Australian Dental Association
PO Box 520, St Leonards NSW 1590
14-16 Chandos Street, St Leonards NSW 2065 Australia
Tel 02 8815 3333

19 March 2018

Mr David Hatfield
Director
Adjudication Branch
Australian Competition and Consumer Commission
GPO Box 3131
Canberra ACT 2601

By email: adjudication@accc.gov.au

Dear Mr Hatfield,

RE: Submission from the Australian Dental Association re Hospitals Contribution Fund of Australia Limited (HCF) application for authorisation AA1000402

Thank you for providing the Australian Dental Association (ADA) with the opportunity to respond to the Australian Competition and Consumer Commission's (ACCC) Draft Determination (DD) regarding Hospitals Contribution Fund of Australia Limited's (HCF) application seeking authorisation (AA1000402 – referred to as the Application) for its conduct (Conduct) as defined by the Application.

Pre-decision conference

The ADA would like the ACCC to hold a pre-decision conference so that oral submissions in relation to the DD can also be made.

While the ADA refers again to the detail of its previous submission outlining why HCF's request for authorisation, if approved, would exacerbate existing public detriments that would far outweigh the benefits; this response addresses the ACCC's specific points raised in its DD.

There is an underlying issue which remains of concern. HCF lodging an application, in the ADA's view, signifies their own acknowledgement that the proposed Conduct potentially can fall foul of competition law. The ACCC should take this into account.

HCF/HBF proposed merger

The announcement that HCF and HBF's plan to merge should give rise to a separate merger authorisation process. The ADA would like to outline the potential impacts this proposed merger would have on the benefits and the likely detriments to result from the conduct for which authorisation is sought.

The announced merger, if authorised and completed, would considerably consolidate HCF and HBF's market power; which increases the likelihood that the public detriments outlined in the ADA's previous submission would be further exacerbated.

HBF operates almost entirely in Western Australia with just over 50% share of private health insurance cover – representing large market power. HBF in Western Australia adopt contracted provider arrangements through which they impose discriminatory rebates (a similar practice applied by HCF's More for Teeth [MFT] programme). Policy holders only get a higher rebate if they attend a dentist contracted to HBF, putting policy holders who choose to see a non-private health insurer contracted dentist at a disadvantage. The ACCC appears to overlook the fact that even though a policy holder pays the same premium for the same HBF policy,

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receives the same items of service, exercises their choice to have their treatment provided by a dentist of their choice, they receive a lower rebate.

The DD has paid scant weight to the underlying principle of private health insurance, i.e. the fundamental right for policy holders receive health treatment by their provider of choice. The ACCC have indicated the merged entity would have a market share nationally of approximately 18% of private health insurance – this significant market power makes activities of steering patients via discriminatory rebates to private health insurer (PHI) contracted providers more egregious for consumers and the health care provider market. The combined net assets of the new merger will exceed $3.7 billion which exceeds Medibank.

Neither fund has adequately increased dental rebates, if at all. Both HBF and HCF have embarked on increased exclusions in their policies. Allowing authorisation, as announced by ACCC, legitimises another inequitable practice to provide differential rebates based on consumers' choice of provider. The ADA opines this does not benefit the public overall. One recent example of HBF's increased exclusionary and inequitable policy practises is the announcement to introduce exclusion for insulin pumps in basic policies.[1] While not pertaining to HCF's MFT and dental clinic network (DCN) *per se*, it nonetheless demonstrates commercial practices that are detrimental to policy holders. If the ACCC were to approve the planned merger, HCF would also apply similar practices to general treatment/extras cover policy holders which will cause additional public detriment that would outweigh any public benefits. Further, the additional DCNs as requested by HCF's Application, supported by the DD effectively endorses and condones the above exclusionary behaviour.

If the ACCC is not going to support equal rebates for the same service under the same policy then why does the ACCC not advocate reduced premiums for contributors who elect to have a lower rebate to see the provider of their choice, i.e. the contributors (actual) preferred provider and not the PHI's 'preferred provider'.

More For Teeth (MFT) program

The ADA's previous submission, as outlined above, states that HCF and the private health insurance industry's practice of applying discriminatory rebates to favour PHI contracted dentists and healthcare providers interferes with policy holders' choice of provider and their continuity of care.[2] The DD notes as at May 2017, approximately 6,400 dentists (by individual dentist headcount) across Australia were MFT Providers (of approximately 15,000 total dentists registered in Australia). Essentially, the DD endorses HCF to steer patients to over 40% of registered dentists. Currently, policy holders who choose to see the almost 60% non-HCF contracted dentists will continue to receive a lower rebate under the proposed conduct. This is not in the public interest.

In other sectors and industries, the ACCC has been aggressive in pursuing price or fee setting activities yet its DD approves HCF's proposed scheme. The Application outlines blatant fee setting thinly disguised as a maximum rather than a minimum fee charged.

Noting that HCF does not compel MFT providers to only provide dental services to HCF policy holders, regardless, the ACCC must recognise HCF's MFT and dental owned clinics (referred to in its Application as its DCN) perpetuate and further spread the practice of discriminatory rebates which impacts all HCF policy holders; especially those who choose to see an independent, non HCF contracted dental practice/practitioner. It is not in the public interest to permit any PHI, including HCF, to apply a regime where the insurer pays higher rebates to one policy holder because they attend an insurer contracted dentist and pay less rebate to a HCF

[1] O'Leary, C., 'Cash-strapped diabetes sufferers to be hit hard as HBF no longer covers insulin pumps in basic policies', https://www.perthnow.com.au/news/health/cash-strapped-diabetes-sufferers-to-be-hit-hard-as-hbp-no-longer-covers-insulin-pumps-in-basic-policies-ng-b88770092z?csp=dc41ec3a407d142c93ad09aa2d4503a0 Accessed Monday 12 March 2018 3:20PM

[2] Australian Competition and Consumer Commission (ACCC), *Draft Determination – Application for authorisation lodged by Hospitals Contribution Fund of Australia Limited, in respect of its Dental Clinic Network and More For Teeth program providers Date: 5 March 2018 Authorisation number: AA1000402*, para 14

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policy holder who chooses to see their non-PHI contracted dentist to maintain continuity of care. Both policy holders have the same policy, pay the same premium, and are seeking the same treatment - they should receive the same rebate. It is not in the public interest to allow the continuation of the practice of PHIs making policy holders not attending an insurer contracted dentist subsidise another policy holder's ability to attend an insurer contracted dentist. This inequitable practice distorts the dental care market by creating arbitrary financial incentives that effectively steer patients to the insurers' 'preferred' providers. Such regimes only favour the insurers' 'preferred' dentists, not all their policy holders' actual dentists of choice.

HCF's Dental Clinic Network

Just because HCF's application currently pertains to clinics across a 'very small number of geographic locations' does not *ipso facto* mean there will not be considerable public detriment.[3] HCF's advice to the ACCC that there are "no other existing substantive plans in place to open any additional clinics" is only a point-in-time statement that has no bearing on their future actions or strategy. Would HCF offer an irrevocable statement to that effect and for the new merged entity with HBF? Considering that the DD proposes to provide HCF authorisation for 10 years, accordingly, the ACCC should provide much greater scrutiny of the broader context of HCF and the PHI practices in the industry; such scrutiny will clearly show that the proposed conduct will exacerbate the public detriments consumers already experience. It stretches belief that within the next 10 HCF will not open any additional clinics.

As a matter of public policy, certain modes of commercial conduct or business arrangements should be deemed to be against the public interest, regardless of the scale, large or small, in which the harm is dealt to consumers and public welfare in the immediate term. The risk of harm and public detriments associated with a business model whereby a conflicted insurer owns and runs its own health clinics, for which it can set policy holders' rebates, premiums and the fees its contracted/employed dentists charge; as well as direct how dentists' in that clinic practice, poses a real risk of consumer detriment in terms of their out-of-pocket costs and the quality of care received. Ultimately, the further proliferation of PHI owned, and operated health clinics will, over time, substantially lessen competition in the dental care services market and limit policy holders' choice of provider. If the ACCC's decision, as outlined in its DD, is reflected in its final determination, it will provide additional momentum to Australia moving in the direction of managed care, which has resulted in disastrous results in the USA both in terms of overall health expenditure and health outcomes.

Recent reporting on other private health insurers who have attempted to only provide gap cover if treated by a Bupa-contracted hospital or day-stay facility, illustrates the real dangers inherent in adopting a permissive approach to HCF's MFT contracted providers and owned clinics. Were the ACCC to authorise HCF's application, there is a real likelihood the public detriments associated with actions such as Bupa could also occur by HCF in the future and allow other PHI to adopt similar health fund owned clinics.[4] The ACCC should not allow nor encourage the expansion of HCF's DCN and exacerbate the detriments that the public already experience.

Parliamentary Inquiries and measures to better regulate insurers' practices

The Australian Senate Committee Inquiry on Private Health Insurance (Senate Committee) Report in December 2017 recognised the deleterious impacts discriminatory rebates have on policy holders and the healthcare services market and recommended prohibiting this practise. The ADA urges the ACCC to take this into account in its final determination.

Recommendations of the Senate Committee also mirror previous initiatives provided by other jurisdictions in other areas of commerce/insurance which were the subject of ACCC investigations - e.g. motor vehicle

[3] Id., para 16, 18, 10
[4] Han, E., 'Bupa tweaks controversial gap cover plan following public outcry', https://www.smh.com.au/healthcare/bupa-tweaks-controversial-gap-cover-plan-following-public-outcry-20180307-p4z39x.html Accessed Monday 19 March 2018 4:16PM

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insurers and related smash repairers.[5] Here, the use, in insurance policies, of provisions that require the use of particular parts or products in the repair of the insured's motor vehicle, restricted the insured's choice of repairer or imposed additional charges on the insured for choosing their own repairer, were all considered anti-competitive.

The New South Wales Legislative Assembly Select Committee on the Motor Vehicle Repair Industry completed its report in July 2014. The NSW Government's response was to support 18 out of the 21 recommendations by the Select Committee. Provisions paralleling the following recommendations of the Committee could easily be adapted to the PHI market by the ACCC and Australian Government:

- Invalidating the use in insurance policies of provisions that restrict the insured's choice of repairer; (choice of provider);
- Invalidating the use in insurance policies of provisions that impose additional charges on an insured for choosing their own repairer; ("free" treatments for contracted provider patients);
- Specifying that such provisions are void;
- Providing that it is an offence to suggest to or advise an insured to choose a particular repairer; (contracted providers adverts and PHI staff);
- Providing that it is an offence to accept or offer kickbacks for steering an insured to a particular repairer; (PHI owned clinics);
- Providing that it is an offence to state or suggest to an insured that a specific repairer should or must be used by the insured for the repair to be covered under their policy; and
- Specifying the penalties for these offences - maximum $110,000 fine for first offence and $165,000 fine and imprisonment for 12 months or both for second or subsequent offence.

The ACCC's final determination should take heed of these state and federal Parliamentary assessments and attempts to curtail practices outlined in HCF's application.

Consultation

The ADA urges the ACCC place greater weight on concerns raised by the Northern Territory Department of Health (NTDH) with:

> *"dental clinic networks and preferred provider arrangements … identified amongst some Northern Territory stakeholders … that increased market presence and overlapping services raise important considerations regarding the potential for price manipulation, particularly in smaller workforces of regional and remote areas".*

While supporting the above, the ADA disagrees with the NTDH's view that "it is possible the Conduct could bolster the dental workforce and provide opportunities for increased access to dental services for the Northern Territory public". Private health insurers' use of discriminatory rebates have been known to force policy holders to travel further distances to obtain their greater rebate even though there is a more local provider who happens to not be contracted to that insurer. Using financial incentives to force policy holders, in regional, rural, and remote areas, to drive further distances to obtain a greater rebate for their care is not in their health care interests and does not facilitate better access to care.

The ADA also urges the DD to explicitly detail the thrust of the ADA's objections to the Conduct. Currently, the DD leaves out critical points.

The DD does not refer to the fact that:

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[5] *Motor Vehicle Repairs (Anti-steering) Bill 2006 (NSW)*

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- The Conduct as well as the existing MFT and DCN framework results in HCF policy holders receiving less access to care from non-MFT/DCN/HCF contracted dentists (via a lower rebate making them less likely to attend a dentist and therefore benefit less from regular dental treatment and education – which is claimed by HCF's Application as the benefit for those who attend MFT/DCN clinics);
- HCF policy holders who exercise their choice to see a non-HCF contracted dentist are effectively subsidising the higher rebates received by policy holders who attend HCF contracted dentists; and
- The practise of discriminatory rebates in tandem with contracted provider arrangements is not applied by HCF alone, but by a significant number of private health insurers. Currently, a large number of policy holders nationally are being negatively impacted by these practices.
- Industry wide, PHI premium increases are higher than both dental fees increases and rebates paid to policyholders. The percentage of general treatment revenue not returned as benefits to policy holders in 2016/17 (24.80%) continues a four-year trend where each year there has been increasingly less premiums paid back to policyholders via rebates – a cumulative total surplus of almost $7 billion ($6.68 billion) over the last five years to the end of financial year 2016-17.[6]
- The 'out-of-pocket' or 'gap' problem experienced by policy holders is not due to provider fees (at least in the context of dental services), but instead is a problem HCF and other private health insurers have created through rebate inequality combined with the fact that private health insurers have failed to increase their rebates in line with premium increases, let alone CPI.

ACCC assessment

a. Future without the conduct

HCF's response to the possibility that were it not to receive authorisation, that:

> *"it would still likely open dental clinics but using a different operational model. Specifically, HCF submits that it would engage dentists as independent contractors to provide services at its DCN clinics"*[7]

The ADA queries whether this alternative arrangement could be legally implemented. Independent contracted dentists fail the Australian Taxation Office test for contractor status; as they have to provide their own equipment and materials (which is a physical impossibility if HCF provide the dental clinic setting).

Also, the above assertion by HCF does not adequately disclose to the ACCC that under such arrangements the underlying detriments associated with HCF and other insurers' use of discriminatory rebates and the ownership and operation of dental practices will continue. The public will continue to experience detriment in the form of reduced access, choice of provider, and continuity of care; not to mention the deleterious impacts that steering would have in the dental care provider market. This is why the ADA urges the ACCC's analysis to recognise that the existing practices of HCF's conflicted DCN, discriminatory rebates and contracted provider networks already cause public detriments and therefore the Application should not be authorised.

The ACCC's final determinations should dissuade the wider, further use of market practices which favour policy holders who attend insurer contracted healthcare providers; provide lower rebates for policy holders who do not see an insurer contracted provider which in turn causes them greater out-of-pocket costs and less likely to access the care they need. Because HCF have outlined they would seek to rearrange their practices to use a model which does not require authorisation does not mean the ACCC should authorise the proposed Conduct in question.

[6] Please see the ADA's previous submission
[7] ACCC, op. cit., para 32

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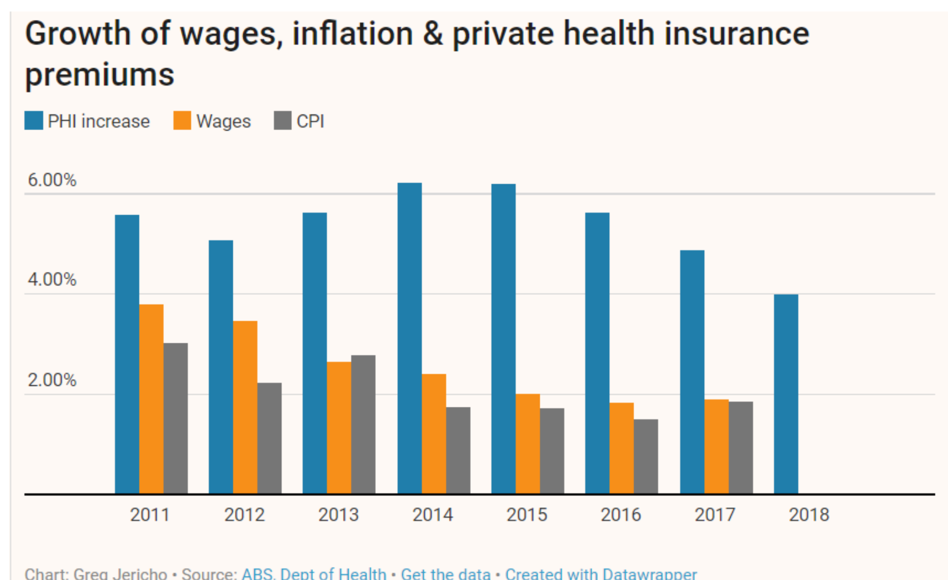
b. Public benefit

The ADA's previous submission outlined that the ACCC adopt a broader framework with which to assess the public benefits and detriments of HCF's Application. The 'rebate certainty' associated with HCF's MFT/DCN should be provided to all HCF policy holders regardless of which dentist they attend and for all dental treatments, not specifically the ones identified – and this should happen now. The main value proposition of private health insurance, as is marketed to Australians, is to enable consumers to choose their healthcare provider; and provide better access to care with low or no out-of-pocket costs. Already, the ADA has outlined that HCF's claim to provide 'price certainty' comes at the expense of other HCF policy holders, who are effectively penalised by receiving a lower rebate if they attend a non-insurer contracted dentist. The ADA has outlined that this 'price certainty' has steering effects which inappropriately distort the dental care provider market. In other words, there are more deleterious impacts that arise from these practices, and approval of HCF's application will see further consolidation of not only MFT providers and DCN, but ultimately insurer operated and owned dental clinics that is not in consumers' economic nor dental health interests.

The claims by HCF that this is somehow an endeavour on their behalf to reduce out-of-pocket expenses belies the fact that HCF's dental rebates are not increased in line with CPI or indeed in line with annual policy cost increases.[8] The ADA has provided evidence of this in its previous submission.



The ACCC must also recognise that for every HCF policy holder attending an MFT provider or DCN, another policy holder who chooses to attend a non-contracted dentist receives a lower rebate, which means less access to dental care, greater out-of-pocket expenses and a higher likelihood they do not attend their dentist regularly which ultimately impacts on their oral health. The DD does not refer to these risks raised by the ADA nor the detriment these policy holders already experience. HCF's MFT program only provides 'more' for some, but not 'all' of its policy holders. In fact, those policy holders wishing to receive health care from their (non-HCF contracted) choice of provider are giving 'more' to policy holders who see a contracted dentist. This inequitable practice, which is the model underpinning HCF's Conduct, should not be authorised.

c. Public detriment

[8] Jericho, G., 'Is private health insurance a con? The answer is in the graphs', *the Guardian*, 6 February 2018, https://www.theguardian.com/business/grogonomics/2018/feb/06/is-private-health-insurance-a-con-the-answer-is-in-the-graphs accessed 15 March 2018

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HCF's Conduct, if approved, will exacerbate the 'race to the bottom' where many insurers continue to adopt the practice of discriminatory rebates that favour their contracted providers. The only way real competition can occur is for HCF's Application to be rejected, and for the ACCC to push all PHI to provide consumers with the same policy, who seek the same treatment, the same rebate. Outlawing discriminatory rebates will provide a platform from which real meaningful competition can occur.

The ADA notes HCF submitted that:

> *"it seeks authorisation for its agreements with MFT program dentists in locations that overlap with its DCN clinics; not for the operation of the MFT program generally, or for the operation of its dental clinics"* [9]

While the authorisation is confined to the scope as outlined, the ACCC must assess whether the proposed Conduct operates within a broader context of PHI industry practices such as discriminatory rebates and the ownership and use of dental clinics by heavily conflicted insurers (including HCF); the conflicts of interest which, combined with commercial pressures over time, will result in more public detriment than any purported public benefit. The ACCC should not make a decision that exacerbates existing public detriments, that is within the scope of the Application. This would occur by directly rejecting the proposed Conduct.

The ADA's submission provided an industry wide view of how PHIs' practices across the industry; namely the use of discriminatory rebates to steer policy holders to use insurer contracted providers, is not in consumers' interests and substantially lessens competition in the healthcare services market. Currently, HCF engages in the aforementioned activities; their Application, if approved by the ACCC, will allow for the further expansion of these practices that will create public detriments that outweigh any purported benefits.

The ACCC's application of the public benefit/interest test should occur within a much broader scope than has been under the DD.

HCF have claimed:

> *"many of the issues raised by the ADA reflect its institutional views on matters such as corporate dentistry, and are not relevant to the application"*[10]

Regardless of the insurer's for-profit/not-for-profit operating model, insurer owned and operated dental clinics contain conflicts of interest that are not in the public interest. This is not an 'institutional view' confined to the ADA, but currently the reality embodied by the example of HCF's DCN. Any situation in which an insurer can set the fee, and the rebate, as well as the premium the policy holder must pay, poses a real conflict which should not be permitted as a matter of public policy. Where there is a driving imperative to have to generate a return whether to shareholders or contributors in a corporate setting, means that over time healthcare providers and ultimately consumers will bear more of the cost and will have less access to care as a result. Such a business model allowing for corporate owned clinics gives rise to public detriments that outweigh any purported benefit and should not be permitted by the ACCC.

HCF's response states that any dentist, whether it be one within a small business independent practice, to those operating within a corporate owned and operated series of networks must work to ensure an adequate business return. The suggestion is that "very similar incentives" exist "in relation to increasing revenue by increasing the number of patients seen per day".[11]

For independent small business practices, where clinical and professional autonomy resides solely within the

[9] ACCC, op. cit., para 41
[10] Ibid.
[11] Ibid.

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practitioner themselves and there is a close relationship between a patient and a dentist, the decisions of the dentist based on needs of the patient are more likely to override the process standardisation mechanisms associated with a corporation. Equally, the motive to maintain the reputation of the practice is significantly stronger when it affects 100% of the single practice versus 1% of the national business.

When closely examined, HCF's conflation of a small business independent practitioner and a health insurance corporation running and owning practices is ill founded.

The Operations of Private Health Insurer's Annual Report data for 2016-17 shows that HBF and HCF's surplus/(deficit) before tax was $59 million and $182 million respectively. For 2016-17, HBF and HCF had no (zero) taxation expenses. Small business dental practices do not have the same access to the tax consultants that HBF, HCF and private health insurers do to restructure their affairs to not pay any tax. To suggest that 'very similar incentives' exist is overly simplistic. There is no public benefit in HBF and HCF not paying any tax.

Table: HCF outcomes 2012-13 to 2016-17

Year	Surplus	Assets
2016-17	$182 + million	$1.484+ billion
2015-16	$174+ million	$1.293+ billion
2014-15	$153+ million	$1.685+ billion
2013-14	$72+ million	$1.535+ billion
2012-13	$99+ million	$1.408+ billion

Source: Private Health Insurance Administration Council / Australian Prudential Regulation Authority Operations of Private Health Insurers Annual Reports, 2012-13 to 2016-17

The above table clearly shows that HCF have accumulated massive surplus and asset growth over the last five financial years. DCN and health fund clinics are simply being promoted to increase the profitability of HCF and other PHI, along with attracting a public taxpayer funded 30% rebate on premiums. During this same time period, HCF have paid nil tax.

Considering policy holders pay yearly premium increases higher than CPI and receive nominal rebate increases for dental services, these outcomes represent considerable public detriment that has occurred and is continuing. This overwhelming public detriment will be further exacerbated if the ACCC's final determination approves HCF's Application.

The most equitable and fairest outcome the ACCC should be advocating is for policy holders with the same policy to receive the same rebate for the same service. Dental practitioners do not begrudge competition, but instead urge for government and policy makers, including the ACCC, to ensure there is a genuinely even level playing field. Rebate equality is the only way in which there would be fair competition even if there are PHI owned clinics.

Balance of public benefit and detriment

The DD's conclusion that in the circumstances, the case for HCF's Conduct being likely to result in a public benefit that will outweigh any likely public detriment has not been credibly established. The opposite has been occurring and will continue to be the case. The public detriments outlined in the ADA's previous submission and in this submission will be more pronounced should the ACCC authorise HCF's Conduct. The proposed

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merger between HCF and HBF will have a similar impact.

The ADA urges the ACCC's final determination to reject HCF's Application.

For further details, please contact Damian Mitsch at ceo@ada.org.au or 02 8815 3333.

Yours sincerely

Dr Hugo Sachs
President
Australian Dental Association