By email 12th February 2021

Medical Surgical Assistants Society of Australia

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Connie Wu
Assistant Director,
Mergers Exemptions and Digital
Australian Competition & Consumer Commission Level 5, 1 William Street
Perth 6000

Dear Connie

Re: Application for authorisation by Honeysuckle Health Ltd and nib health funds limited

I write on behalf of the executive and members of the Medical Surgical Assistants' Society of Australia (MSASA). In turn we represent the interests of the thousands of doctors (members or otherwise) who work as surgical assistants or assistant surgeons in Australian private hospitals every day.

MSASA is alarmed by the proposed conduct by nib and Honeysuckle Health.

We believe the creation of this buying group has a high risk of creating a conglomerate of health funds with excessive market power. We believe the consequences of such an outcome would be detrimental to Australians with private health insurance.

We have considered in detail the document created by MinterEllison on behalf of HH and nib. We believe this document provides poor evidence for many of the claims it makes and in places it is misleading. We also believe that without the attachment of the annexures our ability to assess the proposal has been unfairly impaired. We make the following points:

1. HH and nib assert that the existence of the Australian Health Service Alliance (AHSA) buying group (an alliance of small funds with little market power) justifies the creation of a buying group with unlimited members, irrespective of size/market share. This is clearly non-sensical.

2. Point 1.7 states: "This creates a network of providers that health insurers can promote as being health services where their Customers can receive a no gap or known gap experience". HH and nib hereby imply that they offer a "known gap" product. This is false. In fact, nib is the only Australian fund that does NOT offer a known gap product to medical providers. Further, nib offers among the lowest "no gap" rates to providers in the market. As a consequence, providers who may otherwise use "known gap" schemes are more likely to opt out of the medical gap scheme with nib on a case-by-case basis, leaving the patient with much higher out of pocket costs, purely because they are insured with nib. Unfortunately, the nexus between the patient purchasing their cover with nib and receiving higher medical provider costs at a time of surgery is too distant for the patient to appreciate, and usually too late to avoid.

3. Point 3.14 states that "with the average age of the DVA population rapidly increasing, consequently this segment of the market is **reducing** in activity and relevance with hospital providers". This is patently incorrect. All health insurers know that as a population ages, its consumption of healthcare resources increases.

4. 4.12 provides no evidence of a benefit to patients of "value-based" contracting. The fact a health insurer has shifted to a different funding mechanism is proof of only one fact – the new mechanism is more profitable for the insurer. HH claims this shift from "fee-for-service" to "value-based" contracting sees "improvements" in health outcomes but does NOT provide any evidence to support this claim.

5. 4.14 cites an improvement in quality scores for primary care providers but does not elaborate. A reduction in costs for specialist groups cannot be used to infer any improvement in health outcomes of patients. A 2% lower readmission rate to hospitals is unlikely to be statistically significant, and again is only a very limited measure of health outcomes and could easily be accounted for by other variables.

6. 4.17 again claims improvements in health outcomes but provides no evidence to support this.

7. Based on a weak premise that "value-based" contracting improves health outcomes for patients, HH and nib are seeking to take a lead role in managing patient care. Their long-term vision sees them having a great deal of control over how medical providers manage their patients. This will no doubt improve their profitability and be in the best interests of their shareholders. At the same time, it will almost certainly be to the detriment of their members.

8. Their vision for benchmarking medical providers against each other and against themselves over time is naïve. It assumes all cases within a DRG are comparable. Unfortunately, their vision would lead to a system where no hospital, or provider would be prepared to take on difficult cases, which would clearly be to the detriment of patients.

9. When private healthcare is primarily funded by "for profit" insurers, there is a conflict between shareholders and patients for the economic rents available. The patients want those rents in terms of better services. The shareholders want them in terms of better investment returns. The proposal by HH and nib seeks to increase the power of "for-profit" insurers. Such insurers always place their shareholders' interests above their patients or customer's interests. Therefore, any increase in the power of "for profit" private health insurers is likely to be to the detriment of their consumers or patients.

Yours sincerely

Dr Nigel Munday
President MSASA 2021