AMA

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

Thursday, 23 July 2026

AMA submission to ACCC application for authorisation (revocation and substitution) from Honeysuckle Health Pty Limited and nib health funds Limited

Introduction

The Australian Medical Association (AMA) welcomes the opportunity to comment on the application by Honeysuckle Health Pty Ltd (HH) and nib health funds Limited (nib) for authorisation by revocation and substitution of authorisation AA1000542.

The AMA participated in the original authorisation process and in the subsequent proceedings before the Australian Competition Tribunal. As part of that process, the AMA and other parties raised concerns about the potential for the proposed arrangements to affect clinical independence, patient choice, referral autonomy, practitioner discretion, data use and transparency. Those concerns were addressed, in part, through the Australian Competition and Consumer Commission's (ACCC) authorisation conditions and through additional safeguards agreed with the applicants.

The 2021/2022 ACCC and tribunal processes resulted in a regulatory framework comprising both the ACCC's authorisation conditions and additional safeguards agreed between the parties (Deed of Settlement, July 2022) as part of the resolution of the tribunal proceedings.

This submission focuses on the need to retain those safeguards.

The AMA position

The AMA's position is that any replacement authorisation must retain the substantive safeguards that applied under the previous authorisation framework, including both the conditions imposed by the ACCC and the additional protections ultimately reflected in the Deed of Settlement of the Tribunal proceedings. In the AMA's view, those safeguards represented an appropriate balance between allowing innovation in healthcare funding and protecting clinical independence, patient choice and competition. Without these protections remaining in place, the AMA would oppose the application.

The AMA does not consider there is any demonstrated basis for reducing or removing those protections. To the contrary, if the applicants contend the authorised arrangements have operated successfully over the past five years, that supports the continuation of the existing safeguards.

Background on the 2021 process

In 2021, the AMA's concerns focused on three issues: preserving the safeguards imposed in the ACCC's final determination; ensuring that nib or HH continued to offer a viable fallback medical gap scheme; and removing the most problematic aspects of the HH scheme.

The resulting framework therefore comprised three sets of safeguards:

(1) The conditions in the ACCC final determination, which are included at Appendix A to this submission.
(2) The conditions applicable to the fallback medical gap scheme for doctors who did not opt in to Broad Clinical Partners Program (BCPP) or similar arrangements (Clause 4.2 of the Deed of Settlement), included at Appendix B.
(3) The conditions applicable to BCPP and any other opt-in agreements that did not satisfy Clause 4.2 (Clause 4.3 of the Deed of Settlement), also included at Appendix B.

The AMA submits that these safeguards should not merely be noted as historical context. If the applicants seek the benefit of a substituted authorisation, the safeguards that addressed the concerns raised in the original process should continue in enforceable form, either as conditions of authorisation or through equivalent enforceable undertakings.

Why the conditions of the ACCC determination from 2021 remain important

The ACCC authorised HH and nib to operate the HH Buying Group and collectively negotiate/manage contracts with healthcare providers on behalf of participating healthcare payers in 2021. The full ACCC summary is included at Appendix A.

The conditions imposed by the ACCC remain important because they provide key safeguards against excessive private health insurer market power while allowing the claimed benefits of collective purchasing arrangements to be realised. In particular, the exclusion of major insurers, the prohibition on collective boycotts, and the continued operation of protections under the *Private Health Insurance Act 2007 (Cth)* help preserve clinical autonomy, patient choice and fair bargaining arrangements between insurers and healthcare providers.

These safeguards were central to the ACCC's conclusion the public benefits of the authorisation outweighed its potential detriments, and there is no evidence the underlying concerns they were designed to address have diminished.

Why clauses 4.2 and 4.3 remain important

Clauses 4.2 and 4.3 of the Deed of Settlement formed an important part of the framework that applied following resolution of the tribunal proceedings. They were negotiated to address concerns raised by the AMA and other medical organisations and were material to the resolution of the Tribunal proceedings.

The safeguards contained in clauses 4.2 and 4.3 addressed two distinct contractual arrangements considered during the original proceedings. The tribunal described the distinction between those arrangements in paragraph 102 as follows:

> *Clause 4.2 is concerned with medical gap schemes while cl 4.3 is concerned with the [Broad Clinical Partners Program (BCPP)] and other agreements with medical specialists, typically [medical purchaser provider agreements (MPPAs)]. As discussed earlier, the BCPP is a particular form of arrangement currently offered by nib whereby MPPAs are entered into with all of the medical specialists involved in a single episode of hospital treatment so that there is no "gap" fee payable by the patient for the range of medical services provided during that episode of treatment.* (Paragraph 102)

In other words, Clause 4.3 applied to BCPP and other, similar arrangements. The AMA maintained these arrangements had to be opt in arrangements, both by the treating physician and the patient, and could not be imposed by HH/nib. Consequently, as participation in those arrangements had to be voluntary, the safeguards proposed were directed at ensuring genuine practitioner and patient choice, protecting clinical independence, establishing appropriate parameters around data collection and use, and preventing inappropriate incentives or penalties. The AMA also argued the voluntary nature of such arrangements meant there had to be a 'fallback' medical gap arrangement made available to those who did not opt in.

Clause 4.2 applied to the fallback medical gap arrangements available to medical practitioners who did not choose to participate in the BCPP (or similar) arrangements. The clause preserved important protections relating to clinical independence, patient choice and practitioner autonomy. The need for these protections was consistent with concerns recognised during the tribunal proceedings.

The tribunal's determination on clauses 4.2 and 4.3 of the Revised Deed of Settlement (extracted at Appendix B) is found in paragraphs 105–115. In relation to Clause 4.3:

> *[…] Dealing first with cl 4.3, the Tribunal is satisfied that the conditions imposed by cl 4.3(c)-(l) are directed at addressing the concerns of the Review Applicants and the AMA in relation to the clinical independence of medical specialists when providing medical services pursuant to the BCPP or MPPAs more generally. Those parties accept that these conditions sufficiently address these concerns, and it is not claimed by the ACCC as contradictor that these conditions cause any public detriment. It is not apparent to the Tribunal that any harm to competition or the broader consumer or public interest arises from those conditions.* (Paragraph 105)

In relation to Clause 4.2 the tribunal found:

> *The Tribunal generally accepts the submissions of the Review Applicants and the Authorisation Applicants that the object of most of the remaining conditions is to protect the clinical independence of medical practitioners. That is most apparent in the case of […] paras (b), (c), (d) and (e) in the Revised Deed.* (Paragraph 115)

> *[…] the Tribunal considers that the likely effect of [para (a) in the Revised Deed] is not of sufficient materiality to warrant a refusal of leave to withdraw. In reaching that conclusion, the Tribunal has taken into account the facts that the Authorisation is for a period of five years and the ACCC has power to consider whether the provisions of the Revised Deed cause a "material change in circumstances" pursuant to s 91B of the Act or would otherwise contravene Pt IV of the Act.* (Paragraph 115 (a))

> *[para (f) in the Revised Deed] goes no further than preserving the freedom of medical practitioners to choose the commercial terms on which they will treat individual patients.* (Paragraph 115 (b))

> *[para (g) in the Revised Deed] stipulates that the medical gap scheme offered by nib, and made available by Honeysuckle Health to the HH Buying Group, must not be confidential. It is difficult to conceive how a medical gap scheme, which is offered to medical specialists, could be confidential.* (Paragraph 115 (c))

The tribunal concluded:

> *[…] The Tribunal does not consider that the remaining conditions in the Revised Deed are likely to have a material adverse effect on the interests of medical specialists who participated in the ACCC authorisation process to oppose the Authorisation.*

The AMA submits these remaining safeguards in the Revised Deed remain relevant and should be retained in any future authorisation, covering BCPP, GapSure, or any similar services.

Conclusion

The AMA's starting position is that the ACCC should not grant a broader authorisation, or a less constrained authorisation, than that which ultimately applied following the 2021 authorisation process and subsequent tribunal proceedings. The applicants should bear the onus of demonstrating why any existing limitation, condition or safeguard is no longer required. In the absence of such evidence, the AMA considers the existing framework should be retained.

The AMA requests that the ACCC adopt a staged consultation process, including publication of any draft determination and proposed conditions, a reasonable period for stakeholder submissions in response, and an opportunity for interested parties to be heard before a final determination is made. Given the complexity of the issues and the extensive concerns raised during the previous authorisation, a single round of submissions is unlikely to provide an adequate opportunity for stakeholders to address matters arising during the course of the ACCC's consideration.

The AMA would be pleased to provide further submissions, evidence or expert material should the ACCC consider that would assist its assessment.

Contact

president@ama.com.au

Appendix A: Summary of the ACCC determination from 2021

Below is the unedited (but formatted) summary provided in the ACCC Determination of the Application for authorisation lodged by Honeysuckle Health Pty Ltd and nib health funds limited in respect of the Honeysuckle Health Buying Group Authorisation number: AA1000542 from 21 September 2021 (ACCC Determination, pp1–4).

Summary

The ACCC has decided to authorise Honeysuckle Health (HH) and nib (together, the Applicants) to form and operate a buying group (HH Buying Group) to collectively negotiate and manage contracts with healthcare providers (including hospitals and medical specialists) on behalf of private health insurers (PHIs), medical insurance providers and other payers of healthcare services until 13 October 2026.

Authorisation is granted with a condition that the Applicants must not supply services to Medibank, Bupa, HCF and HBF in Western Australia (Major PHIs).

The application for authorisation

HH currently provides data analytics, contract negotiation, procurement and administration services in relation to nib's contracts with hospitals, medical specialists, general practitioners and allied health professionals.

The Applicants seek authorisation for HH to provide these services to additional healthcare payers and form a joint buying group (the Proposed Conduct).

The Applicants have not sought authorisation for the HH Buying Group to collectively boycott the services of any healthcare provider. This means that the HH Buying Group is not authorised to collectively refuse to deal with any healthcare provider.

Consultation and amendments to the application for authorisation

There has been significant opposition to the application for authorisation from healthcare providers. In response to these concerns, as well as issues identified by the ACCC, the Applicants amended their original application to exclude Major PHIs from participating in the HH Buying Group in relation to hospital contracting, medical gap schemes and general treatment networks.

In the amended application, the Applicants sought authorisation for HH to provide contracting services to all PHIs, including major PHIs, in relation to the Broad Clinical Partners Program (BCPP), subject to a condition that the HH Buying Group would be allowed to represent a maximum of 80 per cent of the national private health insurance market (based on the number of hospital policies) in relation to the BCPP. The BCPP is a program under which HH enters into agreements with medical specialists to ensure that customers are not charged out-of-pocket costs for the range of medical services provided during an episode of hospital treatment (currently only for joint replacement surgery, but it is proposed to apply to other services in the future).

Public benefits

The ACCC considers the Proposed Conduct is likely to result in the following public benefits:

- a greater choice of buying groups for smaller PHIs and increased competition between these buying groups, and
- improved access to information for smaller PHIs, through the option to utilise a particular type of data analytics based on aggregated data of all members of the buying group, which would not otherwise be available to those PHIs and will likely assist them to develop and offer more competitive insurance products and services.

Increased competition between buying groups is likely to foster greater innovation and incentivise the buying groups to provide better value to their participants. In turn, and in combination with the improved information available to them, smaller PHIs are likely to be able to compete more effectively with the Major PHIs to attract customers by offering reduced costs or better services to the benefit of PHI consumers.

The ACCC considers the Proposed Conduct is also likely to result in some public benefits for consumers through the BCPP. The ACCC accepts that the BCPP delivers benefits to existing nib members by giving them the certainty of a no gap experience for the range of services involved in knee and hip replacements with certain medical specialists. To the extent that the program is widened to include new participants in the HH Buying Group and additional procedures and specialists, the ACCC considers this is likely to result in public benefit by extending an increased no gap experience and certainty of costs for customers of those participants.

Public detriments

The ACCC considers that if the Proposed Conduct enabled small and Major PHIs to join the BCPP up to the point where they represented 80 per cent of hospital policies, this would be likely to result in public detriment by creating an imbalance in bargaining power between PHIs and medical specialists, leading to inefficient outcomes in the provision of health services by medical specialists.

In order to address the concern regarding an imbalance in bargaining power, and to ensure the net public benefit test is met, the ACCC has imposed a condition of authorisation that prohibits HH from supplying BCPP services to Major PHIs. The ACCC considers that this will not compromise the public benefits of the Proposed Conduct, because Major PHIs have the scale to develop similar no gap experience programs and can do so without the need to join the BCPP.

The ACCC notes that even without the Major PHIs involved, the HH Buying Group could comprise nib and a significant number of smaller PHIs collectively negotiating with individual medical specialists. The ACCC recognises this is a different type of arrangement to the collective bargaining arrangements that it has previously authorised, which typically involve the aggregation of a number of smaller entities to negotiate with a larger buyer or seller.

However, the ACCC considers that the HH Buying Group's bargaining power in this situation is limited by the Private Health Insurance Act 2007, which provides that in respect of in-hospital medical services provided to private patients PHIs must pay specialists at least 25 per cent of the Medicare Benefits Schedule (MBS) fee for the service (which is set by the Federal Government). The remaining 75 per cent of the MBS fee is payable by Medicare. This means that PHIs (including nib and other HH members) cannot refuse to make a minimum level of payment to specialists with whom the PHI has no Medical Purchaser Provider Agreement (MPPA). Accordingly, the practical effect of any increased bargaining power will be smaller than in other

circumstances where buyers are legally permitted to completely bypass a given supplier by refusing to acquire their products or services.

The ACCC considers that there is insufficient evidence that the Proposed Conduct is likely to result in an imbalance in bargaining power between the HH Buying Group (comprising nib and a number of smaller insurers) and hospitals.

The ACCC also notes the HH Buying Group will not be negotiating agreements with individual providers in the general treatment network, which includes physiotherapists, dentists, optometrists and chiropractors. Any changes in the buying power of the HH Buying Group are unlikely to impact the setting of prices or terms and conditions for the general treatment network.

Concerns about US-style managed care

The ACCC acknowledges that many medical practitioners and their peak representative bodies have raised concerns that the 'value-based' contracting model proposed by the Applicants will lead to the introduction of US-style managed care in Australia.

Authorisation by the ACCC exempts the Applicants from specified sections of the Competition and Consumer Act 2010. Apart from this, it does not alter any existing legal requirements, restrictions or policy settings regarding healthcare in Australia. Value-based contracting is already occurring and will most likely continue in the industry regardless of the formation of another buying group. It is clear nib/HH and other (larger) PHIs are likely to continue to adopt a value-based contracting approach to negotiating with providers even if the authorisation was not granted.

The ACCC has carefully considered how interested party concerns about value-based contracting and the possible introduction of US-style managed care factor into the net public benefit test that must be satisfied in order to grant authorisation. The ACCC recognises that a buying group with sufficient market power and which uses inducements or threats to influence the nature of treatment that medical practitioners and hospitals provide patients, or offers strong financial incentives to patients regarding their choice of practitioner, might be very difficult for many of its participants and members' customers to resist. This may in turn lead to pressure for others to adopt similar arrangements and embolden other insurers to do the same.

The ACCC considers that there has been insufficient evidence provided to support the claim that the Proposed Conduct is likely to cause or lead to US-style managed care in Australia. In any event, if this conduct were to arise it would contravene other legislation as outlined below.

The ACCC notes that the Private Health Insurance Act 2007 (PHI Act), administered by the Commonwealth Department of Health, prohibits PHIs from limiting the professional freedom of medical practitioners. Further, the obligation on insurers under the PHI Act to pay at least 25 per cent of the applicable MBS fee prevents PHIs from altogether refusing to fund treatments by healthcare providers. Authorisation of the Proposed Conduct does not alter the existing legal requirements in the PHI Act, including provisions that ensure or preserve the clinical autonomy of medical practitioners and patient choice. Medical practitioners concerned that their autonomy has been or could be compromised should seek assistance from the Commonwealth Ombudsman or the Commonwealth Department of Health.

The ACCC notes that concerns about the introduction of managed care are not new and that the same arguments were raised by medical practitioner groups opposing legislation permitting the introduction of MPPAs in the mid-1990s.

Overall, the ACCC considers that the Applicants' implementation of value-based contracting is unlikely to change the current Australian healthcare system to a US-style managed care model. In any event, some Australian insurers are already implementing value-based contracting and it appears likely that this will continue. The future without the Proposed Conduct is likely to be one where value based contracting continues to exist.

Balance of public benefits and detriments

On balance, and with the condition of authorisation that has been imposed, the ACCC considers that the Proposed Conduct is likely to result in a public benefit and that this public benefit would outweigh any likely detriment to the public from the Proposed Conduct.

Length of authorisation

The Applicants sought authorisation for 10 years. The ACCC understands that the majority of agreements with private hospitals and medical practitioners have a two to three year term and HH is likely to require time to establish the HH Buying Group and put in place arrangements with healthcare providers. In light of this and the ACCC's assessment of the public benefits and detriments of authorisation, the ACCC considers it appropriate to authorise the Proposed Conduct for five years, rather than the 10 years sought. This will give the ACCC an earlier opportunity to re-assess any public benefits or detriments that have resulted from the Proposed Conduct if the Applicants decide to apply for re-authorisation in the future.

In these circumstances, the ACCC grants authorisation with a condition until 13 October 2026.

Appendix B: Clauses 4.2 and 4.3 from the Revised Deed of Settlement

Below is an extract from pages 9–11 of the Revised Deed of Settlement, specifically clauses 4.2 and 4.3, as included in the Australian Competition Tribunal Applications for review of Honeysuckle Health Buying Group authorisation determination (No 2) [2022].

4.2 Continuation of a Medical Gap Scheme

Without limiting the restrictions in the Final Determination (particularly the restrictions related to Major PHIs), nib or HH must maintain, and HH must make available to all Participants of the HH Buying Group, a medical gap scheme which must:

(a) not require medical specialists to provide Additional Patient Data;

(b) not require medical specialists to:

(i) discharge patients to home treatment;

(ii) refer patients to particular specialists or specialists from a particular group (such as preferred or contracted specialists);

(iii) refer patients to particular allied health services or allied health services from a particular group (such as preferred or contracted services);

(iv) treat patients at particular facilities or facilities in a particular group (such as preferred or contracted facilities);

(c) not vary the fees paid to medical specialists based on whether or not nib or HH has a contract with the facility;

(d) not include Targets or any right to terminate or not renew a contract with a medical specialist for any failure to meet Targets;

(e) apart from the published fees being paid under the medical gap scheme, not include any additional incentive (whether financial or otherwise) for performance or patient outcomes;

(f) allow medical specialists to opt out of the medical gap scheme for individual patients; and

(g) not be confidential.

4.3 Conditions attaching to the BCPP and other agreements with medical specialists

Without limiting the restrictions in the Final Determination (particularly the restrictions related to Major PHIs), the HH Buying Group must only offer:

(a) the BCPP; and

(b) any other alternative agreement with medical specialists that do not meet all the criteria in clause 4.2,

to Participants if those agreements:

(c) do not require medical specialists to have regard to any clinical or treatment guidelines other than those developed or approved by an independent medical specialist body that is relevant to that area of medical specialisation or sub-specialisation;

(d) expressly acknowledge that any such clinical or treatment guidelines must be interpreted and applied independently by the medical specialist with regard to the individual circumstances and best interests of patients;

(e) expressly acknowledge the right of medical practitioners to exercise clinical independence at all times in relation to the provision of medical services;

(f) expressly acknowledge that the HH or the Participant will not interfere with the clinical independence of the medical specialist;

(g) in relation to any obligation to collect and disclose Additional Patient Data, expressly acknowledge that:

(i) medical specialists must obtain informed consent to the collection and disclosure of Additional Patient Data to the Participant and HH;

(ii) a patient can decline to provide consent for the collection and disclosure of Additional Patient Data to the Participant and HH;

(iii) if a patient declines to provide Additional Patient Data, no attempt should be made by HH or PHIs or third parties to contact patients to enter into alternate data collection arrangements outside the specialist-patient relationship;

(iv) a patient may not have the capacity to consent to the collection and disclosure of Additional Patient Data to the Participant and HH;

(v) medical specialists are otherwise not obliged to collect or disclose Additional Patient Data to the Participant and HH where in the medical specialist's reasonable opinion, the collection and disclosure of such data is not in their patient's best interests;

(vi) medical specialists will not be penalised for not collecting and disclosing Additional Patient Data in the circumstances described in subparagraphs (ii) to (v) above, where 'penalising' means terminating or deciding not to renew a contract with a medical specialist or otherwise treating a medical specialist less favourably (including by discouraging referrals to them).

(h) do not require a medical specialist to do any of the following if, in the medical specialist's reasonable independent assessment, this would not be in the best interests of the patient:

(i) apply clinical or treatment guidelines;

(ii) discharge the patient to home treatment;

(iii) refer the patient to particular medical specialists or medical specialists from a particular group (such as preferred or contracted medical specialists); or

(iv) refer the patient to particular allied health providers or allied health services from a particular group (such as preferred or contracted services);

(i) do not impose financial penalties on a medical specialist if they do not do any of the things specified in subparagraph (h) above;

(j) do not restrict a medical specialist from disclosing the existence of the agreement and its terms (other than prices whether in dollar amounts or percentages of Medicare Benefits Schedule Fee) to:

(i) a patient;

(ii) the AMA or other relevant professional body; or

(iii) the medical specialists' professional advisors including suppliers of medical indemnity insurance;

(k) do not include Targets or any right to terminate or not renew a contract with a medical specialist for any failure to meet Targets; and

(l) apart from:

(i) the fees being paid for provision of medical services to the patient; and

(ii) payments for participation in, and facilitation of, Quality Assurance Activities,

not include any incentive (whether financial or otherwise) for performance or patient outcomes.