Australian Dental Association Inc.

ACCC Submission on Private Health Insurance

30 August 2013

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1. About the Australian Dental Association Inc.

The Australian Dental Association Inc. (ADA) is the peak national professional body representing over 14,500 registered dentists engaged in clinical practice, and dentist students. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

2. Introduction

The Australian Competition and Consumer Commission's (ACCC) upcoming Report to the Senate on Private Health Insurance has a focus on end of financial year advertising and consumers experiences of this advertising from 1 July 2012 – 30 June 2013.

The ADA is disappointed that its previous submissions outlining examples of private health insurer (PHI)/health fund[1] anti-competitive behaviour seem to have been completely ignored, which is strange given many funds are now corporations (no longer mutuals) and some with overseas ownership.

While the ADA will provide its views on the ACCC's specified issues, it will also outline the many anti-competitive practices by in Australia the ADA feels should be brought to the attention of the ACCC and the Senate. The ADA has written to the ACCC on these issues numerous times and will continue to do so. Failure to address these on-going systemic issues will impinge upon competition and health providers' ability to provide quality healthcare to patients. The PHI contributors' interests will ultimately continue to be poorly met unless the ACCC and the Australian Parliament take action.

The ADA's response is structured in two sections:

Section 1: A response to the specific questions raised in the ACCC's letter of 6 August 2013.

Section 2: A general response to the Commission dealing with the anti-competitive practices of private health insurers in Australia.

There will be repetition of some aspects within the two sections but that has been deliberately done for ease of reading. Please note the recommendations outlined in Section 2 also have relevance to Section 1, in particular relating to providing more transparent detail about the level of assistance private health insurance policies offer to consumers.

[1] The term 'private health insurer' and 'health funds' will be used interchangeably in this submission.

Section 1:

Response to the letter of 6 August 2013

The ACCC has indicated this year it wishes to deal with:

"*a discrete issue ... the practice by some insurers, comparison services, brokers and intermediaries of using end of financial-year or "tax time" advertising as a tool to encourage consumers to sign up to a fund, or to transfer between funds, in order to "beat the yearly premium increase" or to "avoid crunch time".*

In particular, the ACCC asked for stakeholder's views on the following issues, which the ADA will now address:

To the best of your knowledge, what are consumers' experiences in relation to the end of financial year advertising? Please reference those advertisements or characteristics of those advertisements that raise concerns for you.

Common in all these forms of advertising is they are seeking to cause an element of "panic buying". In products as complex as private health insurance the introduction of "panic" in advertising by PHI constitutes undue exploitation. Panic results in consumers not conducting proper analysis required for these products. This form of advertising creates in the minds of the consumer a degree of urgency due to the taxation implications of non take-up of insurance. Advertisements only ever refer to potential adverse taxation consequences and never suggest to consumers the need to evaluate whether their own situation gives rise to the need for insurance, and if so, what kind. In a market that has a variety of products, each with subtle differences to suit individual situations (often too subtle for proper identification and evaluation by the consumer), the introduction of panic buying makes it more difficult to undertake balanced evaluation of the insurance products. In these circumstances the introduction of panic deliberately exploits the vulnerability of consumers.

The ADA makes the following recommendation to address this:

Recommendation 1

A compulsory advertising code making it mandatory for PHIs to:

1. Recommend that consumers consider whether the Medicare levy surcharge (or other relevant provisions of taxation law) specifically has an impact on them. Depending on the consumer's circumstances, there may not be any taxation implications that would be remedied by having a private health insurance policy.

   This recommendation must include providing consumers with unbiased information regarding the Medicare levy surcharge, etc. so as to make an informed decision; and

2. Advise consumers the importance of evaluating their situation to ensure they take out the insurance they require, and the precise insurance product selected actually meets their requirements.

The Table below compiles the level of membership increases for both hospital and general treatment policies, comparing in particular the differences in the degree of increase between

the previous immediate quarter. The data in this Table has been compiled from Private Health Insurance Administration Council's (PHIAC) quarterly reports. These figures support the concerns suggested by the question above: that such advertising around the removal of the private health insurance rebate and assertions made above unduly influences consumers to purchase PHI policies.

PHIAC figures indicate that while the amount of increase compared to the previous quarter may vary, at times the rate of increase being less than the previous quarter, the overall trend is that:

- PHIs consistently increase their membership; and
- The 'tax time' period heading to the end of financial year always serves as the primary membership recruitment drive.

The end of the financial year is when PHIs obtain the highest increase in consumers compared to all the other quarters.

Quarter	Hospital Treatment Membership increase	% Increase (compared to previous quarter)	General treatment membership	% Increase (compared to previous quarter)
March 2012	51,782	-	84,544	-
June 2012	132,366	156%	147,349	74%
September 2012	83,128	-37%	104,280	-29%
December 2012	39,363	-53%	59,960	-43%
March 2013	52,863	34%	86,974	-45%
June 2013	87,045	65%	107,245	23%

Are consumers experiencing any difficulties when signing up to, or switching between, insurers as a result of end of financial year advertising?

This is difficult to answer as patients are unlikely to discuss this type of information with their dentist. The only way in which this question can be adequately answered is if the public had access to PHIs' reports about the consumers they interact with seeking to sign up to or switch between insurers as a result of this end of financial year advertising.

However, the ADA believes PHI contributors are very much unaware they can change PHI provider or policy without loss of qualifying periods and bonuses and how simple the changeover process can be. The ADA is surprised that relevant government agencies, whether it be the ACCC and/or the Private Health Insurance Ombudsman (PHIO), does not make a concerted effort to inform consumers about the existence and ease of changing private health insurance policies and providers. To facilitate true competition, consumers must be made aware of relevant information that is available to them; especially if information relating to the processes and real costs of changing providers are not being outlined by PHIs themselves.

There have been reports of PHIs' tardiness to supply the exit certificate of membership required to facilitate the consumer's decision to change funds. Such tardiness creates doubt in the minds of consumers as to whether they should commit to changing PHI where otherwise if this tardiness did not exist consumers would in fact change policies. This in fact

ultimately impinges on competition to the detriment of consumers, not enabling them to exercise their intentions.

Recommendation 2

Change the current portability rules relating to issuing transfer certificates under the *Private Health Insurance Act 2007* (and corresponding *Private Health Insurance Code of Conduct*) to require that both old insurers and new insurers give/request the transfer certificate in a faster time than the current 14 day period from ceasing insurance/receiving the request.

Are consumers being given adequate information in relation to policies offered as a part of end of financial year advertising?

PHIs do not provide adequate information to consumers in all their advertising, not just in advertisements appearing near the end of financial year. All PHI advertising is designed to procure contributors and not offer details of the contract of insurance.

Product Disclosure Statements do not disclose all details of the contract. For example, with respect to dental services, there is no transparent outline of the PHI policies:

- Dental rebates for all services;
- Annual limits for all services;
- Rebates per item/service; or
- Qualifying periods.

Another area where inadequate information is provided to consumers as part of the end of financial year and other advertising periods is how PHIs categorise general, complex and major dental services. There is no uniformity in approach, not to mention that some PHIs do not use all three categories. There is a lack of transparency as to the basis on which some services are considered 'complex' but not major and so on. Furthermore, there is little transparency on how annual limits vary per category. This creates confusion to consumers and makes it extremely difficult for them to compare the level of cover offered across policies.

As an example, the ADA invites the ACCC to peruse PHI dental policies and ascertain what the rebate would be for the following:

- Item 222 - Root planning and sub-gingival curettage;
- Item 514 - 4 surface direct metal restoration;
- Item 415 - Complete chemo-mechanical preparation of root canal - 1 canal;
- Item 615 - Full crown veneered – indirect;
- Item 688 - Insertion of one stage endosseous implant - per implant; and
- Item 881 - Complete course of orthodontic treatment.

The ACCC should examine a variety of PHI products and attempt to ascertain:

- What the rebates are for each item?;
- What the annual limit is for each item?;
- What category of treatment they fall into - i.e., general, complex or major?;
- What is the annual limit for each category?;
- What the qualifying periods are for each item listed?;
- What the qualifying periods are for each category?;
- What items are excluded from "join now claim now" policies?;
- What loyalty bonuses are in place for each item?;
- What loyalty bonuses are in place for each category?; and
- What lifetime limits are in place?

The ACCC should address this asymmetry of knowledge so consumers can easily compare policies – this would facilitate better competition and ensure the consumer has appropriate information to evaluate which policies meet their needs.

Are you aware of any difficulties or complaints arising from consumers' experiences with using their coverage after signing up to, or transferring between, insurers? Please provide details.

Yes. PHI often use "bait" adverts of 'join now claim now' but do not define exactly which services are covered and more importantly which services are not covered. The consumer is often not aware of what is not covered until they attempt to make a claim. When the claim is rejected the PHI then places blame upon the healthcare provider of the service for not informing the patient. Clearly, this is not the healthcare provider's fault.

There is a broader smorgasbord of activities by PHIs which impact not only on consumers, but health practitioners as well, the consequences of which usually flows onto the consumer. If the ACCC does not take action to address this state of affairs, consumers will continue to receive suboptimal health insurance outcomes and health care. The ADA will address these activities undertaken by PHIs and reiterate comments made in past submissions to the ACCC.

Section 2:

Anti-competitive practices of PHIs in Australia

The ACCC's report to the Senate with respect to the period 1 July 2011 – 30 June 2012 stated:

> *The ACCC's objective in producing the PHI Report is to comply with the Senate Order and to improve market practices in private health insurance. ACCC responsibility in the private health insurance sector is limited to encouraging compliance with and enforcing the Competition and Consumer Act 2010 (CCA).*

The provision of incentives by the Australian Government to consumers to take up private health insurance provides an economic basis and justification for PHIs to deliver to consumers a product that responds to the Australian Government's objectives. The ADA does not see the behavior of PHIs delivering to Australian Government a product that provides better care to policy holders. Rather it sees the Australian Government's incentives as purely providing the PHIs the opportunity to maximise their profit. On this basis alone, the Australian Government has an interest to take more concerted action to ensure that PHIs operate in a manner that delivers the best possible product for consumers, and respects the autonomy of healthcare providers.

The areas of PHI behaviour that should be investigated by the ACCC concern contracting issues, preferred providers and informed financial consent – the ACCC appropriately sought comment about these issues in previous years. The ADA has repeatedly provided feedback on these issues; however the ACCC seems to have remained inactive on these complaints.

The discussion in this Section is based on the nature of complaints received by the ADA from consumers and its members as to PHI behaviour. It forms the basis for the remaining recommendations the ADA will make to the ACCC, the Senate and the Australian Government:

Recommendation 3
Where health funds attempt to exercise action where the PHI attempts to 'de-recognise' a practitioner, the following must apply:

- There be full and accurate disclosure of the health fund's reasons for such action to both the dentist and the dentist's patients;
- Any communication between a patient and health fund regarding derecognition of the dentist be on agreed terms between the fund and dentist;
- Rights of review of such decisions must be put in place – natural justice must apply; and
- There be procedural fairness in the derecognition process.

Recommendation 4
Controls be put in place to prevent health funds from purporting to 'create' contracts where no consideration or meeting of minds between the health funds and provider exists.

Recommendation 5

Discriminatory conduct relating to the payment of rebates based on the provider of the services affiliation with a PHI be declared anticompetitive, as it is against the health interest of the patient and undermines open competition.

Where the same contribution (premium) rate is paid, the contributor must be entitled to the same rebate for the same itemised procedure regardless of which dentist provided the service. Economic fairness and equality must be maintained.

Recommendation 6
The ADA calls for health funds to be brought to account to provide justification for the effective decline in rebated benefits compared to premium increases and if suitable explanation is not provided then remedial action be imposed through legislation to rectify this decline.

Recommendation 7
As a consequence of Recommendation 6, the ADA calls for health funds to increase dental rebates for all dental services on an annual basis and the review be in line with CPI and/ or premium adjustments, whichever is the higher.

Recommendation 8
There be no annual or lifetime limits on dental rebates in health fund policies.

Recommendation 9
Health funds should be banned from actively and directly attempting to influence their members to receive treatment from the health funds' contracted providers as it interferes with the patient/dentist relationship and substantially lessens competition.

Recommendation 10
Health funds should cease to promote their contracted providers by use of terminology that contravenes the Dental Board of Australia (DBA) Guidelines and the Health Practitioner Regulation National Law Act (National Law).

Recommendation 11
Legislation should be introduced to repeal those sections of health fund legislation that permit non-disclosure of health fund business rules. Instead, legislation should introduce a requirement that health funds publish clear, simple, easy to understand, and publicly available business rules.

Recommendation 12
Health fund rebate structures for services must be designed with the health interests of the member uppermost and should not be constructed to generate unjustified or super profits for the health fund.

Recommendation 13
Health experts be engaged to assess the manner in which health fund rules governing utilisation and rebate levels for services are implemented to ensure the health interests of health fund members are being correctly prioritised.

Recommendation 14

If there are to be annual limits imposed by health funds (which is opposed by the ADA) then health funds be required to provide to all contributors current and complete details of such limits.

Recommendation 15
Health funds be required to provide all general treatment/ancillary policy holders with an itemised copy of current rebate levels for all general treatments.

Recommendation 16
There be greater uniformity in business rules and qualifying periods between PHIs policies in order that for consumers to make valid comparison between health fund policies.

Recommendation 17
When there is evidence of PHIs:

- Attempting to seek repayment of erroneous claims from service providers;
- Providing erroneous interpretation of dental item numbers; or
- Refusing to rebate for dental services carried out over multiple appointments until all the services in a treatment have been completed;

sanctions be imposed (such as financial penalties, or in the case of repeated infringements, loss of licence to operate as a health fund).

Recommendation 18
If the ACCC wishes to assist consumers with provision of information about the financial impact of receiving health care where services are rebated by health funds, the ACCC must demand health funds publish clear, easy to comprehend rebate tables for each health fund policy.

PHI's recognition and derecognition practices

Health funds' recognition and derecognition practices with respect to dentists have given rise to competition and consumer issues.

Recognising some dentists as unacceptable providers (both non contracted and contracted dentists) so their patients will not receive a health fund rebate

PHIs have been known to communicate to dentists' patients of the fund's decision to no longer recognise a patient's claims if they continue to be treated by a particular dentist. This must not be able to take place until there has been some form of due process justifying such action. Being unilaterally deemed an 'unacceptable provider' by a PHI means that patients of that provider receive zero rebates for dental services from that private health insurer.

Removal of recognition is often based on non-compliance by the dentist with certain unilaterally imposed PHI requirements. Such non-compliance does not equate with any form of improper conduct by the dentist or delivery of inferior care. All too often, members have advised the ADA that when the PHI communicates advice to a patient of termination of its recognition of a dentist or makes critical comment about a proposed treatment plan of the provider, the obvious inference drawn by the patient is that the dentist has been providing inappropriate, improper or dishonest treatment. Such comments are clearly outside the area

of competence of most PHI staff and the suggested motive for such comments can only be presumed to be in order to influence the patient to change to a 'preferred provider' of the PHI.

Strict conditions must be introduced on the exercise of such derecognition rights. Not only does this conduct constitute the creation of a false and misleading perception in the mind of the patient, it is contrary to competition policy as it effectively removes a practitioner from treating a health fund member. It removes the health fund member's choice – a fundamental privilege of insurance.

Recommendation 3

Where health funds attempt to exercise action where the PHI attempts to 'de-recognise' a practitioner the following must apply:

- There be full and accurate disclosure of the health fund's reasons for such action to both the dentist and the dentist's patients;
- Any communication between a patient and health fund regarding derecognition of the dentist be on agreed terms between the fund and dentist;
- Rights of review of such decisions must be put in place – natural justice must apply; and
- There be procedural fairness in the derecognition process.

Recognising some dentists as a recognised provider without the dentist's agreement to a contract with the health fund

Some health funds have unilaterally sent correspondence to dentists suggesting that the dentist is a 'recognised provider' of their fund, even though there is no contractual relationship between the two. The claim by the health fund that a contractual agreement is now in place binding the treating dentist to the rules and regulations of that health fund is made simply on the basis the dentist has treated a patient who has insurance cover with the health fund concerned. Once this unilateral 'recognition' is provided, the PHI then seeks to impose certain conditions/rules to ensure the provider's patient receives only certain benefits. This unilateral application of requirements on the provider, when no relationship (contractual or otherwise) exists between the two, is inappropriate. The ADA says it is improper for such requirements to be arbitrarily imposed. Non-compliance with the health fund's unilateral provision of this requirement causes inconvenience to the patient and is often used as an opportunity for the fund to recommend to the patient a change of practitioner to one of the health fund's actual preferred providers. It is, in the ADA's view, an unfair exploitation of market position by the health funds particularly where a health fund may dominate a local market. It also compromises the level of care being provided so as to suit the ends of the PHI.

Recommendation 4

Controls be put in place to prevent health funds from purporting to 'create' contracts where no consideration or meeting of minds between the health funds and provider exists.

PHI practices and activities that result in greater out-of-pocket expenses for consumers

There is a range of activities by health funds which result in greater out-of-pocket expenses for consumers, reduced choice for the consumer and impacts on competition.

The whole philosophy of private health insurance has been built upon the consumer having the choice of provider as distinct from a 'lack of choice' in the public health care system. PHIs, with apparent deliberate intent, have, by means of discriminatory and punitive differences in rebate levels, eroded consumers' freedom of choice of provider.

Health funds have introduced practices that lead to lower rebate levels when the member chooses to use the services from dentists who are not the health fund's 'preferred provider'. This practice does not respect the member's right to choose the dentist that they have an established relationship with. Continuity of care is a key lynch-pin in health care. Continuity enables the practitioner and patient to develop a familiarity with each other and this enhances the quality of care provided. It also has the effect of reducing complaints.

As all members of a fund pay identical premiums, the level of rebates for the same service should also be identical – however, this is not the case. Despite the ADA and members of the public having raised this issue on several occasions there has been no action taken by the ACCC to remove this unfair practice. Transparent competition has been eroded by these 'preferred' contracted provider arrangements and the inequality of rebate is causing increased out-of-pocket expenses for consumers, the very issue the ACCC is trying to address.

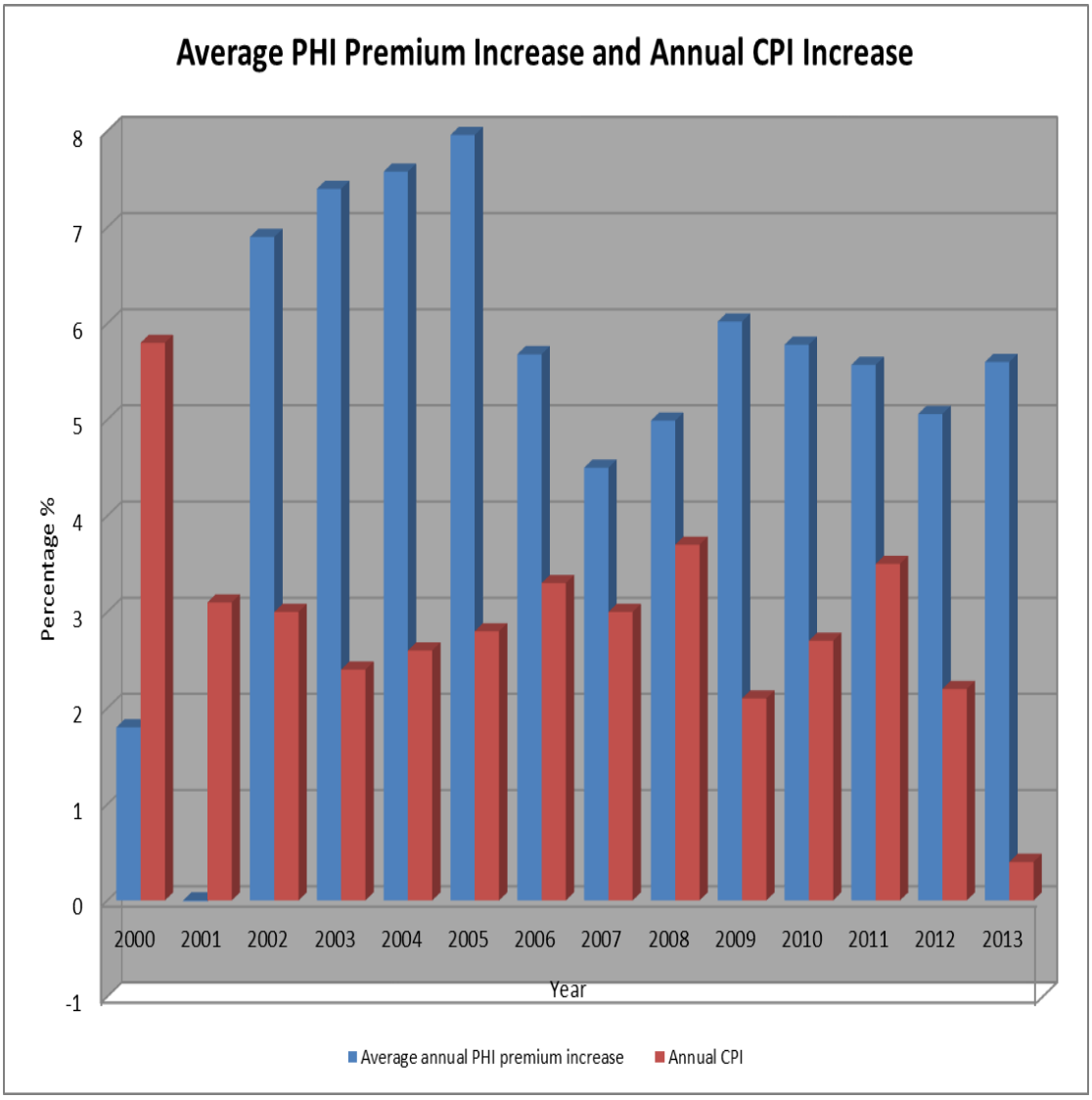
Recommendation 5

Discriminatory conduct relating to the payment of rebates based on the provider of the services affiliation with a PHI be declared anticompetitive, as it is against the health interest of the patient and undermines open competition.

Where the same contribution (premium) rate is paid, the contributor must be entitled to the same rebate for the same itemised procedure regardless of which dentist provided the service. Economic fairness and equality must be maintained.

PHI premium rate increases compared to CPI

The Chart below shows the relationship between PHI contribution rate increases and the cost of living index (CPI), i.e., the impacts on the consumers' out-of-pocket expenses. For the PHI premium increases consumers pay, there appears to be little proportionate value provided in return via rebates.



Sources: Previous media releases from Health Ministers, for example the Hon. Min Plibersek, Transcript - Press Conference Sydney - Private Health Insurance Premium Increases - 8 February 2013; and ABS CPI reports such as 6401.0 Consumer Price Index, Australia June 2013.

With respect to consumers' out-of-pocket expenses, the ADA notes there are some PHIs who have not increased dental rebates across the board since 1994. Many PHIs have placed restrictions on the numbers of dental services allowed to be claimed per annum. This is poorly communicated to contributors by PHI, if at all. It is no wonder the out-of-pocket expense gap has continued to grow. If rebates are not increased annually the expectation must be for consumers' out-of-pocket expenses to increase.

PHI claim the justification for preferred provider contracts is because of increased out-of-pocket expenses due to the increasing fees of the providers. This is both misleading and deceptive. Private health insurance rebates have not increased – that is to say the increase in out-of-pocket expense has been manipulated primarily by the PHI who have increased contribution rates well in excess of CPI but have not correspondingly increased rebates. To then offer higher rebates to contracted preferred providers does not increase competition but restricts competition as the PHI is now determining the out-of-pocket expense, not the open market – that is, PHIs could be seen as engaging in a form of indirect price fixing. Powerful advertising campaigns by larger PHI that refer to 'preferred providers' further lessens the competition amongst PHI.

The ACCC does review the level of out-of-pocket expenses paid by consumers but does not investigate the level of dental rebates. This means that only one side of the equation is being investigated. The ACCC must investigate this and address the increasing disparity between premiums and rebates.

Levels of PHI income from general (ancillary) services vs rebates provided to consumers

Furthermore, the ADA would like to bring to the ACCC's attention to the massive profitability in general (ancillary) services by PHIs in Australia:

Year	Ancillary Income	Ancillary payout	Surplus	Percentage
2000/01	$ 1,920,519,000.00	$ 1,533,122,000.00	$ 387,397,000.00	20.17%
2001/02	$ 2,121,529,000.00	$ 1,900,328,000.00	$ 221,201,000.00	10.43%
2002/03	$ 2,371,360,000.00	$ 2,043,440,000.00	$ 327,920,000.00	13.83%
2003/04	$ 2,556,786,000.00	$ 2,117,299,000.00	$ 439,487,000.00	17.19%
2004/05	$ 2,724,385,000.00	$ 2,239,925,000.00	$ 484,460,000.00	17.78%
2005/06	$ 2,857,096,000.00	$ 2,276,743,000.00	$ 580,353,000.00	20.31%
2006/07	$ 3,049,798,000.00	$ 2,454,356,000.00	$ 595,442,000.00	19.52%
2007/08	$ 3,433,908,000.00	$ 2,656,255,000.00	$ 777,653,000.00	22.65%
2008/09	$ 3,696,018,000.00	$ 2,869,540,000.00	$ 826,478,000.00	22.36%
2009/10	$ 3,996,818,000.00	$ 3,052,757,000.00	$ 944,061,000.00	23.62%
2010/11	$ 4,309,168,000.00	$ 3,209,104,000.00	$ 1,100,064,000.00	25.53%
2011/12	$ 4,675,200,000.00	$ 3,536,925,000.00	$ 1,138,275,000.00	24.35%
Total	**$35,792,066,000.00**	**$28,356,672,000.00**	**$7,435,394,000**	**20.77%**

Source: Private Health Insurance Administration Council Annual Reports

In the 12-year period depicted in the Table above a surplus of nearly $7.4 billion has been achieved in comparing ancillary income with pay-outs. In fact, over the last three years alone PHIs have realised surpluses in excess of $3 billion. It would appear that health funds are using the surplus from ancillary cover to support (subsidise) their other insurance products as the declared overall profit of health funds does not reflect these massive profits from ancillary.

The ADA will opine that health fund contributors are not informed of this massive surplus. In real terms it means contributors to ancillary services are not getting full/appropriate value in rebates as significant amounts are being used to offset other aspects of the health funds' business. This is of great concern to the ADA as PHIAC in its June 2013 Quarterly Statistics indicated about 52% of the ancillary expenditure is for dental services. The ACCC has not challenged those PHIs who have provided the same dental rebates to consumers for decades while at the same time accruing massive surpluses. Further investigation must be made on the annual limits and business rules which further restrict rebates and cause greater out-of-pocket expenses.

There is a significant proportion of consumers who have general treatment only cover and this cohort do not get any benefit from any cross subsidisation. This is inherently unfair to these contributors and further reflects how PHIs have opportunistically not informed them of the massive surplus not being used for rebates for general treatment services. Clearly this group of consumers are being exploited by the PHI and should be offered heavily reduced premiums in light of the massive surplus being generated. PHIO's State of the Health Funds Report 2012 outlined the average amount of costs of dental services covered by open membership PHI funds is 48% in 2011-12, compared to 50% in 2010-11.

The surplus in 2011/12 would indicate that PHIs could have provided consumers a 25% increase in rebates for **all** ancillary services while still making a significant profit. An increase in rebates that significantly reduce out-of-pocket expenses for consumers would benefit all policy holders and encourage more open competition.

These rebate trends are also confirmed by analysis performed by the media, pointing out that:

> *"HEALTH fund rebates for dentists, physiotherapists and optometrists have plunged by almost 20 per cent over the past 16 years. … In 1996, health funds covered 57 per cent, on average, for ancillary services such as dental and optical. Data supplied by the nation's health insurance regulator shows that had dropped to 49 per cent by last year." (Dunlevy S., 'Health funds keeping more', Herald Sun, 25 Aug 2012).*

The ADA believes it is inappropriate for the ACCC and the Senate to be critical of growing out-of-pocket expenses when it continues to allow PHIs to avoid annual review of dental rebates and annual limits.

Given PHIs' massive ancillary surplus, they should not be allowed premium increases of the magnitude currently occurring without increased rebates across the whole range of services.

Annual limits

Since health funds are often profit driven, some use their business rules to this end by placing a limit on their rebates to their contributors (annual limits). Similar to rebate review, health funds do not regularly review the annual limits. Further, health funds also place restrictions on the number of services eligible for rebate within these annual limits.

The creation of such limits is arbitrary, have no relationship to dental needs or the health of the patient and are set by PHIs to ensure profits. These limitations are not well explained by health funds, if at all, to their contributors. Often the first time the contributors are made aware of these restrictions is after the event, i.e., after the provision of the dental service and then attempting to make a claim for rebate. This is misleading behaviour in that contributors are not adequately informed of these limits.

The impact is that it effectively dictates those services that the contributor can use with no regard to the dental health of the patient and the clinical independence of dentist.

Asset Building by 'For Profit' PHI

An issue that the ACCC has failed to take heed of is the decrease in the number of PHIs overall and the increase in the number of 'for profit' PHIs. This market consolidation of 'for profit' PHIs (as outlined in the Table below) is a matter of serious concern.

Year	2000	2005	2011
Number of Insurers	44	40	34
Open Access	29	26	21
For Profit	4	5	7
For Profit Market Share	12.5%	15.9%	68.6%
Total Premium Revenue	$5.46 Billion	$9.38 Billion	$15.42 Billion
Total Benefits Paid	$4.51 Billion	$8.24 Billion	$13.16 Billion
Total Assets	$3.26 Billion	$5.87 Billion	$9.49 Billion

Compiled from PHIAC Annual Reports

Another significant concern is the massive build-up of assets of the 'for profit' group. The top five funds in Australia are MBP, Bupa, HCF, HBF and NIB. All have contracted providers and most are "for profit". Of even greater concern has been the recent takeover by Bupa of other funds now placing it at a level of market share (26.68%) similar to Medibank Private (27.12%) as of 30 June 2012 according to PHIAC's Annual Report. This market consolidation has implications for competition which risk operating to consumers' detriment.

The prevalence of 'for profit' PHIs has been driven by the shareholder returns operating at the expense of the health and welfare of their members. With the increase in market share of "for profit" funds to approximately 70% of the market as at 30 June 2012 (compared to 12.5% in 2000) the impact of this focus on shareholder return will only increase particularly with the Bupa expansion. This profit motive may be acceptable in commercial arrangements but in the sphere of health, it is the interests of the patient (health fund contributor) that must be given the dominant place in the contractual arrangements that exist.

Recommendation 6

The ADA calls for health funds to be brought to account to provide justification for the effective decline in rebated benefits compared to premium increases and if suitable explanation is not provided then remedial action be imposed through legislation to rectify this decline.

Recommendation 7

As a consequence of Recommendation 6, the ADA calls for health funds to increase dental rebates for all dental services on an annual basis and the review be in line with CPI and/ or premium adjustments, whichever is the higher.

Recommendation 8

There be no annual or lifetime limits on dental rebates in health fund policies.

Contracting Issues

The ADA sees health funds as increasingly interfering with the delivery of dental health care by:

Seeking to unduly influence patients in the selection of their dentist for treatment

Continuity of treatment is vital in the proper care of patients. Invaluable bonds and confidences are developed over time between patient and practitioner and these should not be interfered with. This is even more so in dentistry where often phobias or dislike of treatment can be a relatively common occurrence.

Examples of PHI interference with dental treatment are many and varied. Set out below are instances of such conduct:

- Some health funds use the opportunity of discussing written estimates of costs of treatments with their members to deliberately attempt to redirect patients to the funds' contracted (preferred provider) dentists.

- Advertising and advice by health fund staff imply that non-preferred provider practitioners deliver inferior service or are perceived as 'not preferred' or 'not approved'. The use of such terms could be contrary to the DBA Advertising Guidelines which bar the promotion of one health provider over another. Use of such terminology therefore exposes a practitioner to an allegation of inappropriate professional conduct and a risk of deregistration as a health practitioner.

- There is evidence of PHIs pushing preferred provider arrangements in remote areas. This is having a most deleterious effect on established remote practices. Dentists in these areas find the practice's goodwill is being eroded by PHI enticing opposing practice[s] to become a preferred provider and then directing all contributors away from the non-preferred provider practices. This is destroying succession plans for practices in remote areas with the end result being loss of practitioners in the remote areas – which means that local residents' overall access and oral health outcomes suffer. Some PHIs are even attempting to push contributors to travel to adjoining country towns on the basis of a preferred provider being located there. In a situation where there is already the need for incentives to be provided to practices to set up in these areas such activity by PHI is against the interests of the community and must be stopped.

- There is evidence of health funds refusing to accept additional healthcare providers as preferred providers primarily because the health fund has assessed that it would not receive adequate utilisation by the new practice. This reflects the total focus on financial outcomes by PHIs; rather than the interests of their contributor.

- There are cases where the non-preferred provider's entire fee is less than the rebate offered to the preferred provider patient; yet, because the out-of-pocket expense is less, staff of the fund promote the preferred provider as being cheaper. This is clearly not the case and is misleading and deceptive.

- Health funds often advertise 'free services' or 'no charge' services by preferred providers. Quite clearly the provider is paid for their service and the patient pays via their contributions. This is misleading and deceptive. There is lessening of competition as the non-preferred provider's patients are not offered these 'free' services. In addition these free services may be unnecessary and can lead to over servicing.

- There is evidence that health fund counter staff have been interfering with direct referrals by general practice (GP) dental providers to dental specialist providers. This is a most disturbing issue as the referring provider is not consulted or informed that the patient has been diverted to a PHI "preferred provider" specialist. There are cases where the diversion has not been to a *bone fide* specialist but merely a GP practitioner who has limited their practice to a certain field. This is a most significant breach in patient management that has severe professional indemnity ramifications. The patient is not seeing a specialist but is led to believe the contrary. Furthermore, claims for injury as a result of inappropriate referrals are significant.

In all of the above examples the patients are paying the same contribution rates yet if the patient chooses the provider of their choice (who happens to not be a preferred provider of the health fund) they are punitively discriminated against by the differential rebate. This substantially lessens competition.

Recommendation 9

Health funds should be banned from actively and directly attempting to influence their members to receive treatment from the health funds' contracted providers as it interferes with the patient/dentist relationship and substantially lessens competition.

Recommendation 10

Health funds should cease to promote their contracted providers by use of terminology that contravenes the DBA Guidelines and the Health Practitioner Regulation National Law Act (National Law).

Fund business rules relating to rebates create dysfunctional incentives that risk patients opting for a course of treatment that is not best suited to them

Some funds adopt a concept of a 'reasonable utilisation level' which, through imposition of financial limitations on payment of rebates, constrains how treatment should properly be delivered to patients. In some cases, a practitioner's mode of practice and delivery of proper dental care to the patient is adversely affected because of the utilisation level. These practices constitute interference in the delivery of proper dental care. Such utilisation levels are based on economic parameters and are not based on sound clinical evidence applied to individual patients. Where utilisation levels interfere with the delivery of proper healthcare they should be disregarded and the health fund be obligated to meet, in part, the fees incurred for the optimal treatment.

Something similar occurs in the case of annual or 'lifetime' limits. Where health funds apply lifetime limits on those services that will be rebated as a 'business rule', the contributors

often elect to not proceed with necessary treatment if there is no rebate available. Even when the lifetime limit has been received for a particular service, the PHI continues to receive premiums from the contributor for such 'major dental' entitlements knowing the contributor cannot claim for such services again. This is deceptive and misleading as contributors are often not aware of the impact of this business rule.

Lifetime cover and annual limits are not applicable to medical cover. There is no uniformity in health funds' business rules, rebates per service, annual limits, lifetime limits and qualifying periods. No other aspect of insurance has such impossible parameters for direct comparison of levels of cover and premiums. This does not occur with household, car, boat or any other form of insurance. It effectively lessens competition between health funds as it is impossible to make direct comparison of what is covered. It also makes it impossible for the practitioner to obtain informed financial consent.

Lack of transparency of PHI business rules

On a more general level, PHIs business rules are not provided to premium payimg members yet they are applied to members – this contradicts any basic tenet of contract law.

PHIs' non-disclosure of their business rules (either to the ADA and other healthcare providers or to their members) is a cause for concern. All financial products require the publication of product disclosure statements and PHI should be no exception. Why funds are not prepared to disclose their rules supports the concerns that have been raised already: that the profit motive is more important than the rights or more importantly the health of their contributors.

These business rules should be open to public scrutiny and available to not only educate and inform the fund member but also members of the public who wish to compare policies prior to signing up for private health insurance.

Recommendation 11

Legislation should be introduced to repeal those sections of health fund legislation that permit non-disclosure of health fund business rules. Instead, legislation should introduce a requirement that health funds publish clear, simple, easy to understand, and publicly available business rules.

Recommendation 12

Health fund rebate structures for services must be designed with the health interests of the member uppermost and should not be constructed to generate unjustified or super profits for the health fund.

Recommendation 13

Health experts be engaged to assess the manner in which health fund rules governing utilisation and rebate levels for services are implemented to ensure that the health interests of health fund members are being correctly prioritised.

Recommendation 14

If there are to be annual limits imposed by health funds (which are opposed by the ADA) then health funds be required to provide to all contributors current and complete details of such limits.

Recommendation 15

Health funds be required to provide all general treatment/ancillary policy holders with an itemised copy of current rebate levels for all general treatments.

Recommendation 16

There be greater uniformity in business rules and qualifying periods between PHIs policies in order that consumers can make valid comparison between health fund policies.

Attempts to seek repayment of erroneous claims from service provider

Often when PHIs claim there is over-servicing, overpayment or errant claims, the health fund demands repayment of the rebate from the provider of the service. The provider is not insured with the health fund – it is the patient who is insured and it is the patient who ought to be refunding the rebate. The contract of service is between the dentist and the patient. The contract of insurance, however, is only between the patient and the health fund.

In the case of an error in account to the patient the provider should refund the fee to the patient if that is the agreed outcome. The rebate issue is between the health fund and the contributor. The provider should not be expected to fund a claim from the PHI where it is the contributor who has benefitted.

Erroneous interpretation of dental item numbers by PHIs

The *Australian Schedule of Dental Services and Glossary*[2] is prepared by the ADA and provides numbers and descriptors for various dental services. Health funds, with increasing frequency, are placing their own interpretation on dental item numbers. The *Australian Schedule of Dental Services and Glossary* is a copyright-protected document. It has been accepted by the National Coding Centre as the definitive and authoritative descriptor of dental services. Health funds are regularly invited to contribute submissions to the review of the *Australian Schedule of Dental Services and Glossary*.

The accusatory nature and invariably ill informed and inaccurate ways in which health funds make claims that the incorrect item number has been used by dentists are destructive to dentist-patient relationships. These claims often amount to no more than an attempt by PHI to deny legitimate rebates. There are instances where PHIs have placed their own uneducated interpretation on item number utilisation which is not supported by the ADA or dental peers.

Health funds refuse to rebate for dental services carried out over multiple appointments until the services have been completed

[2] The *Australian Schedule of Dental Services and Glossary* has been published by the Australian Dental Association since 1986. Since its inception, it has been accepted as the definitive coding system of dental treatment and endorsed by the National Coding Centre.

Some health funds on a regular basis, but at their discretion, refuse to rebate for dental services carried out over multiple appointments until all the services in a treatment have been completed. This particularly relates to crown and bridge work. These procedures are usually carried out over at least two visits.[3]

The *Australian Schedule of Dental Services and Glossary* clearly defines the accepted protocol of billing for such procedures at the first visit. These protocols are based on common law contract principles. Health funds refuse to accept this protocol.

This is contrary to how health funds deal with general treatment rebates for other providers and is conduct clearly discriminating against the contributor for legitimate dental services provided. The same health funds that do not rebate the crown or bridge at the preparation date will rebate optical services at the issue of the prescription for the lenses even though they have not yet been provided and will rebate for orthotics merely at the impression-taking stage. Unlike the crown preparation, neither the optical nor the orthotic treatments are invasive or irreversible procedures. Patients undergoing orthopaedic joint replacements are billed for the prosthesis well in advance of surgery and rebated for such before the surgery has taken place. Health funds remain inflexible in their attitude to these dental procedures and incorrectly inform patients on a regular basis that it is the dental provider who is at fault and refuse to rebate on presentation of the account even if the patient has paid for the said service in full. The ADA is disappointed that the ACCC remains inactive in the manner in which PHI deal with dental multiple procedure treatments.

Recommendation 17

When there is evidence of PHIs:

- Attempting to seek repayment of erroneous claims from service providers;
- Providing erroneous interpretation of dental item numbers; or
- Refusing to rebate for dental services carried out over multiple appointments until all the services in a treatment have been completed;

sanctions be imposed (such as financial penalties, or in the case of repeated infringements, loss of licence to operate as a health fund).

Preferred Provider Schemes

Examples of third line forcing

The ADA suggests the following examples of third line forcing by preferred provider schemes and health funds:

- Provision of higher rebates for dental services to health funds members **only** if the services are purchased from a PHI contracted dental provider;

[3] The first involves the preparation of the tooth/teeth which is an invasive and totally irreversible procedure. It also involves impression taking, temporisation, haemostasis, extensive laboratory procedures and is usually conducted under local anaesthetic administration. Prior to the next visit the crown or bridge is constructed. The second visit involves the fitting of the crown or bridge.

- **Refusal to supply** a higher rebate to PHI members for dental services if they attend a non-PHI contracted provider;
- Provision of free check-ups to health fund members **only** if the service is purchased from a health fund contracted dental provider;
- **Refusal to supply** a free check-up to health fund members for dental services if they attend a non-health fund contracted provider;
- Provision of free scale and clean treatments to health fund members **only** if the service is purchased from a health fund contracted dental provider;
- **Refusal to supply** a free scale and clean to health fund members for dental services if they attend a non-health fund contracted provider;
- Provision of 'zero out-of-pocket expenses' to health fund members for dental services **only** if provided by a health fund owned dental clinic. The ADA has an additional concern with this issue in that the insurer is providing the service for which the insurance is offered and thus a conflict of interest is created; and
- With Bupa now owning over 170 dental practices employing over 650 dentists the ADA questions the competition aspects of a health insurer providing and charging for the service for which it is offering a rebate and insures.
- Some PHI will not accept preferred providers unless they are contracted to HICAPS (an ancillary health claims billing system).

Informed Financial Consent (IFC)

PHI not adequately facilitating IFC

It must be the health funds', not the providers', responsibility to inform the patient as to what the rebate for the dental service will be. Health funds do not issue to their contributors a list of rebates for dental services and nor is it easily accessible. Health funds do not release the list of rebates to providers. The ADA remains disappointed that the ACCC has in some reports suggested it is the provider's responsibility to inform the contributor what the gap is to be. This is not realistic as the provider has no idea of the level of cover for the contributor or the eligibility of the contributor to claim.

The subject of informed financial consent (IFC)[4] has long been an issue for the ADA and its membership. The ADA recognises that the health provider has an obligation to provide IFC *vis-à-vis* the patient/dentist relationship but that obligation extends no wider.

This is because patients with health fund cover have a direct contractual relationship with their health fund. The health provider is not a party to that contract and therefore has absolutely no obligations under that health fund's arrangement. If the patient wishes to know what out-of-pocket expenses are to be incurred (i.e. above the rebate received from the health fund) then the determination of that information is a matter between the patient and health funds. It remains the responsibility of the practitioner to simply provide the patient with an itemised account.

[4] ADA Policy Statement 5.16 - Informed Financial Consent – that can be accessed at http://www.ada.org.au/about/policies.aspx.

It is the ADA's experience that regularly when patients present their proposed treatment plans and fee estimates to the health funds, health fund staff are instructed to opportunistically use this information to try and influence the patient to see the funds' contracted providers. This is done utilising discriminatory rebates that favour preferred provider arrangements. The patient does not have the choice of a lower premium if they choose to attend non-preferred providers. This is anti-competitive.

Recommendation 18

If the ACCC wishes to assist consumers with provision of information about the financial impact of receipt of healthcare then where services are rebated by health funds, the ACCC must demand health funds publish clear, easy to comprehend rebate tables for each policy health funds provide.

Conclusion

The ADA remains concerned that issues raised in its submissions over previous years have been ignored and it is once again seeking to draw attention to these issues. Health fund behaviour requires significant reform. It is evident health fund behaviour has deteriorated markedly over the last few years. Immediate steps must be taken to make health funds accountable to consumers in the interests of fair financial accountability and more importantly, their health interests.

Adoption of the recommendations made in this submission must occur to achieve this end.

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30 AUGUST 2013