INDEPENDENT COMMUNITY PHARMACY ASSOCIATION

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5 February 2016

Attention: **Mr Clint Oellermann**
The Inquiry Director
Market Inquiry into the Private Healthcare Sector

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Per email: submissions@healthinquiry.net

Dear Mr Clint Oellermann *(Inquiry Director)*

RE: CORRECTION TO ICPA'S SUBMISSION - MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

ICPA would like to correct its submission dated 31 October 2014 in that the methodology used to calculate co-payments has been misrepresented and dually corrected. In addition, we have removed all reference to formulary and non-formulary drugs.

We hereby submit the following correction: **Removal of pages 5 to 10 of the ICPA submission dated 31 October 2014 and replacing the pages with the undermentioned pages 5 to 10.**

Regulation 8(2)(b) similarly does not restrict or regulate a medical aid scheme's discretion when calculating the allowed co-payment that is payable by a beneficiary should he or she utilise the services of a non-DSP. The regulation merely states that the rules of the scheme may provide for the payment of a co-payment, "the quantum of which is specified in the rules of the medical scheme". Schemes therefore unilaterally and without restriction determine how co-payments will be calculated which has resulted in certain schemes charging so-called punitive "penalty" co-payments, calculated as a percentage of the total amount claimed by the service provider/pharmacy from the scheme. In order to clarify and illustrate the consequences of this absolute discretion afforded to schemes to calculate penalty co-payments, we refer to the following examples:-

Glossary:

PMB	= Prescribed Minimum Benefit Conditions
DFR	= Dispensing Fee Rate of the service provider (the rate the scheme is willing to pay in the example is 26% of the price of the medicine capped at R26)
SEP	= Single Exit Price (cost price of medicine)
DF	= Dispensing Fee total the service provider charges
Repriced amount	=The amount which consists of the SEP of the medicines plus the dispensing fee rate the medical scheme is willing to pay.
Penalty Co-payment	= The "penalty" co-payment is calculated as a percentage of the re-priced amount.
Total co-payment	= This amount is the total charged to a Medical Scheme member as a co-payment which monies need to be collected by the service provider

Table 1:

	DFR charged by pharmacy	SEP	Total DF	Total Script Amount	Repriced Amount ie Payment by scheme	40% Penalty co-pay	Non-DSP rate co-pay	Total Co-Pay
DSP	26%/R26	200.00	26.00	R 226.00	R 226.00	0.00	0.00	R 0.00
Non-DSP	26%/R26	200.00	26.00	R 226.00	R 135.60 (less than SEP)	90.40	0.00	R 90.40
Non-DSP with higher DFR*	36%/R59.4	200.00	59.40	R 259.40	R 135.60 (less than SEP)	90.40	33.4	R123.80

** Should the beneficiary of the scheme choose to obtain his or her medicines from a non-DSP and that non-DSP's dispensing fee rate is higher than the DFR of the scheme (as agreed and contracted with their DSPs), the beneficiary will have to pay another co-payment calculated as the difference between the non-DSPs dispensing fee rate and that of the scheme's DSP*

Based on the abovementioned illustration, it is evident that schemes abuse the co-payment mechanism by charging an additional punitive "penalty" co-payment when a beneficiary uses a non-DSP to obtain medicines. This "penalty" co-payment is calculated as a percentage of the re-priced amount which consists of the SEP of the medicines plus the dispensing fee rate at which the medical scheme is willing to pay. We submit that the "penalty" co-payment designed by schemes is unreasonable, not in the best interest of beneficiaries/the public and has no justifiable basis for its implementation.

The calculation of co-payments in terms of Regulation 8(2)(b) should be based on the difference between the dispensing fee rate of the scheme as agreed with the DSP and the dispensing fee rate of the non-DSP (i.e. different dispensing fee rates charged by pharmacies).

The reason why schemes force their beneficiaries to pay these penalty co-payments is not clear nor is it justifiable. By allowing schemes to charge penalty co-payments, schemes are allowed to penalise beneficiaries for fictional "damages" that were not suffered. CMS (Council for Medical Schemes) also published a Managed Health Care Policy, dated August 2003, which provide guidelines with regard to the quantum of co-payments that should be imposed by schemes:-

> *As a guideline, given the intention of the legislation, it would seem reasonable for the quantum of the co-payment to relate to the difference between the actual cost incurred and the cost that would have been incurred had the designated service provider been used (or in the case of drugs, the difference between the cost of the drug and the reference price of the formulary drug).*

ICPA agrees with the abovementioned policy of CMS. The imposition of an additional punitive penalty co-payment, calculated as a percentage on the overall cost incurred by the scheme (dispensing fee rate of the service provider and the SEP of the medicine), is therefore unfounded. This business practice further negatively influences consumer choice by effectively removing the consumer's so-called "choice". The abovementioned explanation of how schemes manipulate the statutory regulations is one example of how co-payments influence consumer choice and is in response to the Panel's request in Clause 26 of the Draft

Statement of Issues[1]. We wish to further qualify Clause 26 in that it is not only the consumer's choice with regards to which scheme he/she will choose that is effected by a scheme's co-payment terms and conditions, but also which pharmacy he/she will subsequently use in order to obtain medicines.

Table 2 below sets out the preferred position where no penalty co-payment applies. The differences between Table 1 and Table 2 demonstrate that only schemes benefit, to the detriment of beneficiaries (the general public), from penalty co-payments. If a beneficiary chooses to use a non-DSP, the scheme's liability in respect of the total amount owing to the service providers decreases substantially:

[1] Draft Statement of Issues, Market Inquiry into the Private Healthcare Sector, dated **30 May 2014:** Clause 26:*"The requirement to make out-of-pocket payments may arise when patients are required to make co-payments, when a patient's scheme savings or benefits are exhausted, or when a patient has no scheme or insurance cover at all. The requirement to make co-payments, or the extent and level of co-payments, will influence consumer choice. Specifically, consumers may select schemes based on their terms and conditions regarding out-of-pocket payments. The Panel wishes to understand the circumstances under which a system of out-of-pocket payments has arisen in South Africa, what this means for the welfare of consumers, and the effect, if any, of out-of-pocket payments on competition".*

Table 2

	DFR charged by pharmacy	SEP	Total DF	Total Script Amount	Payment by scheme	**NO Penalty co-pay**	Non-DSP rate co-pay	Total Co-Pay
DSP	26%/R26	200.00	26.00	R 226.00	R 226.00	0.00	0.00	R 0.00
Non-DSP	26%/R26	200.00	26.00	R 226.00	R 226.00	0.00	0.00	R 0.00
Non-DSP with higher DFR*	36%/R59.4	200.00	59.40	R 259.40	R 226.00	0.00	33.4	R 33.40

It is apparent from Table 2 that a beneficiary's out-of-pocket expense decreases drastically should a penalty co-payment not be charged. Should a beneficiary then choose to use a non-DSP and be charged a co-payment, it is entirely his or her choice. There is no detrimental effect on the scheme whether the beneficiary chooses a DSP or a non-DSP since the SEP of medicines are fixed and schemes only pay pre-determined dispensing fee rates according to the agreement between the DSP and the scheme. The total payment by schemes to service providers also remains the same whether they have DSP status or not. The only apparent reason why this would not sit well with schemes is that they will no longer enjoy the benefit of passing on to their beneficiaries a portion of the script amount payable to a service provider. This practice clearly has a negative effect on the public, especially since their rights of access to healthcare services and medicines are diminished by being forced to pay exorbitant co-payments. Furthermore, should a scheme not charge a penalty co-payment, the

scheme would not pay less than the SEP for medicines. It is not legal or viable for service providers to dispense medicines below cost-price. The SEP for medicine is fixed according to the Medicines and Related Substances Act[2] and its regulations. The SEP is the only price at which manufacturers may sell medicines and scheduled substances to any persons or service providers[3]. Based on **Table 1** above, when imposing penalty co-payments, schemes are not even paying the cost price (SEP) for medicines, which is an unlawful practice. This places community pharmacists in an uncomfortable situation where they do not want to collect the penalty co-payment from their patients for fear of losing them, but they cannot afford to dispense medicines below cost-price. The purpose behind joining a medical aid scheme is to afford beneficiaries with, inter alia, the means to obtain medicine from pharmacies without being "out-of-pocket". The pharmacy then sells its "goods", which it bought from the manufacturer at the legislated cost price (SEP), to the scheme's beneficiary and adds its dispensing fee. The scheme must then reimburse the pharmacy. It could not have been the legislature's intention, by allowing schemes to calculate the quantum of co-payments, to cause pharmacies to sell their "goods" below the price at which they bought it, which will inevitably result in the pharmacy being forced to close its business.

The manner in which medical aid schemes are charging penalty co-payments together with closing their DSP networks, has resulted in undesirable business practices. Monopolies have sprouted amongst schemes since a credible threat of exclusion from a scheme's DSP network provides the scheme with bargaining power allowing it to negotiate unrealistically low dispensing fee rates with service providers/pharmacies. This anomaly has led to many independent community pharmacies being forced to close their doors and further closures are occurring at an alarming rate. It is also the vulnerable (often rural) pharmacies that are forced to close their doors.

[2] Act No. 101 of 1965
[3] Section 22G(3)(a)

Kind Regards

INDEPENDENT COMMUNITY PHARMACY ASSOCIATION

Mark Payne

CEO of ICPA