AUSTRALIAN DENTAL ASSOCIATION

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1 May 2023

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Australian Competition and Consumer Commission
2 Lonsdale Street
Melbourne VIC 3000

By email: naomi.menon@accc.gov.au

Dear Naomi

**Re: ADA Submission on wider issues relating to private health insurance arrangements**

Thank you for providing the Australian Dental Association (ADA) the opportunity to comment on wider issues relating to private health insurance arrangements. The comments herein are relevant to the Australian Competition and Consumer Commission's (ACCC) current consideration of applications from Health Partners Limited and the Hospitals Contribution Fund of Australia Limited. We trust our comments can also help inform consideration of future relevant applications by any private health insurer.

## About us

The ADA is the peak representative body for dentists in Australia and an active member of the World Dental Federation. Our 17,000 members operate more than 7,500 small businesses across Australia. They include dentists who work across the public and private sectors, over 14 specialty areas of practice in education and research roles, and dentistry students currently completing their entry-to-practice qualification.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public, promote the ethics, art and science of dentistry and support members to provide safe, high-quality professional oral care.

## Context

The ADA has raised long-standing concerns about the overall impact of arrangements by private health insurers and whether they are genuinely in the public interest. The ADA is particularly concerned about the competition impacts in relation to price-capping of dental services and the potential for consumer harm. These concerns are wider than any specific insurer or arrangement.

The ACCC is currently considering two authorisations relating to such arrangements. In addition to the specific submissions the ADA has made on each of these authorisations, the ADA wishes to provide to the ACCC a general submission on the wider concerns that it has previously raised and continues to hold.

The ADA acknowledges the difficulty of trying to attribute specific impacts to specific elements of a specific insurer's arrangement. To appreciate what is an insidious problem, it is necessary to see the total picture of what is happening across all such arrangements. This submission seeks to assist the ACCC understand that total picture.

## Confidentiality

Much of the material in this submission is already on the public record, and the ADA has no issue with the ACCC placing this submission on the public register for any authorisations it is currently considering. However, the ADA emphasises that these wider issues are relevant to all price-capping arrangements (whether or not authorisation has been sought) and all authorisations that the ACCC is, or may in future be, considering with respect to price-capping arrangements.

## What the ADA is seeking from the ACCC

The ADA believes that a key reason the wider issues have not been subjected to comprehensive analysis is because of the piecemeal nature of how such arrangements have been brought to the ACCC for authorisation, and the narrow focus of each individual authorisation.

Specifically, insurers who have sought authorisation have only done so where their concern is that operating their own practices puts them at risk of being considered to be in competition with third party dental practices with whom they have price-capping arrangements. This has framed the analysis as coming from a starting point that there is no issue with price-capping arrangements as such and that the issue is simply about a technical *Competition and Consumer Act 2010* (CCA) risk based on the geographic location of the insurer's own dental practices.

The ADA believes that this obscures the real issues that the ACCC should be examining, and in light of this –

a. The ADA is providing this wider submission on the insidious harms in totality.
b. The ADA asks the ACCC to consider whether all arrangements between insurers and dental practices that affect how dental practices operate (including the services they offer and pricing for dental services) should be submitted for authorisation as 'hub and spoke' arrangements.
c. On current authorisation applications relating to price-capping arrangements, the ADA submits that the ACCC should adopt a cautious approach by:
   - granting authorisation for a short term only, so impacts can be monitored and tested more frequently; and
   - limiting the scope of authorisation granted to the application of Division 1 of Part IV of the CCA in so far as the applicant is in competition with the third-party dental practices with whom it has such arrangements.

The cautious approach would allow the ACCC to balance the narrow reasons for which authorisation has been sought and the wider issues which that narrow scope cuts out of vision. In particular –

The cautious approach would allow the ACCC to address the narrow *technical* CCA risk for which insurers have sought authorisation by putting them on the same footing as insurers who do not have their own practices (and have not sought authorisation) where the ACCC believes it is appropriate to do so.

Importantly, the cautious approach would also leave *all insurers* and *all arrangements* subject to the application of Division 2 of Part IV of the CCA in relation to competition impacts, including the impacts of creating and operating 'hub and spoke' arrangements, allowing the ACCC to 'keep its powder dry' while it monitors impacts and develops a considered position on the total picture.

## Competition and consumer harm concerns

Private health insurance should be a choice available to consumers to help manage their health care costs. To the extent that taking up private insurance assists to make health care more accessible and affordable from the consumer's perspective, that is in the public interest. However, it is not in the public interest for private health insurers to control or influence the decisions consumers make about what services they seek and who they use,

or the availability or quality of services that providers of health care offer.

Dental treatments are not simply transactions between a buyer and a seller. It is fundamentally important to understand that the relationship between dentist and patient is a very special one, the patient putting their health in the dentist's hands. Within that relationship, treatment decisions are agreed between the dentist and the patient based on the dentist's clinical assessment and the informed consent of the patient. While a dentist's primary legal duty is to exercise reasonable care and skill in the provision of advice and treatment, there are fiduciary elements to the relationship, these having evolved from the sensitive and intimate nature of patient reliance and the need to disclose confidential information to the dentist. Consistent with those fiduciary elements of the relationship, cost is not the only basis on which patients choose their dentist; non-price service aspects, including feelings of confidence and trust, are also important.

The ADA is concerned that, incrementally and insidiously, financial service providers have reached into this healthcare relationship in a way that risks influencing both treatment decisions and the basis on which patients choose a dentist. As the ADA has previously documented, this is not a theoretical concern; there are actual situations where a dentist and patient have agreed treatment, and the patient's insurer (who was not, and should not be, part of that decision) has subsequently disagreed with that treatment.

Anything that facilitates insurers extending influence into the special relationship between dentist and patient should be something that rings warning bells for the ACCC to scrutinise, and to be asking the following questions.

*Public benefit versus private benefit –*

Are these arrangements in the interests of 'the community as a whole'? Can the ACCC be confident that these arrangements are not making one group of people better off, at the risk of making another group worse off?

Each insurer is making some services cheaper for some patients (i.e. its members). Looked at in isolation, what one small insurer does in this regard on a small scale might not of itself, and if no-one else is doing the same thing, impact on the cost of dental practices providing similar services to other patients or other services to all patients. However, the real question, looking at the total picture, is what is the collective impact of all insurers doing this?

The choices insurers make about which dental services they want to be cheaper, and what they want the price of those dental services to be, is not being driven by competition between dental practices. The prices they want dental practices to charge have not been set by consideration of the cost of providing those services or the impact on other services that patients may need. So how can the ACCC be confident that the choices insurers make do not mean higher prices for patients who are not insured and/or higher prices for other services?

*Competition in dental services versus competition between insurers –*

Almost all the focus in authorisations has been on the market/s in which insurers compete, with little to no analysis of the market/s in which dental practices compete.

Without proper analysis of competition in dental services (with and without such arrangements), how can the ACCC be comfortable that these arrangements are not reducing competition in dental services to suit competition between insurers?

For example, could the totality of these arrangements lead to a stabilisation of price or de facto locational rules? Again, this is not a theoretical concern; in one of the arrangements currently before the ACCC the insurer does not enter into arrangements with dental practices within a certain geographic area around its own practices.

*How voluntary are these arrangements –*

While an individual insurer can say that participation in its program is voluntary, looked at from the total picture, the real question is whether the reality of how these arrangements operate means that once enough insurers are doing this, dental practices need to participate in someone's program. The ADA has documented situations where dental practices cannot compete effectively if they are not part of any arrangement with insurers.

*Impact on how consumers choose dental practices and services –*

There has been very little analysis of how consumers can meaningfully compare the price/service offering of different dental practices if the rebate from their insurer for the same service varies between dental practices.

Do consumers end up being influenced by the best rebate for services they need today (e.g. scale and clean), rather than assessing the dental practice that offers the best price/service for their needs over time, including complex services they may need that are not fully rebated? Are consumers being attracted to a particular dental practice by fully rebated services but then effectively locked into paying more for complex services because they feel uncomfortable or unwilling to change to another practice (perhaps because their insurer may apply differential rebates at other practices)?

Without detailed analysis of the impacts that rebates have on the acquisition and supply of dental services over time, how can the ACCC form a view on the way these arrangements affect competition in dental services and the operation of this market as a discovery mechanism for how the needs of consumers can be best met in the most efficient way? Is the insidious impact that this market simply becomes about meeting what insurers want in the cheapest possible way?

*Are the benefits claimed by insurers actually benefits when the total picture is considered –*

It is worth keeping in mind the reminder from the Tribunal in Re QCMA (1976) 8 ALR 481 that:

> *A claimed benefit may in fact be judged to be a detriment when viewed in terms of its contribution to a socially useful competitive process.*

Language about cost and price should be scrutinised carefully. These arrangements are about reducing the price charged for particular services, not the cost of providing those services. This distinction is important to any analysis of public benefit.

### Examples the ADA has raised in previous submissions

The ADA has attached the following past submissions which contain examples of alleged conduct by insurers that has caused the ADA to have its concerns. The ADA has extracted some of these examples and includes them at **table A** (attached) to illustrate the types of issues we have raised.

- S.1 September 2012 ADA Submission to the ACCC on Private health Insurance
- S.2 13 February 2015 ADA submission to the ACCC on Private Health Insurance
- S.3 17 March 2017 ADA Submission to the ACCC on Private Health Insurance
- S.4 4 August 2017 ADA Submission to Senate Standing Committee on Community Affairs Inquiry
- S.5 19 March 2018 ADA Submission to the ACCC re authorisation AA1000402
- S.6 10 April 2018 ADA Presentation to the ACCC re authorisation AA1000402
- S.7 13 April 2018 ADA Submission to the ACCC re authorisation AA1000402
- S.8 5 February 2021 ADA Submission to the ACCC re authorisation AA1000542
- S.9 22 July 2021 ADA Submission to the ACCC re authorisation AA1000542

The ADA would consider seeking additional feedback from members should there be areas of concern that the ACCC wishes to investigate further.

We would be most happy to discuss the comments provided herein. Should you have any questions, please do not hesitate to contact Mr Damian Mitsch, Chief Executive Officer, on [redacted] or [redacted].

Yours sincerely,

Damian Mitsch
Chief Executive Officer

Encl.

## Table A: Examples the ADA has raised in previous submissions

| Item | Submission | Quote (Please see submission for context) |
|---|---|---|
| 1. | S.5 page 3 | *"[In the context of ADA's response to HCF's authorisation application in respect of its Dental Clinic Network and More For Teeth program] 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"* |
| 2. | S.5 page 5 | *"The Conduct [as defined by HCF's Application in respect of its Dental Clinic Network (DCN) and More For Teeth (MFT) program] 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)"* |
| 3. | S.4 page 31 | *ADA member comment:*<br>*"For most patients, the rules of health funds do not allow for good value of health cover, or allow treatment to be done appropriately - as recommended by the health care provider. Many patients require lots of treatment over the course of a year or two and only maintenance treatment after that for some time. For example, a root canal on a single tooth with a crown can cost more than $3,000-$4,000.*<br>*The health fund rules almost always don't allow you to realistically get your money back for the treatment that you actually use. I get people who will spend thousands on treatment and at the end of it have not used all of their health cover as the rules have not allowed them to access it all. This is not fair at all. e.g. have spent $3,000 on major dental (only to receive $800 back from the health fund - max amount for major dental) but they still have $500 of general dental which they cannot access. That's simply not fair to patients. Patients cannot control their dental needs and so they should be entitled to all of their cover"."* |
| 4. | S.4, page 37<br>See Appendix 1, Complaints 5 & 14 of S.4. | *"The ADA regularly hears that PHI call centre staff: Inform the consumer that no rebate, or a very limited rebate is payable for specific treatments unless they attend a contracted provider"*<br>*[See Appendix 1, Complaints 5 & 14 of S.4.]* |
| 5. | S.4, page 37<br>See Appendix 1, Complaints 18 $ 19 | *"The ADA regularly hears that PHI call centre staff: ... PHI staff interfere in referrals to specialists, directing consumers to attend general practitioner dentists who are contracted to the PHI without explaining that the latter is not a specialist"*<br>*[See Appendix 1, Complaints 18 and 19.]* |
| 6. | S.4, page 40 | *"The ADA has heard that unreasonable contracts imposed by PHIs on private DGAPFs for such [general anaesthesia] services [in appropriately licensed day surgeries or hospital facilities], that do not cover facility costs, are seriously reducing access to affordable care. In some cases, funds will not negotiate at all. The ADA is aware that as a result, multiple facilities have terminated dental lists or closed because the business has become unsustainable financially."* |
| 7. | S.4, page 38 | *"In the past, treating dentists have been able to retain sedation-qualified dentists to provide these [dental sedation] services within their dental surgery when required, with treatment covered by private health insurance under item numbers 927,928, 942, 943 and 949 of The Australian Schedule of Dental Services and Glossary. This has meant that patients have avoided the need for hospital admission requiring specialist anaesthetist services, at considerable cost-saving to both patients and the* |

| Item | Submission | Quote (Please see submission for context) |
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| | | *government's health budget.*<br><br>*Recently, some private health insurers have stopped paying rebates for these services, and many others pay very low rebates that leave patients with significant out-of-pocket costs. The ADA understands that to avoid a situation where patients face high out-of-pocket costs, some treating dentists are using medical practitioners or specialist anaesthetists to provide the sedation services, because the Medicare rebates payable when medical practitioners provide these services means patients have lower out-of-pocket costs."* |
| 8. | S.2 page 41 & 74<br>See Complaint no. 35, page 74 | *"Australian Unity: Patient received several emails suggesting they go to specific dentists (PP)."* |
| 9. | S.3 page 8 | *"Whether by manual processing of claims or through the use of the HICAPS system, where the vast majority of private health insurance claims are processed, PHIs have collated data about the charging practises of individual practitioners across different practices. Where PHIs are operating 'owned' practices they have the advantage of granular sensitive information of the pricing practices, and clinical practices of their competitors (where the PHI's members have attended the 'other' practice and are making a claim following that visit). This places the PHI in an unique position of being privy to the actual prices of its competitors; knowing which services are being provided and the busyness of those practices thus being able to vary its own prices having regard to this information as well as 'steer' customers to the PHI owned dentist either by way of pricing signals such as level of rebate/level of out of pocket expenses or contractually in the terms and conditions of policies. They are also privy to the busyness and volume of trade so may consider establishing a clinic nearby.*<br><br>*Vertically integrated PHIs in the above examples have information advantages about the fee rates of competitor dentists and set the rates of their employed dentists. They have used this information to communicate with nonpreferred dentists about their rates, essentially seeking to affect their rates. Also, PHIs can use this data to derecognise otherwise productive dentists, or reduce rebates on profit draining expensive services which otherwise are in high demand due to the health needs of consumers."* |
| 10. | S.3 page 9 | *"Whitecoat has developed its directory by data mining details from practitioners' practice websites without their consent. Throughout 2015-16 the ADA received complaints from dentists who have requested Whitecoat remove their details from the website. However, the operators of Whitecoat have been tardy in complying with these dentists' wishes; effectively interfering in their practice via potential exposure to unfair comments about the quality of their practice. Furthermore, Nib, the creators of Whitecoat, at its presentation to the Private Healthcare Australia Fraud Conference in December 2016, purported that the site provided practitioners the full choice to participate or not. The ADA made it very clear at this event that this was not the feedback it received from its members"* |
| 11. | S.4, page 41 & 42 | *"The ADA's Victorian Branch has advised of one incident where a health fund conducted a routine claims audit and requested records for five patients from a dentist. When the dentist contacted these patients to seek their consent to share the information, two of them refused. The health fund then threatened the dentist with the loss of "recognised provider" status if the requested information about the patients who had not consented was not forthcoming.*<br><br>*"De-recognition" by the health fund would have prevented all of the dentist's future patients from claiming benefits from that health fund, effectively restricting their choice of health care provider, and limiting their access to care. After lengthy legal exchanges (and costs), the health fund* |

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| | | *agreed to accept the records for only those three patients who gave their consent to share their information, and the claims audit was closed without further penalties to the dentist."* |
| 12. | S.8 page 2 | *"Examples from the recent BUPA terms include clinical documentation requirements beyond the requirements of the Dental Board of Australia (thus opening the door for 'recoveries' should a practitioner practice competently but not in accordance with BUPAs terms) and inserts the ability for BUPA to share data collected from a small business with other BUPA entities, a remarkable condition given BUPA own the global BUPA dental business, the largest dental provider on the planet. BUPA in their latest terms even requires the use of secure messaging schemes - technology not yet generally available to our members."* |
| 13. | S.2 page 41 & 70<br>See Complaint no. 31, page 70 | *"GMHBA: PHI staff unqualified suggestion that dentist's use of particular item numbers not appropriate"* |
| 14. | S.2 page 41 & 71<br>See Complaint no. 32, page 71 | *"HCF: Rebate on orthodontic treatment enquiry - PHI recommended patient too young and should wait"* |
| 15. | S.1 page 10 | *"All too often, members have advised the ADA that when the fund 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 fund 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 fund"* |
| 16. | S.8 | *"For example, BUPA recently wrote to all dentists in Australia (and possibly all primary health care providers) indicating that the mere provision of a service to a person who had purchased a BUPA insurance product is an acceptance of contract terms determined by BUPA. BUPA explicitly stated that if those terms are not accepted, a practitioner is to notify BUPA and that practice will be 'de-recognised', upon which BUPA will not pay any claim by the patient under the patient's policy for treatment by that provider."* |
| 17. | S.9 | *"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."* |
| 18. | S.3 page 7<br>See page 13 for copy of letter from BUPA to a "*valued BUPA Members First Dentist*" (**BUPA Letter**) | *"In early 2016, Bupa issued notices to existing contracted dentists (Appendix 1),19 stating that they will remove the contracted provider status of those dentists if they do not ensure that all other dentists in the practice they work in are also contracted to Bupa."*<br><br>BUPA Letter:<br>"*…the enclosed Schedule will replace the existing Schedule of Set Benefits and Maximum Chargeable Amounts…(**Agreement**)…*<br>*To continue your participation in the Bupa First network, all general dental practitioners at your practice must complete and return a Rules of participation Agreement.*<br>*If we do not receive a completed Agreement prior to 1 June 2013, your current Agreement will end with from 1 June 2016*" |
| 19. | S.8 page 2 | *"Importantly, each new contract [in the context of a "take it or leave it" contract] extends the reach of insurers in relation to clinical matters and audit powers to seek to claw back from the small business funds properly earned through the provision of a legitimate service to a patient. That being* |

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| | | *that a dentist and a patient agree on a course of treatment and then a health insurance company later decides that they have concluded with no genuine right of appeal and without discussion with the patient, that the service doesn't meet the company's self-determined (and usually opaque) business rules Any attempt to debate the merits may be met with 'de-recognition'; derecognition results in the patient receiving no rebates for any services provided by that health care practitioner"* |
| 20. | S.9, page 1 | *"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."* |
| 21. | S.2 page 41 & 72<br>See Complaint no. 33, page 72 | *"HICAPS/Medibank Private: Unilateral withdrawal of funds from provider without adequate processes/notification"* |
| 22. | S.3 page 8 | *"PHIs also require that healthcare providers adopt the HICAPS billing and payment processing system as a condition of entering into a contracted provider agreement – a form of third line forcing that ultimately substantially lessens competition. In other words, these arrangements are requiring healthcare providers to over time disclose their business fee models to PHIs – an untenable proposition in any other industry. Key trend discussed in point two above represents one market consequence of this particular use of sensitive information that is not in the interests of competition nor consumers."* |
| 23. | S.4 page 42 | *"The ADA has received many complaints from non-contracted dentists about the way these larger, vertically integrated for-profit PHIs are using targeted marketing practices directed specifically towards their patients. Independent dentists, who are not subsidised by government in the way that large for-profit health funds are, are usually unable to spend as much on this sort of marketing, or are prevented from marketing in this manner under DBA requirements in relation to advertising."*<br>*[See Appendix 1, Complaint No. 7]* |
| 24. | S.6 page 9 | *"[In the context of ADA's response to HCF's authorisation application in respect of its Dental Clinic Network and More For Teeth program]"*<br>• *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*<br>• *This access to commercially sensitive data gives HCF the ability to undermine and eliminate competition over time via leveraging discriminatory rebates*<br>• *Once competition has effectively been eliminated, the natural progression is to restrict access to the competition further through discriminatory rebates and restrictive contract terms*<br>• *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"* |
| 25. | S.1, page 25 | *"There is evidence of PHIs pushing preferred provider arrangements (PPAs) 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 nonpreferred provider practices. This is destroying succession plans for practices in remote areas with the end result being loss of practitioners in the remote areas – where the public's overall access and oral health outcomes suffer. Some PHIs are even attempting to push contributors to* |

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| | | *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"* |
| 26. | S.2 page 41 & 73<br>See Complaint no. 34, page 73 | *"BUPA: PHI setting up PP practices close to established non PPs in small country town"* |
| 27. | S.5 page 4 | *"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"* |
| 28. | S.4 page 36 and Letter 2, Appendix 2 at page 73 | *ADA member comment:*<br>*"The providers are not chosen by merit. I have every reason to believe so, based on my experience. I worked as a contractor to a corporate company between 2006 and 2010. The corporate company got me to sign preferred provider contracts with Medibank, NIB, BUPA, HCF, MBA, ANZ health etc. I terminated my contract with this corporate in 2010 to start my own business. To kick start my business, I contacted as many health funds as I could, to sign a preferred provider contract. Only one of them obliged. If these funds indeed choose their providers by merit, one would think they would have no issue signing up a dentist who has been their provider for four years, and has been getting nothing but commendations from customers."*<br>*[See Letter # 2: "Moving to new practice – "Preferred" provider status lost when practice moved to a new address in same area: effect on patients", Appendix 2 at page 73 of S.4 for the email from the provider to the PHI]*<br><br>*"Once the fund has what they consider to be a sufficient number of PHI-contracted providers operating within a particular region or metropolitan area, the option to join the network is not open to other dentists. This "closed shop" approach is clearly anticompetitive."* |
| 29. | S.4 page 36 and Letter 2, Appendix 2 at page 73 | *"PHI-contracted providers who (a) decide to move their practice to more suitable premises within the same area, (b) join another practice that includes providers who are not contracted to the same health fund, or (c) invite noncontracted dentists to work in their practices, will often lose their PHI-contracted provider status."*<br>*[See Letter # 2: "Moving to new practice – "Preferred" provider status lost when practice moved to a new address in same area: effect on patients", Appendix 2 at page 73 of S.4 for the email from the provider to the PHI]* |
| 30. | S.1, page 25 | *"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."* |
| 31. | S.9 | *"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."* |
| 32. | S.1, page 25 | *"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"* |

# Attachment A – ADA previous submissions

| S.1 September 2012 ADA Submission to the ACCC on Private health Insurance |
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| S.2 13 February 2015 ADA submission to the ACCC on Private Health Insurance |
| S.3 17 March 2017 ADA Submission to the ACCC on Private Health Insurance |
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