ACCC PRE DECISION CONFERENCE

- *Hospitals Contribution Fund of Australia Limited application for authorisation: Application number: AA1000402*

PROPOSED CONDUCT

- HCF and More for Teeth (MFT) dentists agree on maximum price for ten preventative dental services supplied by those dentists to HCF members; i.e. cap fees.
- This is intended to enable 'no gap' arrangements for the services under MFT as HCF will provide corresponding rebates of those amounts
- HCF seeks to establish a number of new HCF operated dental clinics in its Dental Clinic Network (DCN) to provide those basic dental services to attending policy holders and to charge the same fees

AUSTRALIAN DENTAL ASSOCIATION'S OBJECTIONS

- If the ACCC's final determination authorises the application, current existing public detriments that outweigh the public benefit will be further exacerbated
- The ACCC's final determination must reject HCF's application

PUBLIC DETRIMENTS

- Existing public detriments:
  - Conflict of interest associated with vertical integration: HCF owned/operated dental clinics
  - Rebate inequality used as steering mechanism – consolidating dental services market, substantially lessening competition and impeding policy holders' continuity of care
    - Australian Senate Private Health Insurance Inquiry recommended outlawing discriminatory rebates
  - Potential misuse of patient data obtained through claims processing
  - These practices occur in context of HCF having significant market power
    - >10% market share of policy holders nationally
    - Post merger with HBF: 18% (with 80% market share in WA alone)
    - NB. MFT covers approx. 6,400 dentists, reflecting 40% of registered dentists
- If ACCC approves HCF's application, these public detriments will be further exacerbated

CLAIMED PUBLIC BENEFITS MINIMAL

- 'Price certainty': Not for policyholders who attend non MFT/DCN dentists,
  - Lower rebate, less access to care and continuity of care
  - Instead, policy holders who attend non HCF contracted dentists subsidise higher rebates and better access to care of other HCF policyholders who attend HCF aligned dentists
- 'Gap free' arrangements: Limited to 10 items; more likely to act as loss leader serving steering purposes
- Same premium, same treatment, same rebate should be applied to enable choice for all policy holders

CLAIMED PUBLIC BENEFITS MINIMAL (2)

- General treatment benefits paid to policy holders 'generous'
- Premium increases far outweigh dental fees and largely contribute to health CPI costs

Increases in CPI, Health CPI, Dental CPI and Hospital and Medical CPI compared to the average PHI general treatment premium increase over the period March 2012 to March 2017

	CPI All Groups	CPI Dental services expenditure class	CPI Health Group	CPI Medical & Hospital	Total general treatment premium increase
March 2012	99.90	0.57	5.36	3.45	100
March 2017	110.50	0.63	6.70	4.74	138.49
Index points change	10.6	0.06	1.34	1.29	38.49
% change	10.6	10.5	25.0	37.4	38.5

ABS (2107) Cat. 6401.0 Consumer Price Index, Australia, Table 12, March 2017;
Department of Health (2017) Premium Round Ind. private health insurer average premium increases 2010 to 2017

CLAIMED PUBLIC BENEFITS MINIMAL (3)

- Premium revenue > General treatment benefits paid to policy holders

Comparison of premium revenue not paid back to policy holders as benefits, general treatment policies and hospital treatment policies, for the period 2012-2017

	General Treatment Premium Revenue and Benefits				Hospital Treatment Premium Revenue and Benefits			
Period	Premium revenue $'000	Benefits paid $'000	Premium revenue not paid back as benefits $'000	% Average Premium Revenue not paid back as benefits %	Premium revenue $'000	Benefits paid $'000	Premium revenue not paid back as benefits $'000	% Average Premium Revenue not paid back as benefits %
2012/13 to 2016/17	$28,947,048	$22,266,950	$6,680,098	23%	$74,169,395	$66,077,214	$8,092,181	11%

Source: Private Health Insurance Administration Council (PHIAC) and Australian Prudential Regulation Authority (APRA)'s Reports on the Operations of Health Funds / Private Health Insurers

CLAIMED PUBLIC BENEFITS MINIMAL (4)

AUSTRALIAN DENTAL ASSOCIATION

- HCF Premium Revenue > General treatment benefits paid to policy holders

HCF average premium increases compared to CPI and general treatment policy revenue not paid back to policy holders as benefits, $'000 and as % of premium revenue, 2012-2017

Year	HCF average weighted premium increase on 1 April	Industry average weighted premium increase on 1 April	HCF premium increase as % of industry premium increase	Annual CPI [Mar quarter]	HCF Premium increase as a % of CPI premium increase	Premium revenue $	Benefits paid $	Premium revenue not paid back as benefits $	% Average Premium Revenue not paid back as benefits %
2012/13	5.94%	5.60%	106.07%	2.50%	237.60%	485,444,000	449,247,000	36,197,000	7.46%
2013/14	5.74%	6.20%	92.58%	2.90%	197.93%	534,087,484	460,744,923	73,342,561	13.73%
2014/15	6.89%	6.18%	111.49%	1.30%	530.00%	568,607,401	465,016,472	103,590,929	18.22%
2015/16	6.57%	5.59%	117.53%	1.30%	505.38%	585,889,778	462,154,125	123,735,653	21.12%
2016/17	5.42%	4.84%	111.98%	2.10%	258.10%	594,768,000	476,777,000	117,991,000	19.84%
Total								454,857,143	

Sources: ABS Cat. 6401.0 Consumer Price Index, Australia, March 2013- March 2016; Department of Health (2017) Premium Round Ind. private health insurer average premium increases 2010 to 2017. http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round and PHIAC and APRA Reports on the Operations of Health Funds / Private Health Insurers

AREAS THAT THE ACCC CAN ADDRESS BEYOND TO THE AUTHORISATION PROCESS

- Factors lessening competition
  - HCF has access to commercially sensitive billing patterns and statistics of other practices in the area by virtue of their PHI business and via HICAPS
  - This access to commercially sensitive data gives HCF the ability to undermine and eliminate competition over time via leveraging discriminatory rebates
  - Once competition has effectively been eliminated, the natural progression is to restrict access to the competition further through discriminatory rebates and restrictive contract terms
  - This strategy has been used effectively by BUPA and we are now seeing the outrage of the community at the other end of the process
  - Consumers whose interests are supposedly at the centre of this application are as concerned about the long term consequences of such arrangements as the ADA

WHAT DO WE WANT?

- The ACCC require enforceable undertakings for:
  1. HCF to end discriminatory rebates so that its own clinics compete in a fair and open market and on the same basis as any other dental clinic
  2. HCF to establish independently verifiable 'Chinese wall' arrangements between its health insurance arm and its health service arms to guarantee that commercially sensitive information belonging to competing dental practices is not used to unfairly benefit HCF
  3. HCF and all private health insurers request that HICAPS and other health claiming businesses remove on their behalf clauses from their contracts that allow HCF/insurers to access commercially sensitive information of competitors, such as the prices paid for all services rendered to their patients
  4. That HCF request its association, Private Healthcare Australia, work with the ADA to develop a code of conduct to impose similar restrictions on other private health insurers who own or operate health service businesses