AUSTRALIAN DENTAL ASSOCIATION

14-16 Chandos Street, St Leonards, NSW, 2065, Australia
PO Box 520, St Leonards, 1590
Tel 02 8815 3333 | contact@ada.org.au | ARBN 131 755 989 | ABN 95 174 118 424

22 July 2021

Mr Darrell Channing
Director
Competition Exemptions Branch
Australian Competition & Consumer Commission
GPO Box 3131
Canberra ACT 1111

By email: exemptions@accc.gov.au

Dear Mr Channing

Thank you for providing the Australian Dental Association (ADA) with the opportunity to provide a further submission to the Honeysuckle Health and nib (the Applicants) application for Authorisation AA1000542.

The ADA is the peak body representing dentistry in Australia. It has over 16,000 members working across public and private sectors operating more than 7,500 small business across Australia.

Several statements made at the pre decision conference on the 8th May deserve to be addressed.

There were statements made that the applicant intends that there will be no practitioner boycotted under the buying group, that under the rules they must pay a claim where there is a Medicare rebate and that tier two default benefits act as a safety net to protect smaller providers. It was stated that it's not possible by law. Firstly, Dental treatment is not covered by the rules related to Medicare (dental sits under the Child Dental Benefits Act) so this simply offers no protection. Secondly, practitioner boycott already occurs at several levels in Australia. Practitioners are boycotted from providing services on which insurers will pay and from preferential patient arrangements which directly exert control over the market. There are practitioners where insurers have made a unilateral decision to exclude their patients from all rebates. BUPA wrote to all providers earlier this year that had chosen not to contract with them and informed them that if they treat one patient insured by BUPA, the dentist is subject to BUPAs terms and conditions, including the intrusive rights of BUPA to access the business and patient records of that dentist and potentially de-recognise if non compliant. Practitioners were told that it they didn't agree, no future rebates would be payable to patients for the services provided.

Most of the perverse behaviour aimed at exerting control however is hidden from the public view. Providers feel helpless in the face of threats to 'de-recognise' them if they don't succumb to demands to pay back money to insurers who have unilaterally decided how much to 'recover'. I had an example recently where a dentist fully complied with requests for patient records and received a letter simply stating that the insurer had determined and amount owing, noting de-recognition as a consequence of non compliance. We have certainly had practitioners who pay insurers thousands of dollars because of fear of de-recognition. While insurers would dismiss this as managing fraud, the evidence would suggest that it is a far more widespread problem that just fraud management. The recovery figures have never been shared with the ADA and we're not aware of any insurer that has a transparent process of appeal.

Private Healthcare Australia (PHA who represents NIB) is on record as seeking policy change to "Amend second-tier default benefit to balance the negotiation power between insurers and private hospitals"[i]. PHA argues that tier two default benefits (where hospitals are paid a minimum of 85% of contracted rates) should only apply where providers represent **less than 3% of the market so as to address what they perceive to be a bargaining power imbalance**. The CEO of NIB, Mr Fitzgibbon is a current director of Private Healthcare Australia so one can reasonably assume he has influence in determining PHA policy and that the statements made by PHA are supported by him. By inference it would suggest that he himself believes that a figure over 3% of market share begins to create an imbalance in bargaining power.

The applicant has argued that a 60% market share cap provides adequate protection against power imbalance, an imbalance that they argue is unfair above 3% market share when the providers are larger. It is clear that private health insurers are very aware and concerned about the effects of power imbalance on competition in negotiations between payers and providers, but only where the benefit of bargaining power imbalance rests with providers. We offered evidence in statements from Dr Sanzaro of how patient choice is removed over time as a result of existing bargaining power imbalance, which calls into direct question whether the application meets the no effect on competition or public benefit test.

We note that private health insurance companies argue power imbalance in their favour is used to pursue the interests of consumers, in the public interest. However, that would appear to be at odds with the fiduciary duty of the directors of NIB Ltd as an ASX listed company and Cigna Corp as a USA listed company to act in the interests of their shareholders. A responsibility regularly reinforced by the courts. NIB is a $3.2b listed company with a $7 a share price that trades on the ASX. Cigna Corp who reportedly owns 50% of Honeysuckle Health is an $80b usd American corporation with a share price of $233 usd. They're looking to form a buying group to singularly represent 60% of a sector worth $25.8b a year in turnover.

There's no suggestion that Honeysuckle Health will bring better value to consumers through product innovation instead choosing to tout value based healthcare delivered through a buying group. Value based healthcare principally being an alignment between the health needs of consumers and the most effective intervention to address that need. In twenty years in health associations, I'm yet to have a single material conversation with a health insurer (or honeysuckle health) on data that might assist the profession in determining where waste might exist in the system or where investment might be made to improve outcomes. Conversely, health practitioners and their members have participated in projects like Medicinewise[ii] which aims to reduce unnecessary treatment and actually contribute to value based healthcare. To me, the application looks more like an organisation seeking to take bargaining power imbalance to a new level.

In the case of dentistry, NIB is some 1,250 times the size of our average small business operator and if the applicant were to grow to their target size, they'd represent a buying group with turnover of 4,500 times the size of our average small business. This size creates a bargaining power imbalance and impacts the daily lives of small business owners.

The ADA does not support this application. The ADA requests that if approved a condition be included that all businesses under $10mil a year be excluded as a target and that the cap on market share in any state be set at 20%.

Do not hesitate to get in touch with our CEO, Mr Damian Mitsch if you would like to discuss this matter further on [redacted] or by email to ceo@ada.org.au.

Yours sincerely

[redacted]

Mr Damian Mitsch
Chief Executive Officer

[i] https://www.privatehealthcareaustralia.org.au/wp-content/uploads/Private-Health-Insurance-where-to-next_booklet.pdf
[ii] https://www.choosingwisely.org.au/