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:	Authorisation Applicant's Statement of Facts, Issues and Contentions
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: 20/04/2022 9:00 AM

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 and ACT 5 of 2021

Re: Application for review of authorisation AA1000542 lodged by nib Health Funds Ltd and Honeysuckle Health Pty Ltd and the determination made by ACCC on 21 September 2021.

Applicants: National Association of Practising Psychiatrists and Rehabilitation Medicine Society of Australia and New Zealand

AUTHORISATION APPLICANTS' STATEMENT OF FACTS, ISSUES AND CONTENTIONS

INTRODUCTION

1. This review (**review**) concerns an application (the **Application**) for authorisation under s 88(1) of the *Competition and Consumer Act 2010* (Cth) (**CCA**) by nib Health Funds Ltd (**nib**) and Honeysuckle Health Pty Ltd (**HH**) (together, **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 (**Providers**) on behalf of private health insurers (**PHIs)** and other healthcare payers.

2. The Australian Competition and Consumer Commission (**ACCC**) granted the authorisation with a condition that the HH Buying Group not supply services to Medibank Private Limited, Bupa HI Pty Ltd, Hospitals Contribution Fund of Australia Limited, or HBF Health Limited in Western Australia (collectively the **Major PHIs**).

3. The issues raised by the parties in this review concern only a limited subset of the conduct the subject of the Application:

   (a) the negotiation by the HH Buying Group of contracts with medical specialists including non-price terms that the Applicants allege will limit clinical independence; and

   (b) the inclusion of Major PHIs in the HH Buying Group in respect of medical specialist contracting.

4. Although it is for the Tribunal to be satisfied of the public benefits test in respect of the whole of the conduct the subject of the Application, it is appropriate for the Tribunal to focus on the matters in issue between the parties on the review.[1]

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[1] See *Re 7-Eleven Stores Pty Ltd* [1998] ACompT 3; ATPR 41-666 at 41,453 (von Doussa J, Dr B Aldrich, Prof D Round) in which the Tribunal referred to the observations in *Re Herald & Weekly Times Ltd (Media Council of Australia (No 1))* (1978) ATPR 40-058 at 17,601; (1978) 17 ALR 281 at 296 (Deane J, President, Shipton and Walker, Members) that

PART A: FACTS

The Authorisation Applicants

5. nib is a major private health insurer which supplies private health insurance policies to Australian and New Zealand residents. Currently, nib has an approximately 9.7% share of the Australian private health insurance market.

6. HH is a health services and data science company founded in December 2019 as a joint venture between nib and Cigna Corporation (**Cigna**), a global health services company. nib and Cigna each own 50% of HH. HH acts independently of its owners with its own Board and separate management.

7. In October 2020, nib appointed HH to provide contract negotiation and drafting, data analytics, contract administration and management, dispute resolution and performance and compliance assessment services for nib's contracts and arrangements with Providers. Those services are provided on an arms-length basis.

The Application for Authorisation

8. On 24 December 2020, the Authorisation Applicants jointly applied for authorisation from the ACCC under s 88(1) of the CCA for HH to form a joint buying group and provide the services broadly described in paragraph 7 to PHIs and other healthcare payers.

9. The authorisation process lasted approximately nine months, from December 2020 to September 2021.

10. The Application was twice amended during the authorisation process, for the purpose of responding to issues raised during that process.[2]

11. On 21 September 2021, the ACCC issued its final determination, authorising:

    (a) HH to form and operate the HH Buying Group involving the provision of services to:

        (i) PHIs,[3] except for Major PHIs;[4]

"fairness and common sense combine to require that the Tribunal determine an application for review within the context of matters which can properly be seen to be in issue between the parties or which the Tribunal itself raises or indicates that it regards as being at large". See also, for instance, s 101(1A) of the CCA, which allows the Tribunal to make a determination by consent, whether or not the Tribunal is satisfied of the matters referred to in subsection 90(7).

2 Amended Application for Authorisation dated 8 April 2021 and Further Amended Application for Authorisation dated 6 May 2021. The first amendment excluded Major PHIs from contracting services (other than medical specialists) (referred to in NAPP [57]-[59]; RSMANZ [75]-[77]); the second amendment limited the HH Buying Group to 80 per cent of the national private health insurance market in relation to the BCPP (referred to in NAPP [61]; RSMANZ [79]).

3 Being those PHIs registered under the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth).

4 Major PHIs include any related body corporate (within the meaning of s4A of the Act), acquirer or successor entity of any of these specified entities.

(ii) international medical and travel insurance companies;

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

(iv) any other payer of health services or goods other than a Major PHI, as notified by HH to the ACCC,

(Participants); and

(b) the acquisition of contracting services (as described in paragraphs 17 to 20 below) by the Participants from HH;

(together the **Proposed Conduct**).[5]

12. The ACCC authorised the Proposed Conduct for a period of five years.

13. The ACCC imposed a condition of authorisation that, as part of the Proposed Conduct, the Authorisation Applicants not supply any services to the Major PHIs.

Review of the Authorisation

14. On 8 October 2021, the National Association of Practising Psychiatrists (**NAPP**) and the Rehabilitation Medicine Society of Australia and New Zealand (**RMSANZ**) (together, the **Applicants**) filed separate applications seeking review of the Authorisation before the Australian Competition Tribunal (**Tribunal**).

15. Over 400 entities and individuals who made submissions to the ACCC were given notice of the review; none applied for leave to intervene.

The Proposed Conduct

16. Participation in the HH Buying Group is entirely voluntary and non-exclusive. Participants will be able to choose to use some or all of the contracting services that will be offered by HH.

17. Broadly, HH will offer a range of contracting services to Participants in relation to:

(a) *Hospital contracts:* hospital purchaser provider agreements (**HPPAs**), where PHIs and other healthcare payers agree with private hospitals on fees and other terms for hospital services provided to the healthcare payers' customers (**Customers**).

[5] See paragraph 5.7and 5.8 of the ACCC's Final Determination dated 21 September 2021.

(b) *Medical specialist contracts:* medical purchaser provider agreements (**MPPAs**), where PHIs and other healthcare payers agree with select medical specialists on fees and other terms for select services provided to Customers in hospital.

(c) *Medical gap schemes or "gapcover":* "opt in" schemes open to all medical specialists on a patient-by-patient basis, where PHIs and other healthcare payers offer to pay medical specialists a set fee for services provided to Customers in hospital; in exchange, medical specialists agree not to charge Customers an out of pocket amount ("no gap") or to charge a fixed amount ("known gap"). HH will create its own medical gap scheme largely derived from nib's existing scheme.

(d) *General treatment networks*: arrangements for "extras" services not provided in hospital e.g. physiotherapists, dentists or optometrists, in which Providers agree to a standard set of rates and terms for each type of service.

18. MPPAs and medical gap schemes were introduced by the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995* and the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (Cth), respectively, as the Applicants recognise: NAPP [30], [39]; RSMANZ [49] and [58].

19. The specific contracting services offered by HH that are the focus of this review are:

(a) contract negotiations with medical specialists on behalf of Participants, described in further detail in paragraphs 26 to 29 below; and

(b) data analytics, described in further detail in paragraphs 30 to 31 below.

20. HH will also offer contract negotiation and drafting services for hospital contracts, as well as contract administration and management services, dispute resolution services (in relation to contractual arrangements), management of customer complaints, and performance and compliance assessment of Providers (that is, reporting and oversight of parties' adherence to terms and conditions of contractual arrangements) for all types of contracting. Those services are not in dispute between the parties to this review.

21. The focus of the dispute between the parties in this review is the negotiation by HH of medical specialist contracts and, in particular, MPPAs for the Broad Clinical Partners Program (**BCPP**). The process by which HH will negotiate contracts between Participants and medical specialists for the BCPP is described further in paragraph 28 to 29 below.

The BCPP

22. The BCPP is intended to provide a "no gap experience" to Customers for a single course of treatment involving multiple specialists. At present, under the BCPP, nib has entered into individual MPPAs with orthopaedic surgeons, anaesthetists and assistant surgeons to provide knee and hip replacements to nib Customers on specified price and non-price terms (including not charging any gap fee to nib Customers). nib is currently expanding the program to cover other orthopaedic procedures.

23. The current BCPP differs from ordinary medical gap schemes because under the BCPP:

    (a) *all* medical specialists involved in the covered treatment, including anaesthetists and assistant surgeons agree to provide a 'no-gap experience' to Customers for that treatment (whereas ordinary medical gap schemes only cover the surgeon and not any other specialist involved in the treatment);

    (b) participating medical specialists agree to treat *all* of nib's Customers requiring a joint replacement through the program (whereas, as the Applicants point out at NAPP [49], RSMANZ [68], in ordinary medical gap schemes specialists can opt in and out of the scheme on a per patient basis); and

    (c) the decision as to whether a patient should have rehabilitation at home becomes one that sits with the surgeons in consultation with the patient rather than this being a decision of the hospital or an in-patient rehabilitation physician.

24. The Authorisation Applicants intend that, through the HH Buying Group, the BCPP will be expanded to cover:

    (a) initially, Customers of Participants (who will receive the same benefits as nib Customers when treated by medical specialists already participating in the BCPP); and

    (b) ultimately, a broader group of medical specialists covering more types of treatments and geographical areas.

25. The Authorisation Applicants do not intend the BCPP to replace PHIs' medical gap schemes; rather, it is and will be an <u>additional</u> option for medical specialists who choose to participate in it. Medical specialists who perform treatments not covered by the BCPP, or who choose not to participate (or continue to participate) in the BCPP, will continue to have access to PHIs' ordinary medical gap schemes or the HH medical gap scheme (for those Participants that have opted into receiving this service).

Contract negotiation with medical specialists

26. HH will offer Participants contract negotiation services for Providers, including medical specialists. HH will adopt a "value based contracting" approach for medical specialist contracting. This means that the price negotiated by PHIs for services will be informed by the clinical and patient-reported outcomes of those services relative to the cost of care to achieve those outcomes.

27. The value of a service is a function of its outcome and cost. Value based contracting is intended to encourage hospitals and medical specialists to provide higher-value care – that is, care that either improves outcomes for patients for the same relative cost or care that provides equitable outcomes for lower costs – and to avoid lower-value care – that is, care that either does not improve outcomes or provides equitable outcomes for higher costs. Under a value based contracting model, the price paid by PHIs for services is adjusted to match the value of the services. The savings from avoiding low-value care are instead directed to providing substitutional high-value care, increasing payments to Providers, and removing out of pocket costs for Customers.

28. HH will enter into collective negotiations with medical specialists based on their existing MPPAs with nib (including terms and rates), in the form of the MPPA submitted by the Authorisation Applicants to the ACCC.[6] The Authorisation Applicants accept that the general terms of any MPPA initially negotiated by the HH Buying Group will be based on this MPPA: NAPP [79], [83]; RSMANZ [97].

29. HH will negotiate new contracts as the nib-based contracts expire and will negotiate contracts with new specialists. As part of that process:

    (a) HH will aggregate and analyse Participants' claims data for medical specialists to establish benchmarks for quality of service, price and application of services: see paragraph 30 below;

    (b) HH will conduct collective commercial negotiations with medical specialists based on this aggregated data and other information obtained from Participants;

    (c) if a Participant (and the medical specialist) is satisfied with the negotiated terms, HH will coordinate the execution of the contract (MPPA) between the Participant and the medical specialist;

[6] Document titled "nib health funds limited MPPA Short Stay No Gap, Feb 2021". The specific terms of the MPPAs as negotiated with medical specialists will of course necessarily be adapted and modified to reflect other medical specialities as the BCPP is expanded.

(d) if a Participant is not satisfied with the terms proposed, the Participant may negotiate directly with the medical specialist to enter into an agreement independently of the HH Buying Group or not enter any agreement at all; and

(e) both Participants and medical specialists will have broad no-fault termination rights.

Data analytics

30. HH will offer Participants data analytic services. This involves analysing aggregated data obtained from Participants to provide those same Participants with information about the performance of Providers, benchmarked against aggregated data across the HH Buying Group in relation to:

(a) quality (including the rate of hospital acquired complications, length of hospital stays, unplanned readmission to theatre and conversion to ICU);

(b) compliance (including accuracy of claims, compliance with the contract terms and complaints);

(c) benefits paid (including cost per episode against national peer groups, change in cost over time, and cost variability reporting across the Provider network);

(d) access to services (including network coverage and member access); and

(e) efficiency and value of treatment (including quality scoring of Providers and ranking of value and efficiency against quality).

31. This data collection and analysis underpins the value-based contracting described in paragraphs 26 and 27 above.

Private healthcare and private health insurance

32. The Authorisation Applicants accept that private healthcare in Australia has the general features identified by the Applicants at NAPP [13]-[28]; RSMANZ [23]-[28] and [32]-[41]. The key features of private healthcare in Australia include the following:

(a) PHIs and other healthcare payers pay benefits to Providers for health services provided to Customers;

(b) all medical specialists have a statutory right to be paid for their services (the Schedule Fee under the Medicare Benefits Schedule, of which 75% is required to be paid by Medicare and 25% is paid by PHIs under section 72-1 of the *Private Health Insurance Act 2007* (Cth) (**PHI Act**);

(c) medical specialists may set a higher fee than the Schedule Fee, in which case the Customer may be liable to pay the "gap" (also known as "out of pocket") (unless the medical specialist participates in a medical gap scheme or has an MPPA with the Customer's PHI);

(d) pursuant to the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (Cth) PHIs may offer gap cover arrangements to pay medical benefits in excess of the Schedule Fee;

(e) all PHIs have established medical gap schemes under which medical specialists reduce or eliminate gap fees on a patient-by-patient basis in exchange for a higher benefit paid by PHIs;

(f) pursuant to the PHI Act, the PHIs may enter into MPPAs to pay medical benefits in excess of the Schedule Fee;

(g) medical specialists may elect to: participate in a medical gap scheme; enter into an MPPA; or elect not to enter into an arrangement with any or all PHIs and either accept the Schedule Fee or charge Customers a gap fee;

(h) Customers who want to use a medical specialist who does not participate in a medical gap scheme or have an MPPA with their PHI may:

(i) use their preferred medical specialist but pay a gap fee determined by that medical specialist; or

(ii) switch PHIs to a PHI with whom their preferred medical specialist participates in a medical gap scheme or has an MPPA: see paragraph 34(c)(i) below.

33. The Authorisation Applicants accept that rehabilitation physicians and psychiatrists typically use no gap arrangements: RSMANZ [44]-[45], [156]; NAPP [129].

34. The Authorisation Applicants accept that the characteristics of the private health insurance market include, broadly, those outlined by the Applicants at RSMANZ [70]-[73]; NAPP [53]-[56]. Those characteristics include the following:

(a) 36 PHIs (including nib) operate and compete with each other as purchasers of health services from Providers and as suppliers of private health insurance. The market share of each PHI, measured by total hospital policies as at June 2021 is **annexed** (those shares being broadly consistent with the market shares described by the Applicants at NAPP [53], [56]; RMSANZ [70], [73]);

(b) of the 36 PHIs:

(i) four are Major PHIs who perform their own contracting services internally;

(ii) 22 use the Australian Health Services Alliance (**AHSA**) to perform their contracting services;

(iii) four use the Australian Regional Health Group (**ARHG**) to perform their contracting services;

(c) the market for private health insurance is highly competitive and price-sensitive, including because:

(i) section 78-1 of the PHI Act obliges insurers to recognise waiting periods that have been served for hospital treatment with a previous insurer: this ensures Customers can switch PHIs without incurring detriments in the form of waiting times or exclusions; and

(ii) insurance premiums are price-regulated: pursuant to section 66-10 of the PHI Act, increases in insurance premiums must be approved by the Minister for Health, which requires clear validation and actuarial evidence to justify price increases.

35. Existing features of contracting between PHIs and Providers include:

(a) existing buying groups use collective bargaining to negotiate contracts on behalf of their members;

(b) Major PHIs and existing buying groups use data analytics to determine pricing for hospital and medical specialist contracts;

(c) PHIs, including nib and Major PHIs, engage in value-based contracting with hospitals and medical specialists. In particular, and contrary to the Applicants' assertions (RMSANZ [36], [67]; NAPP [48]), Major PHIs already enter into MPPAs with medical specialists that include non-price terms including performance targets and requirements to adhere to clinical guidelines;

(d) further to subparagraph 36(c), for example, Medibank's "Zero out of pocket" model pays Providers a significantly higher rate for joint replacements performed as a short stay hospital admission.

PART B: ISSUES

36. The issues for consideration by the Tribunal in this review are:

    (a) whether the public benefits test set out in section 90(7)(b) of the CCA is satisfied in all the circumstances in respect of the Proposed Conduct such that:

        (i) the Proposed 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 Proposed Conduct;

    (b) whether the condition of Authorisation imposed by the ACCC is necessary and appropriate under section 88(3) either in its present form or at all, to yield the conclusion that section 90(7)(b) is satisfied in respect of the Proposed Conduct and/or having regard to the subject matter, scope and purposes of the CCA; and

    (c) the length of time for which the Proposed Conduct should be authorised.

37. As already noted, although it is for the Tribunal to be satisfied of the public benefits test in respect of the whole of the Proposed Conduct, it is appropriate for the Tribunal to focus on the matters in issue between the parties: see paragraph 4 above.

38. The only aspects of the Proposed Conduct in issue between the parties in this review concern medical specialist contracting: RSMANZ [86]; NAPP [68], [75]. In particular, the Applicants take issue with:

    (a) the inclusion of non-price terms in MPPAs with medical specialists (specifically for psychiatrists and rehabilitation medicine specialists), which the Applicants contend are likely to compromise the independence of medical specialists to the detriment of patients: NAPP [76(b)], [77]-[78]; RSMANZ [94(b)], [95]-[96]; and

    (b) the inclusion of Major PHIs in the HH Buying Group for the purposes of collective bargaining with medical specialists: NAPP [76(a)]; RSMANZ [94(a)].

39. The Applicants expressly do <u>not</u> object to the collective negotiation of commercial terms of contracts with medical specialists: NAPP [130]; RSMANZ [157].

40. The Authorisation Applicants also take issue with the duration and condition of authorisation.

PART C: CONTENTIONS

Context: Future with and without the Proposed Conduct

41. Having regard to the scope of the issues in dispute between the parties, the Authorisation Applicants contend that:

    (a) the relevant factual is a future with the Proposed Conduct in which:

        (i) all PHIs and other healthcare payers can join and use the services offered by the HH Buying Group;

        (ii) some members of existing buying groups would join the HH Buying Group;

        (iii) one or more Major PHIs would join the HH Buying Group and acquire at least some of the services offered by HH;

        (iv) medical specialists will negotiate collectively with the HH Buying Group;

        (v) MPPAs with medical specialists will include both price and non-price terms;

        (vi) medical specialists will have the option of:

            (A) entering into MPPAs with Participants;

            (B) participating in the BCPP;

            (C) participating in HH's or the Participants' medical gap schemes; or

            (D) charging Customers a gap fee determined at their discretion.

    (b) The relevant counterfactual is a future without the Proposed Conduct in which:

        (i) nib will continue to use the services offered by HH and HH may contract individually with other PHIs and healthcare payers;

        (ii) Major PHIs will continue to undertake contracting services internally;

        (iii) existing buying groups will continue to act on behalf of other PHIs;

        (iv) medical specialists will negotiate separately with HH, Major PHIs and existing buying groups;

        (v) MPPAs with medical specialists will include both price and non-price terms;

        (vi) medical specialists will have the option of:

            (A) entering into MPPAs with nib and other PHIs;

(B) participating in nib's and other PHIs' medical gap schemes;

(C) participating in the BCPP in relation to nib Customers; or

(D) charging Customers a gap fee determined at their discretion.

42. The Authorisation Applicants do not accept the Applicants' contentions that in the future with the Proposed Conduct medical specialists would have no option but to enter MPPAs with the Buying Group (NAPP [72(c)]; RSMANZ [90(c)]) nor that in the counterfactual medical specialists (including psychiatrists and rehabilitation specialists) would not enter MPPAs that included non-price terms (NAPP [73(c]; RMSANZ [91(c)]).

Public benefits of the Proposed Conduct

43. The Authorisation Applicants contend that the Proposed Conduct will give rise to substantial public benefits including:

(a) increasing competition between buying groups;

(b) improving services to Participants and Customers by:

(i) improving access to data analytics and information for smaller PHIs;

(ii) extending the no gap experience to more Customers and increasing certainty of cost for Customers;

(iii) expanding value based contracting; and

(iv) transaction cost savings and increased efficiencies; and

(c) countervailing hospital bargaining power.

Greater choice and increased competition between buying groups

44. The establishment of the HH Buying Group will increase competition by providing PHIs with an alternative to existing buying groups (AHSA and ARHG). The Authorisation Applicants reject the Applicants' contention that the formation of a third buying group will not increase competitive tension in the market: RSMANZ [139]; NAPP [115].

45. For PHIs, choice of buying group will reflect the outcome of competitive market forces. PHIs that are unhappy with the services being provided by the AHSA or ARHG will have an opportunity to take their business to HH or to pressure AHSA or ARHG to provide better or more competitive service offerings. This, in turn, will encourage each buying group to increase efficiencies, lower fees and innovate so as to offer better value and attract or retain members.

46. HH will differentiate itself from existing buying groups by offering:

(a) an alternative model of value-based contracting;

(b) superior data analytics services; and

(c) a combination of hospital and medical specialist contracting (whereas other buying groups focus primarily on hospital contracting).

47. This would force other buying groups to broaden their offering which would bring improved value to all buying group participants and, consequently, Customers who will benefit from lower premiums from a more competitive and aggressive market.

48. As participation in the HH Buying Group is voluntary and non-exclusive (see paragraph 16 above), Participants can return to existing buying groups if they do not realise any benefits from the alternative offering.

Improving access to analytics and information

49. The establishment of the HH Buying Group will give Participants access to HH's significant capabilities in data science, analytics and forecasting. The HH Buying Group will provide Participants with access to, and analysis of, aggregated data from all Participants: see paragraph 30 above.

50. The Applicants accept that access to data analytics is a public benefit: NAPP [131]; RMSANZ [113], [116], [158].

51. The benefit of this access is three-fold:

(a) *First*, it reduces information asymmetry for smaller PHIs by allowing them to gain insights from aggregated data of all Participants, and use data analytics tools on a data sample size typically only available to larger PHIs. This will assist smaller PHIs to negotiate with Providers and compete with Major PHIs more effectively by offering reduced costs or better services (which in turn benefits Customers).

(b) *Second*, it will enable Participants to identify and develop networks of Providers across a range of speciality groups who deliver higher quality and value to Customers, including in geographic areas where Participants would otherwise have insufficient market share to develop such networks.

(c) *Third*, it will enable Participants to share with their Customers information about the quality and value of Providers, to enable Customers to make informed choices about their healthcare.

52. Although Major PHIs and members of existing buying groups already have some access to data analytics services, the data analytics offered by HH provide a public benefit beyond what currently exists in the market, given HH's unique capabilities and access to sophisticated analytics software and its ability to share and benchmark data across Participants.

53. RSMANZ accepts that the collection of data tied to a robust process for improving clinical outcomes may be beneficial to consumers: RSMANZ [113], [115]-[116]. The Authorisation Applicants agree with that contention. One of the largest challenges facing improvement in health care in Australia is the lack of transparency of data on the outcomes and quality of care provided by Providers. For instance, the AROC data referred to by the Applicants (RSMANZ [114]) is not made available by hospitals to PHIs and other healthcare payers. Given the lack of transparency of such data, the collection of data by the HH Buying Group is essential to driving improved outcomes. HH will use aggregated and analysed data to inform quality targets. For example, in relation to rehabilitation, HH will:

    (a) identify where Customers with a high functional independence measure score (who are clinically indicated for day program or outpatient care) are instead referred to inpatient overnight care;

    (b) calculate the functional independence measure efficiency score (the change in functional independence measure between admission and discharge) to assess the efficacy of the care provided;

    (c) thereby determine which Providers are referring patients to care that is not improving Customer outcomes;

    (d) assess the relative value of those Providers against other Providers; and

    (e) adjust funding to Providers to encourage them to provide care that improves Customer outcomes.

Extending the no gap experience

54. For Customers, a key benefit of the Proposed Conduct is extending the no gap experience. This eliminates out of pocket costs and uncertainty for Customers about gap payments when receiving private healthcare services.

55. The Applicants accept this is a public benefit: NAACP [127]-[129]; RSMANZ [154].

56. Networks of preferred Providers offering no or reduced gap payments are an existing feature of the private health insurance market: see 32(e) above. HH's no gap experience will offer a better experience for Customers than existing no gap schemes by:

(a) providing a no-gap experience in relation to all medical specialists involved in an episode of care: see paragraph 23(a) above; and

(b) requiring participating specialists to treat all relevant Customers under the no gap scheme: see paragraph 23(b) above.

57. The BCPP has to date saved nib Customers an estimated $1.5 million in out of pocket expenses.

58. The Authorisation Applicants accept that expanding the no-gap experience does not offer a financial benefit to Customers in specialist areas where patients already generally experience 'no gap' cover for hospital services (such as psychiatry and rehabilitation medicine: see paragraph 33 above). However, such Customers still receive the benefits that result from value based contracting, including better health outcomes and affordability: see paragraph 59 below.

Expanding value based contracting

59. Value based contracting provides benefits for Customers, Providers and Participants by aligning funding to clinical and patient-reported outcomes and thereby:

(a) encouraging Providers to provide and refer Customers to services that are proven to improve health outcomes for Customers;

(b) facilitating Providers' adoption of new technologies or products that improve outcomes for Customers (but that are not funded under the Medicare Benefits Scheme);

(c) reducing costs for PHIs and other healthcare payers, including by encouraging the provision of services that produce better health outcomes (and thereby, for instance, reduce the risk of readmission); and/or lower cost services that produce equitable health outcomes;

(d) in turn, where the market is highly competitive and price-regulated (in particular, where insurance premium increases require Ministerial approval: see paragraph 34(c) above), exerting downward pressure on insurance premiums payable by Customers and offering quality adjusted prices where Customers are provided with more value without a corresponding premium increase;

(e) creating competitive tension in the market by offering an alternative of high value care with the certainty of no out of pocket costs for Customers, without increasing costs for Providers, Participants or Customers.

60. For the reasons explained in paragraph 59(d) above, the Authorisation Applicants reject the Applicants' contention that reductions in healthcare costs are not passed on in savings to consumers: NAPP [117], [119], [126]; RSMANZ [141], [143], [150].

61. The Authorisation Applicants also strongly reject the Applicants' contention that value based contracting shifts cost-savings to patients or the public health system (NAPP [118], [121]; RSMANZ [142], [153]). As explained in paragraph 27 above, value based contracting is based on achieving equitable or better health outcomes for patients. It is fundamentally inconsistent with value based contracting to achieve worse health outcomes for patients.

62. Value based contracting is already utilised on a unilateral basis by Major PHIs in the private health insurance market: see paragraphs 35(c) and 35(d) above. However, the Authorisation Applicants' model of value-based contracting is superior to the value based contracting currently used by Major PHIs because of HH's technical data analytics capabilities and broader access to data. Through the Buying Group, the Authorisation Applicants will make this model of contracting available to smaller PHIs who do not otherwise have the scale and capabilities to achieve it.

Cost savings and increased efficiencies

63. Negotiation, setup and claims management between Providers and PHIs is administratively burdensome and complex. The HH Buying Group will create administrative cost savings for Participants and Providers by:

    (a) reducing duplication of work and resources required for Participants to individually negotiate and contract with Providers;

    (b) simplifying billing processes and thereby reducing administrative costs for Providers, by using consistent contracts, rates and billing rules for Participants; and

    (c) 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.

64. Administrative cost savings ultimately create downward pressure on insurance premium increases for Customers, or allow for quality adjusted pricing, for the reasons explained in paragraph 59(d) above. For these reasons, the Authorisation Applicants reject the Applicants' contention that administrative cost savings from collective bargaining will not be passed on to consumers: RSMANZ [140]-[141], [150]; NAPP [117], [126].

65. The Applicants accept that collective bargaining is likely to generate some cost saving and efficiency, particularly for smaller PHIs: NAPP [110], [117]; RSMANZ [133], [141]. The Authorisation Applicants reject the Applicants' contention that cost savings in respect of negotiations with individual specialists are unlikely to be meaningful because negotiations are limited and contracts are standard form (NAAPP [110]-[112]; RSMANZ [134]-[136]). To the contrary, the Authorisation Applicants contend that negotiations with medical specialists require a significant investment of time and resources because of the large number of contracts required and the diversity in the range of medical specialities and treatments to be covered. Meaningful cost savings and efficiencies arise by Participants not each negotiating individually with thousands of medical specialists.

66. The Authorisation Applicants also reject the contention that there are no cost savings for PHIs switching from existing buying groups: RSMANZ [138]. The Authorisation Applicants contend that there will be cost savings because the HH Buying Group membership fee is intended to, and will need to be, competitive with that of AHSA and ARHG notwithstanding that the services being offered to Participants are intended to be substantially broader than those currently offered by those buying groups.

Countervailing hospital bargaining power

67. The formation of the HH Buying Group will allow PHIs to countervail the bargaining power of major hospitals.

68. Some hospitals have strong bargaining power relative to PHIs and other healthcare payers because:

    (a) of their size, location and/or reputation; and/or

    (b) if the hospital does not enter a HPPA with a PHI, it may apply to be a 'second tier default benefits eligible' hospital under s 121-8 of the PHI Act, in which case it will be entitled to receive at least 85 per cent of the average payment payable under the PHIs' HPPAs with comparable private hospitals.

69. Hospitals with strong bargaining power can and do charge higher prices for the same procedure provided in other hospitals, without any commensurate increase in value for the Customer. 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 (which they are otherwise under no obligation to do). 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).

Public detriments

70. The principal public detriment on which the Applicants rely is that the inclusion of certain non-price terms in MPPAs will, the Applicants contend, interfere with clinical decision-making to the detriment of patients: NAPP [77]-[78]; RSMANZ [95]-[96].

71. At the outset, the Authorisation Applicants emphasise that the need for authorisation arises solely in relation to the collective nature of the Proposed Conduct. The Authorisation Applicants do not require authorisation to engage in value based contracting or otherwise to include non-price terms with medical specialists. That conduct is lawful and an existing feature of contracting in the market: see paragraph 35 above.

72. In any event, for the reasons that follow, the Tribunal should not accept that the Proposed Conduct creates the public detriments alleged by the Applicants.

73. *First,* the MPPA creates no legal obligation to act otherwise than in accordance with the medical practitioner's clinical judgment.

74. Section 172-5 of the PHI Act prevents PHIs from limiting the professional freedom of medical practitioners. It provides:

> 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.

75. The Authorisation Applicants cannot, and do not seek to, be authorised to engage in conduct that contravenes section 172-5 of the PHI Act: any MPPAs negotiated on behalf of the HH Buying Group must not limit the freedom of medical practitioners to identify and provide appropriate treatment within the scope of accepted clinical practice.

76. The MPPAs which will form the basis of collective negotiation by the HH Buying Group provide that:

    (a) Providers must ensure that all Specified Services are undertaken with due care and skill and level of expertise reasonably expected by someone providing services that are the same or similar to the Specified Services and under the Professional Standards (being the professional qualifications, experience, memberships of associations or other professional standards applicable to the Provider): cl 7.1(b) and 5.1;

    (b) Providers must provide or arrange Specified Services to Eligible Customers consistent with best clinical and industry practice: cl 7.1(c);

(c) Providers must ensure that the Specified Services provided are in line with any applicable Medicare guidelines for treatment services as set out in the MBS: cl 7.1(d);

(d) if clinically appropriate, work towards ensuring that the overall Admission to overnight inpatient programs are approximately 30 per cent of nib's Eligible Customers undergoing joint replacement surgery by the Provider (noting that the precise percentage to be applied to the specific inpatient programs may differ, for example: less than 35 per cent for knee surgery patients, and less than 25 per cent for hip surgery patients): cl 7.1(e);

(e) nib will not interfere with and acknowledges the independence of the Provider providing Specified Services to Eligible Customers under this MPPA. Nothing in this MPPA limits the Provider's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments: cl 10.2.

77. *Second,* the Authorisation Applicants reject the Applicants' contention that the adoption of targets for clinical outcomes in the MPPAs is inconsistent with clinical independence or otherwise provides an incentive or inducement to behave in a manner contrary to patients' best clinical outcomes: NAAPP [85(a)], [132]; RSMANZ [101](a)], [105], [159]. To the contrary:

(a) As is apparent from the clauses extracted in paragraph 76 above, the targets are expressly subject to the practitioner's determination of clinical appropriateness in any given case: see, for instance, clause 7.1(e); 7.1(g); 10.2; Schedule 2. That means that there can be no conflict between adherence to the MPPA and the best interests of patients: to the contrary, the medical specialist would not comply with the MPPA if the specialist were to provide treatment that was not clinically appropriate: see for instance clause 7.1(c); cf NAPP [88].

(b) The clinical targets do not involve a "financial incentive" for medical practitioners: cf RSMANZ [109] in that under the current MPPA Providers are paid the same amount regardless of whether targets are met and the MPPA imposes no penalties or other consequences under the MPPA on medical practitioners who do not achieve such targets. However, 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.

(c) Targets do not reduce consumer choice because the medical specialist's clinical assessment will factor in consumer preferences: see paragraph 78(d) below, cf RSMANZ [110]-[111].

(d) Clinical targets are commonly imposed on healthcare providers. For instance, health departments impose on hospitals a range of measured targets including in relation to hospital acquired complications, and access to preventative care to avoid hospitalisation.

78. Relatedly, the Authorisation Applicants reject the contentions of RSMANZ that the targets in the MPAA emphasise discharge over the best outcomes for patients (RSMANZ [106]), require out of scope referrals (RSMANZ [107]-[108]), offer financial incentives to the detriment of patients (RMSANZ [109]), or give Customers no say in medical decision making (RSMANZ [110]-[111]). To the contrary, the Authorisation Applicants contend:

(a) If a medical specialist refers a patient to rehabilitation in the home, the rehabilitation in the home provider has oversight of the patient for the purposes of that rehabilitation, and will escalate any medical issues that arise during the course of such rehabilitation through ordinary clinical pathways to the surgeon who remains responsible for the post-surgical recovery of their patient: cf RSMANZ [31], [106].

(b) Surgeons are able to determine the post-operative care required for their patient and to refer the patient for such care as they determine to be clinically appropriate: cf RSMANZ [107]. This may include:

(i) no referral (patient to self-rehabilitate at home);

(ii) referral to a rehabilitation in the home program or chronic disease management program;

(iii) referral to in-patient rehabilitation in a hospital; or

(iv) referral to a rehabilitation specialist.

(c) The BCPP offers no additional financial incentives to achieve targets, nor penalises providers who do not achieve targets: see paragraph 77(b) above; cf RSMANZ [109]. Any financial incentive by way of payment of fees for the performance of the MPPA cannot logically be said to be any different to the existing financial incentive of medical specialists to provide treatment on a fee-for-service basis: see paragraph 82 below.

(d) Under the BCPP, customer preferences can and do play a role in medical providers' assessment of what rehabilitation care (if any) is clinically appropriate: cf RSMANZ [111]. However, ultimately it is for the medical specialist to determine what treatment is clinically appropriate – medical care is never only a matter of consumer choice.

(e) 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: cf RSMANZ [30]-[31], [149] and [151]-[152]; see also NAPP [125].

79. *Third,* the Authorisation Applicants reject the Applicants' contention that collecting, reporting and benchmarking data on patient outcomes is inconsistent with clinical independence and contrary to patients' best interests: NAAPP [89]-[91], [124], [133], [159]; RSMANZ [112], [148].

(a) Benchmarking is a standard and effective approach used in health care to improve outcomes, including in relation to hand hygiene compliance rates and hospital acquired complication rates.

(b) To the extent that data is used to benchmark clinicians, it is as against outcomes that matter to patients. It cannot logically be said that collecting, analysing and benchmarking data about outcomes that matter to patients is contrary to patients' best interests: cf NAPP [133].

(c) The Authorisation Applicants accept that patient care is individual and nuanced: NAPP [51]-[52], [124]; RSMANZ [148]. Benchmarking does not prevent Providers from responding to such nuances in the most clinically appropriate way. Rather, benchmarking identifies where there are potentially systemic issues with Providers causing poor outcomes for Customers and unnecessary healthcare costs (for example, extremely high rates of conversion to intensive care, or readmission after surgery, compared with national averages).

(d) The Authorisation Applicants accept that patient confidentiality is an essential aspect of psychiatry: NAPP [89]. However, the Authorisation Applicants reject the contention that the collection and reporting of aggregated and de-identified patient outcomes is likely to undermine that principle: NAPP [90]. That is particularly the case where Providers are obliged under the MPPA to obtain informed consent from the patient for the disclosure of such data: see cl 19.4 of the MPPA.

80. *Fourth,* the Authorisation Applicants reject the Applicants' contention that the requirement in the MPPA to adhere to clinical guidelines is inconsistent with clinical independence and provides a commercial incentive or inducement to behave in a manner contrary to patients' best clinical outcomes: NAAPP [85(b)]; RSMANZ [101](b)].

(a) 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.

(b) The Applicants accept that uniform guidelines produced by and under the control of expert medical bodies, with the aim of maximising clinical efficacy and effectiveness may generate benefits for patients: NAPP [95]; RSMANZ [117]. Contrary to the Applicants' speculation (NAPP [97], RSMANZ [119]), HH does not propose to apply guidelines for the treatment of patients other than in that manner. This is reflected in the conditions the Authorisation Applications have indicated they would not oppose in this review: see paragraph 95(b) below.

81. *Fifth,* medical specialists will not be commercially compelled to enter or continue a MPPA with members of the Buying Group: see paragraph 16 above. The Authorisation Applicants reject the Applicants' contention that, as a matter of commercial reality, medical specialists have no option but to enter MPPAs with Participants (NAPP [99]-[107]; RSMANZ [121]-[126]) for the following reasons:

(a) Medical specialists who do not wish to enter or continue with an MPPA may instead participate in PHIs' or HH's medical gap schemes or charge Customers a gap fee: see paragraph 25 and 32(g) above; cf NAPP [102]-[104]; RSMANZ [124]-[126].

(b) HH does not seek authorisation to engage in a collective boycott – meaning that the HH Buying Group will not be permitted to boycott Providers that refuse to deal with the group.

(c) The BCPP will only expand if Providers choose to join and stay in the program and if Customers choose PHIs that participate in the BCPP. As is apparent from the Applicants' contentions (RSMANZ [127]), market forces will determine whether medical specialists will be willing to enter MPPAs negotiated by the Buying Group, given price and alternatives.

(d) Nor do financial incentives in the form of administration cost savings provide an incentive to participate in MPPAs over medical gap schemes: cf RSMANZ [130]; NAPP [107]. That is because processing and payment of fees for MPPAs occurs in the same way as for medical gap schemes.

82. *Sixth,* having regard to the absence of any conflict between the obligations under the MPPA and the exercise of medical practitioners' clinical judgment, a financial incentive in the form of payment for services cannot be said to disrupt clinical judgment. Medical specialists already have a financial incentive to provide services under a fee for service model. On the Applicants' reasoning, the fee for service model could equally be said to incentivise medical specialists to provide funded and higher cost services to obtain higher fees. For instance, adopting this reasoning, medical specialists have a financial incentive to refer patients to in-patient rehabilitation (a Medicare funded service for which PHIs pay benefits) over ordinary at-home rehabilitation (for which PHIs would not pay the in-patient rehabilitation physician but would pay a third party provider of at-home rehabilitation).

83. In the circumstances outlined above, the Authorisation Applicants reject the Applicants' contentions that medical specialists will make clinical decisions to the detriment of their patients in order to maintain an MPPA with Participants (NAPP [87]-[88]; RSMANZ [102]-[103]).

Net public benefit

84. In the circumstances outlined in paragraphs 43 to 83 above, the Authorisation Applicants contend that the public benefits of the Proposed Conduct outweigh the public detriments asserted by the Applicants and the Proposed Conduct accordingly satisfies the public benefits test in section 90(7) of the CCA.

Appropriateness of Condition of Authorisation: Participation by Major PHIs in the HH Buying Group

85. The condition that the Authorisation Applicants not supply any services to the Major PHIs in connection with the Proposed Conduct is neither necessary nor appropriate.

86. The Application at first instance did not exclude Major PHIs from the Proposed Conduct. The subsequent amendments to the Application were to address issues raised during the course of the authorisation process: see paragraph 10 above. In particular, in the Application as finally amended, the Authorisation Applicants proposed that the HH Buying Group be limited to representing 80 per cent of the national private health insurance market in relation to medical specialist contracting. Instead, the ACCC considered it appropriate

to make a determination granting an authorisation in respect of that Application excluding the Major PHIs from the HH Buying Group.

87. In a *de novo* review of the matter under s 101 of the CCA, it is for the Tribunal to review the determination made by the ACCC. That requires the Tribunal to consider the appropriateness of the inclusion of the Major PHIs in the Buying Group for medical specialist contracting.

88. In this review, the Authorisation Applicants maintain their contention that permitting Major PHIs to join the HH Buying Group for the purposes of medical specialist contracting will increase the scale of the material public benefits identified in paragraph 43 above, including:

    (a) extending the "no gap experience" to a broader group of Customers, treatments, and geographical areas;

    (b) in turn, increasing the efficiencies for medical specialists by enabling them to provide more treatments to more Customers using the same funding model;

    (c) thereby facilitating participation in the BCPP by medical specialists who may otherwise be deterred from participating by the time and effort required to establish a funding model that will not cover a broad group of Customers or treatments;

    (d) reducing transaction costs for Major PHIs compared to the creation of programs similar to the BCPP, which in turn reduces Customer costs;

89. The Authorisation Applicants reject the contention that the inclusion of Major PHIs in the HH Buying Group for medical specialist contracting would create an imbalance of bargaining power between PHIs and medical specialists in circumstances where:

    (a) the Proposed Conduct is entirely voluntary for Participants (see 16 above) and any Major PHIs that joined the HH Buying Group retain discretion to:

        (i) agree or not agree to any MPPA negotiated on their behalf: see paragraphs 29(c) and 29(d) above;

        (ii) negotiate and contract with medical specialists directly, outside the HH Buying Group: see paragraph 29(d) above;

    (b) the BCPP is intended to be additional to, and not to replace, medical gap schemes: see paragraph 25 above;

(c) PHIs cannot bypass or boycott medical specialists who decline to join the BCPP: see paragraph 81(b) above;

(d) the onus will be on HH to persuade medical specialists to participate in the BCPP, including by paying a higher level of benefits than under medical gap schemes to encourage participation and compensate medical specialists for providing higher quality services: see paragraph 81(c) above;

(e) Major PHIs are already operating with sufficient scale to act unilaterally to develop no gap experiences in competition with the BCPP, such that the normal outworking of competition will ensure that the HH Buying Group will not achieve an excessive market share. In particular:

(i) there is no realistic prospect that all of the Major PHIs would join the HH Buying Group in relation to medical specialist contracting and acquire all of the services offered by HH; and

(ii) it is much more likely that most Major PHIs would continue to conduct these functions internally and compete against the HH Buying Group, other buying groups and other Major PHIs in the market.

90. The ACCC has power to revoke the authorisation pursuant to s 91B of the CCA. The process for considering revocation provides a more appropriate mechanism to re-assess the expected benefits and detriments of the Proposed Conduct, should there be a material change in circumstances.

91. If the Tribunal holds residual concerns, an appropriate alternative may be to impose a condition that the Authorisation Applicants have an ongoing obligation to report any increase in market share over a certain value to the ACCC.

Duration of authorisation

92. The Authorisation Applicants sought authorisation for the Proposed Conduct for 10 years from the date of final determination by the ACCC. This time period was selected so as to give the Authorisation Applicants an opportunity to realise the public benefits of the Proposed Conduct in circumstances where:

(a) the negotiations, planning and analysis which will underpin HH's medical specialist contracting requires a significant investment in time and effort to negotiate contracts with potentially thousands of medical specialists, which could take upwards of two years and maybe up to five years to achieve sufficient scale;

(b) MPPAs and HPPAs traditionally have a three year term and, in some instances, have a term of up to five years;

(c) at least two contract cycles are required for the benefits to be fully realised, as medical practitioners adapt their care to improve outcomes and/or efficiency; and

(d) the net result is that the public benefits are not likely to be fully realised within a period of 5 years from the date of authorisation.

93. The granting of a 10 year period is also consistent with previous authorisations given for similar conduct.

94. For the reasons outlined above, the Proposed Conduct should be authorised for a period of 10 years.

Additional conditions

95. Notwithstanding the matters set out in paragraph 85 to 94 above, to satisfy the concerns raised by the Applicants, the Authorisation Applicants would not oppose conditions that:

(a) 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;

(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, as per NAPP [137(b)(ii)]; RSMANZ [163(b)(iii)];

(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, as per NAPP [137(b)(iiI)]; RSMANZ [163(b)(iv)]; 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: as per NAPP [137(b)(iv)]; RSMANZ [163(b)(iii)].

DECISION SOUGHT

96. For the reasons outlined above, the Authorisation Applicants contend that the Tribunal should affirm the ACCC decision to authorise the Proposed Conduct and otherwise amend the Authorisation such that:

    (a) the period of Authorisation is extended from 5 to 10 years; and

    (b) the condition preventing Major PHIs from joining the HH Buying Group is removed in respect of medical specialist contracting.

Dated: 19 April 2022

M Borsky QC

Ninian Stephen Chambers

A Lord

Owen Dixon West Chambers

MinterEllison

Solicitors for the Authorisation Applicants

Annexure A: Private health insurer market shares

Insurer	Party that undertakes contracting services	National Market Share Hospital Policies June 2021
Medibank Private Limited	Medibank	26.1%
Bupa Australia Pty Ltd	Bupa	24.2%
The Hospitals Contribution Fund of Australia Limited	HCF	12.6%
nib Health Fund Ltd	nib	9.7%
HBF Health Limited (WA)	HBF	6.0%
HBF Health Limited (All other states)	AHSA	0.8%
Teachers Federation Health Limited	AHSA	2.8%
Australian Unity Health Limited	AHSA	2.8%
Defence Health Limited	AHSA	2.2%
GMHBA Limited	AHSA	2.2%
CBHS Health Fund Limited	AHSA	1.7%
Westfund Limited	AHSA	0.8%
Latrobe Health Services Limited	ARHG	0.8%
Health Partners Limited	AHSA	0.7%
Health Insurance Fund of Australia Limited	AHSA	0.7%
TUH Health Fund	AHSA	0.6%
St Lukes Health	ARHG	0.6%
CUA Health Pty Ltd	AHSA	0.6%
Queensland Country Health Fund Ltd	AHSA	0.5%
Peoplecare Health Limited	AHSA	0.5%
Doctors' Health Fund Pty Ltd	AHSA	0.5%
Police Health Limited	AHSA	0.4%
health.com.au Pty Limited	AHSA	0.4%
Railway & Transport Health Fund Limited	AHSA	0.4%
Navy Health Ltd	AHSA	0.4%
MO Health Pty Ltd	AHSA	0.3%
Mildura District Hospital Fund Limited	ARHG	0.2%
Phoenix Health Fund Limited	AHSA	0.2%
National Health Benefits Fund Australia Pty Ltd	AHSA	0.1%
Nurses & Midwives Health Pty Ltd	AHSA	0.1%
Health Care Insurance Limited	AHSA	0.1%
ACA Health Beneifts Fund Limited	AHSA	0.1%
Transport Health Pty Ltd	AHSA	0.1%
Hunter Health Insurance	ARHG	0.0%
Reserve Bank Health Society Limited	AHSA	0.0%
CBHS Corporate Health Pty Ltd	AHSA	0.0%

Sourced from *Operations of Private Health Insurers Annual Report 2020-2021*, published by APRA on 27 October 2021.