to outweigh the public detriments in five years' time. While there may be administrative benefits to HH, the PHI market is changing rapidly and there is likely to be significant changes during this period. HH's proposal (at paragraph [90] of its SOFIC] that the ACCC continue to monitor the situation and revoke the authorisation imposes considerable administrative costs on the ACCC and doctors. The onus should always be on HH and NIB to show why conduct that would otherwise be unlawful should be authorised.

10. Conclusion

In conclusion:

- No gap and known gap schemes are a key part of the market for medical services in all jurisdictions and across all specialties.

- PHI already have substantial power to set the prices and contract terms for their no gap and known gap schemes.

- The authorisation is likely to increase the share of medical services contracted either directly or indirectly by HH. This will further increase HH's ability to set prices and contract terms under both no gap schemes (such as Medigap) and BCPP.

- While HH is prepared to agree to a requirement that it continue to offer a no-gap scheme [paragraph 95(a) of its SOFIC], HH may still use its market power to limit above MBS payments to those doctors who agree to provide it with patient data and/ or to meet PHI targets. This is contrary to the spirit of section 172.5 of the PHI Act (clinical independence) and may give rise to an actual, potential or perceived conflict of interest between the financial interests of the doctor and the interests of the patient

- The AMA submits that nib and HH should also be:

    - Prohibited from providing services to the Major PHIs (as per the ACCC Final Determination).

    - Prohibited from including targets in any agreements covered by the authorisation; and

    - Required to explicitly acknowledge clinical autonomy in any agreements covered by the authorisation.

- We also recommend that, as a condition of being allowed to offer the BCPP to its competitors, nib and HH must continue to offer a no gap (or known gap scheme) that does not include financial or non-financial incentives or involve collection of patient data (beyond that required to verify claims) and at least maintains the real value (in dollar terms) of no gap or known gap schemes to ensure that practitioners are not subject to a form of economic coercion.

Yours sincerely

Dr Omar Khorshid
President, AMA

Annexure A – Medical Practitioner Provider Agreements

PHI	Scheme type	Clinical independence	Collection of patient information	Collection and publication of provider information	Unusual terms
nib MediGap https://www.nib.com.au/docs/medigap-terms-and-conditions/ Administered by Honeysuckle Health on behalf of nib Providers must consent to Honeysuckle Health and nib sharing Practitioner Information with one another for the purpose of administering and managing the MediGap network (section 8)	No gap Doctors can opt out for individual patients (Section 1)	nib acknowledges the right of medical practitioners to exercise clinical independence at all times in relation to the provision of medical services. nib will not interfere in the clinical relationship between medical practitioners and their patients.	Should nib or Honeysuckle Health reasonably suspect a breach of these Terms and Conditions or inappropriate billing practices nib or Honeysuckle Health may contact you to understand our information in greater detail… if we require further clarification, it may be necessary for you to provide us with access to, or copies of, additional Records, as required, during the course of a more detailed audit. "Records" includes financial records, books of account, medical records and other documents and information which may be stored electronically or manually	You consent to Honeysuckle Health and nib collecting your information including: • information about how often you make a Claim through MediGap or charge the MBS Fee for Members including your Participation Rate; • average Gap charges (if any) for procedures performed by you during a certain period; • number of services provided to Members over a certain period; • your surgical partners (for example, anaesthetist) over a certain period; and • the name of the Hospitals in which you have provided services to Members over a certain period. Nib may disclose or publish, by any means, Practitioner Information to third parties, such as Members, consumers or referring doctors, including general practitioners or other specialists for the purpose of administering MediGap and to help Members and consumers find a practitioner who suits their needs, including who is more likely to participate in MediGap.	Pathologists are not eligible to participate in MediGap (Section 3) Anaesthetists are not eligible to participate if they are registered with the GapSure Anaesthetics network (section 2). Providers must consent to their Practitioner Information being published on websites controlled by third parties. This includes publication via online healthcare provider directories. (Section 8) Providers must obtain Informed Financial Consent from Members when using surgically implanted prosthetic devices which will result in the Member having an out-of-pocket expense. Members should also be advised if there are suitable alternate devices which could be fully covered. (Section 9). Providers must comply with the nib Supplier Code of Conduct (section 10), which is available from https://www.nib.com.au/docs/supplier-code-of-conduct nib can cancel participation in MediGap if a supplier does not comply with the terms and conditions (including the Code of Conduct). nib also may suspend or cancel a provider's registration with MediGap [if] nib determines, acting reasonably, that suspension is required to protect its interests or reputation (Section 11)
Medibank https://www.medibank.com.au/content/dam/retail/providers/gap-cover/Revised_Terms_and_Conditions.pdf https://www.medibank.com.au/content/dam/retail/providers/gap-cover/GapCover-booklet-2018.pdf	No gap and Known Gap (maximum of $500) Doctors can opt out for individual patients (clause 8)	You retain complete clinical independence	Medibank may make arrangements with a Provider from time to time in order to audit claims made by the Provider under the GapCover scheme. The Provider will assist Medibank in the conduct of any such audit.	A Provider who participates in the GapCover scheme may be publicly identified by Medibank (or by a third party, at Medibank's direction) as a 'GapCover Provider' or 'GapCover participant' or via a similar designation. This may occur through the publication of information (online or in other media) for the benefit of Members, consumers and referring doctors. This may include …information relating to charging and GapCover scheme participation. A Provider may elect to be excluded	21. **No disadvantage**. A Provider may be excluded by Medibank from being able to participate in the GapCover scheme if the Provider has treated a Member less favourably than she or he treats a patient who is the policyholder of another insurer, unless the Provider can satisfy Medibank as to the difference in treatment being appropriate in the particular circumstances. 22. **No solicitation**. Providers agree they will not encourage or suggest to a Member to change his or her private health insurance and to become a policyholder of another private health insurer. 24. **Prostheses**. A Provider who proposes to bill for professional services under the GapCover scheme and who proposes to recommend, as part of the provision of those

PHI	Scheme type	Clinical independence	Collection of patient information	Collection and publication of provider information	Unusual terms
				from publication. Medibank may also publish (or cause to be published) information and statistics relating to GapCover scheme claims	professional services, a gap permitted prosthesis or a prosthesis that is not listed in the Schedule to the Private Health Insurance (Prostheses) Rules to a Member agrees to discuss with the Member alternative no-gap prostheses and will obtain IFC from the Member to any out-of-pocket expense that the Member may incur in relation to a charge for the selected prosthesis.
Bupa Medical Gap Scheme https://www.bupa.com.au/-/media/Dotcom/Files/For-Provider/bupa-medical-scheme-terms-and-conditions-1-december-2021.pdf	No gap or known gap (maximum of $500) Doctors can opt out for individual patients (page 2)	Bupa acknowledges that Providers are to exercise their independent clinical judgement at all times in relation to the provision of services to eligible Bupa customers. Bupa will preserve Providers' professional freedom and will not interfere in the autonomous relationship between Providers and their patients. Bupa accepts no responsibility (other than paying benefits) for the medical treatment of customers	Bupa undertakes regular audits of customers and Providers to ensure that the Terms are adhered to. As a Scheme Provider you must, when we or our agents request, provide additional information for this purpose where it relates to a claim submitted under the Scheme.	Bupa may publicise or make available to Bupa customers or prospective customers, moderated feedback about Providers on Bupa websites, digital applications ("Apps"), and Bupa approved third party websites or Apps.	[If you choose] not to accept the Scheme rates … you must … bill the Bupa customer directly. Bupa will pay the customer 25% of the MBS rate for eligible services. We may also terminate this agreement and your status as a Registered Scheme Provider with immediate effect if … in Bupa's reasonable opinion, your conduct … may adversely impact our brand, goodwill, reputation or business.
HCF Medicover https://www.hcf.com.au/pdf/provider-portals/HCF_Medicover_Terms_and_Conditions.pdf	No gap or known gap (maximum $500) Doctors can opt out for individual patients (clause 3.2)	You can expect us to acknowledge Your freedom to identify and provide, within the scope of accepted clinical practice, the appropriate form of clinical treatment for HCF Members in Your care.	You [must] maintain a copy of all information, documents, records, working papers and other materials used, obtained or created in performing Professional Services for which HCF benefits are payable; and make any information, documents, records, working papers and other materials referred to above available to HCF on HCF's request.	We may identify You as a Medicover No Gap or Known Gap Recognised Provider to HCF Members and referring doctors and publish Your …charging and Medicover usage information by, including but not limited to, posting it on Our website or an affiliated website or in member communications.	(n) You [must] notify Us immediately if a Professional Body places or proposes to place any restrictions or limitations on Your registration with or membership of it or notifies You of any potential disciplinary action against You; (o) You must not deal or act differently with HCF Members because they are covered by private health insurance or due to their membership with HCF. This includes, but is not limited to, charging HCF Members more than the standard fee that You set for Your service/s and product/s or which is actually charged to people who are not HCF Members; (p) You or any other person associated with You must not directly or indirectly coax, coerce, suggest, require or persuade any HCF Member or any member of another private health insurer to alter, switch or terminate their membership with their current private health insurer; (u) You agree to indemnify HCF against any claims or liabilities whatsoever arising out of any negligence or wrong doing on the part of You, or others acting on Your behalf, arising from or in connection with the provision of Professional Services for which benefits are paid to You by HCF. 9.1. You and Your Representatives [must] comply with any HCF policy relating to modern slavery; 10.1.HCF can cancel or suspend Your registration as a Recognised Provider [if] you have engaged in conduct that

PHI	Scheme type	Clinical independence	Collection of patient information	Collection and publication of provider information	Unusual terms
					is: • such that HCF reasonably concludes the conduct would be unacceptable to the general body of providers in Your discipline; • in HCF's reasonable opinion, unsatisfactory as regards to billing; • adverse to the interests, business or reputation of HCF; or • in substantial non-compliance with requests made of You by HCF in connection with any HCF review of You.
AHSA Access Gap Cover https://www.ahsa.com.au/web/doctors/agc/billing_guide_terms_and_conditions HBF uses AHSA Access Gap Cover for services outside WA.	No gap or known gap (maximum $500 other than for obstetrics) Doctors can opt out for individual patients (clause 3.4)	Page 20 of the Billing Guide (FAQ) The autonomous relationship between you and your patients will not be affected in any way. The AHSA and participating funds acknowledge that you exercise your own clinical judgement at all times in the provision of services to your patients.	10 AHSA, the relevant Fund and/or their respective nominees may contact the Provider to request further information about a Claim. [The Provider must] promptly provide relevant information and grant access to relevant documents and records.	13.1 AHSA and each Fund may … collect information from the Provider's registration forms and other communications with AHSA and/or Funds (including information from Claims). [This includes] information (including past Claims data) relating to the charges rendered, services provided (including where a Provider operates and their surgical partners) and participation in the AGC scheme, 13.1.2 [AHSA may] disclose Provider Information and other information about the Provider to the public, including Fund Members and referring doctors, including for the purposes of … setting out information relating to the charges rendered, quality of service and statistical information relating to participation in the AGC scheme; and 13.1.3 [AHSA may] use Provider Information for internal statistical analysis.	14.1.2 The Provider warrants … that the Provider has obtained any necessary consents from the individuals whose Personal Information is being used or disclosed to provide that Personal Information to AHSA and for AHSA to use that Personal Information for AHSA Purposes. **AHSA Purposes** include… (c) AHSA using information from the Provider and other Medical Professionals who participate in the AGC scheme to populate its data warehouse, and drawing on the information to provide services to Funds and other persons; (d) AHSA negotiating with the Provider or other persons providing health services on behalf of one or more Funds; (e) AHSA analysing the markets for private health insurance and health services and reporting on this to, or on behalf of, one or more Funds…
HBF Full Cover scheme (WA only) The proposed new terms are available from: https://www.hbf.com.au/-/media/files/pdfs/provider-forms/medical/hbf16778-medical-gap-agreement-tcs.pdf The existing terms are available from: hbf14652-medical-gap-arrangement-terms--conditions.pd The terms in this table are substantially the same across both sets of terms.	No gap. No ability to opt out of Full Cover (no gap) for individual patients.	The terms and conditions of this Agreement must not interfere with the Practitioner's clinical decision making.	The Practitioner agrees to: (i) maintain appropriate copies of medical records, account and other records that relate to the provision of Services by the Practitioner to HBF Members; (ii) comply with any reasonable request by HBF: (A) to provide information in order to verify any claim …; or	in the event of any HBF concerns or where HBF needs to seek advice, share the Practitioner's claiming patterns and individual patient case studies (with patient information de-identified) with government bodies such as Medicare or industry bodies, including the AMA and specialist medical membership or peak bodies. Attachment 2 we may collect and use	

PHI	Scheme type	Clinical independence	Collection of patient information	Collection and publication of provider information	Unusual terms
			(B) for an audit of a Practitioners records in relation to HBF Members, including assisting HBF by: (C) providing further information in regard to claims; and (D) releasing information required for the review or processing of a claim in accordance with the authority signed by the Eligible Member on the National Private Patient Hospital Claim Form.	your personal information to: • conduct data analysis based on treatments performed and the associated fees and costs, and use results from our analysis of this data to measure trends, such as out of pocket (gap) expenses; • obtain and record feedback from our members on the service you provide and deal with complaints; HBF may disclose your personal information to persons or organisations such as: • other health funds and other service providers or other third parties who assist us in the prevention, detection and investigation of fraud; • our service providers (who may provide services directly to you or on our behalf) including mailhouses, persons conducting surveys and market research and claims administrators and other persons auditing or reviewing claims history or claiming patterns or providing IT support; • external consultants to review the claims history and claiming patterns of HBF members;	