Submission on the Health Market Inquiry Provisional Report

September 2018

A Member of AfroCentric Group
medscheme

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Statement of support

Medscheme supports the need for a health system (public and private) that is regulated in a fair and transparent manner, with sufficient regulatory oversight that ensures cost effective, accessible, sustainable and affordable health care for all. However, it is our view that the existing legislative and regulatory framework (including any planned amendments) must foster innovation and enable healthy competition among various industry stakeholders. It is only through a developmental and inclusive regulatory framework that we believe sustainability of the health system can be achieved, to support the move towards universal health coverage among many other imperatives.

We appreciate the opportunity to make comments on the Health Market Inquiry's (HMI) Provisional Findings and Preliminary Recommendations Report that was published on 5 July 2018.

We recognise that this publication is a culmination of a long process of engagements. Medscheme, in the spirit of ongoing constructive engagement, has been continuously involved in various discussions and has made many technical submissions on all matters pertaining to market structure, tariffs processes as well as supplier induced demand since the initiation of the Inquiry in 2014. It is with respect for this process that we have methodically reviewed the report's recommended interventions and submit our comments.

The HMI's position that the recommendations have clear interdependencies and that these recommendations must be implemented in a holistic manner is supported and Medscheme welcomes this approach.

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Points of difference

In the spirit of enhancing the Provisional Report's findings and the applicability of its recommendations, there are some key points that we would like to draw the panel's attention to. These include, but are not limited to, the various elements outlined in Medscheme's original detailed submission, specific submissions on key matters of further engagements (throughout the HMI's existence) as well as those relating to some of the commentary in the Provisional Findings Report, and why our position differs with those contained in the Provisional Report.

Market "failure"

It is Medscheme's view that the majority of the current competition failures and challenges being experienced in the private health care industry is largely as a result of an incomplete and/or fragmented legislative and regulatory regime. We believe the opening statement of the recommendations section of the Provisional Report concluding that the South African private health sector suffered from multiple market failures is therefore incomplete. "Failure" is a strong word and the evidence, in our opinion, suggests problems areas and some failures but not total market failure. The statement does not provide the necessary context of the significant and detrimental impact that the incomplete and/or fragmented legislative and regulatory regime had in distorting market forces and leading to some of the core challenges faced by the market currently. Nor does the statement recognise the world-class quality of care delivered in the private sector. In this regard, we respectfully refer to the Medscheme submission dated October 2014 (**Appendix A**) detailing our position on the impact of the incomplete regulatory regime in driving some market failures and the elements driving costs and utilization within the sector.

Procuring value

Medscheme believes the inference that only Discovery is able to procure value through its various operational models, including the collective bargaining with various suppliers such as hospital groups, is inaccurate and a misrepresentation of Medscheme's competitive position. This statement seems to only relate to procurement of hospital services. Further in this we document we address the matter of collective bargaining to which hospital negotiation relates.
While it is appreciated that the data and analyses upon which this sentiment is based is for the period 2010 to 2014, it is our view that this opinion is potentially outdated and many elements have changed over the period 2014 to 2018.

Medscheme has been able to procure pathology, renal dialysis and specialist services at competitive rates. **Figure 1** indicates that Medscheme has consistently been able negotiate annual pathology tariff increases that are below CPI and this translates into reasonably good savings for our client schemes.

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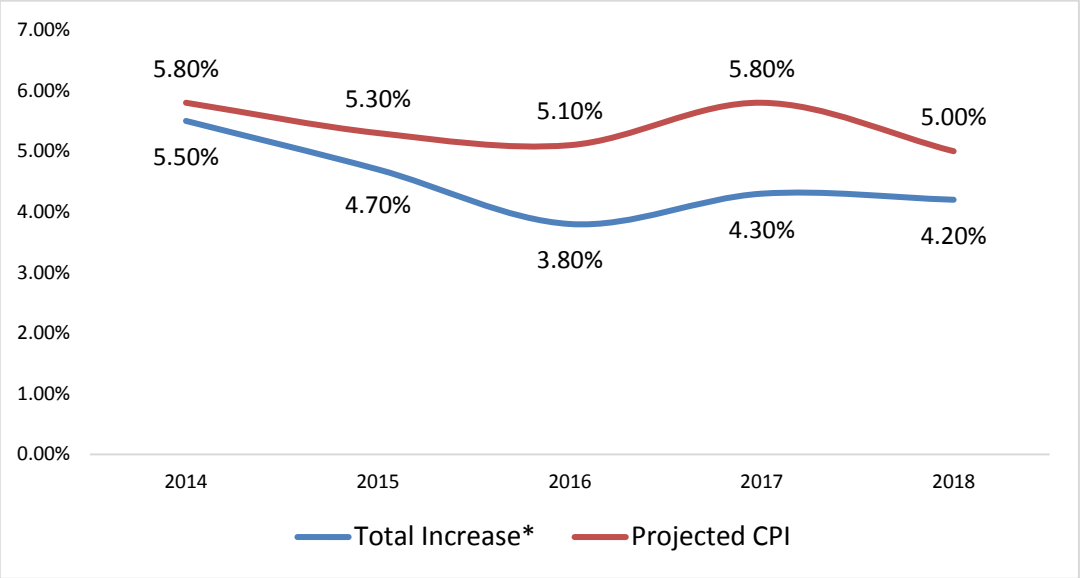
Figure 1: Average pathology tariff increase (2014 – 2018)



Medscheme also submits a pathology savings report to each client on a monthly basis.

We have attached **Appendix B.1 and B.2**[1] to show that we also have a clear strategy within the renal dialysis space with regards to not only effectively managing costs for our clients but proactively collecting and collating information on key quality metrics as well. The Medscheme contract with renal dialysis providers (**B.1**) has quality requirements referred to in points *6.7 through to 6.13* and *7.8* respectively. Additionally, **B.2** is the Medscheme draft renal dialysis facility profile report that we are working on and will be finalised once we get the quality data from the providers. The sections that specifically speak to quality include sections 6, 7 and 8 and the intention is to add more as the structure and content of the report are enhanced over time.

Medscheme also actively involved in the procuring of value for client schemes within the hospitals space. We share quality metrics on a quarterly basis with the various hospital groups and all of our RFPs for DSP arrangements include a requirement for hospitals to share hospital quality metrics with us. The RFPs are evaluated taking into account the hospital groups' commitment to sharing quality metrics.

Lastly, one of our biggest client schemes has benefited immensely from their relationship with Medscheme by successfully implementing one of the largest and stable general practitioner networks that is based on the principle of value-based contracting linked to clear metrics, accessibility and enhanced reimbursement. This general practitioner network was implemented in 2010 and reimburses the contracted practitioners on both cost efficiency and quality metrics, includes peer review, skills development and regular engagements between the practitioner leadership, Medscheme and scheme representatives, employing principles highlighted by the report's findings and recommendations.

[1] Appendix B.1 and B.2 are confidential and not to be circulated publicly

Value of managed care

Asserting that it is difficult to assess the appropriateness of certain courses of treatment and to evaluate quality of care and value for money in the healthcare sector as well as to demonstrate the value of managed care services within the current medical schemes environment is not an entirely accurate assessment, in our view. While the criteria and mechanisms that different administrators/managed care organisations utilise to prove value to their respective clients may differ, we would like to indicate that all our schemes hold contracted managed care organisations accountable for various elements related to the managed care obligations. The measurement of our performance against predefined yet evolving criteria and our transparent reporting thereon takes place through a number of different channels, including quarterly performance reports, proactive and ongoing fraud, waste and abuse interventions and reporting, and claims/risk management forums to mention but a few. We agree that these interventions and engagements focus on the client and rarely make it into the members' view, and more should be done to ensure that client scheme members have access to this information in a more regular, accessible and transparent manner. It would be welcomed for recommendations to be made on what a 'value of managed care scorecard' could look like, noting that it is likely to have qualitative as well as quantitative metrics. Included in **Appendix C.1, C.2** and **C.3**[2] are examples of some of the ways Medscheme articulates its value to the client. This value can be experienced by beneficiaries in cases of disease management, some is delivered to corporates registered on the scheme, while others are scheme population metrics, whether financial or clinical.

Furthermore, the current procurement and deployment of managed care services by medical schemes has traditionally been within a legal framework where most managed care service providers are paid *per member per month* fees to deliver a series of interventions and services. These interventions and services are generally transactional and aim to manage costs through the application of benefit limits and funding rules. This model is not unlike the current fee-for-service health delivery model where providers are paid for the services provided to members with little or no focus on value-based outcomes.

Medscheme believes that the persistence of the current fee for service transactional healthcare delivery model has in many ways entrenched the current managed care model and components of this traditional model will remain.

The Council of Medical Schemes has also insisted that each product is costed individually and schemes can procure bits and pieces, further fragmenting the way managed care is delivered in order to achieve some of outcomes in a system known to have interdependencies.
A recommendation that encourages many permutations of contracting arrangements between managed care organisations and client schemes would be welcomed.

The HMI Provisional Findings Report indicates a series of changes that must be effected to the existing regulatory environment so as to facilitate the implementation of new healthcare delivery models that move away from the current transactional fee for service model. This has bearing on the work and resultant value of managed care.

[2] Appendix C.1, C.2 and C.3 are confidential and not to be circulated publicly

An example of a model that changes the transactional managed care contracts and the fee for service supply-side (facilities and providers) would be a fully integrated model such as a Health Maintenance Organisation (HMO). Essentially in this integrated model, the funder can be a for-profit organization that proactively manages the health care needs of a defined population by interacting with targeted healthcare providers (contracted or employed doctors, hospitals, etc.) who agree to render services according to agreed evidence-based medicine. Within the context of a fully integrated HMO model the strategic procurement of appropriate managed care services will be a differentiator and critical to the competitiveness of a managed care organisation, especially a regulatory environment that promotes/supports/enables vertical integration, ARMs and multidisciplinary provider teams. Kaizer Permanente is one such model with a not-for-profit funder and in South America there is a for-profit insurer called Amil which is also an HMO, integrated model. We propose that that the HMI considers making a strong recommendation that enables such an environment.

In the provisional report, much is said about the closeness of relationship between schemes and administrators or managed care organisations. Administration and managed care is an extension of a scheme. We assert that the success of the system depends on shared value, cost, process and outcomes of the entities. We would agree that the governance relating to these relationships needs to be strong, however the interwoven nature of the relationship must not be compromised in the process, as this is critical to deliver value to schemes, providers, beneficiaries and the system as a whole.

We believe that the HMI recommendations should also be directed at creating an environment where new healthcare delivery models can be implemented with minimal regulatory restrictions.

Claims experience

The Provisional Report continues to make reference to Medscheme experiencing a 10.9% increase in claims over 2010 to 2014 period, as compared to a 9.2% industry average over the same period. We would like to reiterate that this statement is based on an error in calculations. Medscheme submitted supplementary evidence outlining the error in calculation (see response letter dated January 2018, **Appendix D**). The HMI has not updated its commentary nor engaged with Medscheme on the matter as to how and why the difference arose. Medscheme therefore disagrees with the statement and its implications and request that this section of the report and related calculations be amended.

Loyalty and wellness programmes

It is Medscheme's understanding that a number of stakeholders submitted information to the HMI regarding the appropriateness and necessity of loyalty and wellness programmes and how these have been utilised by long standing industry players to build brand loyalty among consumers and brokers and also to act as barriers to entry for new entrants. The HMI Provisional Report states that:

> *"Overall, open medical schemes with a loyalty and wellness programme have experienced an increase in membership growth, but not a younger age profile. However, experiences of individual wellness programmes differ and some*

> *programmes may be more successful at attracting younger, healthier members than others. Administrators and other companies in the group pay additional funds (either as fees or in the form of intercompany transfers) to loyalty and wellness programmes. The lack of transparency surrounding the funding of these programmes may allow medical schemes and their administrators to circumvent regulations through increasing the commission brokers receive. This may provide them with an unfair competitive advantage in the market."* pages 139 to 140, paragraphs 369 and 370.

Despite the far-reaching implications of loyalty and wellness programmes and how various stakeholders utilise them to attract members, ensure member retention and growth, let alone create a barrier to entry for new entrants, it is surprising that the HMI did not make a recommendation on possible legislative or regulatory review that should be implemented to promote better competition and prevent their use as a barrier to entry for new entrants. On this matter, we refer you to our 2014 submission regarding loyalty programmes and their relevance to the growth of medical schemes. In that submission, we stated the following:

> *"Loyalty programmes have become the norm for open schemes who wish to attract and retain healthier lives. The MSA does not allow medical schemes to provide loyalty products and a new entrant therefore requires significant financial backing outside of the MSA in order to compete. This places new entrants without links to large insurers at a disadvantage. Whilst some loyalty programmes are considered purely of marketing nature, other loyalty programmes are designed to support wellness and preventative care initiatives,"* **and we also suggested that** *"… wellness programmes should be contracted by Medical Schemes in terms of the Medical Schemes Act 131 of 1998 and that the definition of relevant healthcare service should be expanded to include funding for wellness. This would lower the financial barrier to entry, allowing new wellness service providers to enter the market. From a competition perspective this would facilitate transparency amongst wellness providers who would be forced to publish their outcomes in order to remain competitive. This would also improve the standards of healthcare as beneficiaries would be empowered to make informed choices regarding their care."*

However, it appears that the implications for competition arising out of loyalty and wellness programmes have not been fully considered, and no firm recommendation on this is outlined in the Provisional Report.

Accountable, clean and transparent leadership

Medscheme, and the AfroCentric Group, unequivocally supports the principles of accountable leadership, transparent and responsive corporate governance. Medscheme fully subscribes to the King III principles and other international benchmarking practices intended to ensure proper and accountable management. It is therefore to our disappointment that the Provisional Report (for instance, in *Figure 3.5, page 48* and its accompanying paragraphs) continues to assert that

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there is potentially serious conflict in the cross-directorships and ownership within the AfroCentric stable.

The HMI goes further to make a highly subjective statement indicating that it *"…is concerned about the chilling effect that cross-directorships may have on competition."* This is despite their being no evidence to support how this may affect competition among administrators and managed care organisations, except that it is based on the untested assumption that *"Common shareholding and cross-directorships may distort or prevent vigorous competition as firms seek not to disadvantage returns to companies with multiple shareholding."*

AfroCentric submitted a response to the research note on which this inaccurate conclusion was reached yet it clearly indicated that the cross-directorships do not reflect any findings of anti-competitive conduct on the part of AfroCentric. AfroCentric strongly disputes that that is the case. Despite our submission, there was no further interaction from the HMI and yet no evident adjustment to the initial insinuations contained in the original research note that seems to have informed this conclusion. We stand by our initial response and urge the HMI to amend the wording in the Final Report to avoid statements with a potentially damaging reputational impact that has no basis in evidence.

Medscheme's previous representations on this issue to the HMI have been included as **Appendix E**.

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Specific comments on the recommendations

In terms of the recommendations outlined in Chapter 10 of the Provisional Report, Medscheme would like to make the following observations and comments, particularly focusing on funders and providers.

Funders

The conclusion by the HMI panel that *"… though the inquiry supports the principle of mandatory membership, we do not believe that it should be implemented within the current flawed system. At this stage, mandatory membership would simply add more beneficiaries into a system with high and rising costs, significant SID, limited competition and* ***no incentives to create value for members****,"* is not supported. The reason why the private healthcare industry is in its current state is not purely because of market failures that can be placed at the doorstep of the private industry players – majority of the challenges are as result of the fragmented legislative framework and the piecemeal implementation (or lack thereof) of key pieces of legislation that would have helped to ensure reasonable membership growth, address SID problems and deliver better value for members. The lack of a timely and clear regulatory decision on mandatory membership is one such flaw. Mandatory membership deals with the matters of anti-selection and enlargement of risk pools, which does impact on costs and thus contributions. Many health systems are based on this principle for this reason. That there are other system challenges does not negate the need and benefits of mandatory membership.

In order to ensure reasonable progress towards universal health coverage, and to ensure that majority of South Africans have access to needed quality health care at affordable levels, **membership to medical schemes should be made mandatory** especially for those that can afford it. It is therefore surprising that no such recommendation is contained in the provisional report despite that this would lead to significant progress towards social solidarity principles and would help the medical schemes industry proactively mitigate against anti-selection challenges.

Medscheme understands the principle behind the recommendations to reform the Prescribed Minimum Benefits **(PMBs**) framework to introduction of a stand-alone, standardised, **obligatory 'base' benefit package** for the purpose of comparability between schemes**.** Noting the overlap between this recommendation and the NHI Bill and Medical Schemes Amendment Bill, it is recommended that these be looked at together to enable clarity.

It is also suggested that such package must cover the current PMB-like catastrophic cover including making provision for treating PMBs out of hospital and additionally, include, primary and preventative care. This suggestion seems more concerned about the extent of cover, mainly to move away from a hospi-centric approach and for to allow access to preventive and primary services. It is not clear whether the intention is for provision of essential services or for comprehensive services. We would support an approach that starts with essential care, which could be defined as primary and preventative care and then adding more specialised and catastrophic cover. These are two different objectives which can, but not necessarily must be, linked together.

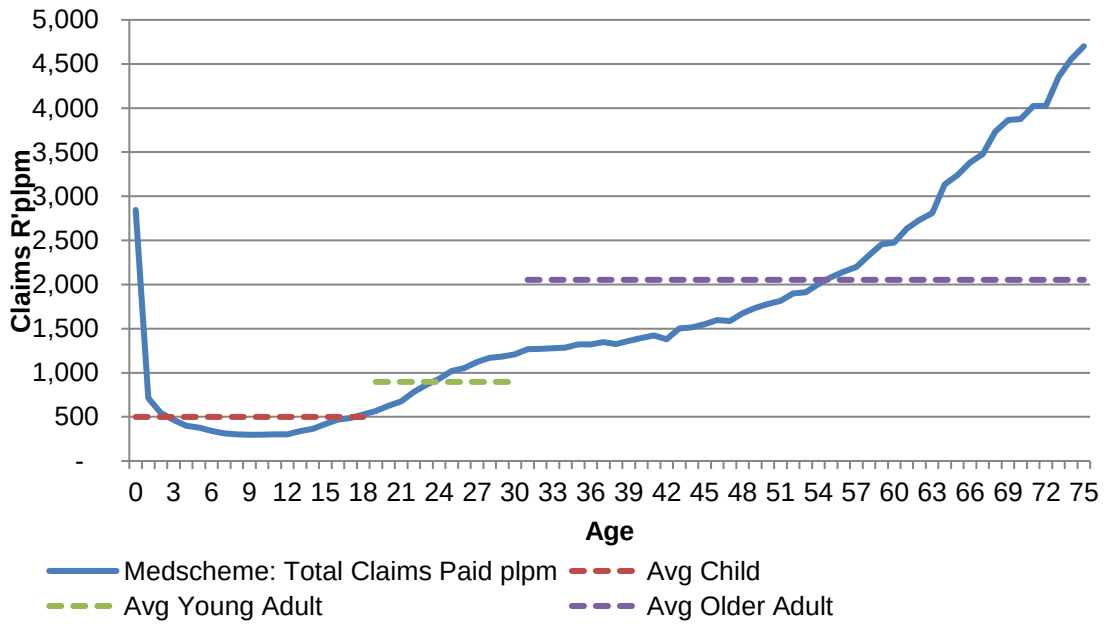
However, we suggest that the introduction of the revised package of care be subjected to proper affordability tests, for both the current group of covered members and those that would be entering the market, especially at the lower end.

An additional element that should be looked at is the phasing of these changes that accompanies such a change and the reasonable timelines to support the implementation process.

Regarding the matter of **anti-selection** and the late joiner penalties applicable to individuals who opt to join a scheme when they are 35 years or older and the HMI recommended changes to the waiting periods and late joiner penalties regime, Medscheme proposes that these changes be effected via a phased process that is linked to timelines for the various reforms being implemented in the health sector. This is primarily with regards to the proposed implementation of a Risk Adjustment Mechanism as well as the amendments to the Medical Schemes Act as recently published by the NDoH. Thus, changes to underwriting rules need to be implemented at the same time or after the implementation of the Risk Adjustment Mechanism (including income cross-subsidisation). This would help manage and spread any risk impacts from such a change.

The age cost curve graph in **Figure 2** highlights the significantly higher claims for older ages and it is critical to encourage younger healthier lives to join the medical schemes to ensure cross-subsidisation and thereby financial sustainability. The late joiner penalty and waiting periods are essential in helping to manage risk in a voluntary system.

Figure 2: Age cost curve



In respect of the proposed **discounted contributions** for beneficiaries under age 35, our analyses indicate that although this would be a positive step towards attracting younger members into the covered population, it is likely to push up contributions for older adults to cover lost income. The impact will vary by benefit option depending on the option's specific split of beneficiaries by age and relative claims cost experience, with an estimated 17% increase required for older adults based on Medscheme data across approximately 3 million lives. It is proposed

that an acceptable contribution impact on older lives is chosen, e.g. a 3% impact per year over 3 years at most. This would determine the appropriate age cut-off for the young adult discount (a younger age cut-off would lower the impact on the older lives). In our view a 17% impact on older lives is considered too large to implement, and especially in a single step.

Medscheme agrees that the existing Independent Advisory Model can be improved. We support the assertion that **brokers** form an integral part of the private healthcare funders landscape, and that it is important to ensure there is adequate alignment between their and the members interests. We support that the intermediaries role and remuneration structure should be reviewed periodically to ensure best service and value to customer. The value that health intermediaries add to the industry is demonstrated by the fact that more medical scheme members utilise the services and advice of intermediaries than ever before as is reflected in the CMS annual reports.

Our view is that the changes proposed must apply progressively for all new contracts, while allowing the current regime to come to its natural conclusion over time. It must also be kept in mind that there are potentially significant costs associated with retrospectively contacting every single member that has a broker, and this would prove to be an administratively complex and burdensome process.

There is no irrefutable evidence that the current process for utilising brokers and the applicable remuneration model is not effective. More investigation and analysis should be done in this area as we believe that the proposed "opt-in" and "opt-out" system can and will have huge implications to the industry (administrators, corporate companies and members). The opt-in process would be even more administratively intense for corporates than individuals. Members employed by corporates are currently given the opportunity to select their broker during office hours, in an organised manner to follow a reputable process to appoint their brokers. The administrative burden on their Human Resources department to manage and reconcile individual contributions to correct broker appointments, or not when going direct, is likely to be particularly onerous and add to costs for employers.

Medscheme supports the need for managed care organisations and administrators to provide client scheme members (and the general public) with access to information that is transparent, accountable and accessible regarding the **value of services providers**. In order for this to be effectively achieved, we are of the view that certain principles must apply almost universally:

a) Care coordination: The *"interdisciplinary approach to integrate healthcare and social support services in a cost-effective manner in which the individual's needs and preferences are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator"*.[3] Ensuring that all members/patients have access to a principal provider (usually a general practitioner) to take responsible for the health care of the patient and how they access and utilise health services (specialists and hospitals) helps funders to better manage costs and support access to quality, needed care;

[3] National Coalition on Care Coordination, 2011

b) Active disease risk management: Population health management is a strategic lever that must be drawn on within the managed care and administrator space. Medscheme strongly believes that active disease risk management, particularly in an era of a growing burden of chronic diseases (diabetes, hypertension, etc.), provides a robust and reliable solution that delivers sustained value to clients. This is because it enables the identification of high risk members of a given population, allows for targeted interventions with customised formularies and treatment protocols (that are evidence based); and ongoing member/patient support, coaching and education.

   This principle also directly speaks to the element of outcomes based reporting as it is designed to ensure ongoing monitoring and counselling of members to ensure compliance to treatment plans, and required behaviour modification, monitoring and evaluation and recording of processes and outcomes such as clinical outcomes, financial outcomes measures as well as quality;

c) Integrated health information platforms: The advent of the information age and the inherent "doctor hopping" of patients/members makes it even more important that all relevant patient data (clinical and non-clinical) must be easily accessible to those managing the patients' health and well-being. This information allows a treating provider to have a full view of what has been done to the patient thus enabling better clinical decision making, elimination of fragmented care and where necessary eliminates duplication of interventions (e.g. repetition of tests). This requires some form of electronic health record on which providers collect and collate patient data for tracking clinical care as well as for outcomes based reporting; and

d) An enabling and proactive legislative and regulatory framework: The legislative framework must ensure that it allows for flexibility in product offering, promotes innovation in the manner in which individual and group practices deliver care, encourages multidisciplinary practices and various reimbursement mechanisms including global fees.

The HMI asserts that *"… administrators' comparative performance on metrics such as non-healthcare costs; the value of PPNs, DSPs and ARMs, claims payment ratio, and the proportion of PMB and non-PMB claims paid from risk versus those paid from savings be published annually for each administrator compared to a national average"* sub-paragraph 32.2 on page 458. We support the notion of defined metrics to demonstration performance. It may not be prudent to publish annually as some changes require time to mature, especially those that require behaviour change.

Medscheme's overall managed care strategy is already based on the first three outlined principles and these principles are the basis upon which we report and prove value to our clients. We believe that in order for there to be readily available, accessible and useable information to compare the value offered by various administrators and managed care companies, the metrics for the performance measurement must be uniformly applied to all stakeholders. The framework that informs such a process must be robust and regularly updated to keep in line with developments in health care, evidence-based medicine, client needs and patient/member expectations.

Providers

We support the proposed creation of the **SSRH and OMRO**. We believe that the recommended functions and responsibilities of the two entities will help foster a better reporting environment that supports outcomes based reimbursement and contracting.

The first recommendation that Medscheme would like to add is with regards to the synchronisation of the data format requirements and regularity of submission timeframes with regards to reporting and submission of mandatory data. Supplementary to this would be the need for the regulators to proactively consider the costs associated with systems development, enhancement and implementation for relevant industry stakeholders.

This consideration is particularly important in the overall regulatory framework with respect to the **data requirements** envisaged in the Medical Schemes Amendment Bill (i.e. creation of the beneficiary and healthcare provider registries). Should all these data intensive requirements be implemented in a fragmented and haphazard manner, they could lead to a serious duplication of effort and avoidable costs that would be counter to their purposes.

Secondly, there would need to be clarity between the roles and responsibilities of all the regulators in the system to reduce overlap, friction, confusion and potential administrative burden on all stakeholders. This will have to be in tandem with the review of the relevant pieces of legislation. Further, the scope of regulation must be such that it provides a framework and standardization, especially relating to accreditation, billing, quality, but it must allow sufficient room for competitive contracting and reimbursement arrangements between funders and the providers.

Medscheme is concerned with the relatively weak provisional recommendations as pertains to the level of **market concentration in the private hospital space**. We refer to our initial submissions regarding this matter (see **Appendix A**). We are concerned that despite the HMI having had access to volumes of data, ample opportunity to undertake supplementary analyses and consultation and then stating that:

> *"We have considered a number of options on how to address this, including divestiture and imposing a moratorium on issuing licences to the three large hospital groups, namely, Netcare, Life and Mediclinic. The moratorium would require that these hospital groups should not be granted licences for new facilities, nor licences or permission to increase the number of beds within existing facilities until such time as the national market share of each of the big three hospital groups, by number of beds, is no more than 20%. The moratorium will be in place until new entry or growth in the private sector achieves a better competitive balance."* Paragraph 79, page 465,

the recommendation reached regarding this key matter is without practical impact. There is no clear recommendation on whether current regulatory entities must develop and progressively enforce a framework enabling for an effective and competitive hospital facility landscape

Taking this into consideration, and the evidence submitted previously, Medscheme is of the opinion that the HMI position on the hospital market dynamics is weak. This is because (i) it will

have limited material impact on the three large hospital groups to reduce their dominant market shares both nationally and regionally. The recommended moratorium that these hospital groups *"should not be granted licences for new facilities, nor licences or permission to increase the number of beds within existing facilities until such time as the national market share of each of the big three hospital groups, by number of beds, is no more than 20%"* will have limited impact, particularly on regional dominance; (ii) it does not adequately enable the creation of substantive opportunities for new entrants; (iii) allows the existing dominant groups to continue their tariffs negotiations with funders as currently is the case; and (iv) it does not address supply induced demand.

We hereby reiterate our comment from our 2014 submission that *"Hospitals consolidated into three major groups, which generated a negotiation imbalance with the less concentrated medical schemes and administrators. This placed the hospital groups in an oligopoly position which has largely eliminated price competition. The levels of concentration and the geographic distribution of the three main hospital groups have resulted in regional or local dominance. This affects the ability to negotiate competitive prices due to schemes' requirement of comprehensive geographical coverage. Hospital groups may adjust their rates in return for greater volume and the assumption of greater efficiencies, however where geographic dominance exists, members of medical schemes are balance billed by the hospital where the medical scheme and hospital group are unable to reach agreement on rates",* on page 85 – 86. This is especially so because the report indicates that the hospital market was measured as 'highly concentrated' using HHI or LOCI and also that at the local level, 58% of the 195 local markets that the HMI has distinguished are also 'highly concentrated'.

We are of the view that without any decisive intervention regarding the market shares of the hospital groups both regionally and nationally, and without adequately addressing changes in the manner in which tariffs are negotiated and agreed to within this environment, very little progress will be achieved to promote better competition and fairer tariffs determination processes.

Therefore, Medscheme recommends that the panel strengthens the provisional report with regards to the hospital market and the timelines within which such changes should be implemented.

Tariffs negotiation

Medscheme supports the need to have a regulatory environment that enables for the determination of health services tariffs utilising transparent, inclusive and efficient mechanisms. However, we are of the view that of the three alternative approaches outlined in the provisional report, the option on ***regulatory pricing*** would be the most protracted and risky option to implement. Given the court cases that lead to the abolition of the NHRPL process, it is not unthinkable to expect that a regulated pricing regime would lead to contentious, acrimonious and prolonged court cases without leading to a solution that benefits patients/members.

It also carries the real risk of alienating key providers and potentially leading to a market exodus of this key human resources for health. This is based on the experiences with the National Health Reference Price List processes that was previously in place and administered by the CMS and later the National Department of Health (NDoH). We also believe that having a pricing regime that allows for different tariffs depending on whether a condition is a PMB or non-PMB is problematic

and would simply entrench inefficiencies in the current system as it provides health services providers the opportunity to game the system and shifts costs where possible.

In our view, our submission for a reference tariff that is transparently published is still preferred. But, in the absence of such a solution, the option for a ***multilateral tariff negotiation forum*** where stakeholders conduct tariff negotiations under a framework determined by the SSRH (and if where the processes reach deadlock, the regulator will refer the dispute to an independent arbitrator for final decision) is our preferred framework. It potentially has the effect of removing the imbalances that characterise the current tariffs negotiations processes, provided that it is adequately transparent and the SSRH remains independent and impartial throughout the entire process.

Medscheme is concerned that the HMI recommendation that a **bilateral process** be allowed to continue but only for corporate providers (e.g. pathology practices and facility groups) could prove counter-productive. If we follow the statements in paragraphs *"135.2 Stakeholder submissions and analyses conducted by the HMI have shown that expenditure is high and continues to rise, while consumers continue to face higher premiums, out of pocket payments and gradually reducing scheme benefits; and 135.3. There is reasonable justification for regulatory intervention if the industry is to remain sustainable,"* it then follows that there is evident need to intervene decisively in changing the manner in which **current** bilateral negotiations are undertaken. Enabling specific corporate entities (such as pathology practices and hospital groups) to not be part of the multilateral process defeats the purpose of trying to manage affordability.

Medscheme recommends that the HMI considers a rephrasing of the recommendations in this area, to ensure that **bilateral negotiation** process allows all and any stakeholders to be involved, not just specific corporate groups or practices. This would allow for better competition and increased innovation among stakeholders as it would push healthcare providers (individual/group practices, hospitals) to proactively strive towards ARMs below the level determined by multilateral negotiations without entrenching their current advantages at the expense of other market players. As such, the multilateral negotiations to set fee-for-service rates should also apply to all stakeholders, corporate providers or not. There should be **no special dispensation for corporates**.

As a supplementary comment, **the provisional report appears to encourage collective bargaining** of medical schemes. The report (i) congratulates Discovery Health's collective bargaining approach, (ii) confirms that restricted schemes do not compete with open schemes, nor with other restricted schemes and (ii) supports the continuance of bilateral negotiations. It is our assertion that restricted schemes, to an extent, do compete against open schemes for members as even in compulsory scheme corporate environments, employees are free to join their spouse's medical scheme and a large portion of employees opt to do so. All open and restricted schemes also currently compete for access to affordable healthcare and collective bargaining favours scale and therefore more favourable tariffs. We therefore request that the HMI's final report creates certainty regarding the legality of collective bargaining of medical schemes.

Medscheme strongly recommends that the HMI makes a clear recommendation directed at the Competition Commission to reconsider the 2003 decision to prohibit collective bargaining. A review of this decision would go a long way towards addressing the imbalanced tariff setting regime that currently plagues the private health care market, and it would introduce better

transparency in terms of agreed tariffs between different funders (and administrators) and providers (especially the corporate sector).

As a further supplementary comment on the tariffs setting recommendations, Medscheme would like to bring to the HMI's attention the contents of the National Health Insurance **(NHI) Bill** published by the NDoH on 21 June 2018, specifically Part 4, section 22 subsection 3, which speaks to the functions of the Chief Executive Officer of the NHI Fund and the various units that will be established to ensure its effective and efficient functioning. There is significant overlap on the functions and responsibilities of the recommended SSRH in relation to those of the NHI Fund, particularly in relation to tariff setting or determination. This overlap would need to be addressed to ensure consistency in approaches and phasing, so as to minimise industry confusion and eliminate market disruptions. It would be best if the tariff function was housed in a single entity, preferably the SSRH, and the ensuing agreed-to tariffs would be universally applicable to all parties.

On the matter of the **HPCSA and the ethical rules**, we had recommended that the ethical and professional rules must be revised to expand the definition of recognised employment agencies and criteria for employment of doctors, in order to allow innovative healthcare delivery structures. It is appreciated that this recommendation has been incorporated in the Provisional Findings report.

Nonetheless, as indicated in the introductory part of this commentary, no timelines are proposed for when this review should have been completed so as to expediently enable the growth of multidisciplinary practices, innovative service delivery models and the implementation of alternative reimbursement mechanisms. Our suggestion on this matter is that the HMI considers revising the said set of recommendations by strengthening them to include clear, urgent timelines by which the HPCSA ethical rules process should have been finalised and the changes implemented.

A matter of clarity is required regarding paragraph 176.3 on page 479 in Chapter 10 of the Provisional Report. Part of the said paragraph reads *"… The Inquiry recommends that **employment of doctors** should not be prohibited, but employment of doctors should be conditional. There are other forms of employment of doctors outside of employment by for profit private hospitals. Where such employment can demonstrate that it is pro-competitive and adds value and that benefits accrue to consumers, it should **not** be encouraged. The HMI would welcome well-motivated proposals where employment of specified categories of doctors by the private sector would be a net positive for the sector as a whole."* Is it correct for us to assume that the word "***not***" [own emphasis] should not have been included here?

Medscheme believes that **provider networks**, whether Designated Service Provider (DSP) or Preferred Provider networks, are important to support alignment between funders and providers and to meet member needs in terms of access to required services and the affordability principle. Our years of experience in provider networks contracting and management demonstrates the effectiveness of using provider networks to enable better coordinated care of patients, provide mechanisms to monitor and report quality and cost outcomes as well as allow incentives to be paid to encourage best practice. DSP arrangement should indeed be transparent – but we do not think they must be exceptionally tightly regulated as the risk here would be to stifle innovation and variability in approaches.

The HMI appears to recommend that **selective contracting** should only be allowed within an ARMs environment taking into account patient volumes, price and quality as this is only when it would be effective in delivering value for funders and patients. Our view is that selective contracting should be allowed for in all contexts, whether ARMs or FFS based. Providing a fair enabling framework for selective contracting that is applicable to all reimbursement regimes will enable healthcare providers to compete on outcomes (price and quality) which will benefit the beneficiary and medical scheme, irrespective of the reimbursement regime that is applicable for the contracted provider.

The recommendations on practice code numbering (paragraphs 84 – 93, pages 466 – 467) propose practice numbers for facilities, practitioners and group practices i.e. a claim would need to include at least the practitioner and facility practice numbers; if the claim is from a group practice, then a group practice number would also be required. Medscheme's recommendation is that there is also intelligence built into the system to allow for the identification of corporate affiliation. This could include an additional practice number (similar to a group practice number) or through some other methodology e.g. a prefix that clearly indicates the corporate entity identity/affiliation of the billing practice. Currently the linking of facilities/practitioners to a corporate is manually done by administrators (e.g. hospital practice numbers are manually linked to a hospital group). It is our view that it would make operational sense and yield efficiencies if this process was done centrally.

The need for comprehensive timelines

A general element that we would like to bring to the attention of the panel is a matter pertaining to timelines associated with the implementation of the full suite of recommendations. This is particularly important given the many changes envisaged for the private health sector, especially as outlined in the Medical Schemes Amendment Bill and the NHI Bill published on 21 June 2018. It is appreciated that the HMI has set phased timelines to be associated with the phased implementation of some of the institutional and organisational reforms for the Supply Side Regulator of Health (SSRH) and the Outcome Measurement and Reporting Organisation (OMRO).

However, no such timelines are proposed for other equally important reforms – for instance, the Provisional Findings recommend that the Health Professional Council of South Africa (HPCSA) must review a number of their ethical rules to enable multidisciplinary practices, innovative service delivery models and the implementation of alternative reimbursement mechanisms but no timelines are set by when these changes should have happened. A similar case is made for the recommendations that pertain to actions that must be undertaken by the Council for Medical Schemes.

Conclusion

Medscheme recognises the extent of work that has been undertaken by the HMI over the past 5 years. There are many changes being proposed for the health sector in the coming few years, and these changes are extensive, including the introduction of alternative reimbursement models and a different tariff determination regime.

The increased focus on value-driven health care, including outcomes reporting have a direct bearing on the manner in which managed care organisations and administrators will be held accountable in terms of how they deliver value to funders and the members they cover. The principles thereof are supported, and we welcome recommendations that enable these through a constructive process of change management.

Inevitably, these large-scale changes would affect providers of care (individual providers and corporates), including the data requirements and contracting and tariff regulations that will be applicable not only as result of the recommendations contained in the Provisional Report, but also as a result of the envisaged changes to the Medical Schemes Act and the implementation of NHI. Due regard of the implications and impact of these changes must be considered.

We feel it is important that some recommendations are made more firmly and supported by clearer timelines indicating by when certain actions should have been taken and implemented.

Equally important is the need to have better synergy with regards to legislative and regulatory demands that are placed on industry players by regulators (e.g. data demands, regularity of submissions and format of the data submission across existing and proposed regulators e.g. CMS versus SSRH).

Finally, whist there are elements that have failed, the private market by international standards have significant skills, is a highly competent, shows medical inflationary trends that are admittedly too high but still reflective of global medical inflationary trends and provides a reasonably high clinical standard of care. The entire private market is not a failure but there are elements therein, some of which have been identified by the HMI, which need urgent attention. They must be addressed specifically and sequenced correctly.

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