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:	Statement
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: 14/06/2022 4:25 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.

IN THE AUSTRALIAN COMPETITION TRIBUNAL

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

STATEMENT

Statement of:	Dr Omar Mohamed Khorshid
Position	President of the Australian Medical Association
Address:	39 Brisbane Street Ave, Barton ACT 2600
Date:	14 June 2022

I, Omar Mohamed Khorshid, say as follows:

1. I am an orthopaedic surgeon, fellow of the Royal Australasian College of Surgeons and President of the Australian Medical Association Limited (**AMA**).

2. I am authorised to make this statement on behalf of the AMA and, except where otherwise stated, make this statement from my own knowledge.

Professional background

3. I obtained a medical degree at the University of Western Australia in 1997, following which I completed my advanced surgical training in orthopaedics and was awarded Fellowship of the Royal Australasian College of Surgeons in 2007.

4. After a year as a consultant orthopaedic surgeon at Fremantle and Rockingham Hospitals, I spent a year performing Fellowships in Sydney (knee surgery) and Edinburgh (complex joint replacement), before returning to Perth in 2009.

5. I continue to practice as an orthopaedic surgeon, specialising in arthroscopic and reconstructive surgery of the knee and hip.

6. Between June 2017 and July 2019, I served as the President of Australian Medical Association (WA) Incorporated. In August 2020, I was elected President of the AMA, for a two-year term.

7. 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 the Federal and State governments to develop and influence health policy to provide the best outcomes for doctors, their patients, and the community.

8. Through my direct experience as an orthopaedic surgeon, and also through my past and present roles within the WA and national AMA, I am familiar with the commercial arrangements between private health insurers (**PHIs**) (on the one hand) and medical specialists and hospitals (on the other) with respect to the provision of medical care to consumers under their private health insurance agreements with PHIs.

9. I am also familiar with the policy and legislative framework that underpins these commercial arrangements, as well being familiar with the Australian private health insurance sector more generally.

The application for authorisation

10. The AMA took an active role in the ACCC's public authorisation process. I recently approved the AMA's application to intervene in these proceedings on the basis that I – and the AMA – considered that the proposed arrangements submitted by the authorisation applicants for authorisation are likely to give rise to harmful effects in the way in which medical services are provided by specialists in Australian hospitals.

11. I understand that, under the application for authorisation, the authorisation applicants propose to establish a joint buying group, under which participating PHIs will enter into commercial arrangements with either hospitals or individual medical specialists.

12. In my experience, I am aware that specialists largely work within hospitals as independent contractors, but that in many instances – principally in the public hospital sector – they may work as employees of the hospital.

13. Insofar as the authorisation applicants propose to negotiate commercial arrangements with hospitals, the AMA does not object to that conduct, subject to the following exceptions:

    a. first, that just as the AMA objects to forms of proposed arrangements between PHIs and independent specialists (discussed below), the AMA similarly objects to the authorisation applicants being permitted to enter into commercial arrangements directly with hospitals which are designed to, or have, the same effect, in those circumstances where the hospitals contract with specialists for the acquisition of specialist services.

    b. second, that to the extent that the authorisation applicants propose to use commercial arrangements made directly with hospitals to impose outcome targets on specialists who participate in a Medical Purchaser Provider Agreement (**MPPA**) (which I discuss further below), the AMA objects to that course; and

    c. third, the AMA objects to the authorisation of any conduct that has the effect (or likely effect) of creating such concentration among PHIs in any relevant geographic market (whether National, State or regional) that would enable the PHIs to require (whether by way of incentivisation or coercion) hospitals to impose onerous and/or inefficient contracting terms on specialists.

14. Subject to those exceptions, the AMA's concerns are limited to the proposed terms under which the participating PHIs will contract with specialists in respect of the reimbursement rates offered to those specialists for medical services provided to patients insured by the relevant PHIs.

An overview of private health insurance reimbursement arrangements in Australia

15. Under the Commonwealth Medicare Benefits Scheme (**MBS**), the Commonwealth government fixes a minimum amount to be reimbursed to patients for medical services provided by them by a medical practitioner. These amounts are recorded on the Schedule to the MBS (**Schedule Fees**).
16. Where a patient holds private health insurance and is treated as an in-patient or, in some cases, a day patient, the patient is entitled to be reimbursed by the

Commonwealth up to an amount equal to 75% of the Schedule Fees. The PHI is responsible for the remaining 25% of the applicable Schedule Fees. This is the case, regardless of whether or not the specialist has any commercial arrangement in place with the patient's PHI.

17. However, most specialists enter in contracts with the PHIs, under which the PHI offers to reimburse the specialist an amount in excess of the total Schedule Fee if the specialist agrees to either treat the patient on a "no gap" or "known gap" basis (i.e. where the patient faces no out of pocket costs, or where those such costs are capped). These contracts are known as MPPAs.

18. Under the MPPA, the PHI also provides the specialist with billing and administrative services. In essence, the PHI pays the specialist an agreed amount and the PHI attends to claiming the MBS component from the Commonwealth. This represents a considerable saving for the specialist in administration costs.

19. Historically, MPPAs – which are ubiquitous – have largely been limited to the broad commercial terms underpinning the arrangements described above.

20. However, it is my understanding that the authorisation applicants propose to introduce a new form of MPPA which potentially will include performance targets and other reporting obligations, so as to enable the authorisation applicants to undertake detailed data analytics based on specialist performance (**New MPPA**).

The AMA's concerns

21. Following applications by the National Association of Practising Psychiatrists (**NAPP**) and Rehabilitation Medicine Society of Australia and New Zealand Ltd (**RMSANZ**) for review of the ACCC's authorisation of the proposed conduct, the AMA maintains its opposition to the authorisation application insofar as it relates to negotiations with specialist practitioners, or (as noted in paragraph 13 above) hospitals where the effect (or likely effect) of the contract is to compromise the clinical independence of treating specialists.

22. The AMA considers that the conduct the subject of the authorisation applicants' application will, if authorised by the Tribunal, have a direct and immediate impact on the commercial arrangements that underpin the provision of inpatient and day patient services by specialist medical practitioners in private and public hospitals in Australia.

23. The AMA considers that the proposed conduct is likely to result in the proposed buying group accumulating a level of market power that would allow it to impose terms and conditions on the medical specialists and private hospitals with which it negotiates that any individual participants in the buying group, absent the proposed conduct, would not be able to achieve. If achieved, such terms may either directly or indirectly affect patient outcomes and have a deleterious impact on the Australian healthcare system more generally.

24. The AMA's concerns with the proposed conduct are twofold. The first concern relates to the prospect that the New MPPA may erode doctors' clinical independence, and the second concern is that the proposed buying group could accumulate such substantial market power such that it could – among other things – advance an agenda of 'managed care' in Australia (in circumstances where that would not otherwise be likely to occur).

25. Both outcomes would be likely to result in significant public detriments while, at the same time, not be likely to generate any public benefits not already available through the roles carried out by the not-for-profit medical buying groups, AHSA and ARHG.

26. There is no limitation on those PHIs who could participate in the buying group. There are four major PHIs operating across Australia, being Medibank Private Ltd (**Medibank**), BUPA HI Pty Ltd (**Bupa**), Hospital Contribution Fund of Australia Ltd (**HCF**) and HBF Health Ltd in Western Australia (**HBF**) (each a **Major PHI**).

27. While their market penetration varies from State to State, the participation of any Major PHI in the buying group would be likely to dramatically affect the competitive landscape for the negotiation MPPAs, even more than would be the case without the participation of a Major PHI.

28. The fact that the authorisation applicants seek to limit the size of the proposed buying group to 80% of the national private health insurance market (in in the case of the Broad Clinical Partners Program (**BCPP**) only) does not resolve the AMA's concerns with or in respect of BCPP or more generally.

29. In the balance of this statement, I address the following topics:

    a. the operation of Australia's mixed public-private healthcare system;

    b. the role of MPPAs, detrimental terms of MPPAs, and opportunities for coercion created by the proposed conduct;

c. observations as to the markets likely to be adversely affected by the proposed conduct; and

d. observations as to the term of the authorisation sought by the authorisation applicants.

Australia's healthcare system: a brief overview

30. The Australian healthcare system is a mixed public-private system.

31. The public system guarantees treatment to public patients in public hospitals and is paid for by state/territory governments and the Commonwealth at no charge to the patient. The Commonwealth, through Medicare, also provides a rebate to patients that covers either part or all of the costs of seeing a private general practitioner, or specialist, and some allied health services. Whether Medicare covers part or all of those costs depends on whether the provider of medical services chooses to set its fees at, or above, the Schedule Fee for those services under the MBS.

32. 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 policyholders' in-patient and day care in private hospitals.

33. Again, depending on the scope of cover, insurers will pay for covered patients' hospital charges and the charges levied by treating specialists operating from the relevant hospital. Private health insurance allows patients to choose their own doctor, have the benefit of timely medical interventions (i.e. where the circumstances do not warrant emergency treatment, and so are referred to as 'elective' treatments), and the benefits of continuity of care with a particular specialist or treatment team.

34. 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% of the Schedule Fee. However, each of these amounts is only notionally reimbursed to the patient; in practice in most cases, the patient assigns their right to the Medicare-paid component to the treating specialist, and the PHI pays its 25% component directly to the specialist on behalf of the covered patient.

35. The Schedule Fee is set by the Commonwealth and, for the vast majority of services, represents a figure below the prevailing market rate for the relevant service. Only a

minority (fewer than 25%) of medical services are not provided at a premium to the Schedule Fee. The amount of the difference between the Schedule Fee and the actual fee charged by the treating specialist is called the “out of pocket” or “gap” amount.

36. In addition to covering 25% of the Schedule Fee, PHIs will also, in most cases, cover all or part of the “gap” that remains and that, absent insurance, would otherwise fall to be paid by the patient.

The role of MPPAs

37. So that PHIs are not in a position where their policyholders must pay “gaps” of unknown or unpredictable amounts, PHIs generally enter into agreements with individual medical practitioners for the specialist costs and, separately, with private hospitals for the associated hospital fees and charges, so that the total “gap” that is not covered by the insurer on behalf of its policyholders is known in advance,

38. Under those agreements, the medical specialist agrees either not to charge covered patients any “gap” at all, or only an agreed, “known” amount.

39. Some insurers have also implemented a model where they enter into a separate agreement with a hospital to pay above the contracted amount to establish a “no gap” scheme for specific treatments. This requires all the specialists involved in the service being provided to the patient to agree to the “no gap” benefit for the patient.

40. These agreements are generally attractive to both covered patients and some, but not all, medical specialists.

41. They are attractive to covered patients, because they mean that the policyholder faces no gap or only needs to contribute a fixed amount. This certainty is important to patients.

42. They can be attractive to medical specialists for two reasons:

    a. first, by entering into such an agreement with a PHI, the policyholder is more likely to select that practitioner over another, who has not entered into such an arrangement with the policyholder’s PHI (on the basis that the patient has confidence that they will not be liable for “out of pocket” expenses or, at the very least, only for a fixed amount, than if they obtained the same service from a practitioner who had not entered into an agreement with the patient’s insurer); and

b. second, MPPAs provide certainty as to the revenue that the practitioner is likely to make from providing each service, even if the fees offered under the MPPA may be below the market rate for those services. By 'market rates', I refer to the rates that the AMA considers to be fair value for the relevant service, and rates which the AMA understand are often charged by specialists who are providing that service other than as pursuant to "no gap" or "known gap" MPPAs.

43. A critical element of the current MPPA regime is the fact that (with the exception of specific arrangements such as BCPP) specialists – even if they have entered into an MPPA with a PHI – have the discretion to decline to offer the services to a policyholder under that MPPA. That is, they may elect to provide the services to patient outside a no or known gap scheme, with the subsequent gap being the difference between the Schedule Fee and the fee charged by the specialist.

44. While specialists with MPPAs typically provide services pursuant to the MPPA, the AMA considers that an important element of the current structure of the commercial arrangements is that specialists are not compelled to supply all services pursuant to the MPPA.

45. Based on analysis undertaken by the AMA, on average, for "no gap" or "known gap" agreements, PHIs pay an amount equal to approximately 64% of the Schedule Fee (as opposed to their legally obligation to contribute 25% of the Schedule Fee). In essence, this means that, on average, the specialist receives reimbursement from the insurer that it significantly higher than the Schedule Fee. This is illustrated in Table 1 below for the March 2022 quarter.

	No gap and no agreement (5% of services)	No gap agreement (84% of services)	Known gap (8% of services)	All agreements (92% of services)	No agreement and a gap (3% of services)	All services
MBS (75%)	$72	$72	$124	$77	$192	$80
PHI	$24	$60	$119	$66	$70	$64
Patient	$0	$0	$114	$10	$474	$23
Total fee	**$96**	**$133**	**$358**	**$153**	**$736**	**$167**
MBS fee (100%)	$96	$96	$166	$103	$256	$107
Total fee as a percentage of MBS fee	100%	138%	216%	149%	288%	156%
PHI as a percentage of MBS fee	25%	63%	72%	64%	27%	60%

Table 1: Average value of reimbursements by agreement type (Source: AMA analysis)

46. Together with the patient contribution (around $10), the specialist generally receives around 50% more under an MPPA than they would if they simply obtained the Schedule Fee.

47. For this reason, the majority of specialists agree to enter into MPPAs containing "no gap" or "known gap" agreements.

48. According to data collected and compiled by APRA (and reflected in Table 1 above), for the March 2022 quarter, 84% of all medical services covered by an insurer were provided to the patient under a "no gap" agreement, and a further 8% involved "known gap" arrangements. While this suggests that 92% of services were provided pursuant to MPPAs, the penetration of MPPAs is likely to be larger, given that specialists may opt out from providing services under their MPPAs on a case-by-case basis.

49. Table 2 below reflects quarterly statistics for the March 2022 quarter, as to the usage of MPPAs by reference to specialty groupings. It shows the use of MPPAs (both no gap and known gap agreements) across some of these groupings in Australia. Psychiatry services, relevant to NAPP, fall within Group 1. Rehabilitation services, relevant to RMSANZ, fall within either Group 1 or Group 18.

MBS Speciality Block Groupings	MPPAs (as a percentage of all services)
Group (1) Specialist, consultant physician, and consultant psychiatric attendances [Groups A3, A4 and A8; items 104-108, 110-131, 300-352]	95.65%
Group (4) Anaesthesia [Groups T6, T7, and T10; items 17603 – 18298, 20100-25205]	95.34%
Group (6) Colorectal surgical operations [Subgroup T8.2; items 32000 – 32212]	97.56%
Group (10) Neurosurgical surgical operations [Subgroup T8.7; items 39000 – 40903]	95.92%
Group (18) All other items.	94.19%
Total all services	92.16%

Table 2: Usage of MPPAs by specialty grouping (Source: AMA analysis of APRA data)

Detrimental terms of MPPAs

50. As noted above, MPPAs have historically been limited to providing details relating to the mechanisms for implementation of the reimbursement of specialists who agree to offer services on a no or known gap basis.

51. However, the AMA is aware that the authorisation applicants have developed a template MPPA which extends the scope of the MPPA far more broadly, intruding into areas of medical decision making in a way that they have never previously done.

52. While this template agreement has been described by the authorisation applicants as being designed – at least initially – for the BCPP services, the authorisation applicants have indicated a desire to expand its application across other specialities more broadly.

53. Further, and significantly, it is proposed that the template arrangement be compulsory for its term (i.e. that specialists cannot opt out on a case by case basis). This severely impacts on specialists' clinical discretion.

54. In addition to the terms contained in the template MPPA, authorisation is sought for collective bargaining more generally, and does not impose any limit on the kinds of

terms that could be included in such contracts. As such, the scope of the conduct is unknown, extending far beyond pricing matters, and the potential harms are conceivably unlimited. In this regard, PHIs change their terms and conditions for MPPAs from time to time and have been known to take unilateral action that imposes new and more stringent conditions on participating doctors.

55. For example, terms that could be imposed in MPPAs include the introduction of 'performance' or 'quality' metrics or benchmarks that could result in:

    a. practitioners electing to turn away patients who are considered 'high risk' or otherwise requiring treatments that are not likely to advance the practitioner's achievement of the relevant target (which could, in turn, have the effect of forcing those patients into the public system);

    b. practitioners being incentivised to treat patients in a different manner than they otherwise would in the absence of the performance targets (thus, compromising clinical independence); and/or

    c. incentivising 'cost-cutting' in order to maintain existing margins to the detriment of patient wellbeing and health outcomes generally.

56. In addition, a new MPPA can effectively limit which other specialists a doctor may choose to work with in delivering care for a patient in so far as it requires all participants to agree to charge no out of pocket costs to a patient. It is important that specialists know and understand the clinical practice of other specialists involved in the delivery of services to a patient, including areas of specific expertise, so that the best possible care is provided. Changes that deconstruct this well-established feature of care delivery have the potential to result in lower quality of care for patients.

57. Given these risks for clinical independence, it makes sense to me that specialists would – at least in the first instance – need to be provided with an incentive to switch from the MPPA to the New MPPA. It is the AMA's expectation that this incentive would occur by way of greater levels of reimbursement under a New MPPA than currently offered under the MPPAs.

58. As discussed below, the ability of specialists to reject such proposed terms is severely constrained by the commercial need for the specialists to enter into such arrangements once they are offered by PHIs representing anything more than a marginal proportion of the PHI market in each relevant geographic market.

59. If a specialist decides not to participate in an MPPA then it is highly likely that their patients will face higher out of pocket costs as a result. While this will put pressure on many specialists to participate in an MPPA, there will be some who for reasons of reputation or the nature of their practice will be able to opt out of MPPAs altogether. As noted above, currently only 3% of services are provided on this basis.

Risk of economic coercion

60. Against this background, the AMA is concerned that the proposed conduct may create opportunities to economically coerce practitioners into agreeing to the proffered New MPPA, whether as part of the BCPP or otherwise.

61. As the proposed conduct will extend the availability of agreements between PHIs (represented by the proposed buying group) and practitioners, the total share of medical services provided pursuant to “no gap” or “known gap” MPPAs is likely to increase. An increased prevalence of such MPPAs will, in turn, present more opportunities for PHIs who are contracting with medical specialists to impose other terms on practitioners requiring them to provide patient data or meet certain performance targets.

62. Further, given the commercial incentives – if not imperatives – for specialists to enter into MPPAs, there is a real risk that specialists will have no option but to enter into such an arrangement with the PHI members of the buying group. This is exacerbated by the participation of any Major PHI.

63. This presents the risk that the New MPPA could be used to leverage behavioural outcomes inconsistent with independent clinical practice where there is a financial consequence for not doing so.

64. The risk increases where the New MPPAs progressively replace the MPPAs. In my opinion, there would then be no commercial imperative for the PHIs to retain the MPPAs, as specialists will be compelled to enter into whatever form of MPPA is offered (i.e. the New MPPA).

65. To that end, the AMA is very concerned about the authorisation of the proposed conduct in the absence of guarantees that MPPAs would be retained (at consistent reimbursement levels) so as to ensure that specialists were not economically coerced into accepting the New MPPA.

Observations about markets affected by the proposed conduct

66. Unlike the market for the private health insurance, where insurers are required by legislation to offer policyholders within the same State the same terms (with ACT and NSW treated as one market), the markets in which AMA members provide medical services are complex and nuanced. The complexities and nuances arise because the medical practitioner profession comprises a range of specialties many of which operate in different markets to one another, and all of which are subject to different market dynamics.

67. This can be observed through an analysis of the proportion of a specialty's services in a given region that are charged at or below the Schedule Fee. The higher the proportion of services, the more significant that specialty's bargaining power vis-à-vis private health insurers; whereas the lower the proportion of services, the less significant that specialty's bargaining power.

68. For example, in the case of urologists operating in the ACT for the March 2022 quarter:
    a. less than 2% of services were charged at or below the Schedule Fee;
    b. approximately 49% of services involved no agreement and a gap paid by the patient;
    c. approximately 23% of services involved a 'no gap' agreement; and
    d. approximately 27% of services involved a 'known gap' agreement.
69. By contrast, for the same period for the average medical practitioner operating anywhere in Australia:
    a. approximately 5% of services were charged at or below the Schedule Fee;
    b. approximately 3% of services involved no agreement and a gap paid by the patient; and
    c. approximately 92% of services involved a 'no gap' or 'known gap' agreement.
70. Because different specialties are subject to different market dynamics (as the example above shows), it is highly unlikely that the proposed conduct will have a uniform effect on each specialty and in each geographic market within the medical profession.

71. For most specialties – where practitioners do not enjoy the kind of bargaining power enjoyed by urologists in the ACT, for instance – the consequences for practitioners choosing not to enter into 'no gap' or 'known gap' agreements are likely to be significant. In those circumstances, practitioners face a choice between:

a. charging only the Schedule Fee (with no additional charge to the patient or insurer), which will reduce the practitioner's revenue; or

b. charging the patient a 'gap', which will maintain the practitioner's revenue by discourage patients from seeking treatment.

72. Notwithstanding the comments above, Table 3, which contains market data collected by APRA, describes the State-based market shares for the Major PHIs.

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

Table 3: PHI market share by State/Territory (Source: APRA data)

73. The smaller PHIs – which the authorisation applicants anticipate will join the buying group – are contained within the "Other funds" line item.

74. As a result, even assuming no participation by Major PHIs, the market share of the buying group could conceivably become that largest PHI block in NSW/ACT (~34%), Victoria (~38%) and Tasmania (~38%). In Queensland, it could account for ~30%, meaning that ~90% of the market would effectively be shared across 3 parties in that State.

75. In some instances, the participation of even a single Major PHI could result in likely market shares equal to or greater than double the market share of the current largest PHI.

76. Where one or more PHIs have a significant share in a geographic market, there is an even stronger economic incentive for practitioners to accept no or known gap agreements with that PHI. For example, the AMA's members have told me that it is not feasible to operate in the South Australian market without an agreement in place with Bupa.

77. nib is the only Major PHI that currently does not offer a known gap program. I consider that it is likely that if PHIs that currently use the AHSA buying group shift to the proposed buying group operated by the authorisation applicants, this will increase the likelihood that specialists will be required to enter into MPPAs with the members of the buying group and that this will reduce the number of PHIs that offer known gap schemes.

78. More generally, the AMA is concerned that the participation of a Major PHI in the buying group will be likely to prompt further consolidation in the market, resulting in a reduction in the options available to consumers, an increase in the bargaining power of the remaining PHIs and detriment for specialists and consumers.

79. As discussed above, over 90% of medical services funded by PHIs are provided under unregulated known or no gap agreements, and in respect of which the terms of the MPPAs can be changed by PHIs them at any time.

80. The AMA is concerned that increased market power generated by the authorisation will undermine the current competition among insurers on benefits paid. nib generally provides the lowest benefits for private medical services of the major PHIs, as demonstrated in the AMA's 2021 Private Health Insurance Report Card, figure 6, which can be found at https://www.ama.com.au/articles/ama-private-health-insurance-report-card-2021.

Term of the proposed authorisation

81. The AMA objects to the proposed term of authorisation of 10 years. The AMA considers that the PHI market is changing rapidly and that there are likely to be significant changes over the next 5 – 10 years.

82. Consistent with its broad role, the AMA anticipates being heavily involved in working with the Commonwealth Government in the development of statutory and regulatory responses to developments in this area.

83. As such, the AMA is concerned that an authorisation for a period in excess of 5 years could materially affect the ability of the Commonwealth Government – and industry more generally – to effectively and meaningfully respond to such changes and, particularly, any changes that arise as a result of the authorised conduct. This is particularly the case where there is significant uncertainty as to the impact of the

authorised conduct in an environment where aspects of the proposed conduct have not previously been explored in Australia.

Date: 14 June 2022

Dr Omar Khorshid
President, AMA