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:	Submissions
File Number:	ACT 5 of 2021
File Title:	RMSANZ APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Registry:	VICTORIA – AUSTRALIAN COMPETITION TRIBUNAL

REGISTRAR

Dated: 15/07/2022 4:00 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.

COMMONWEALTH OF AUSTRALIA

Competition and Consumer Act 2010 (Cth)

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:	Application for Review of Authorisation AA1000542 Determination made on 21 September 2021
Applicant:	Rehabilitation Medicine Society of Australia and New Zealand Ltd

SUBMISSIONS OF THE AUSTRALIAN MEDICAL ASSOCIATION LTD (INTERVENER)

INTRODUCTION

1. These proceedings concern applications under s101 of the *Competition and Consumer Act 2010* (Cth) (**CCA**) by the National Association of Practising Psychiatrists (**NAPP**) and the Rehabilitation Medicine Society of Australia and New Zealand Ltd (**RMSANZ**) for review of a decision of the Australian Competition and Consumer Commission (**ACCC**) made pursuant to s88 of the CCA.

2. The ACCC conditionally authorised nib Health Funds Ltd (**nib**) and Honeysuckle Health Pty Ltd (**HH**) (together, the **Authorisation Applicants**) to form and operate a buying group (the **HH Buying Group**) to collectively negotiate and manage contracts with hospitals, medical specialists, and other healthcare providers on behalf of private health insurers (**PHIs**) and other healthcare payers.[1]

[1] ACCC Determination: Honeysuckle Health Buying Group (AA1000542) dated 21 September 2021 (**ACCC Determination**), [1.1].

3. The authorisation, limited to a term of five years, was conditional upon Medibank, Bupa, HCF and HBF in Western Australia (each a **Major PHI**) being excluded from participating in the HH Buying Group.[2]

4. In these proceedings, the Authorisation Applicants ask the Tribunal to affirm the ACCC's determination, but amend the authorisation so as to extend the authorised period to ten years and remove the condition excluding Major PHIs in respect of medical specialist contracting[3] – in essence, an unconditional authorisation of the conduct for which authorisation is sought.

5. Pursuant to s109(2) of the CCA, the Australian Medical Association Ltd (**AMA**) has been granted permission to intervene in the proceedings.[4]

6. The AMA submits that the HH Buying Group should not be authorised to engage in collective negotiation with medical specialists or with hospitals insofar as the negotiation relates to services provided by medical specialists in those hospitals.

7. The AMA submits that the Tribunal should:

   a. set aside the ACCC's determination and decline to authorise the conduct the subject of the application for authorisation; or

   b. alternatively, vary the ACCC's determination such that the authorisation is granted subject to conditions that:

      I. the Authorisation Applicants must not supply services to any Major PHI;

      II. the Authorisation Applicants, and other participants in the HH Buying Group, must not impose targets or other performance indicators, measured in quantitative terms, for treatment or outcomes for patients of medical specialists, in any agreements with hospitals or medical specialists;

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[2] ACCC Determination, [5.11], [6.1].

[3] Authorisation Applicants' Statement of Facts, Issues and Contentions dated 19 April 2022 (**Authorisation Applicants' SOFIC**), [85], [92].

[4] Under s 109(2), the Tribunal is entitled to permit intervention "upon such conditions as it thinks fit". The Tribunal imposed no such conditions on the participation of the AMA in these proceedings: *Re Honeysuckle Health Buying Group* [2022] ACompT 3, [8].

III. participants in the HH Buying Group must continue to offer opt-out "gap-cover" contracts to medical specialists (as an alternative to any collectively negotiated contract); and

IV. its term be limited to 5 years; or

c. alternatively, affirm the ACCC's conditional determination.

8. The AMA considers that the Proposed Conduct (described at paragraph 12 below) will involve the imposition of commercial terms on specialists which are likely to limit specialists' freedom to provide appropriate treatments to their patients.

9. The AMA has not put on evidence, and makes no submissions, in relation to contractual negotiations proposed to be undertaken by the HH Buying Group with hospitals more generally. However, to the extent that any contractual arrangements entered into between the HH Buying Group Participants and hospitals may have the effect of similarly limiting specialists' clinical independence, the AMA submits that such arrangements should be similarly proscribed or curtailed.

10. Accordingly, in the event the Tribunal proposes to conditionally authorise the Proposed Conduct insofar as it relates to collective negotiations with specialists, the AMA submits that Tribunal should impose such equivalent conditions in respect of contract negotiations with hospitals.

BACKGROUND

The AMA

11. 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.

The Proposed Conduct

12. The Authorisation Applicants propose to form the HH Buying Group and have HH provide services (including negotiating contracts and providing data analytic services) to the group's members, with the group's members to be comprised of:

a. nib and various other PHIs, for the purposes of:

   I. negotiating commercial terms with Australian hospitals; and

   II. negotiating terms with specialists involved in the provision of medical services defined as falling within a Broad Clinical Partners Program (**BCPP**) (discussed further below); and

b. nib and various other PHIs (but excluding the Major PHIs), for the purpose of negotiating commercial terms with individual medical specialists (other than those falling within the BCPP) with respect to the commercial basis on which each specialist would treat policyholders of each member of that buying group,

(the **Proposed Conduct**).

Australia's healthcare system

13. The Medicare Benefits Scheme (**MBS**) contains a schedule setting out the level of reimbursement that the Commonwealth will provide to patients for various medical and allied services provided to them out of a hospital setting (**Schedule**). Reimbursement under the Schedule may cover part or all of the patient's costs.[5] Most of the time, it covers only part of the patient's costs.[6]

14. Under the Australian public healthcare system, treatment provided to public patients in public hospitals and is fully funded by state/territory governments.[7]

15. The consumers in the private health system comprise PHIs (and their policyholders) and patients who pay their own way. Depending on the level of a policyholder's private health insurance, PHIs pay for the policyholder's in-patient and day care in private hospitals.

16. When a patient who holds private health insurance obtains a medical service which is listed on the Schedule, Medicare will reimburse the patient for 75% of the Schedule fee for that service, and the patient's PHI will reimburse the patient for the remaining 25%[8].

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[5] Statement of Omar Mohamed Khorshid dated 14 June 2022 (**Khorshid**), [15].

[6] Khorshid, [35].

[7] Khorshid, [31].

[8] Khorshid, [34]. The patient is only notionally reimbursed; in practice, in most cases the patient assigns their right to the Medicare-paid component to the medical specialist. The PHI pays its component directly to the medical specialist on behalf of the patient.

17. The overwhelming majority of medical services are provided at a rate above the Schedule fee and, for the majority of services, the Schedule fee represents a figure below the prevailing market rate for the relevant service (and well below what the AMA considers the appropriate rate for the service).[9]

18. The difference between the Schedule fee and the actual fee charged by the treating specialist is known as the "out of pocket" or "gap" amount. In most cases, PHIs cover all or part of the "gap" that remains and that, absent insurance, would otherwise fall to be paid by the patient.[10]

Private health insurance reimbursement

19. Since the introduction of the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* (Cth), PHIs have been permitted to enter into commercial agreements with specialists, under which the PHI can compensate the specialist in excess of the Schedule fee.[11] These agreements are known as Medical Purchaser Provider Agreements (**MPPAs**).

20. At the time, practitioners were concerned that the MPPAs might interfere with their clinical independence[12] and uptake of MPPAs was low.[13]

21. The *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (Cth) was subsequently introduced with the aim of enabling PHIs to provide private insurance to cover any "gap" that might exist between the Schedule fee and the fee actually charged to the patient.

22. These arrangements are known as "gap cover" arrangements, and are underpinned by various contractual arrangements, with the principal arrangement being that between the specialist and the PHI, under which the specialist agrees not to charge the patient more than an agreed amount,[14] in return for the PHI reimbursing the specialist for the difference between the 75% of the Schedule fee and the PHI's fee for that item.[15] This allowed PHIs to

[9] NAPP's Statement of Facts, Issues and Contentions dated 4 April 2022 (**NAPP SOFIC**), [27]; RMSANZ Statement of Facts, Issues and Contentions dated 4 April 2022 (**RMSANZ SOFIC**), [43].

[10] Khorshid, [36].

[11] NAPP SOFIC, [24]; RMSANZ SOFIC, [40].

[12] NAPP SOFIC, [35]; RMSANZ SOFIC, [54].

[13] Affidavit of David Malcolm Du Plessis affirmed 13 June 2022 (**Du Plessis**), [65].

[14] In the case of "no gap" agreements, the amount charged is fully reimbursed by the PHI and in the case of "known gap" agreements, a proportion of the gap is paid by the PHI and a proportion is paid by the patient.

[15] NAPP SOFIC, [24]; RMSANZ SOFIC, [40].

enter into arrangements with specialists through a registration process involving standard terms and conditions and avoided the need for individual contracts with specialists.[16]

23. One important feature of the gap cover agreements, which are ubiquitous,[17] is that they are generally opt out,[18] such that a specialist is permitted to decline to treat a patient under the gap cover agreement (in which case the patient is compelled to pay the gap). Where a specialist treats a patient outside the gap cover arrangement, the PHI's liability is limited to their 25% share of the Schedule fee.

24. nib currently utilises a form of MPPA for specialists who participate in its BCPP scheme. BCPP is designed to apply to all specialists involved in a given episode of care and participating specialists do not have the right to opt out of the arrangement.

25. Unlike the gap cover arrangements, the terms of the BCPP MPPA are not public.

Australian private health insurance landscape

26. There are 34 independent PHIs currently operating in Australia.[19] Together with nib and its related entities, the Major PHIs and their various related entities command approximately 72% of private health insurance policies nationally. However, market shares differ between each state and territory, ranging from a combined market share of 65% in Tasmania to 91% in Western Australia.[20]

27. Each of the Major PHIs currently manages contracting with healthcare providers internally, and nib's contracting function is managed by HH. The contracting function of all other PHIs is managed by one of two existing collective buying groups, the Australian Health Service Alliance (**AHSA**) and the Australian Regional Health Group (**ARHG**).[21] AHSA and ARHG engage in collective negotiations on behalf of their PHI members.

28. The Authorisation Applicants differentiate the services to be provided by HH to the HH Buying Group from those provided by AHSA and ARHG.[22] On the basis of this

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[16] Du Plessis, [66].
[17] NAPP SOFIC, [26]; RMSANZ SOFIC, [42].
[18] Du Plessis, [67].
[19] Du Plessis, [29].
[20] Khorshid, [72].
[21] AHSA represents 27 PHIs and ARHG represents 4 PHIs.
[22] Du Plessis, [198].

differentiation, the Authorisation Applicants anticipate attracting a proportion of the current members of AHSA and ARHG.[23]

APPLICABLE LEGAL PRINCIPLES

Overview

29. Applications for review under s101 are conducted as a hearing *de novo*,[24] and the Review Applicants do not need to show any error in the ACCC's determination;[25] rather, the Authorisation Applicants must satisfy the Tribunal that the conduct the subject of their application would result, or be likely to result, in a benefit to the public that would outweigh the detriment to the public that would result, or be likely to result, from the conduct.[26]

30. Section 88 of the CCA provides that:

> *Subject to this Part, the Commission may, on an application by a person, grant an authorisation to a person to engage in conduct, specified in the authorisation, to which one of the provisions of Part IV specified in the authorisation would or might apply.*

31. Section 90(7) of the CCA relevantly provides that:

> *The Commission must not make a determination granting an authorisation under section 88 in relation to conduct unless the Commission is satisfied in all the circumstances:*
>
> …
>
> *(b) that:*
>
> *(i) the conduct would result, or be likely to result, in a benefit to the public; and*
>
> *(ii) the benefit would outweigh the detriment to the public that would result, or be likely to result, from the conduct.*
>
> (***net public benefit test***)

32. In all cases, the Tribunal must be able to define the conduct for which authorisation is sought with a degree of precision or certainty.[27]

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[23] Du Plessis, [177], [207].

[24] CCA, s101(2).

[25] *Application by Medicines Australia Inc* [2007] ACompT 4; (2007) ATPR 42-164 (***Medicines Australia***), [138].

[26] CCA, s90(7)(b).

[27] *Application by Flexigroup Ltd (No 2)* [2020] ACompT 2 (***Flexigroup***), [403]-[406]. This mirrors similar 'soft' requirements imposed by the ACCC in its *Guidelines for Authorisation of Conduct* (see [3.1.1]).

33. The net public benefit test requires the Tribunal to "…examine on one hand the anti-competitive aspects of the conduct … and on the other hand the public benefits arising from it and weigh the two".[28]

34. In assessing relevant public benefits and detriments, the Tribunal must only take into account those benefits and detriments for which it considers there is "a real chance, and not a mere possibility, of the benefit or detriment eventuating".[29]

35. Benefits or detriments that are "speculative or a theoretical possibility" will not be enough,[30] and while precise quantification of the relevant benefits or detriments is not required, "there must be a factual basis for concluding that the public benefits are likely to result".[31]

36. The person seeking authorisation of conduct must define the nature of the public benefits said to result from the conduct "with some precision, a degree of precision which lies somewhere between quantification in numerical terms at one end of the spectrum and general statements about possible or likely benefits at the other end of the spectrum".[32]

37. The power conferred by s 88 is discretionary: it exists only when the necessary pre-conditions (here, the net public benefit test) are satisfied, but satisfaction of the necessary pre-conditions does not require that the discretion be exercised by granting authorisation.[33] Even though authorisation will ordinarily be granted upon satisfaction of the necessary preconditions,[34] there remains a discretion to refuse authorisation even where the relevant test is satisfied.[35] Such a discretion might be exercised against the grant of authorisation in circumstances where the proposed conduct meets the statutory test but nevertheless fails to yield some substantial measure of public benefit sufficient to attract the ACCC's (or the Tribunal's) official sanction.[36]

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[28] *Re 7-Eleven Stores Pty Ltd* [1994] ATPR 41-357 (***Re 7-Eleven Stores***), 42,654. See also *Qantas Airways Limited* [2004] ACompT 9; (2005) ATPR 42-065 (***Qantas Airways***), [149].

[29] *Qantas Airways*, [156]; cited with approval by the Tribunal in *Application for Authorisation of Acquisition of Macquarie Generation by AGL Energy Limited* [2014] ACompT 1, [164].

[30] *Qantas Airways*, [156]; *Medicines Australia*, [109]; *Application by Port of Newcastle Operations Pty Ltd (No 2)* [2022] ACompT1 (***PNO***), [56]-[60].

[31] *Qantas Airways*, [188].

[32] *Qantas Airways*, [204]; cited with approval in *PNO*, [34]-[35].

[33] *Medicines Australia*, [106].

[34] *Flexigroup*, [138].

[35] *Medicines Australia*, [122]-[128].

[36] *Medicines Australia,* [128]. See also *PNO*, [38]-[40].

Future with and without

38. In identifying and weighing the relevant benefits and detriments associated with the conduct for which authorisation is sought, a comparison between the hypothetical futures with the proposed conduct (the factual) and without the proposed conduct (the counter-factual) is carried out.[37] Consideration of and comparison between the factual and counter-factual allows assessment of the nature and scale of relevant benefits and detriments, the likelihood of their occurrence, and the extent to which they genuinely flow from the proposed conduct (or, to the contrary, would occur irrespective of the proposed conduct).[38]

39. In this case, the AMA submits that the factual involves a future where:

    a. the HH Buying Group collectively negotiates contracts with hospitals, medical specialists, and other healthcare providers on behalf of PHIs and other healthcare payers;

    b. those contracts will offer specialists a level of remuneration that is higher than that offered to them under existing gap cover arrangements;

    c. a large proportion of specialists will be commercially compelled to enter into these arrangements;

    d. non-price terms will be included in the proposed agreements, including clinical performance targets and requirements to adhere to clinical guidelines determined by the relevant PHI;

    e. non-compliance with the non-price terms will have financial consequences, in the sense that the agreement could be terminated; and

    f. the imposition and enforcement of the non-price terms will directly affect medical specialists' clinical independence, with the real chance that patient outcomes will be adversely affected.

40. In the alternative, the AMA submits that the counterfactual involves the maintenance of the status quo in which, relevantly:

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[37] *Medicines Australia*, [117]; *Flexigroup*, [137]; *PNO*, [26].
[38] *Medicines Australia*, [118]-[120].

a. nib does not collectively negotiate with any other PHI with respect to MPPA arrangements or more generally;

b. none of the Major PHIs collectively negotiate with each other or any other PHI;

c. non-price terms involving clinical targets or clinical guidelines unilaterally determined by PHIs do *not* form part of the commercial arrangements between PHIs and specialists; and

d. medical specialists' clinical independence remains unfettered, allowing medical specialists to determine, together with their patient, the most appropriate treatment for each patient, having regard to the patient's particular circumstances.

Conditions of authorisation

41. Authorisations may be expressed to be subject to conditions such that the authorisation is not effective unless the condition is satisfied. Such conditions may be conditions precedent (things that must be done before the authorisation comes into effect) or continuing conditions (things that must be done, either continuously or from time to time, in order for the authorisation to continue).[39]

42. A condition may be imposed to reduce a public detriment or increase a public benefit associated with the proposed conduct such that, with the benefit of the condition, the net public benefit set is satisfied; or increase or decrease the likelihood of the occurrence of a public benefit or public detriment respectively so as to satisfy the net public benefit test.[40] Although the kinds of conditions that may be imposed is not expressly limited, the power to impose conditions is limited by the subject matter, scope and purpose of the CCA and the statutory context in which it appears.[41]

43. On review, the Tribunal is entitled to have regard to conditions imposed by the ACCC, and any alternative conditions proposed by parties to the Tribunal proceeding, and decide whether such conditions are necessary or appropriate. The Tribunal may also conceive of its own condition(s) to be imposed subject to the implied limitation on the power referred to above, and subject to hearing the parties on the practical implications of its imposition.[42]

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[39] *Medicines Australia*, [132].

[40] *Medicines Australia*, [133].

[41] *Medicines Australia*, [126], [129]; *Water Conservation and Irrigation Commission (NSW) v Browning* (1947) 74 CLR 492, 505; *Oshlack v Richmond River Council* (1998) 193 CLR 72, 84.

[42] *Medicines Australia*, [139].

THE PROPOSED CONDUCT IS TOO UNCERTAIN

44. The AMA submits that the formulation of the Proposed Conduct means that the Tribunal is not able to properly apply the net public benefits test and undertake the necessary analysis.

45. The AMA submits that it is implicit from the proposition that the person seeking authorisation need to define the nature of the associated public benefits "with some precision",[43] that the spectrum of conduct likely to be undertaken pursuant to the authorisation must also be capable of being defined with similar precision.

46. The Proposed Conduct is framed by reference to the collective negotiation of price and non-price terms with private hospitals and individual medical specialists. But although the Authorisation Applicants have produced a copy of their template BCPP MPPA and suggested that future commercial contracts to be jointly negotiated will rely on that arrangement as a "base agreement",[44] they are not compelled to adhere to the terms of that agreement (and neither do they commit to do so).

47. Even *if* the Tribunal concludes that the collective negotiation of agreements strictly consistent with the BCPP MPPA satisfies the net public benefit test, it is submitted that the Tribunal cannot similarly be satisfied with respect to the Proposed Conduct, as defined in the application for authorisation, which does not, or does not adequately, constrain the extent to which the Authorisation Applicants may depart from the terms of the BCPP MPPA in future agreements to be offered to specialists as part of an expanded BCPP, the terms of which are yet to be determined.

48. PHIs unilaterally change the governing terms for their existing gap cover agreements from time to time,[45] and there is no basis upon which the Tribunal can be confident as to the non-price terms – and the effect of those terms – which might be included in the future. This uncertainty is reflected in HH's evidence to the effect that it will replace the current nib gap cover terms and conditions with new terms and conditions if the Proposed Conduct is authorised.[46]

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[43] *Qantas Airways*, [204]; cited with approval in *PNO*, [34]-[35].

[44] Du Plessis, [183(a)], [226].

[45] Khorshid, [54].

[46] Du Plessis, [189].

49. Notwithstanding this submission, for the reasons addressed below, the AMA submits that insofar as the Proposed Conduct is limited to the terms of BCPP MPPA, it would still fail to satisfy the net public benefit test.

CLAIMED PUBLIC BENEFITS ARE OVERSTATED OR UNLIKELY

Addition of HH Buying Group unlikely to materially increase competitive tension

50. The Authorisation Applicants assert that the HH Buying Group, once formed, will provide PHIs with an alternative to the offerings of the existing buying groups (AHSA and ARHG),[47] and that it will result in "a significant improvement" in competitive tension in the market for health provider contracting services. It is said that this will "encourage each buying group to increase efficiencies, lower fees and innovate so as to offer better value and attract or retain members". The Authorisation Applicants rely on the expert report of Greg Houston, who states:

> *The increase in competition will put pressure on the incumbent buying groups to lower their prices for health provider contracting services and/or to innovate to attract and retain PHIs, leading to greater efficiency and an increase in surplus. Put another way, greater competition will result in an increase in the quality of health provider contracting services (ie, quality of output), and put downward pressure on the price of health provider contracting services.*[48]

51. The AMA disagrees and submits that a third buying group is unlikely result in any material improvement in competition in that market.

52. Rather, in circumstances where all non-Major PHIs are already members of one of the two existing buying groups (such that any non-Major PHIs choosing to join the HH Buying Group will likely cease their membership of either AHSA or ARHG), the AMA submits that it is more likely that no *additional* benefits will result.

53. Instead, it is likely that existing benefits (that already accrue as a result of the collective negotiations carried out by the existing two buying groups) will either be spread across three buying groups, thus diluting those existing benefits,[49] or that migration of "a number of (and potentially all)"[50] PHIs from existing buying groups to the HH Buying Group will result in the

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[47] Du Plessis, [198]-[210].

[48] Expert Report of Greg Houston dated 14 June 2022 (**Houston**), [131].

[49] AHSA Submission to the ACCC dated 12 February 2021, [37].

[50] Siolis, [28].

collapse of one of either AHSA or ARHG, resulting in no material improvement in competition in that market that is "of a more lasting nature".[51]

54. Moreover, quite apart from improving competitive tension in that market, the addition of an additional buying group may in fact have the effect of reducing the competitive pressure that non-Major PHIs, through a buying group, exert on Major PHIs (who do not currently participate in either of AHSA or ARHG). In this respect, the AMA's economic expert observes that:

> *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. For example, according to the mechanism detailed in sub-section 3.3, the competitive presence of the smaller PHIs may prevent the Major PHIs from adopting a value-based contracting model.*[52]

Passthrough of savings and efficiencies to policyholders not likely

55. The Authorisation Applicants contend that the Proposed Conduct will result in savings and efficiencies that will be passed through to patients and policyholders in the form of lower premiums.[53]

56. Even if the Tribunal accepts that savings and efficiencies are likely to occur more generally,[54] the AMA submits that any suggestion that any savings enjoyed by participating PHIs will be passed through to consumers is speculative and fails to rise above the level of "general statements" about possible benefits.[55]

57. The AMA submits that that there is no basis for concluding that any savings achieved by the PHIs as a result of their participation in the HH Buying Group will be passed on to consumers.

58. The Authorisation Applicants rely upon their economic expert to support their assertion as to the likelihood of the passthrough of any savings. However, this assertion similarly relies on

[51] *Application by Sea Swift Pty Limited* [2016] ACompT 9, [46].

[52] Siolis, [62].

[53] Du Plessis, [120], [131]-[132].

[54] Siolis considers that reduced transaction costs for PHIs *cannot* be considered to be benefits generated by the Proposed Conduct because in the hypothetical world without the conduct, PHIs will continue to derive transaction cost savings through their ongoing participation in either AHSA or ARHG: Siolis, [61].

[55] *Qantas Airways* [204]; cited with approval in *PNO*, [34]-[35].

presumptions as to the competitiveness of the market for the provision of private health insurance, rather than any analysis of market dynamics to support that conclusion.[56]

59. The AMA acknowledges that public benefits are to be assessed on a "total welfare" or "total surplus" approach[57] meaning that any reduction in costs or improvement in efficiency – no matter to whom it accrues – may be recognised as a public benefit. However, the AMA submits that the Tribunal should be cautious about accepting the Authorisation Applicants' assertions in relation to the likelihood of the delivery of reduced private health insurance premiums and the weight of any public benefit attributable to financial savings alleged to arise from the Proposed Conduct.

Proposed Conduct will not improve access to "no gap" experiences

60. The Authorisation Applicants contend that the Proposed Conduct will provide a better no gap experience for customers,[58] although the Authorisation Applicants acknowledge that this will not offer a financial benefit to consumers in specialist areas where the patients already generally experience no gap cover (such as psychiatry and rehabilitation medicine).[59]

61. Equally, the Authorisation Applicants have not addressed the extent to which exposure to gap payments is the result of specialists opting out of gap cover agreements, as opposed to consumers failing to take out an adequate level of insurance.[60]

62. Of all covered services supplied to holders of private health insurance policies in the first quarter of 2022, only 11% involved the charging of a gap (and of those, 3% were supplied in circumstances where the specialist either had no gap cover arrangement or opted out of the arrangement.[61]

63. Although precise quantification is not required,[62] in circumstances where the vast majority of medical services already enjoy a no gap experience, the Authorisation Applicants have failed to quantify the source and magnitude of the benefit claimed.[63]

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[56] Houston, [138]-[140].
[57] *Qantas Airways*, [166]-[191].
[58] Reply Statement of Zoe Adey-Wakeling dated 28 June 2022 (**Adey-Wakeling Reply**), [45].
[59] Authorisation Applicants' SOFIC, [58]; Statement of Gary Alexander Galambos dated 13 May 2022 (**Galambos**), [28].
[60] Submission to the ACCC by the Council of Procedural Specialists dated 15 February 2021 (**COPS Submission**), [3.25].
[61] Khorshid, [45] and Table 1.
[62] *Qantas Airways*, [188].
[63] Siolis, [63].

64. Accordingly, the Tribunal cannot be confident as to the extent to which the Proposed Conduct is likely to result in any greater availability of a no gap experience.

PUBLIC DETRIMENTS ARE MATERIAL AND OUTWEIGH ANY BENEFITS

Specialists will be compelled to accept the terms offered by the HH Buying Group

65. Gap cover arrangements between specialists and PHIs are ubiquitous, enabling PHIs to offer no gap or known gap policies to consumers.[64] Based on AMA analysis, 92% of services provided by specialists are provided under either a no gap or known gap arrangement,[65] although this is as high as 97% in some specialties, such as colorectal surgical operations.[66]

66. The arrangements are particularly attractive to specialists, as it enables them to earn fees in excess of the Schedule fees, in circumstances where the Schedule fees are uneconomic,[67] and well below those rates that the AMA considers reflect fair value for service.[68] The AMA estimates that specialists generally receive around 50% more than the Schedule fee under a gap arrangement.[69]

67. In the absence of a commercial arrangement with a PHI under which a margin is earned by the specialist over and above the Schedule fee, it is likely that many specialists will charge the gap to the patient for inpatient services or,[70] where optional (such as for psychiatrists) reduce in-patient work.[71] In these cases, this will reduce the number of specialists available to treat patients, increase the strain on the public hospital system and shift the costs from the PHIs to the patients, who will need to obtain specialists services in an out-patients environment, where the fees are not covered by the PHI.

68. In the case of psychiatry, close to 100% of psychiatrists utilise no gap arrangements, in order to prevent their patients from facing financial stress.[72]

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64 NAPP SOFIC, [26]; RMSANZ SOFIC, [42].
65 Khorshid, [45] and Table 1.
66 Khorshid, [49] and Table 2.
67 Statement of Philip Leo Patrick Morris dated 10 May 2022 (**Morris**), [28].
68 NAPP SOFIC, [27]; RMSANZ SOFIC, [43].
69 Khorshid, [46].
70 Statement of Peter Sumich dated 13 May 2022 (**Sumich**), [36].
71 Sumich, [35].
72 Galambos, [28].

69. Gap cover agreements are provided with standard form contracts, offered on a "take it or leave it" basis. There is no negotiation in relation to those agreements and there is no reason to expect that the HH Buying Group will operate any differently.[73]

70. As a result, the practical reality is that specialists have little option – either having regard to their own commercial interests or the interests of their patients – but to accept the commercial terms offered by PHIs, particularly when starting out in their careers.[74]

71. There is no statutory obligation on PHIs to offer gap cover arrangements. While the Authorisation Applicants assert that PHIs will retain their existing gap cover policies,[75] they cannot know what participating PHIs will, or will not do.

72. Further, there is no reason to prevent the HH Buying Group (or participating PHIs independently) reducing the value of compensation offered under their gap cover agreements, so as to effectively compel the specialists to enter into the proffered MPPA.

The template MPPA compromises clinical independence

73. While clinical targets are currently imposed on specialists, these are mainly used for hospital accreditation and benchmarking, and not in respect of clinical decision making.[76] Contracts between PHIs and specialists do not commonly include clinical targets or clinical guidelines formulated by PHIs.[77]

74. The template BCPP MPPA imposes targets in relation to overnight admissions and rehabilitation at home.[78]

75. In the AMA's submission, it is inappropriate for any clinical targets to be formulated across a patient population without appropriate regard being had to the individual characteristics of the patient.

76. No evidence is provided by the Authorisation Applicants to substantiate the appropriateness of such targets, and the targets appear to be arbitrary and to have been chosen with the primary purpose of reducing the incidence of overnight admissions and referrals to inpatient

[73] COPS Submission, [1.13].
[74] Adey-Wakeling Reply, [55.3].
[75] Authorisation Applicants' SOFIC, [25].
[76] Adey-Wakeling Reply, [40.2].
[77] Statement of Zoe Adey-Wakeling dated 16 May 2022 (**Adey-Wakeling**), [35].
[78] See template BCPP MPPA, clauses 7.1(e) and (f).

rehabilitation following joint replacement surgery.[79] Any homogenisation of treatment via the use of generalised targets fails to reflect clinical realities and may be dangerous for patients.[80]

77. Similar concerns arise in the context of the use of guidelines formulated by nib or HH.

78. Under the template BCPP MPPA, specialists are obliged to follow clinical guidelines as reasonably required by nib from time to time.[81] This is notwithstanding the fact that nib accepts that it is not a health professional or practice.

79. Any clinical guidelines that relate to the clinical treatment of patients must reflect professional and peer input. No detail is provided as to how such guidelines are to be formulated, and this risks imposing obligations on specialists that may be contrary to the appropriate treatment of individual patients.

80. In the AMA's submission, the assertion by nib that, notwithstanding the obligations with respect to targets and guidelines obligation, it does not intend to trammel the specialist's clinical independence, does no more than pay lip service to their statutory obligations under the *Private Health Insurance Act 2007* (Cth) (**PHIA**).[82]

81. On the contrary, it is the AMA's submission that the linking of the benefits provided under the BCPP MPPA to compliance with clinical targets and guidelines in circumstances where specialists are effectively compelled to enter into these commercial arrangements, is likely to limit the specialists' professional freedom, thereby potentially contravening the PHIA.

82. In these circumstances, the AMA submits that the target and guideline obligations give rise to a significant public detriment and that this remains the case, even if the clauses of the template BCPP MPPA agreement do not strictly contravene the PHIA.

Increased market concentration

83. Even where the Major PHIs are excluded from the HH Buying Group, it is still possible that the HH Buying Group could constitute the largest commercial counterparty for specialists. For example, in NSW nib and other smaller funds account for ~35% of the market.[83]

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[79] Adey-Wakeling Reply, [40.2].

[80] Morris, [35]; Adey-Wakeling Reply, [46].

[81] See template BCPP MPPA, clause 10.3.

[82] See cl 172-5(1); RMSANZ SOFIC, [62].

[83] See AMA letter to Tribunal dated 6 May 2022, page 6 (Table 2).

84. Not only would the HH Buying Group have significant power in its own right, but the increased concentration increases the risks of co-ordinated effects in a much more concentrated market. This position becomes exacerbated if one or more Major PHIs were permitted to participate in the HH Buying Group.

85. If only all of the smaller PHIs joined the HH Buying Group, this would still result in a market concentration of more than 87% across three players nationally.[84]

Authorisation Applicants' assertions in relation to public detriments

86. The Authorisation Applicants' expert concludes that that there are no public detriments arising in the relevant primary market (being a national market for the provision of health provider contracting services to PHIs) or in any of the dependent markets (including a national market for private health insurance and a series of local or regional markets for the supply of medical services) identified by the expert.[85]

87. However, in considering dependent markets, the Authorisation Applicants' expert does not consider any market in which PHIs acquire services from medical specialists (as payers of those services). This is what leads the expert to conclude that no public detriments arise from the Proposed Conduct: it is precisely in *that* market that many of the public detriments – including the compulsion to accept inefficient non-price terms, the effect of such terms on the exercise of specialists' clinical independence, and the accumulation of significant monopsony power – are likely to be experienced.

88. It is in the context of the acquisition of medical specialist services by PHIs that many of the public detriments arising from the HH Buying Group's conduct will manifest.

89. Certainly, it is the expectation or ambition of the Authorisation Applicants that the increase in concentration in the provision of medical services will enable the HH Buying Group to achieve the financial savings projected to flow from the Proposed Conduct.

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[84] Siolis, [33].
[85] Houston, [18], [94]-[113].

Term of the proposed authorisation

90. In the AMA's submission, the consequences of any conduct which represents such a marked departure from the manner in which market participants have historically behaved is necessarily attendant with uncertainty as to how it will affect the market.

91. An authorisation for a period of in excess of 5 years could impair the ability of government, regulators and industry bodies to respond to other changes occurring in the market and, in particular, changes that arise as a result of the authorised conduct.

92. In the AMA's submission, it is appropriate that any authorisation be limited to a term of 5 years, so that the impact of the Proposed Conduct in the market can be properly assessed. The Authorisation Applicants have not demonstrated any harm that would arise by reason of a 5-year term of authorisation. It should fall to the Authorisation Applicants to demonstrate why, in 5 years' time, the Proposed Conduct should be re-authorised.

15 July 2022

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