Australian Dental Association Inc.

Submission to the Department of Health and Ageing

Private Health Insurance Consultation 2015-16

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Introduction

The Australian Dental Association (ADA) welcomes the opportunity to participate in the private health insurance consultation. The ADA is the peak national body representing dentistry in Australia. The majority of our dentist members work across approximately 7,500 small private practices providing around 85% of the dental health care services in Australia.

In Australia, some surveys have indicated that consumers with private health insurance (PHI) General Treatment cover [Ancillary] as distinct from Hospital cover are more likely to attend dentists than those without PHI. Some 55% of the Australian population have General Treatment cover but despite this only 17% of dental services are funded by PHI.

The nature of the relationship between a dentist and a patient and their involvement with their PHI has enabled our members, over time, to understand many of the concerns Australians have with PHI.

In this submission, the ADA seeks to:

1. Share insights with Government about the concerns which consumers have with PHI;
2. Respond to the issues raised during the roundtable discussions; and
3. Propose suggestions for reform.

1. Consumer concerns

a) Poor value for money

Consumers regularly complain to dentists about the poor rebates they receive for dental care pursuant to their PHI polices. While figures for total rebates paid by PHI for the cost of dental care in Australia are accessible, at the individual consumer level such information is not easily available and so consumers are unable to compare PHI dental rebates for the same dental service[s]. Our members and surveys of consumers by the ADA inform us that patients believe they are not getting good value for money from PHI for dental services. Consumers regularly face increases in premiums but rebates for dental items have not increased for many years. One major fund has not increased dental rebates across the board for services since 1999 and, in respect of some services, has decreased the rebate that was on offer in 1999 to what is offered in 2015.

PHI assertions about dental fee costs being the reason for increased out-of-pocket expenses is not supported by the evidence. The ADA's annual Dental Fee Surveys consistently show that over the last five years average dental fee increases have been:

- substantially lower than each of the PHI premium increases;
- lower than the general CPI; and
- significantly lower than the health CPI.

For dental care, PHI polices are therefore not seen as providing the insurance coverage for which they are designed. This makes PHI for General Treatment [ancillary cover] increasingly uneconomical for consumers.

b) Poor understanding of PHI generally and individual policies specifically

Consumers looking for information about PHI have great difficulty navigating the PHI landscape. The Australian Competition and Consumer Commission's (ACCC) recent report *Information and Informed decision-making,* highlights the difficulty which consumers experience in understanding the PHI sector and the range of available policies. Our members inform us that consumers regularly seek their advice about the best PHI policy for dental care. When, as quoted by the ACCC, there are over 20,000 policies on offer, it is inevitable consumers will be confused and unable to easily compare policies.

The current arrangements for informing consumers about PHI either through individual PHI websites, PHI comparator websites or government supported websites are still too complex. Indeed the ACCC has published its own report into comparator websites (*The Comparator Website Industry in Australia November 2014*), which has detailed concerns about PHI comparator websites including confusion among consumers and information overload. Many of the PHI comparison websites do not offer unbiased opinions and leave the consumer vulnerable to their suggested "best" PHI cover.

There is an obvious need for more transparency in the PHI sector and a greater emphasis upon tools which educate and inform consumers about their entitlements. It seems that the complexities of the policies themselves, particularly the terms, conditions and internal unique business rules that are not easily obtainable by consumers, place consumers at a distinct disadvantage. In health care, these terms, conditions and business rules, can often impact upon the treatment that consumers can receive. In the dental care space, terms and conditions can include:

a) Treatment exclusions;
b) Restrictions on treatment modalities;
c) Restrictions on frequency of treatment;
d) Restrictions on the number of services per patient;
e) Life time limits;
f) Annual limits on treatments;, and
g) Varying qualifying periods for certain services.

It is abundantly clear given the comments by our members that many of their patients only learn of the restrictions imposed by particular PHI funds when their claim for a rebate is rejected. Further, in some instances, PHIs unilaterally revise rebates, limits on services and qualifying periods without fully informing consumers, let alone informing them in advance.

Often many of the restrictions on cover are arbitrarily created by the PHI and have no relationship to "best practice'. They are imposed purely on monetary/profit driven motives.

This is not in the best interests of consumers. Rules to justify such restrictions on valid health grounds (not profit) need to be imposed.

There is considerable pressure placed upon consumers to take up PHI before they may be fully aware of the policy details. Some advertise *"join now, claim now"* but the terms and conditions of the actual polices, particularly restrictions applicable, are not clear and do not deliver on the promises made. Government has a role to ensure that advertising does not mislead consumers.

c) Differential rebates and interference in patient choice

The important and philosophical reason why many consumers take out PHI is for the purpose of having the choice of health care provider. Freedom to attend the provider of their choice supports continuity of care - a concept that is universally known to enhance the quality of care delivered and enduring confidence in the provider of the service. This freedom of choice of provider is undermined by the practises of some PHI funds. Terms and conditions of some PHI policies seek to interfere with choice of provider by influencing consumers' decisions.

Examples of such behaviours include:

i. excluding any liability for a rebate if health care is provided by a provider not in a contracted relationship with the insurer; or

ii. despite the payment of an identical premium, applying a system of differential rebates payable if particular health care providers are accessed; i.e. consumers accessing a PHI contracted health care provider, receive a higher rebate than a consumer who receives the same service from a non-contracted provider even if the fees are the same or in some cases lower at the non-contracted provider.

Our members have been informed by their patients that PHI funds have advised them to seek treatment away from their own family dentist to a dentist contracted with a PHI fund in order to get a better rebate. The ADA is aware of consumers directly raising this issue with the Minister for Health only to have it summarily dismissed under the guise of such activity enhancing competition. At first blush this may be seen as competitive conduct by PHIs but closer analysis shows it can compromise the quality of care that a consumer might receive from their regular family dentist.

Further, the adoption of differential rebates is contrary to the whole principle of PHI to provide insurance for health care. It is also contrary to the payment model under the Medicare Benefits Scheme (MBS) which pays a fixed rebate amount for a service regardless of the location of the provider. As noted in Option 2 of the *Reform of Federation Discussion Paper*, the recommendation was that in respect of hospital benefits the benefit payable should be the same regardless of the provider - be it a private or public hospital. The same should apply for any benefit payable under a PHI General Treatment policy. If the consumer has the same policy with the same insurer then the same benefit for the same service should

be paid regardless of the provider. This also appears to be the intention of s63-5(2) of the PHI Act.

The payment of rebates should be uniform under a policy regardless of the health care provider seen. Choice of provider should play no part. Where two consumers with identical PHI policies receive identical dental care, those two consumers should receive an identical rebate in return for the premium that has been charged. This does not occur with medical services under Medicare. Why should it occur with PHI?

PHI operated clinics

In addition, the increasing propensity of PHIs to conduct and/or own dental clinics raises considerable concerns. PHIs are encouraging Australians to take out PHI cover (thus collecting a premium from members); operating clinics where they employ the professional health providers (potentially influencing the type of care to be delivered); providing services at a cost set by the PHI and then determining the rebate for the services delivered. Such arrangements are open to conflicts of interest. Such arrangements will be difficult to dissect and any suggestion that market forces will come into play to protect consumers is wishful thinking. The ability of PHIs to profit at the expense of the member of the fund in such arrangements is immense and cannot be condoned.

2. ADA's response to the roundtable discussions

The ADA seeks to refer to those issues raised during the roundtable discussions but not addressed above.

a) Community rating

The ADA does not support any change to the current community rating process. Any change can only lead to discriminatory practices by PHI funds in refusing to cover particular consumers for particular treatments or at all.

The existing arrangements provide the most equitable outcome for most Australians. If community rating is abolished, those most in need will face increased premiums for care they were previously insured for. It will create greater tiered levels of cover. The market is already overburdened with more than 20,000 policies. Adding to this will only further confuse the consumer.

b) The Private Health Insurance rebate

ADA policy, "*Delivery of Oral Health Care: Funding: Government"* provides:

> *Financing of Government incentives for the community to take out private health insurance [including ancillary cover] should not diminish the Government's obligation to fund reasonable levels of oral health care preferentially for those disadvantaged and special needs groups who are unable to access care without that assistance.*

The ADA therefore leaves the decision regarding retention or removal of the rebate to the government. However, the ADA is of the belief that if the rebate were to be discontinued, then it is important that a representative portion of any monies saved, be applied towards Commonwealth Government funded dental care delivery to deserving Australians as opposed to being subsumed within the overall health budget.

The ADA has already proposed that Government introduce an *Age Pension Dental Benefits Schedule* which is a targeted scheme designed to provide for the oral health needs of the eligible aged. This proposal will be an enormous step forward in the treatment of the oral health of the aged which will benefit Australia's health system overall. It represents an ideal application for a portion of monies saved if the PHI rebate is discontinued.

3. ADA Suggestions for an improved system

In the final paragraphs of this submission, the ADA puts forward some suggestions to the consultation for an improved PHI system. These suggestions are based upon the feedback dentists give to us about patients' concerns with PHI.

a) Enforce the principles of PHI insurance

The role of PHI is to insure consumers for the cost of their health care; not to determine the health care that consumers can access. It is important that Government commit to this principle. The need for health care is a decision for the consumer to make in consultation with their treating health care provider to satisfy their clinical needs. Unfortunately, the terms of PHI policies seek to undermine this principle through the imposition of restrictions or exclusions on treatment modalities and treatment frequency. The unilateral refusal to rebate a particular item by a PHI may deter or prevent the consumer from accessing particular health care contrary to the advice of their health care provider. All limitations or restrictions on cover need to be justified on best practice grounds. To decline benefits under a policy for reasons other than the potential for it to be a departure from best practice must be prohibited.

Further, some PHI promote unnecessary services by so called "free treatments". The essential principle of health care services is that there must be a clear underlying clinical need for the healthcare services provided. This principle in enshrined within Medicare legislation for medical services yet PHI openly flout this with their advertisements for "free" care and "free joggers, free gym membership, free movie voucher", etc. Surely the cost of the "free" services offered to entice membership should be directed to increase rebates. In nearly all cases of the "free" offers there are restrictions in place which are very poorly advertised and often not discovered until a rebate for a service is rejected.

b) Introduce a model PHI policy in plain English

The Government should consider the adoption of a uniform model PHI policy that will be the basis of all PHI policies. A commitment by the Government to a minimum standard of cover to be provided by PHI, will lead to greater uniformity in the PHI sector and more knowledge of the consumer to their basic rights and their unambiguous level of cover. Greater

uniformity among policies is essential to assisting consumers to understand their individual polices. Uniformity encourages familiarity which will increase consumer knowledge.

The model policy should set out the purpose of PHI and the obligations upon the parties to the PHI policy in simple terms. The Government and PHIs should determine the uniform basic cover to which all consumers should be entitled under the terms of all PHI policies. The model policy should also confirm that the rebates paid under identical policies should be the same regardless of the health care provider seen.

Each insurer retains the ability to tailor PHI polices to meet individual needs but does so by identifying how each type of cover varies from the model policy. Exclusions, annual monetary limits (AML) and qualifying periods (QP) would be clearly noted as would any additional benefits or restrictions or loyalty bonus. Under these policies, annual policy updates to consumers could be issued, informing them regularly about the terms and conditions of their policies and any modifications made. While PHIs may argue that the ability to do this exists now, that is incorrect. Currently the plethora of policies and variations within them create a maze of more than 20,000 policies which only the most astute policy holder would have any hope to be able to discern.

For example, if a policy is developed that will provide a higher rebate based on the health provider who provides that service, then that policy should make that clear and the premium charged for cover reflect the level of rebate payable. If a policy holder wishes to maintain their choice of provider and is willing to accept the lower rebate then the premium must be lower than that charged for the policy that returns a higher rebate due to the provider engaged.

c) Implement and support a new Consumer resource

A belief of patients that PHI does not provide value for money is commonly reported by our members. The ADA submits that keeping consumers adequately informed about their PHI, including providing the tools necessary for them to weigh up their premium costs against the benefits they receive for health care given, is essential.

At a minimum, the Government should implement and support easy access to a straightforward online resource (or call centre for those unable to access the internet) which would include for each policy in existence details of:

i. the rebates for each item of health care including dental care so that any out of pocket expense can be calculated; and
ii. any limitations and exclusion of benefits which might apply to each item of health care including dental care.

This information should be available for all policies in an established uniform manner and could be managed by Government with information submitted by individual PHI funds which should also be responsible for funding the site/call centre. Currently

www.privatehealth.gov.au does not sufficiently meet this consumer need nor do individual PHI websites which highlight premium cost as opposed to the benefits available under particular policies.

The ADA has equipped our members with tools to assist them in communicating with patients about PHI and dental care. These information sheets are accessible on the ADA website by clicking on this link: http://www.ada.org.au/phi_facts/phifacts_.aspx.

d) Promote Consumers' rights

Whilst portability of PHI is referred to in advertising, the patients of our members have informed us the actual process of transfer is very difficult and arduous. Consequences of any transfer are often difficult to determine. Eligibility for benefits can be affected if new qualification periods for cover are involved. The flow on of loyalty bonuses is not clear or well understood by consumers. This is not well publicised to consumers and many consumers are completely unaware of the process. In order to transfer a PHI policy the consumer must obtain a "Transfer Certificate" from the fund they are leaving. The Private Health Insurance Administration Council reports these certificates must be provided within 14 days. The ADA is aware that PHIs are tardy and in some cases antagonistic in the provision of these certificates. Furthermore, the ADA believes there is no reason to restrict consumers' portability rights to only hospital cover products and not general treatment policies. Portability is a competition enabler and should be simple.

Conclusion

The ADA would welcome an opportunity to continue to be involved in this consultation. Should you wish to meet to discuss any of the issues raised or otherwise have any questions, please contact Mr Robert Boyd Boland at ceo@ada.org.au.

Yours faithfully,

Rick Olive AM RFD
Federal President
4 December 2015