Medscheme submission on the HMI Seminars (9 – 12 April 2019)

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Medscheme Holdings (Pty) Ltd ("Medscheme"), an accredited managed care organisation and administrator of various medical schemes, hereby submits its reflections on the Health Market Inquiry ("HMI") seminars held during 9th to 12th April 2019.

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Submission in respect of HMI Seminars 9 – 12 April 2019
1. Introduction

Medscheme is a wholly owned subsidiary of AfroCentric Health Ltd and is the largest asset in the AfroCentric Group. AfroCentric has the largest black-ownership in the healthcare sector. Other AfroCentric subsidiaries include an IT company, specialising in healthcare, a medicine courier company and an HIV disease management company among others.

Medscheme is a leading player within the healthcare industry. It has been in existence since the early 1970s and has over the years developed extensive expertise in the provision of healthcare funding support services i.e. administration, managed care, actuarial services, healthcare provider networks management, health intelligence analytics and IT systems.

Medscheme has been actively pursuing solutions for the medical schemes (and their beneficiaries) under our administration to address the rising tide of healthcare expenditure increases and over the years we have learnt many valuable lessons. Developing effective expenditure containment solutions for healthcare funding requires a unique combination of actuarial, operational and clinical expertise. Medscheme’s Health Intelligence Unit employs such a blend of expert skills to monitor claims expenditure, fee and healthcare services utilisation trends in our client medical schemes and their work underpins the solutions we develop. Medscheme employs a value-based health risk management strategy in its managed care activities. This ensures a patient-centric approach that balances cost with quality and access to healthcare, rather than the traditional cost-cutting approach. The focus on better quality healthcare outcomes has led to the expansion of Medscheme’s role as active purchaser of medical services on behalf of medical scheme clients.

Medscheme’s active purchasing includes the profiling of healthcare providers (e.g. assessing the manner in which some doctors practice medicine relative to cost and healthcare outcomes); the measurement of quality indicators (e.g. assessing how some doctors’ diabetic patients get hospitalised more frequently than others despite similar health status); implementation of provider networks and the negotiation of alternative reimbursement models. We have implemented a number of ARMs over the years e.g. global fees for hip and knee replacements for a number of years which showed significant financial savings and reduced the patient’s length of stay in hospital without compromising health outcomes. Medscheme’s healthcare service provider network initiatives are used to facilitate and manage equitable access to appropriate and cost-effective care, within what is affordable.

2. Submission of reflections on the Seminars held between 9 – 12 April 2019

Medscheme appreciates the opportunity afforded by the HMI Panel to participants to make comments regarding the presentations and discussions at the Seminars held in Pretoria from the 9 to 12 April 2019. We would like to take this opportunity to reaffirm the contents of all our previous submissions to the HMI, including the detailed commentary dated 6th September 2018 (titled Medscheme Submission on the Health Market Inquiry Provisional Report – September 2018) we made with regards to the provisional findings and recommendations report.
3. Facilities’ Concentration and Remedies seminar

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

The presentations from the hospital groups (namely Netcare, Life Healthcare and Mediclinic) argued that the HMI had used flawed methodologies (e.g. inclusion of municipalities with zero beds, use of a very small sample of acute beds, incomplete hospital beds data, etc.) to reach their results and hence the conclusion by the HMI that the hospital market is concentrated as published in the Provisional Report were incorrect, particularly at the local geographical level. In our view, and as reflected in our presentation at the Seminar, the hospital market based on admission rates is moderately concentrated. It is however within the upper limits of the ‘moderately concentrated’ band. This is supported by the HMI in Figure 2 of the updated Seminar brief, in which HHI trends from 2010 to 2017 show moderate concentration based on registered beds.

The hospital groups argued that the facilities market in South Africa is dynamic and reasonably competitive – and that this is supported by the significant entry of the National Hospital Network (NHN) as a fourth hospital group and other independent facilities which all offer funders alternatives for setting up their networks and DSP anchor arrangements. The hospital groups also generally indicated that funders (administrators and medical schemes) have sufficient countervailing power to ensure they get fair tariffs through bilateral negotiations. For instance, it was presented by Netcare that there are quite a few medical schemes where hospitals (or parts of hospital groups) have been excluded from networks or DSPs. It was submitted that this is reflected in the lack of excessive profits on the part of hospital groups and that HMI did not find any evidence of collusion with regards to tariffs setting processes.

The figure above, as presented by Medscheme, shows that while NHN has led to some level of deconcentration in the acute and day clinic market, the relative market shares of the three other groups have remained relatively stable, as has the Medscheme admission-based HHI for the period 2014 – 2018. Medscheme agrees that NHN’s growth has created competition in the selection of networks as it offers an alternative anchor network.
group. This competition has been enhanced by the CMS’s approval of Efficiency Discount Options and by an increased willingness of trustees to implement stricter networks. However, for non-network options with national membership distribution, schemes’ countervailing power remains relatively weak. The schemes’ ability to negotiate alternative reimbursement models that encourage risk and information sharing remains weak.

Discovery Health and Medscheme’s presentations highlighted that supply induced demand (SID), due to an oversupply of beds per risk adjusted insured population, has had a greater negative influence than issues of market concentration. Both administrators indicated that the disproportionate increase in the number of new beds compared to the insured population, particularly in areas of adequate supply, has had a significant impact on SID and scheme expenditure. Medscheme expressed its concern that the significant number of new acute and day facilities, planned from 2019 will exacerbate SID. The hospital groups on the other hand viewed divestiture and placing cap limits on hospital market shares as highly intrusive interventions that could adversely impact on future investments and employment opportunities in the private hospitals sector. Several stakeholders, including Medscheme, highlighted that the current fragmented and unstructured licensing regime has contributed significantly to issues of SID and recommended that a coordinated centralized national licensing framework be expedited. Support was expressed for the proposed data submission and reporting framework with reports being made readily available to the public.

As outlined in the Medscheme approach to hospital negotiations document submitted to the HMI on 1 April 2019, we concur with the HMI’s concern regarding SID and support its recommendation to establish a Supply Side Regulator for Healthcare. We support the proposal regarded healthcare capacity planning, a centralised national licensing framework for all health establishments and an enhanced practice code numbering system. However, we anticipate that these initiatives will take some time to implement and in the interim our client schemes will continue to be unfairly exposed to above-inflation increases in hospital expenses in the face of SID particularly as it relates to new facilities, expansions of facilities and new services. To proactively address and manage this risk, several of Medscheme’s client schemes have taken the initiative to limit their annual tariff negotiations to apply to facilities operational at the time of negotiations. Historically new facilities would automatically default onto a hospital group’s negotiated tariff files. However, the 2019 negotiations stipulated that any new facility, either built or acquired, that opens in 2019 onwards would not automatically be added to a given hospital group’s negotiated tariff files for that scheme, but would rather be defaulted to each scheme’s non-negotiated scheme tariff rate. The non-negotiated scheme rate is typically significantly lower than the negotiated rate. Additionally, the hospital groups are required to inform Medscheme of any plans to acquire and/or open a new facility. The hospital groups are also requested to provide information including administrative, demographic and service detail requirements, to assist Medscheme’s assessment of the facility.

The Medscheme hospital negotiations strategy is not intended to create a barrier to new entrants in the market, rather to proactively manage the oversupply of beds in specific geographic areas. In principle, Medscheme is not opposed to the HMI recommendations regarding divestiture and the limitation of market share caps. The challenge that the HMI faces is that, in our opinion, divestiture in the hospital market should have happened earlier, and in the current market dynamics the deconcentration (although not very significant) has come at the expense of SID. As was reiterated in our detailed commentary on the report, we strongly believe that the HMI can strengthen this set of recommendations to ensure that the current hospital market concentration and related dynamics are decisively dealt with henceforth. We believe that these and other recommendations would benefit from a clearer indication of timelines within which actions should have been implemented to effectively and appropriately address identified issues.

Given the time lapse between the initial analyses and that further developments have occurred in the market in the period 2014 – 2019, Medscheme recommends that the HMI considers reviewing the hospital market concentration analyses and associated recommendations based on current and projected expansions, specialties, growth, mergers and acquisitions.
Medscheme reaffirms its position on the existence of SID in the facilities market. This is supported by the moderate levels of the hospital market concentration as demonstrated in the revised HMI analyses as well as in the presentation that we provided at the seminar. To address SID, we support the need for the expedited implementation of a consistent and centralised national facilities licensing framework. We also support the need for a better coordinated and structured data submission and reporting framework with regular reports published in the public domain. However, we would like to reiterate that the HMI cautiously considers the cost impact associated with the development and implementation of such systems.

4. Funders’ market concentration and countervailing power seminar

Medscheme notes that the HMI technical analyses indicates that the funder market concentration index was approaching 3,500 compared to the facilities market concentration index which was approaching 2,500. Furthermore, we note that a number of the stakeholders argued that strong funders are critical for strategic/active procurement of healthcare services and countervailing power against large, powerful hospitals and other provider groups (i.e. specialists and pathology services). We support this assertion fully, and our active purchasing function in this area is reflected in the supplementary document that we have previously submitted to the HMI outlining Medscheme’s strategy in terms of annual hospital negotiations for and on behalf of some of our clients.

In analysing the HHI for funders, Medscheme would like to caution that in the funding industry, many of the large schemes undertake their own negotiations with hospitals and hence the implications of the relatively high funder concentration index of 3,500 are exaggerated on paper. For instance, in the Medscheme stable GEMS, Polmed, Bonitas, Medshield and Hosmed conduct their own separate negotiations while it is understood that Discovery negotiates on behalf of all the schemes under it. This clearly creates an uneven power balance in the negotiation process which benefits those negotiating collectively.

We support the notion of product (benefit options) simplicity as argued by many stakeholders, such as CMS and GEMS. However, we believe that product simplification must be accompanied by equally important interventions to ensure member value. These include active member education programmes to empower members about benefit offerings and how best to get value by utilising contracted providers. Medscheme believes that value based contracting linked to ARMs (with a progressive reduction in providers’ reliance on fee for service as a preferred reimbursement tool) will contribute towards ensuring that funders and administrators provide better and sustained outcomes based value for members going forward. This requires some urgent regulatory interventions, on the parts of both the CMS and HPCSA, in terms of creating an enabling environment that supports the use of multidisciplinary teams and makes providers more accountable for member health outcomes.

The consideration of regional schemes and/or benefit options in terms of addressing funder concentration is noted. We support the proposition that it must be an option that is open to existing schemes and new entrants. This is the only way fair competition would be promoted across all role players and it would potentially create a growth area for the medical schemes industry. This should be carefully considered taking into account the CMS’ strategy around consolidation of medical schemes and the possible finalisation of the Low Cost Benefit Option framework.
Medscheme reiterates its position that there is an urgent need to make decisive policy interventions regarding the manner in which healthcare tariffs are negotiated and agreed to within the private health care market. Otherwise, very little progress will be achieved to promote better competition and fairer tariffs determination processes that actually ensure efficiency in service provision, value for money and affordability for members. Therefore, we strongly recommend that the panel strengthens the provisional report’s recommendations with regards to the tariffs negotiation processes in the private healthcare market and the timelines within which such changes should be implemented. This is particularly the case with regards to the HPCSA’s review of its ethical rules to enable the faster development and testing of ARMs and multidisciplinary team initiatives, as well as the roll out of associated institutional and organisational elements to support the implementation of such interventions.

5. Excessive utilisation and supplier induced demand seminar

During the course of the seminars, stakeholders raised a number of concerns around the HMI’s technical analyses, modelling and other related methodologies – without attempting to rehash all the concerns, these included that (i) the HMI utilised narrow, incomplete and incorrect datasets and samples; (ii) there was double categorisation of data and use of incomparable OECD countries; and (iii) there was an inadequate assessment of whether initial facility supply was necessary or unnecessary, among many others. There was also a general consensus that the data that the HMI relied for its analyses was based on outdated data and that the industry had reasonably changed since the period of the analyses focus and data for the period 2014 – 2019 must be included as part of an updated analyses process.

Medscheme notes the methodological and related shortfalls noted by a number of stakeholders with regards to the HMI’s technical analyses and that because of these shortfalls, it is inappropriate for the HMI to make such far-reaching, and sometimes intrusive recommendations. We are of the view that the data and methodological concerns remit further engagements and that the technical analyses can be better enhanced through the inclusion of more updated data that includes the period 2014 – 2019. An updated analyses would potentially address many of the objections/concerns outlined and could actually enhance the quality of the provisional findings and recommendations.

In our opinion, as was presented by some stakeholders, SID is prevalent in the private healthcare market and is driven by a market dynamic that is related to regulatory and policy failure. The HMI analysis is the most insightful and detailed explanation of supplier-induced demand we have seen on the private healthcare market. The close proximity within which specialists and hospitals operate has been demonstrated to consistently have a bearing on how medical scheme members access and utilise hospital services including admissions. This is actually supported by the conclusions in Dr Soderlund’s presentation where he concludes that the evidence available to the Panel proves that more doctors in a geography is associated with a higher rate of admission, that doctors are in position to recommend treatment or not and impact over servicing incentive, that hospitals do indeed benefit from higher admission rates, and that there is a relationship between market concentration and SID. All these statements are true of the South African private healthcare market and were in principle affirmed at the Facilities’ Concentration and Remedies seminar.

It is true that the current structure of the Prescribed Minimum Benefits (PMBs) regime (and the lack of review of the PMBs by the CMS despite the law stipulating that they should be reviewed every two years) has significantly contributed to the high hospital admission and utilisation rates observed for the sector. Indeed, there are other factors that continue to drive SID and excessive utilisation rates, and these include the fragmented and unstructured approach to licensing facilities and services, the lack of an adequately regulated tariffs process, the dominance of fee for service as a reimbursement tool of choice among providers, inflexibility
within the HPCSA to review its ethical rules in a manner that supports ARMs and multidisciplinary team innovations.

We concur with the conclusions of many of the stakeholders that participated in the seminar in that the solutions to the problem of SID lie in a mix of interventions. These include development and implementation of provider-driven and patient-centric ARMs (such as that presented by South African Society of Anaesthetists), the urgent need to review the HPCSA rules around employment of doctors, teamwork and multidisciplinary teams, implementation of a consistent, structured licensing regime and mandating the collation and transparent reporting of quality and outcomes measurements for all industry participants. Medscheme fully supports the preliminary conclusions contained in the Seminar Discussion Note.

6. Conclusion

Medscheme appreciates the opportunity to engage the HMI on the various elements outlined in the provisional findings and recommendations report of July 2018.

We urge the HMI to consider strengthening a number of the recommendations as regard to dealing with hospital market concentration, particularly the evident oversupply that is already in existence in specific geographical areas. Medscheme is of the view that without any decisive intervention regarding the market shares of the hospital groups both regionally and nationally, and without adequately addressing changes in the manner in which tariffs are negotiated and agreed to within this environment, very little progress will be achieved to promote better competition and fairer tariffs determination processes. Lack of a definitive intervention in this area will be counterproductive to the already weak countervailing power of medical schemes’ and adversely impact members.

On the matter of tariffs negotiation, we recognise that the current gap in the determination and setting of tariffs leads to member uncertainty and exposes many individuals and households to unplanned co-payments and balance billing. While we support the proposals on the implementation of some sort of tariff regime, we are of the view that of the three alternative approaches outlined in the provisional report, the option on regulatory pricing would be the most protracted and risky option to implement. We have always been of the position that a reference tariff that is transparently published is preferred and in the absence of such a solution, the option for a multilateral tariff negotiation forum where stakeholders conduct tariff negotiations under a framework determined by an independent regulatory body (and where the processes reach deadlock, the regulator will refer the dispute to an independent arbitrator for final decision) is our preferred framework. We also would support a bilateral negotiation framework that is not exclusive to corporates as this would potentially contribute to stimulating improved ARMs in the healthcare market. These solutions have the potential effect of removing the imbalances that characterise the current tariffs negotiations processes, provided that it is an adequately transparent process and impartially implemented.

Medscheme remains open and willing to participate in initiatives in order to share knowledge, experience and the context of lessons learnt as part of enhancing the HMI process and final report.