Comments on the Competition Commission Market Inquiry: Responses to inaccurate statements

5 March 2015

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1. Introduction

The Council for Medical Schemes (CMS) welcomes the opportunity of providing comments and corrective arguments where applicable on the submissions from the healthcare industry stakeholders.

Although the CMS is fully aware that the response should not be another submission, many of the issues raised and statements inaccurately made by industry stakeholders are either based on misinterpretation of the Medical Schemes Act, 131 of 1998 (the Act) or to defend their profit making, rather than acting in the best interest of private healthcare users. Therefore, the CMS firstly reiterate the purpose of the Act and address in general the number of issues inaccurately stated in some of the submissions.

As indicated in the CMS response (30 June 2014) to the Statement of Issues and Theories of Harm, the absence of statutory price regulation within the private healthcare market is a key challenge. The mere fact that fees are no longer regulated and that tariff setting by providers is not regulated has contributed significantly towards the rise in healthcare costs. Because medical schemes are obliged by law to cover the cost of Prescribed Minimum Benefits (PMB) conditions in full, a number of providers have seen this as an opportunity to increase the fees they normally charge merely because a condition is a PMB. As a result medical schemes have to find other means to remain sustainable. This includes, but is not limited to a reduction in discretionary benefits, application of co-payments on certain procedures, balance billing of members and access to care organised through the application of protocols and formularies. Provision, financing and access to the PMB package were not designed to operate in an environment where there is no price regulation.

These undesired market conditions often influence the provision, financing and access to private healthcare services. Furthermore, consumers do not understand many aspects of medical schemes benefit option products and the absence of supply-side and demand-side regulation within the market will have an adverse impact on members, especially the old and sick. Within this context, the role of government and other government entities is to protect the interests of consumers by promoting equitable access to private healthcare.

It should be noted that some of the graphs were copied from a memorandum that was submitted to the Minister of Health towards the end of 2013 (memorandum attached). The CMS Annual Report of 2013/2014 contains the latest figures.

More detailed responses addressing particular statements made by industry stakeholders are provided in table format. CMS apologises for duplication in some of the detailed responses, but in our opinion it makes the reading easier.

2. The Medical Schemes Act, 131 of 1998 and pillars of the Act

Medical Schemes are trusts and belong to its members. This is why the best interests of the members of medical schemes form the core of the Medical Schemes Act 131 of 1998 (the Act). The Act aims to promote equal access to private healthcare for all members through the following pillars:

a) **Open enrolment**

In terms of this provision any person may join any open medical scheme of their choice and the medical scheme may not turn them away. Restricted schemes may also not turn any person away as long as they meet the relevant eligibility criteria of that scheme.

b) **Community rating**

Community rating provides that all members on the same benefit option of a medical scheme must pay the same contributions regardless of your age or health status. Contributions may only vary based on the member's income band and the number of dependants registered on the option.

c) **Prescribed Minimum Benefits (PMBs)**

PMBs refer to the minimum package of benefits that must be offered by all medical schemes on all options to protect members from catastrophic out of pocket expenditure. Included in the package is medical emergencies, diagnosis and treatment pairs and a number of chronic conditions which are all legislated.

d) **Governance**

In order to ensure that schemes are properly governed the Act makes provision for the appointment of a Board of Trustees and a Principal Officer to run a medical scheme. It further sets out the duties and responsibilities of the appointed officials and requires them to act with due care, diligence, skill and good faith and to avoid conflicts of interest.

3. Membership of medical schemes

Between 2000 and 2013, medical scheme membership grew from 6.7 million to 8.7 million lives. The enrolment numbers increased significantly from 2006 with the inception of the Government Employees Medical Scheme (GEMS); it led to 1.6 million more lives being covered between 2006 and 2011 within the restricted schemes market. Unfortunately there was no significant growth in the open scheme industry. The growth in membership is important for the protection of risk pools, especially growth in the younger age bands. This trend in membership can be seen in Figure 1.

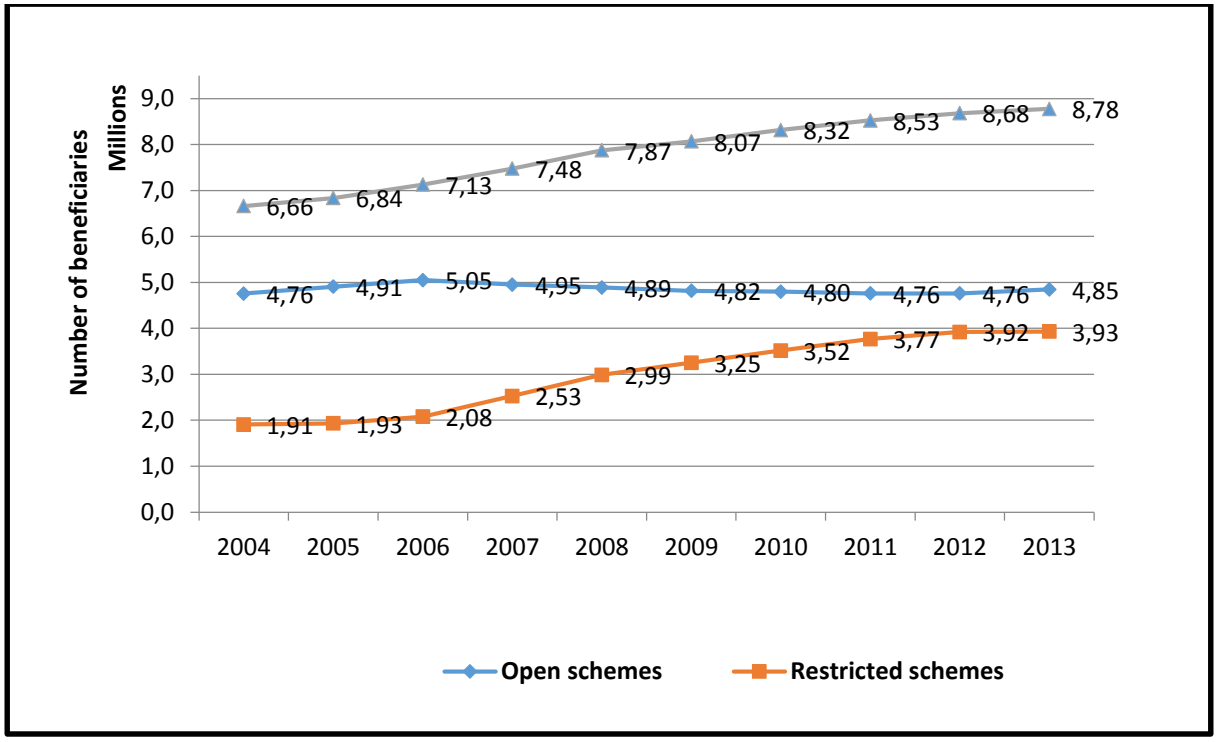

Figure 1: Medical scheme membership 2000-2013

One of the factors influencing a consumer's choice of a medical scheme is the apparent lack of freedom to belong to a scheme of their choice by virtue of the existence of an employment contract. A distinction should be made between open and restricted medical schemes. A restricted scheme allows only members employed by a specific employer or entity, for example BMW employees, who may only belong to the BMW Medical Scheme. Often contributions are subsidised partially or in full by such employers. Open schemes on the other hand are open for enrolment by any person.

Employers often select a specific scheme and require their employees to join this scheme as a condition of employment, even though there is no significant benefit for that employee to join the scheme. This is evident for employees who are employed on the basis of a cost-to-company package which means that they self-fund their contributions. This restriction of choice implies that a consumer is limited to one scheme and its benefit options which might not cater for the needs of the member. Often, members cannot afford to upgrade to a higher benefit option that could cater for their needs, however, had they been able to choose another scheme, they would have had access to better benefits. The aforesaid is not regulated by the Act.

The younger and healthier consumers might choose to buy only a hospital plan or alternative insurance cover in light of the fact that it is in most instances more affordable than a medical scheme. However, such consumers may not receive the same benefits as they would be entitled to in terms of the provision of the Act and may face possible risk rating by the insurer as such policies fall outside the scope of the Act. Mandatory membership above a certain income level can help to enhance the risk pools in the industry and at the same time alleviate the burden on public and state facilities.

4. Anti-selection behaviour and adverse selection

A number of submissions referred to anti-selection, adverse selection and ageing of the private healthcare industry. According to the CMS Annual Report, the average age of medical scheme beneficiaries in 2013 was 31.9, slightly younger than the 32 years reported in 2012. However, the variation in age from year to year is much more significant for certain individual medical schemes.

CMS would like to clarify that individual members of medical schemes will select amongst a set of contracts based upon their expected probability of utilising healthcare services. Thus, those individuals who anticipate requiring medical care regularly choose more generous plans compared to those requiring limited care. Insurers attempt to overcome this problem by employing some form of a screening device. The use of waiting periods and late joiner's penalties within the South African context is one such mechanism.

The objective of waiting periods often include addressing anti-selection behaviour; encouraging more members to join medical schemes; facilitates optimal cross-subsidisation between young and old, healthier and sick individuals; and improves affordability of health cover for the entire covered population.

The impact of age related anti-selection behaviour was clearly outlined in the CMS submission of 30 June 2014 and evidence provided from studies conducted by Mcleod and Ramjee in 2007. It has been acknowledged that the impact of anti-selection behaviour by those with chronic disease within the medical schemes has been observed through the unusual bulge in the young adult years for some severe diseases such as multiple sclerosis; suggesting that families with someone with an expensive disease would try to join a medical scheme (Mcleod & Ramjee, 2007).

This behaviour can be stratified according to the following categories:

- *Age:* young people defer scheme membership;
- *Gender*: females during child-bearing ages;
- *Disease burden:* people with expensive illnesses to treat or multiple illnesses;
- *Benefit options*: members selecting options with higher benefits only when their likelihood of needing those benefits is high; and
- *Individuals*: voluntary membership.

Figure 2 shows the age and gender distribution of medical scheme beneficiaries for 2012 and 2013. A bimodal distribution was again evident, for both male and female beneficiaries. Age bands <1 to 15-19 attracted more male beneficiaries but there were more female beneficiaries in the age group of 20 and older. For 2013, 52.4% of all the beneficiaries are females and 47.6% males.

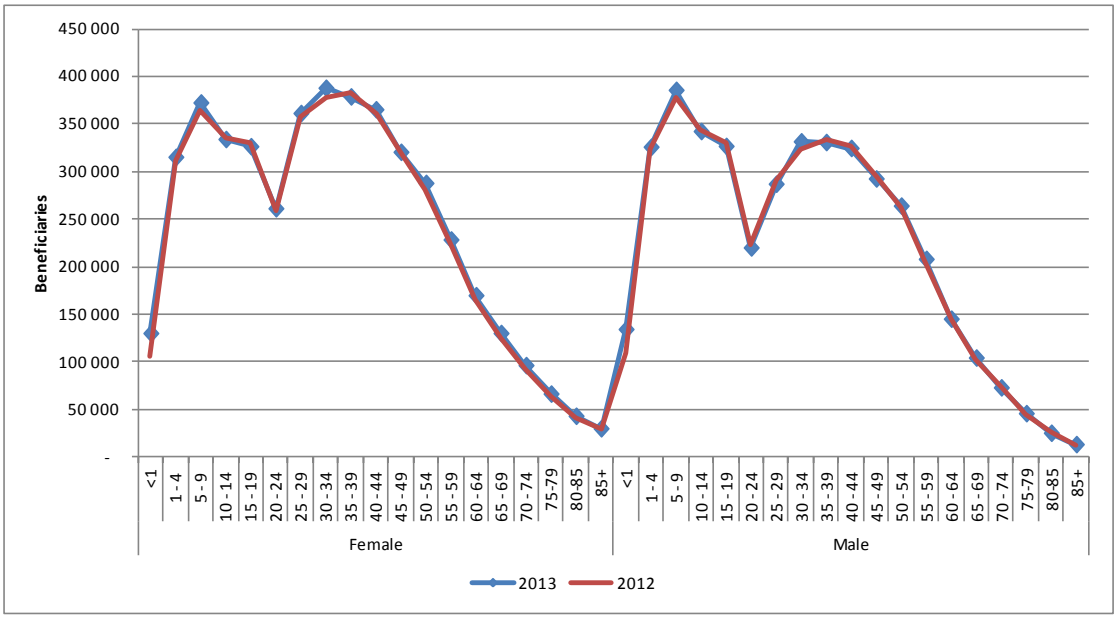

Figure 2: Age and gender distribution of beneficiaries 2012 and 2013

The significant drop in membership growth of the young and healthy members might be informed by factors such affordability and adverse selection. The increase in 35-49 of the covered population correlates with an increase in claims experience, non-healthcare costs and high contribution increases within comprehensive options. This increase can be attributed to older members likely to claim more due to their conditions; and such claims experience is likely to exceed their monthly contributions within purchased options.

Figure 3 depicts the trend in the average age of beneficiaries from 2004 to 2013. The Figure illustrates that, until 2006, restricted medical schemes were older than open schemes. This changed in 2007; restricted schemes were suddenly younger than open schemes, primarily due to the introduction of GEMS.

Figure 3 further illustrates that the average age of open schemes in 2013 was 33.5 years (34.8 years if the DHMS is excluded); the average age of restricted schemes in 2013 was 30 years (31.1 years excluding GEMS).

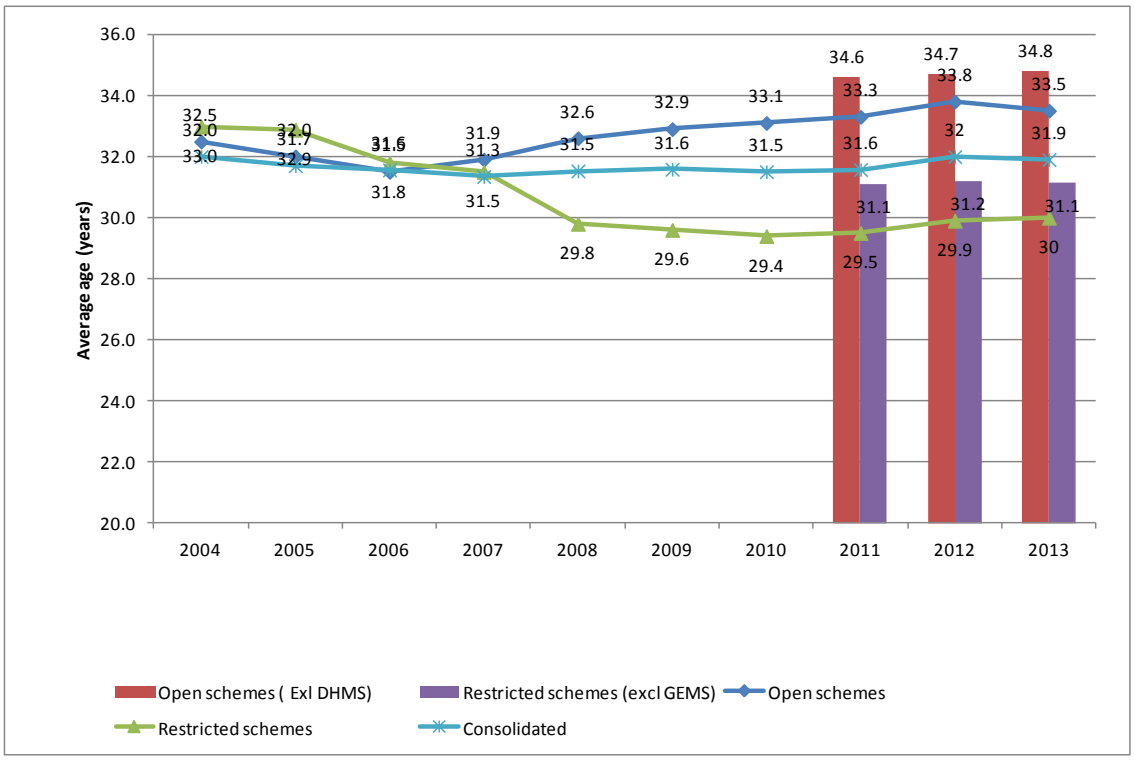

Figure 3: Age of beneficiaries 2004-2013

The changes in the age profile of medical scheme beneficiaries, and its impacts on the utilisation of health services, as well as the risk profile of medical schemes will also influence healthcare costs as well as non-healthcare costs experienced within each option.

5. Solvency of medical schemes

Medical schemes in particular raised the issue around the solvency framework. One of the pillars of the Act is open enrolment and CMS had to intervene in instances where certain medical schemes refused to accept high risk members of another scheme as the scheme was of the view that this will affect the solvency levels of the scheme in such a way that it is not compliant with the minimum legislated solvency ratio of 25%.

Despite concerns about the current solvency ratio, the medical schemes industry is healthy in terms of the reserves it has built up. The solvency ratio for 2013 was 33.4%, well above the statutory requirement of 25.0%. The solvency ratio of the medical schemes industry from 2000 to 2013 is shown in Figure 4.

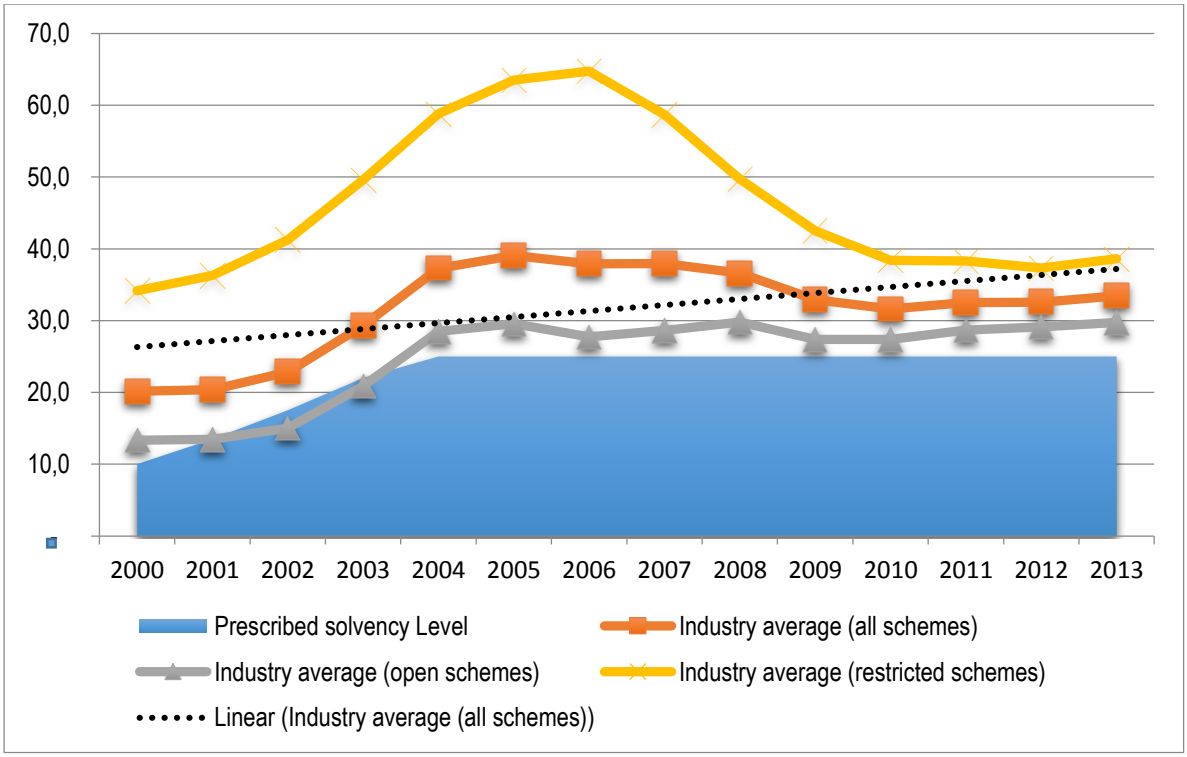

Figure 4: Solvency of the medical schemes industry 2000-2013

Some schemes are motivating for a change in the solvency framework based on projection studies that the current solvency ratio of 25% is actually influencing member contributions negatively. The CMS would like to respond that a project is underway to investigate a possible alternative solvency framework.

6. Prescribed Minimum Benefits (PMB)

A large portion of submissions alluded to the prescribed minimum benefits (PMBs) and the cost of PMBs. PMBs form an important component of the policy principles designed to facilitate access to healthcare services. PMBs operate within a health insurance environment where the focus is on risk-pooling and cross-subsidisation between the young and old and the sick and healthy to prevent a potentially catastrophic financial impact on households. Pooling also deals with the accumulation and management of contributions so that members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures.

The PMB provisions in the Medical Schemes Act 131 of 1998 eliminate unfair discrimination on the basis of health status and address unfair risk selection by medical schemes by removing their ability to separate insurable and uninsurable (or less insurable) individuals through benefit design. PMBs, therefore, protect access to healthcare by protecting access to “insurance” for less preferred risks. The overall objective of the PMB package is to protect medical scheme members against severe financial and economic shocks associated with the high costs of certain healthcare services.

Local experience and international evidence show that there is a need to have a holistic regulatory approach to private healthcare. This approach should seek to regulate effectively and efficiently both the supply and the demand side of the market. The absence of such an approach can have a direct impact on the provision, affordability, and long-term sustainability of the PMB package.

7. Affordability and sustainability of the PMB package

In 2002, the CMS commissioned the Centre for Actuarial Research to conduct research on the affordability of the PMB package within the medical schemes industry. This study found that "the complete PMB package was well covered within overall industry expenditure on benefits, and was therefore unlikely to put upward pressure on contributions. After meeting costs associated with the PMB package, schemes in general were observed to still have more than half of their pooled contributions for other benefits and non-healthcare costs in excess of those already accounted for in the PMB price". While the analysis on affordability of the PMB package undertaken in 2002 showed positive results, Figure 5 shows a concerning trend with regards to the PMB cost (community rate) and risk benefits (Net Relevant Expenditure) between 2005 and 2012. Figure 5 shows that, over time, there has been a decrease in the risk benefit amount per beneficiary per month (pbpm) in relation to the PMB amount pbpm. The PMB cost as a percentage of Net Healthcare Expenditure grew from 38.96% in 2005 to 53.07% in 2012, which is an indication that, over time, the PMB package has been crowding out other risk benefits, but overall 47% of risk benefits were paid out by schemes, or for Non-PMB claims.

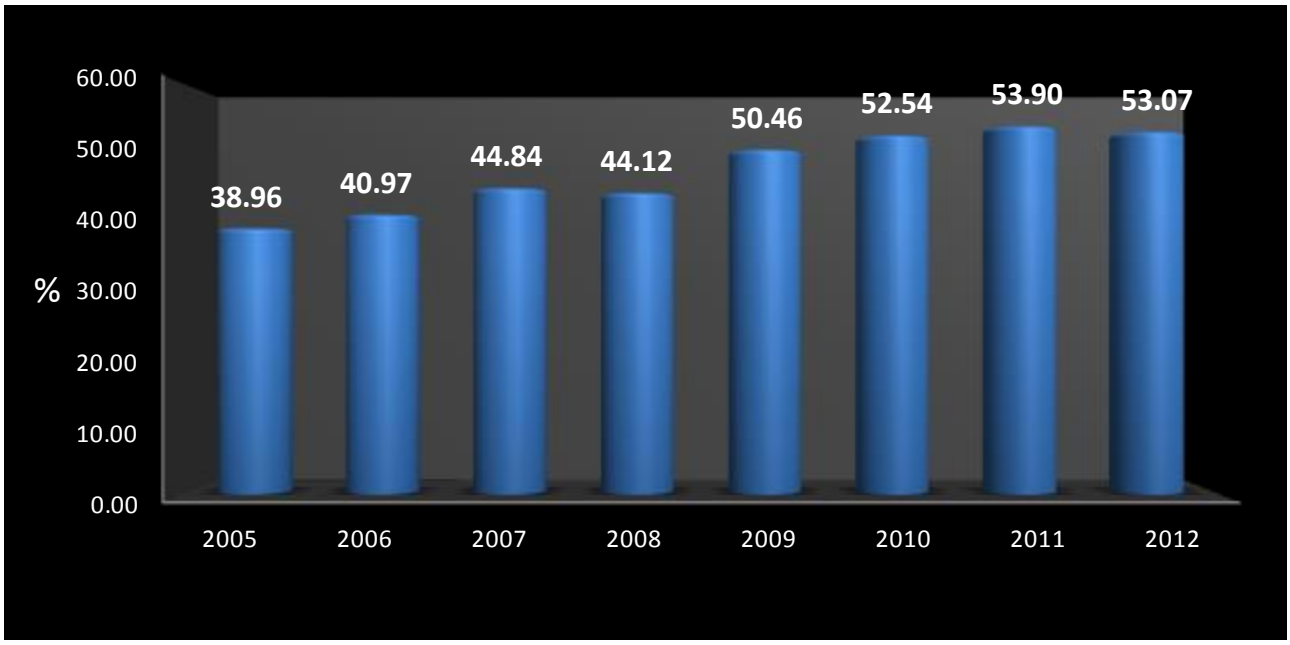

Figure 5: Cost of PMBs & benefits paid from the risk pool

This observation could be as a result of a variety of demand-side and supply-side factors such as changes in beneficiary profiles, coding practice, provider behaviour, and benefit option design which all influence the PMB cost in various degrees. Furthermore, the National Health Reference Price List (NHRPL) published by the Department of Health in 2009 was declared null and void by the Gauteng High Court, leaving a vacuum in the determination of tariffs within the medical schemes industry. However, there is still a significant proportion of risk benefits that schemes pay on top of the PMBs.

On provider behaviour, there has been poor harmonisation of regulatory provisions for the determination of the scope of provider practice and tariffs; this situation has led some providers (outliers) to abuse the PMB legislation. In addition, the CMS, through engagement with medical schemes, has been made aware that some providers are abusing the definition of "payment at cost", resulting in a "blank cheque" approach where healthcare services are provided excessively and/or charged at higher fees for PMB conditions. There have also been instances of "diagnosis creep", where related non-PMB conditions are coded as PMB conditions and are remunerated at higher-than-average levels. Furthermore, there is a need to create an awareness for members to better their

understanding of the meaning "payment at cost" since it relates to the contracted DSP's by the medical schemes Within this context, the level of supplier-induced demand continues to persist within a market that is highly concentrated.

The estimated cost of the PMB package per beneficiary per month (pbpm) per scheme for 2012 is shown in Figure 6. The cost varies between R240,60 pbpm and R925,32 pbpm. Figure 6 also illustrates that medical schemes are facing different risks. Based on differences in the risk profiles of medical schemes, it is clear that they do not compete on equal grounds. A system of risk adjustment is required to adjust the risk so that all medial schemes compete on equal grounds; it would force medical schemes to be more efficient.

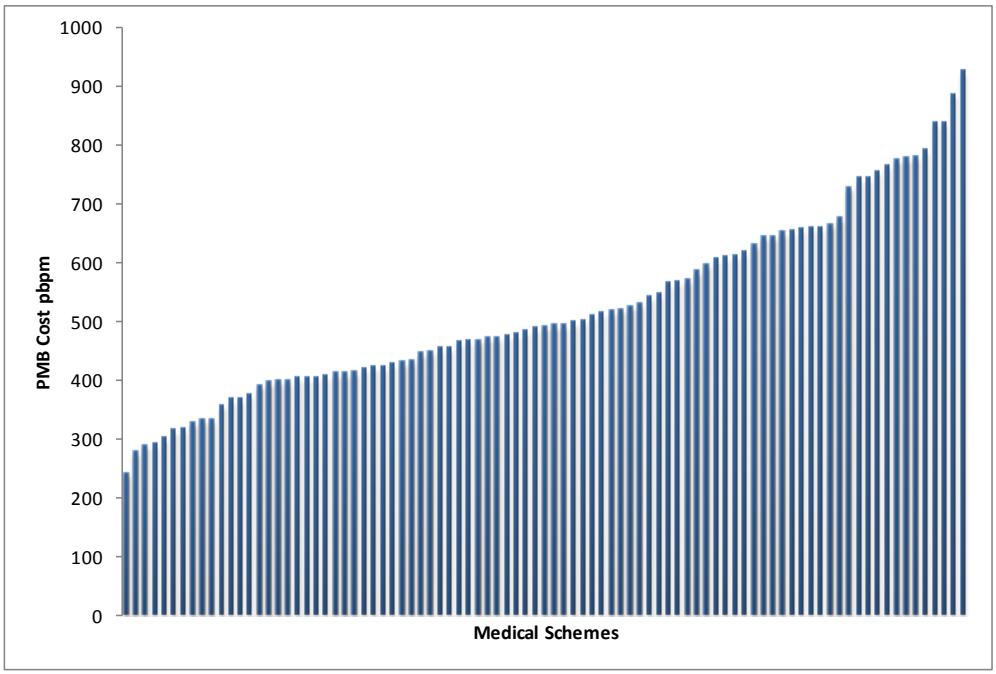

Figure 6: Estimated cost of PMBs per scheme for 2012

The estimated cost of the PMB package for the industry for 2013 is R508 pbpm. Unfortunately the CMS does not have access to personal income information. This could be used to calculate the cost of PMBs as a percentage of income for the medical schemes industry. The Household Survey by StatsSA could also be helpful to calculate affordability ranges of the PMB benefit package and healthcare cover in general. CMS is also in the process to improve their systems that will enable them to collect more information on the PMB's.

Furthermore, it seems as if the medical schemes industry experienced an increase in the prevalence of chronic conditions between 2006 and 2011. The top 10 chronic conditions that showed the fastest increase within the same period were hypertension, hyperlipidaemia, diabetes mellitus type 2, hypothyroidism, glaucoma, rheumatoid arthritis, bipolar mood disorder (BMD), Parkinson's disease, chronic renal disease, and systemic lupus erythematosus (SLE), which is an autoimmune disease. Bipolar mood disorder experienced the highest increase in this period. However, it is not possible to isolate the different components of the trend i.e. changes in beneficiary profiles, coding practice, provider behaviour, and benefit option design. It is not clear if this trend is a real increase in the prevalence of the chronic conditions, but it is important to monitor the trend and collect more information on the PMBs.

Medical schemes manage this behaviour through managed care interventions such as contract arrangements to provide full cover to members at better rates, but the schemes that tend to benefit from such arrangements are those who have economies of scale compared to the small and medium schemes. Most schemes are price-takers during tariff increase negotiations, especially in the absence of tariff guidelines.

Structural issues affecting affordability of the PMB package include the following:

a) absence of mandatory membership by the employed population
   - This limits the cross-subsidisation between the young and old, the healthy and sick.

b) absence of a risk adjustment mechanism
   - Such a mechanism is required to assist in the redistribution of risk among medical schemes. Its continued absence results in a skewed market structure where some schemes continue to benefit from their risk profiles while others experience worsening demographic profiles.

c) price regulation
   - collective bargaining within the industry is important to address supply side price issues.

d) healthcare technology assessment
   - Uncontrolled introduction of new healthcare technology may result in cost increases without an improvement in the quality of care.

e) continuous PMB review
   - The Medical Schemes Act 131 of 1998 prescribes that the PMB Regulations must be reviewed at least every two years.
   - A revision of the PMB definitions may make the PMB package more affordable.
   - The CMS and the Department of Health should speed up the revision process of the PMB definitions.

f) beneficiary registry
   - A beneficiary registry would allow the CMS to monitor the movement of beneficiaries between benefit options and medical schemes (risk profiling). It could also assist in calculating family income. If linked to the South African Revenue Service (SARS), it could be very helpful in affordability studies and support the development of the proposed National Health Insurance (NHI) Fund. The Department of Health could use the beneficiary registry to verify medical scheme membership when members utilise state facilities.

g) Health insurance products
   - There is a need to understand the relationship between PMB coverage and the uptake of health insurance products, also referred to as demarcation products.

8. Benefit option design and selection

A concern was raised by some industry stakeholders about so-called unfairness in terms of benefit options. The CMS would like to submit that whilst medical schemes have to comply with the regulatory provisions, it is a fact that the medical schemes market has been consolidating over time. Between 2005 and 2012 the number of benefit options within the medical schemes market declined from 412 in 2005 to about 309 in 2012. At an industry level, this decrease represents a 25% change in the number of options; whilst it represents a 33.8% reduction within the open schemes market and about a 12% decrease in the restricted market (see Figure 7). This trend relates to the consolidation in the medical schemes market.

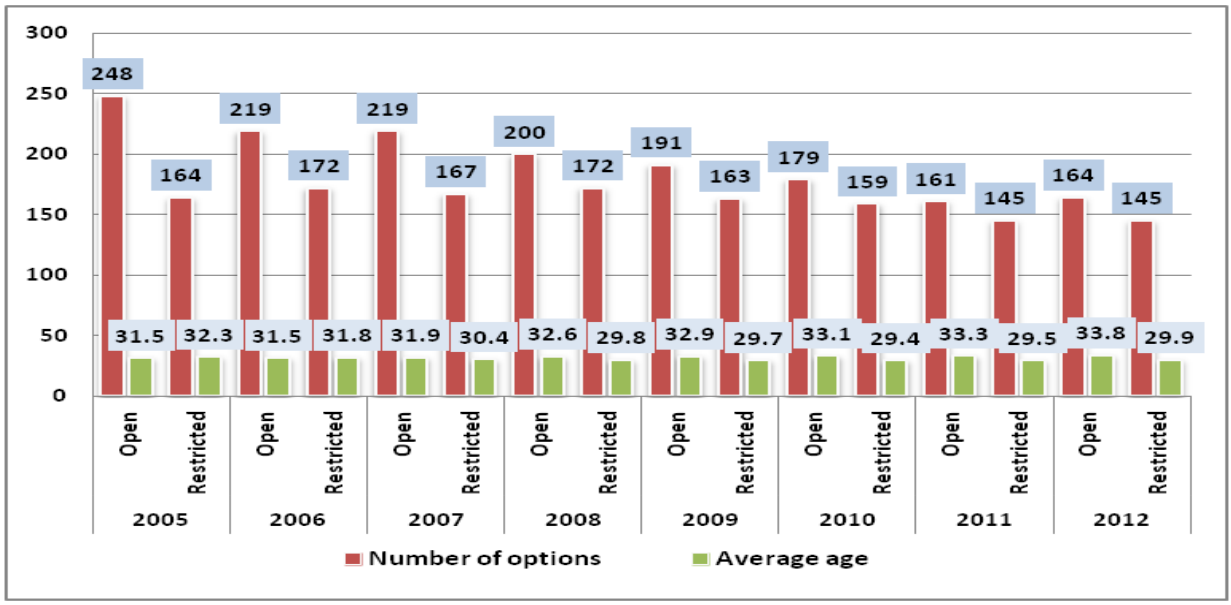

Figure 7: Number of options and average age (2005-2012)

9. Medical schemes affordability / Medical inflation

Affordability of medical schemes and medical inflation are concerns raised in many submissions. The CMS agrees that closely correlated medical schemes membership to employment statistics and contribution increase in excess to CPI have been observed to erode the real growth in income over the years, especially for those households where medical schemes contributions form a larger proportion of the household budget. In addition, an economic analysis of the 2006 General Household Survey (GHS) and Income and Expenditure Survey (IES) data by the CMS also indicated that a key constraint preventing medical scheme membership by a larger portion of the population is the affordability of medical schemes.

Table 1 below provides a comparison of contribution increases and CPI changes over time. High increases in contributions have been observed to create an affordability challenge. This trend affects membership growth in the industry, for example, between 2010 and 2013 percentage increase in membership has been decreasing from 3.1% in 2010 to about 1.8% in 2013. This affordability barrier also prevents low-income members from participating meaningfully within the medical scheme market, limiting opportunities for real growth in the industry including risk pooling and cross subsidisation.

Table 1: Overview of contribution increase trend (2001-2013)

Year	CPI	Average Contribution Increase
2001	6.6%	15.3%
2002	9.3%	14.1%
2003	6.8%	11.5%
2004	4.3%	6.8%
2005	3.9%	6%
2006	4.6%	6.7%
2007	6.7%	8.3%
2008	8.5%	11.3%
2009	7.1%	13%
2010	4.3%	9.2%
2011	5.0%	8.8%
2012	5.6%	9.7%
2013	6.0%	8.9%

Source: CMS annual report (2001-2013)

In addition, member sensitivity to price changes of their benefit options also influences anti- selection (buy-up or buy-down behaviour) due to expected healthcare costs by members. Young and healthier beneficiaries tend to be much more sensitive to price changes than old and sick beneficiaries. Furthermore, for some beneficiaries contributions paid are typically not always related to their own expected spending. This situation therefore creates an environment which encourages those members with higher expected spending to select generous benefit options.

Rendering these options results in a poor financial deal for healthier beneficiaries since the benefit option will have to charge high premiums to cover the costs of the less healthy beneficiaries, hence the CMS' observation on the high number of loss making options. Other issues related to elasticity of demand is the reduction of employer subsidy for medical aid cover that has also contributed significantly to the affordability challenge experienced by most members in the industry. For example, in the 1990's, most employers offered approximately between 50 % to just above 65 % subsidy for medical aid cover and retirement benefits. This trend changed drastically over time, leaving some members to pay their contributions in full or with a small subsidy from their employers.

This change in remuneration philosophy meant that medical schemes membership is seldom offered as an additional benefit but it is cost as part of the total cost-to-company salary package of an employee. Within this background medical scheme members were therefore exposed to financial pressures as contributions continue to spiral uncontrollably, including out of pocket payments. Some research shows that pensioners were amongst the groups experiencing high financial pressures leading to the demand of low cost options, capitation models and additional health insurance cover through other products, such as gap covers1.

[1] Center for Actuarial Research: Low cost options in the medical schemes , 2001

10. Broker incentives

Various issues were raised about brokers and commission paid to brokers. CMS would like to explain that open schemes are exposed to intermediary (broker) incentives as they drive demand. Schemes focusing on employers base it on dealing with brokers contracted by employers to advise them generally on employee benefits. Schemes that target the individual market depend on many broker practices; financial advisors that service the individual member.

CMS would also like to correct some inaccurate statements by clarifying that whilst brokers play an important role in guiding members in choosing a healthcare plan, the incentive to brokers is paid on an on-going basis despite the fact that there were no services rendered to members. This payment structure is flawed as the brokers get continuous commission from medical schemes.

Insurance products are not regulated by the Act; hence a separate commission can be paid to the brokers, for example gap health cover is sold to the individual by the broker. Schemes often design coverage gaps in its benefits to create a market for gap cover. Brokers consequently try to sell both the scheme (medical aid) and the gap product to consumers. Wellness programmes are also sold on commission and can be used to top-up commissions in excess of the regulated capped fees. Schemes often allocate brokers to members where they (members) have not selected a broker. This commonly occurs without the member being aware. The broker receives income in respect of a member that never uses their services or is even aware of their existence. Such allocations are done to reward brokers for bringing in lots of business and results in anti-competiveness.

The competition issue facing schemes is the relationship between open schemes and its brokers. Product complexity is prevailing in the industry, whereas brokers are required to assist members and potential members to understand the option s/he is purchasing in order to overcome the complexity. This is not the reality due to brokers' conflicted relationships with schemes; the product complexity lowers transparency within the industry and exposes members to manipulation by the product suppliers.

The Board of Healthcare Funders (BHF) argues that open schemes are vulnerable to broker activities as they drive demand. Brokers enjoy perverse incentives as their remuneration is based on a scale which is lucrative to sell more costly benefit options. As low cost schemes are prejudiced, the remuneration model is wrong.

BHF further claims that brokers add significantly to non-healthcare costs and their value proposition remains questionable. It recommends changes to the remuneration model to address matters pertaining to who should appoint brokers, who should pay them etc.

Financial Intermediaries Association of South Africa (FIA) submits that broker activities are not cost drivers; that they are remunerated for value added service provided and they play a vital role in the distribution channel. They demonstrate the fact that brokers place 85% of members in schemes. Competition amongst brokers is fierce and the individual has the right to appoint a broker of choice in a regulated environment.

FIA further makes a case that brokers fulfil a role in educating members, provide guidance and facilitate consumer interactions between clients and their medical schemes. FIA proposes that the dual regulatory provisions of accrediting and licensing brokers is untenable and recommends that the role should be taken over by the Financial Services Board (FSB) as appropriate organ of state to supervise the financial services sector.

The CMS agrees that brokers do add value, but the appointment of brokers adds to the cost of non-healthcare costs as it is currently an expense for medical schemes. The CMS does not agree that healthcare brokers should only be regulated by the FSB, due to various reasons, including the complexity of the private healthcare industry and interpretation and understanding of the Act. Issues regarding brokers are under consideration as part of the Medical Schemes Amendment Bill. It is envisaged to amend the remuneration model to be in line with the financial

services industry where the client who makes use of the service rendered by brokers, pay for the service from his/her own pocket.

11. Risk transfer and health funding arrangements

Various submissions focused on risk issues, in particular involvement of third parties providing services to medical schemes. Statements made are not all factually correct and in CMS' opinion warrants a proper response.

South African medical schemes operate as mutual funds. Their reserves belong to the members, and the administrators appointed by the scheme are paid administration fees from which they may derive administration profits. As Managed Care Organisations (MCOs) develop and sell management services to medical schemes, the terms of agreements between the contracting parties will determine whether risk profits are made. The benefit of these arrangements is often illustrated as cost savings and the reports may not always reflect the clinical health outcomes associated with the services being offered. The CMS is developing a framework which will assist MCOs in illustrating their value in relation to their impact on quality health outcomes and costs. Stakeholders in the medical schemes environment agree that managed care arrangements provide an action-oriented response to problems associated with information asymmetries and other market failures that characterise the private healthcare market. Managed care arrangements are there to support managed care services in attaining cost-effective delivery of care.

MCO arrangements include contractual arrangements that medical schemes enter into with providers to manage "clinical and financial risk", as well as to assess and manage healthcare with the view to facilitate appropriateness, and the cost-effective use of a relevant health service within the constraints of what is affordable. These providers include MCOs as well as private providers such as private hospitals, specialist groups, and primary healthcare facilities and general practitioners. In essence, with managed care arrangements, medical schemes try to integrate sound financial and clinical risk management in order to ensure that interventions are clinically appropriate, evidence-based, and affordable. MCOs contracted to medical schemes often use best-practice models and benefit management techniques to manage utilisation, clinical pathways, costs, and quality health outcomes. These arrangements include:

- risk transfer arrangements (a total risk transfer to the MCO);
- risk-sharing arrangements (a partial risk transfer to the MCO);
- arrangements to manage benefits in terms of the scheme rules;
- contracts and fee arrangements;
- protocols and formularies;
- designated service provider (DSP) arrangements and fee negotiations; and
- benefit management tools (as well as the application of exclusions depending on the purchased option, option and/or sub-option limits).

Several reimbursement models (specifics were provided in the CMS submission of 30 June 2014) are used by medical schemes to pay healthcare providers who are part of their network arrangements as well as other providers (e.g. MCOs) participating in risk transfer arrangements. Within risk transfer arrangements, medical schemes do not require reserves to cover claim fluctuations since the claims risk is borne by the MCO. The medical scheme can continue to hold reserves for other purposes, e.g. long-term funding or ex gratia payments. In 2012, only 13 of the 39 MCOs accredited by the CMS participated in risk transfer arrangements. Of the 13, only a few were able to sustain their business model due to the contextual factors previously outlined (CMS, 30 June 2014). These market conditions have led to some MCOs exiting risk transfer arrangements.

12. Designated service providers (DSP)

In relation to the previous section, some submissions contained inaccurate facts about designated service providers (DSP), while other submissions were clearly in favour of DSPs. In order to address these matters, the CMS would like to clarify that entities contracted to medical schemes as DSPs include private hospitals, specialists, general practitioners, dentists, optometrists, pharmacists, allied healthcare workers, etc. The conduct and accountability of these entities lies with other regulators such as the Health Professions Council of South Africa (HPCSA), Nursing Council and Pharmacy Council, Allied Health Professions Council, Medicines Control Council and the South African Dental Technicians Council, etc.

When medical schemes enter into contractual arrangements with these providers the CMS through the Act ensures that such arrangements are of value and benefit to members, since schemes use members' money to enter into tariff negotiations and payment with these private providers.

Depending on a benefit option, a tariff negotiated with providers facilitates payment of services offered in full and should members opt to make use of a DSP, accounts are funded in full. The aforesaid is however not without its problems and relates back to the issue of the lack of price regulation. Depending on the benefit option members belong to, they might find themselves in a position where a certain provider is a DSP for a higher benefit option, but for members on a lower benefit option, the choice of providers is restricted. In some instances providers are only DSPs should members require their service in hospital. Should members see the provider on an out-patient basis, a co-payment is applicable.

Within this context, members might not be able to access the benefits they pay for due to the lack of choice of providers. There are also providers in selected geographical areas and specialists who have a monopoly in that there are no other providers in reasonable proximity who can deliver the same service. Those providers often refuse to enter into contractual agreements with the schemes to provide services at certain rates. Because of their specialty (for example cardiology) the bulk of the conditions that they treat are PMB conditions, which means that these providers feel that they are entitled to charge excessive fees, thereby crippling the medical scheme.

CMS has observed that medical schemes with economies of scale tend to have some negotiating power which in some instances translates into a relatively lower tariff increase. This is not the case for medium to small schemes. The Competition Commission's ruling in 2004 placed restrictions on the extent to which a representative body of, for example, a group of specialists or an independent practitioners' association could negotiate on behalf of its members with medical schemes as far as fees, and the conditions related to fees, were concerned. It is therefore evident in the analysis of medical schemes' cost assumptions that only a few schemes have the ability of negotiating a reasonable tariff increase.

The demographic profile of members plays an important consideration on the extent of benefits offered by medical schemes. CMS has noted a trend that most medical schemes with aging demographic profile tend to appoint the state as a DSP for treatment of PMBs. These medical schemes will mitigate the financial risks they are exposed to as they are aware of the short-comings in the state billing system. This re-imbursement mechanism ensures that they protect themselves against service providers who charge excessive fees and ensure that the control the funds spent on services to their members.

13. Utilisation data: definitions

A few submissions referred to wrong data published by CMS in their Annual Reports. Mediclinic purport that t**he** CMS' methodology of measuring and reporting healthcare utilisation is flawed. Definitions change from one year

to the next, making it impossible to infer any trends from the data. Furthermore, it is alleged that indicators on utilisation are frequently added or removed, with no explanation on how new indicators should be interpreted. According to them, these factors led to inconsistent results, leaving the industry with no credible data on healthcare utilisation such as admission rates, length of stay, or number of visits to doctors.

CMS would like to respond that in previous years there were not many changes to data collected by CMS. There is therefore enough data to get utilisation trends. However, it should be noted that for submissions from 2015 onwards, the method of collecting data has improved tremendously. The definitions have changed completely in some instances to ensure they are clear and to be used consistently and universally. These changes were made in consultation with industry stakeholders. Any future changes will also be effected in consultation with the stakeholders and will be based on valid reasons.

14. Coding in the healthcare industry

Multiple provider disciplines have reported that the current NRPL 2006 coding system is inadequate to address the procedures and treatment they provide to their patients.

The inadequacy of the current NRPL 2006 codes have been discussed in the private healthcare industry and in meetings with the National Department of Health. In 2008 a due diligence on various coding systems was performed after a formal meeting between all stakeholders in the industry. The final report was submitted to the National Department of Health but no final decision was reached or implemented.

The NRPL 2006 tariff coding system has not been updated since its publication and therefore does not allow for providers to adequately claim for new procedures that were developed after 2006. The inability to accurately reflect the procedures that are performed further lead to:

- Inadequate data collection and reporting;
- Inability to measure the quality of healthcare, health outcomes and perform other health economic studies;
- Inability to perform international and national benchmarking;
- Inability to manage the cost of the delivery of healthcare through the introduction of alternative reimbursement models and case-mix groupings.

The Office of the Registrar and specifically the Clinical Unit receive numerous enquiries from providers and provider associations with regards to the updating of coding systems. The National Department of Health refers these providers to the Clinical Unit as they interpreted the 2010 court case ruling that the National Department of Health may not publish a coding system. The problem has now reached a critical point as there are thousands of procedures that do not have tariff codes.

Provider disciplines have started to draft their own coding systems but such coding systems are not discussed with the medical schemes. Claims submitted on these codes are then rejected and the complaints and enquiries from members and medical schemes are ultimately referred to the clinical unit of CMS.

CMS is recommending that the Minister of Health must appoint an entity to establish and maintain an effective medical coding system for South Africa.

15. Conclusion

In absence of a holistic regulatory framework, affordability of private healthcare and the long term financial sustainability of the PMB package will always be a discussion point, especially in absence of tariff guidelines. Risk

adjustment and the protection of risk pools are important contributing factors to PMB affordability. Medical scheme cover is predominately curative and more can be done on preventive care.

Medical schemes are not-for-profit entities. Issues affecting affordability of medical scheme cover and quality of coverage in South Africa should be based on the member's perspective. Without members, there would be no medical schemes. The observed trends are a concern, but there are solutions to address the systemic problems facing the private health sector. It is important that the medical schemes industry, the CMS, and the Department of Health work together and consider proper academic exploration and researched economic arguments to implement the solutions.

16. Table addressing specific submission inaccurasies

1	**Board of Healthcare Funders (BHF)**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** In its submission to the Competition Commission the BHF alleges that PMBs are poorly structured and unconstitutional in that they discriminate on the basis of diagnosis and the severity of the health condition concerned. **CMS response:** This statement is unfounded as only the High Court or Supreme Court of Appeal or the Constitutional court may declare legislation unconstitutional, as provided for in section 172 of the Constitution. Any declaration of unconstitutionality must be confirmed by the Constitutional Court. The allegation relating to the discriminatory nature of the PMBs are also not substantiated by the BHF especially in the light of section 27(2) of the Bill of Rights which requires the State to take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of the right to healthcare services. The PMB package includes a minimum set of benefits that are equally available on all the options of all the registered medical schemes. The BHF further states that the way in which the CMS interprets Regulation 8 to the Medical Schemes Act (the Act) imposes limitless liability upon medical schemes and that they have no option but to pay whatever a provider charges. **CMS response:** This is also factually incorrect as Regulation 8 also provides the following mechanisms to manage the financial risks posed by PMBs: a) The use of DSPs in terms of which fees are negotiated with service providers. Where a DSP was appointed and a member voluntarily uses a non-DSP, the scheme will not be liable to fund the subsequent account in full. b) The use of formularies (list of approved drugs) which has the same implications as stated above where a member opts to use an out of formulary drug. c) Treatment protocols which provide guidelines for the treatment of certain medical conditions aimed to prohibit over-servicing by providers.

		d) Pre-authorisation, a process during which the clinical appropriateness of services is assessed and approved or declined.
4	**Charles Cawood**	**<u>Medical inflation:</u> Summary of Submissions:** • Schemes submitted that healthcare cost inflation is much higher than Consumer Price Index (CPI), hence the CPI is an inappropriate measure of healthcare inflation. • Several reasons where attributed to these increases such as plan mix and demographic factors. **CMS response:** • Globally, medical inflation is always far above CPI, this is mainly due to new technology (cost of biologics for cancer), increase in the burden of disease (chronic disease of life style) and supply side factors. Locally, the impact on medical inflation for some schemes can lead the schemes experiencing operating deficit especially in light of member sensitivity to benefit option price changes. • Medical inflation and utilisation indicators mean different things to different individuals within the medical schemes industry. These indicators are often computed and interpreted in a variety of ways depending on each stakeholder's perspective and interests. • Therefore, medical inflation is a function of many variables where there is also a demand side and supply side impact. • For some stakeholders, medical inflation might include: - Medical schemes contribution increases and tariff increase; - Others view medical schemes inflation as a function of all of the above including out-of-pocket payments, the impact of benefit design, reserve loading and non-healthcare costs; - Whilst others may view medical scheme inflation as what is reported by StatsSA in the CPI "health basket". • Closely associated to medical inflation is utilisation definitions, certain utilisation indicators currently included in the Annual Statutory Return (ASR) are being revised to ensure that they are relevant and accepted by all stakeholders within the medical schemes industry. This project is therefore envisaged to assist CMS in improving monitoring, evaluation and reporting on medical inflation and utilisation statistics. • Whilst CMS agrees that healthcare inflation is higher than CPI, it also acknowledges that schemes are able to address some of the variables listed above through a variety of cost pull interventions. • Such interventions and/or market positions can include, but not limited to the following:

		○ Innovative use of managed care principles (cost effective management of conditions through efficient application of managed care principles); ○ Innovative contracting; ○ Maximise the benefits of the economies of scale (i.e. big medical schemes, administrators and/or managed care companies); ○ Innovative reimbursement methods and associated rates linked to quality health outcomes. • Such interventions will address some of the medical inflation variables. • There have been projects carried out by CMS and the industry to identify the major reasons for inflation above tariff increases as well as quantify the extent of each of these factors. • Factors which are being investigated are demographic, plan mix and other factors. • Out-of-pocket payment, benefit design, reserve loading and non-healthcare costs are amongst the factors considered by CMS to be equally important and the Industry Technical Advisory Panel (ITAP) will in the near future be expanded to include these factors. • This exercise is yet to be completed and there is therefore no consensus as to how far each inflation component contributes to overall inflation.
6	**The Pharmaceutical Society of South Africa (PSSA)**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** The Associations mention a number of issues that they have experienced with the appointment of DSPs by medical schemes. It can be summarised as follows: a) In healthcare, a relationship of trust is usually built up between a patient and the healthcare professional, and unfortunately this is not taken into account when members are obliged to get services from a DSP. There is no face to face interaction with the pharmacist where courier pharmacies are appointed. b) If a patient ceases to take a particular medicine, it sometimes happens that the supplier cannot be notified in advance, and the patient receives unnecessary medicines. This is both dangerous and adds to the cost. c) Co-payments are imposed on members where non-DSPs are used. d) Certain pharmacies are denied the right to compete and excluded DSP arrangements.

		CMS response: The CMS was previously requested to investigate a complaint lodged with the honourable Minister of Health by Independent Community Pharmacy Association (ICPA) based on the same allegations listed above. Meetings were conducted with ICPA and 4 medical schemes to gain a better understanding of the problem and challenges faced by the relevant stakeholders. The medical schemes involved were strategically selected to include the biggest restricted and open medical schemes as well as smaller open and restricted medical schemes. The findings that emerged from our engagement with the relevant medical schemes demonstrated that: • Medical schemes are indeed contracting with community pharmacies; • DSP legislation does not contribute or create exclusive arrangements that limit competition; and • The number of pharmacies in South Africa relative to the number of registered medical schemes is significantly in excess of the number of DSP providers needed to service the beneficiaries. The Competition Commission has in its findings on the same complaint excluded unfair discrimination by schemes through DSP arrangements. This together with the fact that both retail and community pharmacies are free to serve the 84% of the population that is not covered on medical schemes dismiss the allegation that monopolies are created in the pharmaceutical industry and more so that DSP arrangements are the cause thereof. DSP arrangements are an essential mechanism in the managing of healthcare costs and serves to protect the interest of members of medical schemes. In the absence thereof members will have out of pocket payments and contributions will increase to such an extent that medical coverage will become unaffordable. Further DSP arrangements are applicable to all health care providers and does not in any way discriminate or single out any provider or group of providers. Courier pharmacies deliver medication at the workplace or residence of the member, based on his/her preference. If medication cannot be provided by a DSP the member can go to any pharmacy to obtain his/her medication without a co-payment. The face to face interactions and relationship of trust should rather be established with the treating provider who will prescribe the medication to a member. Lastly we agree that in the instance where a member receives unnecessary medicine it results in wasteful expenditure but this has no effect on the pharmacy and the medical scheme will suffer the loss.

13	**Brian Watson**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** Mr. Watson states in his submission that Regulation 8 to the Medical Schemes Act is permitting certain healthcare providers to charge fees without limit and that the regulation should be repealed as its original promulgation was *ultra vires* the then Minister's power. **CMS response:** As mentioned above this allegation is unfounded and incorrect as only a court can declare legislation invalid and repeal it. Mr. Watson further contents that if Regulation 8 is repealed and struck down it will result in medical schemes funding all PMB claims in full where the treatment is received in the state. All claims for treatment in the private sector will then be paid according to the tariffs set out in the rules. **CMS response:** This is also an assumption of what the legislature intended when the Act was promulgated. For example if a person is in a motor vehicle accident as sustains serious injuries and it constitutes a medical emergency, he or she will be transported to the nearest hospital. On Mr. Watson's version the claims resulting from his treatment and care will only be funded in full if he goes to a state facility. The state may not be the nearest hospital or it may not have the capacity or resources to deal with all the services that are needed by the patient. If he/she goes to the nearest private hospital the accounts will be paid at the scheme rate and the member will be liable for the difference between the scheme rate and the fees of all the service providers. **CMS response:** This is not in line with the purpose of PMBs which are aimed at ensuring access to health-care and protection from catastrophic out-of-pocket expenditure. Mr. Watson incorrectly state that only doctors can be appointed as DSPs as the definition in Regulation 7 to the Act states that the DSP provide to its members a diagnosis, treatment or care in respect of PMBs. **CMS response:** Hospitals and other service providers can also be appointed as DSPs as they can also provide treatment and care.
14	**Medscheme**	**<u>Solvency:</u> Summary of Submissions:**

		• Schemes highlighted that the current solvency requirement was inappropriate – suggesting moving towards a risk based solvency framework. • These schemes argue that the current framework ties up a lot of capital especially for big schemes - which is unnecessary. • The investment restrictions provided by Annexure B are too restrictive and limit the schemes' ability to earn investment returns in access of contribution increases. **CMS response:** • There was no statement of fact to confirm that the current framework 25% of gross contribution is inappropriate. • When reviewing the solvency framework there are plenty of factors to consider, such as ensuring equity between schemes and maintain a fair playing field for all schemes. The implementation of a risk based framework may be favourable for a large scheme, but could be to the detriment of smaller schemes. It is factors like these that require investigation. • However CMS acknowledges that the investments prescribed by the Act and per Annexure B would limit the schemes' ability to earn investment returns in access of the increase in contribution rates. This has an impact of requiring schemes to increase contribution rates so as to maintain solvency. Annexure B is currently being reviewed to address this concern. • The CMS is furthermore investigating the appropriateness of the current solvency framework. This investigation will be carried out in consultation with industry stakeholders. **<u>Medical inflation:</u> Summary of Submissions:** • Schemes submitted that healthcare cost inflation is much higher than Consumer Price Index (CPI), hence the CPI is an inappropriate measure of healthcare inflation. • Several reasons where attributed to these increases such as plan mix and demographic factors. **CMS response:** • Globally, medical inflation is always far above CPI, this is mainly due to new technology (cost of biologics for cancer), increase in the burden of disease (chronic disease of life style) and supply side factors. Locally, the impact on medical inflation for some schemes can lead the schemes experiencing operating deficit especially in light of member sensitivity to benefit option price changes. • Medical inflation and utilisation indicators mean different things to different individuals within the medical schemes industry. These

		indicators are often computed and interpreted in a variety of ways depending on each stakeholder's perspective and interests. • Therefore, medical inflation is a function of many variables where there is also a demand side and supply side impact. • For some stakeholders, medical inflation might include: - Medical schemes contribution increases and tariff increase; - Others view medical schemes inflation as a function of all of the above including out-of-pocket payments, the impact of benefit design, reserve loading and non-healthcare costs; - Whilst others may view medical scheme inflation as what is reported by StatsSA in the CPI "health basket". • Closely associated to medical inflation is utilisation definitions, certain utilisation indicators currently included in the Annual Statutory Return (ASR) are being revised to ensure that they are relevant and accepted by all stakeholders within the medical schemes industry. This project is therefore envisaged to assist CMS in improving monitoring, evaluation and reporting on medical inflation and utilisation statistics. • Whilst CMS agrees that healthcare inflation is higher than CPI, it also acknowledges that schemes are able to address some of the variables listed above through a variety of cost pull interventions. • Such interventions and/or market positions can include, but not limited to the following: o Innovative use of managed care principles (cost effective management of conditions through efficient application of managed care principles); o Innovative contracting; o Maximise the benefits of the economies of scale (i.e. big medical schemes, administrators and/or managed care companies); o Innovative reimbursement methods and associated rates linked to quality health outcomes. • Such interventions will address some of the medical inflation variables. • There have been projects carried out by CMS and the industry to identify the major reasons for inflation above tariff increases as well as quantify the extent of each of these factors. • Factors which are being investigated are demographic, plan mix and other factors. • Out-of-pocket payment, benefit design, reserve loading and non-healthcare costs are amongst the factors considered by CMS to be equally important and the Industry Technical Advisory Panel (ITAP) will in the near future be expanded to include these factors.

		This exercise is yet to be completed and there is therefore no consensus as to how far each inflation component contributes to overall inflation.
19	**Profmed**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** Profmed also mentions that the only mechanism medical schemes may utilise to mitigate their risk is to contract with Designated Service Providers (DSPs). **CMS response:** This is incorrect as the Regulations provide a number of other interventions that a scheme can use to manage the costs of PMBs. Included in Regulation 8(4) is the use of formularies, treatment protocols and pre-authorisation. It is incorrect of the scheme to state that small- to medium sized schemes do not have bargaining power to enter into DSP arrangements as the scheme itself have DSP arrangements in place. The bargaining power may be less than that of bigger medical schemes but it still exists and can be used to appoint DSPs. **<u>Compliance and cost of regulation</u>** In its submission to the Competition Commission Profmed alleges that regulation of medical schemes has been unduly burdensome resulting in unnecessary litigation between CMS and medical schemes, with the cost of compliance contributing to the increase in both non-healthcare expenditure and healthcare costs. **CMS response:** This statement is factually incorrect as data from the CMS 2013/2014 Annual Report shows that CMS spent a mere R9.5 million on legal fees to regulate and supervise an industry worth over R100 billion in annual member contributions. The total CMS expenditure on litigation as a proportion of the R129.7 billion annual contribution is only 7.35%. Furthermore, the schemes with the top highest expenditure on legal fees spent a combined R26 million rand. Supervision and enforcement by means of litigation is an inherent feature of any regulatory regime and therefore not unique to the healthcare industry. Both section 56 of the Act and section 5 of the Financial Institution (protection of the funds) Act 28 of 2001 (the FIA) oblige the Registrar to resort to litigation in some instances. It is also the responsibility of the industry to act in a manner such that the costs and the need of litigation is minimised. This could be achieved through high level of compliance within the industry and the application of sound governance principles in the manner in which medical schemes and their contracted third parties are conducting their

		business. This will no doubt reduce the regulatory costs for CMS and the medical schemes.
20	**Cape Medical Plan**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** The scheme mentions that disputes declared over the payment for disputed PMBs puts the member of the scheme in an adversarial position and that while disputes are pending, members can be sued by service providers. Even if the service provider then loses the case, the member would have been financially disadvantaged whilst awaiting the outcome of the dispute. **CMS response:** The CMS' experience as Regulator has been that providers are reluctant to institute legal action against their patients as it results in legal fees that have to be paid. There have even been instances where practices will follow up on the status of a complaint with the Regulator while holding a matter in abeyance. There should be no reason why members should be financially disadvantaged based on the fact that when the dispute is resolved there will be a clear indication if they were entitled to the benefit in which case the accounts will be paid. If there is no entitlement the scheme will not be liable for the costs and the member will have to honour the payment with the provider as per the contract between them. Cape Medical Plan mentions that there is a lack of proper regulation guarding against hopping on and off a scheme during the year, which adds to anti-selection. **CMS response:** The CMS disagrees with this statement as the Act provides sufficient tools for schemes to limit scheme hopping by members. The right to impose waiting periods and late joiner penalties are discretionary and will only be effective if applied by medical schemes. Regulation 9 to the Act also provides that a medical scheme may reduce the annual benefits, with the exceptions of PMBs, pro rata to the period of membership in the financial year concerned calculated from the date of admission to the end of the financial year concerned.
22	**Verirad (Pty) Ltd**	**<u>Medical inflation:</u> Summary of Submissions:** • Schemes submitted that healthcare cost inflation is much higher than Consumer Price Index (CPI), hence the CPI is an inappropriate measure of healthcare inflation. • Several reasons where attributed to these increases such as plan mix and demographic factors. **CMS response:**

		• Globally, medical inflation is always far above CPI, this is mainly due to new technology (cost of biologics for cancer), increase in the burden of disease (chronic disease of life style) and supply side factors. Locally, the impact on medical inflation for some schemes can lead the schemes experiencing operating deficit especially in light of member sensitivity to benefit option price changes. • Medical inflation and utilisation indicators mean different things to different individuals within the medical schemes industry. These indicators are often computed and interpreted in a variety of ways depending on each stakeholder's perspective and interests. • Therefore, medical inflation is a function of many variables where there is also a demand side and supply side impact. • For some stakeholders, medical inflation might include: - Medical schemes contribution increases and tariff increase; - Others view medical schemes inflation as a function of all of the above including out-of-pocket payments, the impact of benefit design, reserve loading and non-healthcare costs; - Whilst others may view medical scheme inflation as what is reported by StatsSA in the CPI "health basket". • Closely associated to medical inflation is utilisation definitions, certain utilisation indicators currently included in the Annual Statutory Return (ASR) are being revised to ensure that they are relevant and accepted by all stakeholders within the medical schemes industry. This project is therefore envisaged to assist CMS in improving monitoring, evaluation and reporting on medical inflation and utilisation statistics. • Whilst CMS agrees that healthcare inflation is higher than CPI, it also acknowledges that schemes are able to address some of the variables listed above through a variety of cost pull interventions. • Such interventions and/or market positions can include, but not limited to the following: o Innovative use of managed care principles (cost effective management of conditions through efficient application of managed care principles); o Innovative contracting; o Maximise the benefits of the economies of scale (i.e. big medical schemes, administrators and/or managed care companies); o Innovative reimbursement methods and associated rates linked to quality health outcomes. • Such interventions will address some of the medical inflation variables.

		• There have been projects carried out by CMS and the industry to identify the major reasons for inflation above tariff increases as well as quantify the extent of each of these factors. • Factors which are being investigated are demographic, plan mix and other factors. • Out-of-pocket payment, benefit design, reserve loading and non-healthcare costs are amongst the factors considered by CMS to be equally important and the Industry Technical Advisory Panel (ITAP) will in the near future be expanded to include these factors. This exercise is yet to be completed and there is therefore no consensus as to how far each inflation component contributes to overall inflation.
27	**Roche Diagnostics**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** In its submission the laboratory referred to Regulation 8 and indicated that unless a test result is positive, thereby indicating the presence of the PMB condition, patients and providers would carry the financial risks of such test or, if deciding to not take it because of schemes not funding same. They further state that this leads to the under-diagnosing or inappropriate, or late, commencement of treatment, with resultant harm to patients. **CMS response:** This statement is incorrect as the position is that where a PMB condition is suspected all the clinically appropriate diagnostic tests are funded up to the point where the PMB status of the condition was confirmed.
37	**Section 27**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** Section 27 referred to the Constitutional right of access to health and provided testimonials of members whose PMB treatments were not funded in full. **CMS response:** As mentioned above the Constitution acknowledges the right to limit the right to access to health within the available recourses. It is important to note that there may be a number of valid reasons why a PMB account was not paid in full, including but not limited to: • The member's premiums are not paid which means that he is not entitled to benefits. • The condition is a PMB but the level of care is not in line with the Regulations

		• The account was not submitted within the allowed time frames in the Act • The treatment is not cost-effective or based on evidence based medicine and therefore not included in the scheme's protocol. • The services were rendered while the member's membership was still subject to a waiting period. **<u>Solvency:</u> Summary of Submissions:** • Schemes highlighted that the current solvency requirement was inappropriate – suggesting moving towards a risk based solvency framework. • These schemes argue that the current framework ties up a lot of capital especially for big schemes - which is unnecessary. • The investment restrictions provided by Annexure B are too restrictive and limit the schemes' ability to earn investment returns in access of contribution increases. **CMS response:** • There was no statement of fact to confirm that the current framework 25% of gross contribution is inappropriate. • When reviewing the solvency framework there are plenty of factors to consider, such as ensuring equity between schemes and maintain a fair playing field for all schemes. The implementation of a risk based framework may be favourable for a large scheme, but could be to the detriment of smaller schemes. It is factors like these that require investigation. • However CMS acknowledges that the investments prescribed by the Act and per Annexure B would limit the schemes' ability to earn investment returns in access of the increase in contribution rates. This has an impact of requiring schemes to increase contribution rates so as to maintain solvency. Annexure B is currently being reviewed to address this concern. • The CMS is furthermore investigating the appropriateness of the current solvency framework. This investigation will be carried out in consultation with industry stakeholders. **<u>Fines</u>** Section 27 states that the CMS does not have the power to impose fines. **CMS response:** Section 66 of the Act provides for the imposition of fines and penalties for the contravention of the Act.

40	**The Unlimited Group (Pty) Ltd**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** The organisation refers to GAP cover and state that as insurers (and their intermediaries) they are not constrained by the obligation to provide PMBs. They are therefore more flexible to develop innovative solutions which are aimed at those that cannot afford medical schemes cover. **CMS response:** It is important to note that although GAP products may be more flexible in its nature they lack the protection that is afforded by the benefits of registered medical schemes in that they are allowed to discriminate based on health status, age etc. Whereas PMBs have to be funded in full, GAP cover will only pay up to a certain level. The Demarcation Regulations, which will address this issue are in the process of being finalised and published.
42	**Netcare Limited**	**<u>Solvency:</u> Summary of Submissions:** • Schemes highlighted that the current solvency requirement was inappropriate – suggesting moving towards a risk based solvency framework. • These schemes argue that the current framework ties up a lot of capital especially for big schemes - which is unnecessary. • The investment restrictions provided by Annexure B are too restrictive and limit the schemes' ability to earn investment returns in access of contribution increases. **CMS response:** • There was no statement of fact to confirm that the current framework 25% of gross contribution is inappropriate. • When reviewing the solvency framework there are plenty of factors to consider, such as ensuring equity between schemes and maintain a fair playing field for all schemes. The implementation of a risk based framework may be favourable for a large scheme, but could be to the detriment of smaller schemes. It is factors like these that require investigation. • However CMS acknowledges that the investments prescribed by the Act and per Annexure B would limit the schemes' ability to earn investment returns in access of the increase in contribution rates. This has an impact of requiring schemes to increase contribution rates so as to maintain solvency. Annexure B is currently being reviewed to address this concern. • The CMS is furthermore investigating the appropriateness of the current solvency framework. This investigation will be carried out in consultation with industry stakeholders.

		<u>Medical inflation:</u> Summary of Submissions: • Schemes submitted that healthcare cost inflation is much higher than Consumer Price Index (CPI), hence the CPI is an inappropriate measure of healthcare inflation. • Several reasons where attributed to these increases such as plan mix and demographic factors. **CMS response:** • Globally, medical inflation is always far above CPI, this is mainly due to new technology (cost of biologics for cancer), increase in the burden of disease (chronic disease of life style) and supply side factors. Locally, the impact on medical inflation for some schemes can lead the schemes experiencing operating deficit especially in light of member sensitivity to benefit option price changes. • Medical inflation and utilisation indicators mean different things to different individuals within the medical schemes industry. These indicators are often computed and interpreted in a variety of ways depending on each stakeholder's perspective and interests. • Therefore, medical inflation is a function of many variables where there is also a demand side and supply side impact. • For some stakeholders, medical inflation might include: - Medical schemes contribution increases and tariff increase; - Others view medical schemes inflation as a function of all of the above including out-of-pocket payments, the impact of benefit design, reserve loading and non-healthcare costs; - Whilst others may view medical scheme inflation as what is reported by StatsSA in the CPI "health basket". • Closely associated to medical inflation is utilisation definitions, certain utilisation indicators currently included in the Annual Statutory Return (ASR) are being revised to ensure that they are relevant and accepted by all stakeholders within the medical schemes industry. This project is therefore envisaged to assist CMS in improving monitoring, evaluation and reporting on medical inflation and utilisation statistics. • Whilst CMS agrees that healthcare inflation is higher than CPI, it also acknowledges that schemes are able to address some of the variables listed above through a variety of cost pull interventions. • Such interventions and/or market positions can include, but not limited to the following: o Innovative use of managed care principles (cost effective management of conditions through efficient application of managed care principles); o Innovative contracting;

		○ Maximise the benefits of the economies of scale (i.e. big medical schemes, administrators and/or managed care companies); ○ Innovative reimbursement methods and associated rates linked to quality health outcomes. • Such interventions will address some of the medical inflation variables. • There have been projects carried out by CMS and the industry to identify the major reasons for inflation above tariff increases as well as quantify the extent of each of these factors. • Factors which are being investigated are demographic, plan mix and other factors. • Out-of-pocket payment, benefit design, reserve loading and non-healthcare costs are amongst the factors considered by CMS to be equally important and the Industry Technical Advisory Panel (ITAP) will in the near future be expanded to include these factors. This exercise is yet to be completed and there is therefore no consensus as to how far each inflation component contributes to overall inflation.
43	**Mediclinic**	**<u>Solvency:</u> Summary of Submissions:** • Schemes highlighted that the current solvency requirement was inappropriate – suggesting moving towards a risk based solvency framework. • These schemes argue that the current framework ties up a lot of capital especially for big schemes - which is unnecessary. • The investment restrictions provided by Annexure B are too restrictive and limit the schemes' ability to earn investment returns in access of contribution increases. **CMS response:** • There was no statement of fact to confirm that the current framework 25% of gross contribution is inappropriate. • When reviewing the solvency framework there are plenty of factors to consider, such as ensuring equity between schemes and maintain a fair playing field for all schemes. The implementation of a risk based framework may be favourable for a large scheme, but could be to the detriment of smaller schemes. It is factors like these that require investigation. • However CMS acknowledges that the investments prescribed by the Act and per Annexure B would limit the schemes' ability to earn investment returns in access of the increase in contribution rates. This has an impact of requiring schemes to increase contribution rates so as to maintain solvency. Annexure B is currently being reviewed to address this concern.

		• The CMS is furthermore investigating the appropriateness of the current solvency framework. This investigation will be carried out in consultation with industry stakeholders. **<u>Medical inflation:</u> Summary of Submissions:** • Schemes submitted that healthcare cost inflation is much higher than Consumer Price Index (CPI), hence the CPI is an inappropriate measure of healthcare inflation. • Several reasons where attributed to these increases such as plan mix and demographic factors. **CMS response:** • Globally, medical inflation is always far above CPI, this is mainly due to new technology (cost of biologics for cancer), increase in the burden of disease (chronic disease of life style) and supply side factors. Locally, the impact on medical inflation for some schemes can lead the schemes experiencing operating deficit especially in light of member sensitivity to benefit option price changes. • Medical inflation and utilisation indicators mean different things to different individuals within the medical schemes industry. These indicators are often computed and interpreted in a variety of ways depending on each stakeholder's perspective and interests. • Therefore, medical inflation is a function of many variables where there is also a demand side and supply side impact. • For some stakeholders, medical inflation might include: - Medical schemes contribution increases and tariff increase; - Others view medical schemes inflation as a function of all of the above including out-of-pocket payments, the impact of benefit design, reserve loading and non-healthcare costs; - Whilst others may view medical scheme inflation as what is reported by StatsSA in the CPI "health basket". • Closely associated to medical inflation is utilisation definitions, certain utilisation indicators currently included in the Annual Statutory Return (ASR) are being revised to ensure that they are relevant and accepted by all stakeholders within the medical schemes industry. This project is therefore envisaged to assist CMS in improving monitoring, evaluation and reporting on medical inflation and utilisation statistics. • Whilst CMS agrees that healthcare inflation is higher than CPI, it also acknowledges that schemes are able to address some of the variables listed above through a variety of cost pull interventions. • Such interventions and/or market positions can include, but not limited to the following:

		○ Innovative use of managed care principles (cost effective management of conditions through efficient application of managed care principles); ○ Innovative contracting; ○ Maximise the benefits of the economies of scale (i.e. big medical schemes, administrators and/or managed care companies); ○ Innovative reimbursement methods and associated rates linked to quality health outcomes. • Such interventions will address some of the medical inflation variables. • There have been projects carried out by CMS and the industry to identify the major reasons for inflation above tariff increases as well as quantify the extent of each of these factors. • Factors which are being investigated are demographic, plan mix and other factors. • Out-of-pocket payment, benefit design, reserve loading and non-healthcare costs are amongst the factors considered by CMS to be equally important and the Industry Technical Advisory Panel (ITAP) will in the near future be expanded to include these factors. This exercise is yet to be completed and there is therefore no consensus as to how far each inflation component contributes to overall inflation.
44	**Life Healthcare Group**	**<u>Medical inflation:</u> Summary of Submissions:** • Schemes submitted that healthcare cost inflation is much higher than Consumer Price Index (CPI), hence the CPI is an inappropriate measure of healthcare inflation. • Several reasons where attributed to these increases such as plan mix and demographic factors. **CMS response:** • Globally, medical inflation is always far above CPI, this is mainly due to new technology (cost of biologics for cancer), increase in the burden of disease (chronic disease of life style) and supply side factors. Locally, the impact on medical inflation for some schemes can lead the schemes experiencing operating deficit especially in light of member sensitivity to benefit option price changes. • Medical inflation and utilisation indicators mean different things to different individuals within the medical schemes industry. These indicators are often computed and interpreted in a variety of ways depending on each stakeholder's perspective and interests. • Therefore, medical inflation is a function of many variables where there is also a demand side and supply side impact.

		• For some stakeholders, medical inflation might include: - Medical schemes contribution increases and tariff increase; - Others view medical schemes inflation as a function of all of the above including out-of-pocket payments, the impact of benefit design, reserve loading and non-healthcare costs; - Whilst others may view medical scheme inflation as what is reported by StatsSA in the CPI "health basket". • Closely associated to medical inflation is utilisation definitions, certain utilisation indicators currently included in the Annual Statutory Return (ASR) are being revised to ensure that they are relevant and accepted by all stakeholders within the medical schemes industry. This project is therefore envisaged to assist CMS in improving monitoring, evaluation and reporting on medical inflation and utilisation statistics. • Whilst CMS agrees that healthcare inflation is higher than CPI, it also acknowledges that schemes are able to address some of the variables listed above through a variety of cost pull interventions. • Such interventions and/or market positions can include, but not limited to the following: o Innovative use of managed care principles (cost effective management of conditions through efficient application of managed care principles); o Innovative contracting; o Maximise the benefits of the economies of scale (i.e. big medical schemes, administrators and/or managed care companies); o Innovative reimbursement methods and associated rates linked to quality health outcomes. • Such interventions will address some of the medical inflation variables. • There have been projects carried out by CMS and the industry to identify the major reasons for inflation above tariff increases as well as quantify the extent of each of these factors. • Factors which are being investigated are demographic, plan mix and other factors. • Out-of-pocket payment, benefit design, reserve loading and non-healthcare costs are amongst the factors considered by CMS to be equally important and the Industry Technical Advisory Panel (ITAP) will in the near future be expanded to include these factors. This exercise is yet to be completed and there is therefore no consensus as to how far each inflation component contributes to overall inflation.

45	**Drs Dietrich, Voigt (Pathcare)**	Pathcare was particularly against pricing regulations. **CMS response:** It is CMS' view that price regulation will contain healthcare costs in South Africa. Since the inception of the regulation of medicines, costs of medicine in the country has reduced.
48	**Independent Community Pharmacy Association (ICPA)**	**<u>Regulation 8: Prescribed Minimum Benefits (PMBs) and Designated Service Providers (DSPs)</u>** The Associations mention a number of issues that they have experienced with the appointment of DSPs by medical schemes. It can be summarised as follows: a) In healthcare, a relationship of trust is usually built up between a patient and the healthcare professional, and unfortunately this is not taken into account when members are obliged to get services from a DSP. There is no face to face interaction with the pharmacist where courier pharmacies are appointed. b) If a patient ceases to take a particular medicine, it sometimes happens that the supplier cannot be notified in advance, and the patient receives unnecessary medicines. This is both dangerous and adds to the cost. c) Co-payments are imposed on members where non-DSPs are used. d) Certain pharmacies are denied the right to compete and excluded DSP arrangements. **CMS response:** The CMS was previously requested to investigate a complaint lodged with the honourable Minister of Health by Independent Community Pharmacy Association (ICPA) based on the same allegations listed above. Meetings were conducted with ICPA and 4 medical schemes to gain a better understanding of the problem and challenges faced by the relevant stakeholders. The medical schemes involved were strategically selected to include the biggest restricted and open medical schemes as well as smaller open and restricted medical schemes. The findings that emerged from our engagement with the relevant medical schemes demonstrated that: • Medical schemes are indeed contracting with community pharmacies; • DSP legislation does not contribute or create exclusive arrangements that limit competition; and

		• The number of pharmacies in South Africa relative to the number of registered medical schemes is significantly in excess of the number of DSP providers needed to service the beneficiaries. The Competition Commission has in its findings on the same complaint excluded unfair discrimination by schemes through DSP arrangements. This together with the fact that both retail and community pharmacies are free to serve the 84% of the population that is not covered on medical schemes dismiss the allegation that monopolies are created in the pharmaceutical industry and more so that DSP arrangements are the cause thereof. DSP arrangements are an essential mechanism in the managing of healthcare costs and serves to protect the interest of members of medical schemes. In the absence thereof members will have out of pocket payments and contributions will increase to such an extent that medical coverage will become unaffordable. Further DSP arrangements are applicable to all health care providers and does not in any way discriminate or single out any provider or group of providers. Courier pharmacies deliver medication at the workplace or residence of the member, based on his/her preference. If medication cannot be provided by a DSP the member can go to any pharmacy to obtain his/her medication without a co-payment. The face to face interactions and relationship of trust should rather be established with the treating provider who will prescribe the medication to a member. Lastly we agree that in the instance where a member receives unnecessary medicine it results in wasteful expenditure but this has no effect on the pharmacy and the medical scheme will suffer the loss. **<u>Other</u>** The Independent Community Pharmacy Association (ICPA) also referred to the Medsaver product in its submission. **CMS response:** This forms part of the Vitality product of Discovery Health Pty Ltd. and not of the medical scheme. These issues have successfully been dealt with by the Department of Health and the Public Protector following complaints by ICPA.
52	**South African Society of Anaesthesiologists (SASA)**	This submission refers to the less than arm's length relationships that exists between schemes and administrators. **CMS response:** It should be noted that medical schemes are non-profit entities, while administrators are registered companies and profit making entities. CMS is concerned that the relationship between some administrators and schemes might not be independent enough seen in the light of the different objectives relating to profit.

55	**Emerging Market Healthcare (EMC)**	According to EMC managed healthcare interventions have not brought down general healthcare costs in a fair and appropriate manner. **CMS response:** The CMS would disagree as the statement is a general one and contrary thereto, substantial evidence is available to corroborate this view. It is however difficult to quote global figures but adequate steps are taken to ensure that managed care is practiced in a manner and over time to secure quality outcomes. Managed care entities are regulated by the CMS utilising numerous standards which demand a high and appropriate skills base handling patient management according to managed care techniques. This also includes peer review mechanisms and regular updating of clinical protocols and drug formularies. The accreditation process includes on-site evaluation of infrastructure, skills and facilities to verify factual correctness of information provided.
60	**Discovery Health**	**<u>Solvency:</u> Summary of Submissions:** • Schemes highlighted that the current solvency requirement was inappropriate – suggesting moving towards a risk based solvency framework. • These schemes argue that the current framework ties up a lot of capital especially for big schemes - which is unnecessary. • The investment restrictions provided by Annexure B are too restrictive and limit the schemes' ability to earn investment returns in access of contribution increases. **CMS response:** • There was no statement of fact to confirm that the current framework 25% of gross contribution is inappropriate. • When reviewing the solvency framework there are plenty of factors to consider, such as ensuring equity between schemes and maintain a fair playing field for all schemes. The implementation of a risk based framework may be favourable for a large scheme, but could be to the detriment of smaller schemes. It is factors like these that require investigation. • However CMS acknowledges that the investments prescribed by the Act and per Annexure B would limit the schemes' ability to earn investment returns in access of the increase in contribution rates. This has an impact of requiring schemes to increase contribution rates so as to maintain solvency. Annexure B is currently being reviewed to address this concern.

		• The CMS is furthermore investigating the appropriateness of the current solvency framework. This investigation will be carried out in consultation with industry stakeholders.
61	**Discovery Health (Pty) Ltd**	**<u>Solvency:</u> Summary of Submissions:** • Schemes highlighted that the current solvency requirement was inappropriate – suggesting moving towards a risk based solvency framework. • These schemes argue that the current framework ties up a lot of capital especially for big schemes - which is unnecessary. • The investment restrictions provided by Annexure B are too restrictive and limit the schemes' ability to earn investment returns in access of contribution increases. **CMS response:** • There was no statement of fact to confirm that the current framework 25% of gross contribution is inappropriate. • When reviewing the solvency framework there are plenty of factors to consider, such as ensuring equity between schemes and maintain a fair playing field for all schemes. The implementation of a risk based framework may be favourable for a large scheme, but could be to the detriment of smaller schemes. It is factors like these that require investigation. • However CMS acknowledges that the investments prescribed by the Act and per Annexure B would limit the schemes' ability to earn investment returns in access of the increase in contribution rates. This has an impact of requiring schemes to increase contribution rates so as to maintain solvency. Annexure B is currently being reviewed to address this concern. • The CMS is furthermore investigating the appropriateness of the current solvency framework. This investigation will be carried out in consultation with industry stakeholders. **<u>Medical inflation:</u> Summary of Submissions:** • Schemes submitted that healthcare cost inflation is much higher than Consumer Price Index (CPI), hence the CPI is an inappropriate measure of healthcare inflation. • Several reasons where attributed to these increases such as plan mix and demographic factors. **CMS response:** • Globally, medical inflation is always far above CPI, this is mainly due to new technology (cost of biologics for cancer), increase in the burden of disease (chronic disease of life style) and supply side factors. Locally, the impact on medical inflation for some schemes can lead the schemes experiencing operating deficit

		especially in light of member sensitivity to benefit option price changes. • Medical inflation and utilisation indicators mean different things to different individuals within the medical schemes industry. These indicators are often computed and interpreted in a variety of ways depending on each stakeholder's perspective and interests. • Therefore, medical inflation is a function of many variables where there is also a demand side and supply side impact. • For some stakeholders, medical inflation might include: - Medical schemes contribution increases and tariff increase; - Others view medical schemes inflation as a function of all of the above including out-of-pocket payments, the impact of benefit design, reserve loading and non-healthcare costs; - Whilst others may view medical scheme inflation as what is reported by StatsSA in the CPI "health basket". • Closely associated to medical inflation is utilisation definitions, certain utilisation indicators currently included in the Annual Statutory Return (ASR) are being revised to ensure that they are relevant and accepted by all stakeholders within the medical schemes industry. This project is therefore envisaged to assist CMS in improving monitoring, evaluation and reporting on medical inflation and utilisation statistics. • Whilst CMS agrees that healthcare inflation is higher than CPI, it also acknowledges that schemes are able to address some of the variables listed above through a variety of cost pull interventions. • Such interventions and/or market positions can include, but not limited to the following: o Innovative use of managed care principles (cost effective management of conditions through efficient application of managed care principles); o Innovative contracting; o Maximise the benefits of the economies of scale (i.e. big medical schemes, administrators and/or managed care companies); o Innovative reimbursement methods and associated rates linked to quality health outcomes. • Such interventions will address some of the medical inflation variables. • There have been projects carried out by CMS and the industry to identify the major reasons for inflation above tariff increases as well as quantify the extent of each of these factors. • Factors which are being investigated are demographic, plan mix and other factors.

		• Out-of-pocket payment, benefit design, reserve loading and non-healthcare costs are amongst the factors considered by CMS to be equally important and the Industry Technical Advisory Panel (ITAP) will in the near future be expanded to include these factors. This exercise is yet to be completed and there is therefore no consensus as to how far each inflation component contributes to overall inflation.
65	**SAPPF**	**<u>Medical inflation:</u> Summary of Submissions:** • Schemes submitted that healthcare cost inflation is much higher than Consumer Price Index (CPI), hence the CPI is an inappropriate measure of healthcare inflation. • Several reasons where attributed to these increases such as plan mix and demographic factors. **CMS response:** • Globally, medical inflation is always far above CPI, this is mainly due to new technology (cost of biologics for cancer), increase in the burden of disease (chronic disease of life style) and supply side factors. Locally, the impact on medical inflation for some schemes can lead the schemes experiencing operating deficit especially in light of member sensitivity to benefit option price changes. • Medical inflation and utilisation indicators mean different things to different individuals within the medical schemes industry. These indicators are often computed and interpreted in a variety of ways depending on each stakeholder's perspective and interests. • Therefore, medical inflation is a function of many variables where there is also a demand side and supply side impact. • For some stakeholders, medical inflation might include: - Medical schemes contribution increases and tariff increase; - Others view medical schemes inflation as a function of all of the above including out-of-pocket payments, the impact of benefit design, reserve loading and non-healthcare costs; - Whilst others may view medical scheme inflation as what is reported by StatsSA in the CPI "health basket". • Closely associated to medical inflation is utilisation definitions, certain utilisation indicators currently included in the Annual Statutory Return (ASR) are being revised to ensure that they are relevant and accepted by all stakeholders within the medical schemes industry. This project is therefore envisaged to assist CMS in improving monitoring, evaluation and reporting on medical inflation and utilisation statistics.

		• Whilst CMS agrees that healthcare inflation is higher than CPI, it also acknowledges that schemes are able to address some of the variables listed above through a variety of cost pull interventions. • Such interventions and/or market positions can include, but not limited to the following: o Innovative use of managed care principles (cost effective management of conditions through efficient application of managed care principles); o Innovative contracting; o Maximise the benefits of the economies of scale (i.e. big medical schemes, administrators and/or managed care companies); o Innovative reimbursement methods and associated rates linked to quality health outcomes. • Such interventions will address some of the medical inflation variables. • There have been projects carried out by CMS and the industry to identify the major reasons for inflation above tariff increases as well as quantify the extent of each of these factors. • Factors which are being investigated are demographic, plan mix and other factors. • Out-of-pocket payment, benefit design, reserve loading and non-healthcare costs are amongst the factors considered by CMS to be equally important and the Industry Technical Advisory Panel (ITAP) will in the near future be expanded to include these factors. This exercise is yet to be completed and there is therefore no consensus as to how far each inflation component contributes to overall inflation.
66	**SAMA**	SAMA perceives managed care to add to non-healthcare expenditure by schemes without requisite value in the chain. **CMS response:** The CMS would disagree as the statement is a general one and contrary thereto, substantial evidence is available to corroborate this view. It is however difficult to quote global figures but adequate steps are taken to ensure that managed care is practiced in a manner and over time to secure quality outcomes. Managed care entities are regulated by the CMS utilising numerous standards which demand a high and appropriate skills base handling patient management according to managed care techniques. This also includes peer review mechanisms and regular updating of clinical protocols and drug formularies. The accreditation process includes on-site evaluation of infrastructure, skills and facilities to verify factual correctness of information provided.
