SEMINAR NOTE
Overview of HMI Funders' market concentration and remedies

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INTRODUCTION

1. This note provides further context for the purpose and objectives of the HMI hosting a seminar for stakeholders on the funders’ market. The seminar will be dealing with the countervailing power of schemes vis-à-vis providers of health care, funder market concentration, and the prevalence and effectiveness of DSPs.

2. The seminar will take place on the 10th of April, 2019 following immediately from the Facilities’ market concentration seminar on the 9th of April, 2019. These seminars are interconnected and some of the discussions will be overlapping.

3. The previous issues paper which was published late 2018 with the announcement of the seminar has provided context and background for the funders’ seminar. This note will build on the previous work by focusing on the questions posed by the HMI in relation to the proposed recommendations.

4. The information presented below expands on the HMI’s views and where relevant includes references to the input received from stakeholders. In the interest of brevity, references to submissions in this note are by no means meant to be comprehensive.

TOPICS / QUESTIONS

5. The HMI has previously identified a series of questions to be addressed during the seminar. These questions, alongside additional questions raised by stakeholders will be further unpacked in this note as guidance for the seminar. For each question the underlying findings will be presented alongside the views submitted by stakeholders before outlining the HMI’s proposed recommendations to address the concern.

TOPIC 1: COUNTERVAILING ROLE OF FUNDERS

6. The HMI has found that concentration in the funders market can be divided into its effects on what the provisional report called the downstream market, when providing coverage and services to beneficiaries, and in the upstream market, when procuring services e.g. from practitioners and facilities. In the coverage market, the HMI is of the view that there is limited competition between schemes on factors that define the value of medical scheme cover (in terms of both premiums and extent of coverage). And in the upstream procurement markets, the HMI has observed limited implementation of alternative reimbursement models (ARMs) to contain expenditure, utilisation, and encourage value-based contracting. The HMI believes that more should be done by funders in terms of applying effective competitive pressure on providers to increase efficiency, effectiveness, and quality of healthcare provided. This should be done for the benefit of the beneficiary and ultimately the patient.

1 The HMI’s previous notice is available online at: http://www.compcom.co.za/wp-content/uploads/2018/12/Final-Funders-Seminar-invite-200219.pdf
7. The HMI believes that there are failures in regulation, governance and adverse incentives associated with the current market structure that contribute to this lack of competition and innovation. Specifically, a profound lack of transparency (both on scheme options and quality of outcomes), a lack of accountability of schemes to members, and a failure of governance which aligns scheme interests too closely with those of administrators.

8. With respect to the lack of transparency, consumers simply do not know what they are purchasing and therefore cannot hold funders accountable. A number of stakeholder submissions have indicated support for the finding that benefit options are too complex for consumers to understand, let alone compare across providers. Despite this, some stakeholders maintain that benefit complexity is an unavoidable result of the varying needs of beneficiaries and that the large number of options increases consumer welfare. Further, that this complexity can be mitigated through the use of brokers.

9. Be that as it may, the HMI has found option differentiation to be a tactical response by medical schemes to the absence of a risk adjustment mechanism. Absent this mechanism, but in an environment of community rating and open enrolment, it becomes necessary to attract younger and healthier members i.e. funders are incentivised to compete on risk selection. The complexity may also be a characteristic of an oligopolistic market strategy to avoid direct price competition. Irrespective of the underlying reasoning, the HMI’s position is that individuals are unable to compare options effectively which restricts the consumers’ ability to discipline funders through switching. Lacking this disciplining force, medical schemes have reduced incentives to contract effectively or innovatively with providers.

10. As an inquiry, the HMI is seeking to address any market structures that may impede greater pro-consumer competition amongst medical schemes. In this regard, in order to address the issue of transparency on options, the HMI has proposed a standardised benefit package to be developed that must be offered by all schemes (the obligatory ‘base benefit option’). The HMI has also recommended that, alongside the standardisation of benefits, a risk adjustment

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2 See for example: HFA: “The HFA shares the concern that members are confused by multiple benefit options and lack of comparability.”
Nehawu: “NEHAWU observed that challenges faced by consumers includes not knowing which option to choose from based on the number of options offered by the funders. There are currently approximately more than 270 options that consumers are supposed to choose from.” And Profmed: “Profmed agrees that medical scheme cover has become unnecessarily complex.”
3 See for example: GEMAS: “…has the view that one size fits all approach is not the best option given the varying needs of members.”; and
DH: “Product complexity arises from the need to meet widely varying medical needs and financial constraints, as well as from the need to comply with complex PMB legislation and to ensure ongoing affordability in the face of high claims inflation.”
4 See for example: DH “Our experience suggests that many members are able to select appropriately based on their medical and financial needs, often with the support of a broker.”
mechanism must be implemented. The HMI believes these recommendations will remove schemes’ incentives to compete on risk factors and will instead encourage schemes to compete on value for money and innovative models of care. Both these recommendations have received support by the majority of stakeholders.\(^5\)

11. In terms of addressing transparency on outcomes, the HMI has recommended outcome registration and reporting in order to facilitate contracting on value for money instead of FFS only. The requirement for quality and outcomes measurement is largely supported by stakeholders with the majority of concerns raised being practical in nature.\(^6\) E.g. whether a new body is required, funding of said body, and how these functions may overlap with existing structures.\(^7\)

12. In terms of accountability and governance, the HMI has found there to be few incentives to ensure that scheme employees, trustees and principal officers always act in the best interest of consumers. And even if they tried, administrators generally have far more analytical capacity and ‘know how’ than schemes. These findings have found little support amongst funders,\(^8\) but several other stakeholders do acknowledge that scheme governance is problematic and should be improved.\(^9\)

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\(^5\) Regarding standardised benefit options, see for example: GEMS: “GEMS members confirmed the need to reduce the number of benefit options.”

CMS: “The standard benefit option forms part of the current regulatory work the CMS has prioritised, and is in line with the MSAB.” And

HFA: “Support a benefit option which is standard across all schemes.”

Regarding RAM: Actuarial Society: “The Society welcomes the opportunity to provide the HMI with the analytical support required to develop such a model. Standardised benefits are required for the implementation of a RAM.” And,

DH: “DH supports the implementation of a RAM to level the playing field between schemes…”

\(^6\) See for example: Netcare: “There should be a more comprehensive system of reporting outcomes and that practitioners and facilities should work in conjunction with one another with this objective.” And, “GEMAS supports the recommendation that standards be developed to measure cost effectiveness.”

\(^7\) See for example: Massmart: “The establishment of three bodies will have cost implications (SSRH, OMRO, RAM). This raises an issue of affordability.”

Makoti: “Clarity on funding is required as it will result in an increase in non-healthcare expenditure if funded by medical schemes.” And

DH: “Improved quality outcome data is only one of a range of interventions available to improve consumer empowerment. The establishment of a new and separate entity to measure and report on quality outcomes is not necessary given the existence of organisations such as HQA, COHSASA and CMS who report on quality in a fragmented way.”

\(^8\) See for example: DH “In our experience, the Trustees of DHMS and of all of our restricted scheme clients take their fiduciary duties to protect the interests of the scheme and its members extremely seriously.” And

Profmed: “Profmed wants to point out that is holds its administrator accountable, which results in penalties being payable for any administrative failures.”

\(^9\) See for example: BHF: “The HMI report identifies inadequate / poor oversight by board of trustees in the management of scheme. Strongly related to this is the significant skills gap and capacity between the board of trustees and the administrators. The HMI rightly identifies this as a problem which often leads to sub-optimal health outcomes as well as cost-ineffective healthcare provision.”
13. In order to improve governance, the HMI has recommended a number of interventions. These include measures to address transparency:
   a. Administrators to report on the value and outcomes of all ARMs, PPNs, and DSP arrangements;
   b. That administrators’ comparative performance on a number of metrics are publically reported and measured against a national average; and
   c. That the CMS produce a biannual report which reports on the value of managed care services, the extent of risk transfer, and savings pass-through;

14. Measures to address scheme employee (e.g. principal officers and trustees) performance. Notably:
   a. That remuneration packages be linked explicitly to the performance of schemes, measured by value delivered to members. This is closely linked to the implementation of the CMS remuneration framework, which the HMI supports; and
   b. A set of core competencies for trustees also needs to be developed, taking into account the diversity of expertise required.

15. And, measures to encourage beneficiaries to hold schemes to account, through interventions designed to increase AGM participation. In this regard, the HMI is aware that the MSAB provides for election of trustees only at AGMs which may contradict the HMI’s recommendation on this point, particularly the use of technology for absent members. The HMI believes its recommendations will facilitate greater member participation but welcomes discussion at the seminar regarding this point.

16. The recommendations designed to improve transparency and facilitate greater competition are generally supported by stakeholders who suggest metrics should be clearly defined, comparable, considerate of commercially sensitive information, and should not allow for any marketing spin.\(^\text{10}\) Some stakeholders have indicated that many of these metrics are already reported by administrators to schemes,\(^\text{11}\) however this argument misses the competitive benefits that could arise from making this reporting standardised, comparable and public. Legitimate concerns have arisen regarding the complexity in measuring some of these metrics which could be addressed through industry participation.\(^\text{12}\)

\(^{10}\) See for example: MMI: “Care would need to be taken to ensure that the mentioned reports on values and outcomes are subject to unambiguously prescribed or agreed standards and methodologies in order to avoid “marketing angles” or “spin”. “ And DH: “DH supports the call for public reporting of the value of ARMs, PPNs and DSPs, provided that such reporting always protects commercially sensitive information, and does not undermine competition nor inhibit contract negotiation.”

\(^{11}\) See for example, Universal Administrators: “The quality of outcomes is extensively reported on and demanded of the administrators by the well governed schemes.”

\(^{12}\) See for example, Actuarial Society: “The calculations of Managed Care and SID are technically complex. Increased transparency must be accompanied by clear guidelines for these calculations (or mechanisms to develop such guidelines)”
17. Regarding changes to the remuneration framework of principal officers and trustees, such measures seem to be generally supported by the industry. The CMS has indicated that in addition to remuneration, training of trustees should be improved both in terms of content and attendance. Further, the CMS supports a stringent penalty system which will include personal liability for negligent or fraudulent activities.

18. The question for stakeholders to be discussed during the seminar is whether HMI’s above recommendations will result in their intended outcomes. In other words, will the base benefit option and improved governance have the effect of reinforcing the countervailing role of funders and re-align schemes and administrators interests to beneficiaries? If not, what more should be done?

TOPIC 2: ALIGNING INCENTIVES

19. Continuing with the theme of re-aligning incentives, a submission from the University of Fort Hare contains a potential remedy to address the HMI’s concern regarding the artificial distinction between non-profit schemes and for-profit administrators.

20. The HMI is of the view that this false divide is problematic and disturbs incentive structures and prevents the alignment of interests between members, trustees of schemes, administrators / MCOs. In it’s submission, the University of Fort Hare has proposed legal measures to impose fiduciary duties on administrators in order to align the interests of administrators to the interests of the schemes under administration, and in particular to the interest of its members.

21. In summary, the HMI’s recommendations seek to empower beneficiaries to hold schemes accountable, schemes to hold administrators accountable, and the CMS to oversee all the funders. Instead, the University of Fort Hare proposes that, as is done under RFA in Botswana and ERISA in the US, the fiduciary duty imposed on scheme principal officers and trustees be explicitly applied to administrators and service providers. This would effectively result in the alignment of the interests of administrators, schemes, and beneficiaries and provide legal recourse should this duty not be adhered to.

22. The respondent is of the view that such an intervention will have a number of positive implications for consumer welfare through, for example: a. Improving accountability as both administrators and medical schemes will be legally expected to act in the interest of the scheme and members;

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13 See for example: BHF: “The BHF agrees with the HMI recommendation that the trustee and principal officer remuneration should be linked to performance, as well as the contracts of administrators be linked to metrics.” and
b. Scheme and administrator interests will be aligned and this alignment will be legally enforceable. Just the potential to be held liability for a breach of fiduciary duty will incentivise this alignment; and

c. Clarifying the line of accountability when administrators make decisions on behalf of trustees.

23. The HMI has noted that DH has chosen to talk to the University of Fort Hare proposal in its seminar presentation.

24. Fort Hare’s submission has been published on the HMI’s website (along with all other public submissions) and a link to this submission has been provided in the footnote below. Participants in the seminar are invited to provide input as to whether the proposal has merit, whether it would be difficult to practically implement, and what other solutions can be proposed to address the issue of incentive alignment.

TOPIC 3: UNEVEN DISTRIBUTION OF MARKET SHARES

25. The unchallenged dominance of a small number of large funders is a concern to the HMI. Particularly given that the benefits accruing to the larger funders have led to a positive feedback loop which will continue to entrench their position. In a market-led environment, stakeholders should be exposed to competition in order to perform optimally for the benefit of the consumer and for the industry to remain competitive in the long-run.

26. Submissions by hospital groups have pointed to a lack of structural remedies to address concentration in the funders market. Given similar concentration findings in the facilities market, and associated structural remedies to address these findings, the concern notes there is a lack of similar structural remedies to address the findings of funder concentration. Netcare has proposed an addition topic to discuss the balance in recommendations between funders and facilities.

27. The HMI recognises the apparent incongruence but is of the view that, despite a similar finding of concentration, the differences in the proposed remedies are appropriate. The difference in remedies reflects the view that competition authorities the world over are less concerned with concentration which results in buyer power as, from a competition perspective, it is theoretically more likely to result in lower prices for consumers. The HMI nevertheless remains concerned with the potential anti-competitive outcomes arising from such concentration, where a lack of

14 The University of Fort Hare submission is available online at: http://www.compcom.co.za/wp-content/uploads/2018/12/University-of-Fort-Hare.pdf

15 See for example, LHC: “Despite the adverse findings in respect of medical schemes market, the HMI has not proposed any structural remedies to address the concerns raised regarding concentration, market power and lack of new entry – as it has done for the private hospital services market.”
effective competition amongst funders on the downstream markets prevent the lower prices achieved upstream to be passed-on to consumers. Which then results in significant and persistent administrator profitability. Although the lack of corrective competition is a concern to the HMI, the HMI believes that reducing buying power is not the solution; increasing competition on the downstream market of funders is.

28. While the HMI has stated its position, it nevertheless wishes to engage stakeholders on whether this approach is correct, and whether - in the absence of structural remedies to intervene directly in the market share of one or more of the funders which would effectively reduce bargaining power – the transparency and incentive alignment remedies of the provisional findings report are sufficient. And whether other measures are necessary, available and feasible to make sure that positive results of bargaining power on the procurement markets are passed-on to beneficiaries through significantly lower premiums – and not to supernormal profits for shareholders. What is the role of MCO’s in this regard?

29. Furthermore, the HMI is of the view that a recommended multilateral tariff-setting mechanism for the industry, one which includes funder/facility negotiations, will put more pressure on baseline FFS tariffs and shift the competitive paradigm towards innovative value and outcomes based ARM agreements, including the quality of healthcare outcomes and utilisation.

30. To further encourage competition, the HMI has recommended that regional based schemes are allowed to enter the market. The difficulties associated with smaller schemes being effective competitors, namely small risk pools and power imbalance in tariff negotiations, will be mitigated through allowing reinsurance, the implementation of the REF, and tariff-setting mechanism. The ability to focus on a smaller beneficiary pool could result in schemes adopting innovative and cost-effective models which uniquely address those particular demographics.

31. Removing the requirement that a new entrant has to offer its services nationally will reduce the barriers to entry, encourage and reward nimble entrants who are willing to adopt innovation, and, in time, may lead to smaller regional schemes being able to enter and compete on a national level.

32. While these measures, alongside the HMI’s other proposals, may serve to increase competition in the funders market to an extent, the question is whether that will be enough to seriously address the current imbalance and dominance attributable to a small number of administrators and schemes. Are additional measures, such as levelling the playing field for administrators – either allowing them all to negotiate on behalf of all of their restricted schemes, or to forbid all of them to do so a solution or contribution? What other behavioural and structural measures are missing?

TOPIC 4: NETWORKS AND DSPS
33. The HMI had expressed a concern that, despite being obviously beneficial, the adoption of provider networks by funders had been limited. The HMI is encouraged to note that the prevalence of networks, as reported by some submissions, has been increasing over time.

34. The HMI has made a number of recommendations in respect of networks in order to further encourage adoption, sustainable risk-transfer, value based contracting, and ensuring no anti-competitive effects arise. Submissions from stakeholders have highlighted that the wording used in the provisional report regarding the ‘any willing provider’ principal may have been ambiguous. To clarify the HMI’s position; provider networks which are contracted on a purely FFS basis should be open to any willing provider who is able to match the negotiated tariffs. Networks which are contracted on ARMs which include additional metrics such as value, volumes, quality, etc. require selective contracting in order to be effective and therefore are not required to be open to any willing provider. The HMI would like to invite input from stakeholders during the seminar on the issue of the ‘any willing provider’ principal versus the need to selectively contract in order to reward network members for participation.

35. It should be noted that the any willing provider principal would still require the provider to agree and sign acceptance of the terms of the network agreement.

36. In terms of the requirement that networks be established through open tenders, the HMI acknowledges the concerns raised by stakeholders regarding the practicality, expense, and technical requirements of running tenders every two years. In this regard the HMI is of the view that indefinite contracts prevent entry, do not incentivise continued innovation, and reduce competition on efficiencies. Further, provider networks are often opaque on the terms and conditions for acceptance, preventing otherwise amenable providers from improving on the required metrics. The HMI would welcome input regarding:

   a. To improve transparency and competition, whether networks should be formed only after an open tender process, and
   b. What is a suitable timeframe for the duration of these network agreements which will allow for the benefits to accrue but also avoids complacency in the market?

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16 See, for example, LHC response to HMI Provisional Report, paragraph 4.5.3.3.3

17 See, for example, DH: “Paragraph 155.6 is contradictory as it stipulates that any provider willing to match the price must be included, yet it goes on to say selective contracting based on volumes, price and quality must be allowed for ARMs to be effective.”

18 See, for example, Universal Care: “Universal does not agree that DSP partners should only be appointed after an open tender process. To conduct tenders will require resources and this will increase the non-healthcare expenditure of a medical scheme. Also, some healthcare providers may not have the time or experience to complete tender documents.” And Tiger Brands: “In principle it is desirable that DSPs should be appointed after an open tender and results lodged with the SSRH. However, this is not practical for restricted schemes as it will be time consuming and cumbersome and therefore not feasible.”
37. Networks can be effective in dealing with health care delivery inefficiencies at the local level, even in reversing what the report found to be perverse outcomes of local facility competition. Specifically, the HMI has found evidence that hospitals located in concentrated areas may exhibit lower than expected admissions and expenditure relative to hospitals facing greater local competition.\(^\text{19}\)

38. The HMI has theorised that this is potentially as a result of inefficient competition arising from facilities competing for doctors, who bring reputation, patients, and admissions. This inefficient competition does not occur when hospitals are local monopolists. The HMI believes that effective use of networks should enable funders to focus hospital competition back to pro-consumer metrics, such as: price, volume, value, and outcomes.

39. The questions the HMI would like answered are:
   a. Whether DSPs already delivering on this promise and what can be done to make them more effective in this regard; and
   b. what other impediments exist and what further recommendations could alleviate these concerns.

CONCLUSION

40. The HMI has received support and criticism from stakeholders for a number of its proposed recommendations on the funder market. The purpose of the funders’ seminar is to allow for the HMI to engage in meaningful participation with stakeholders on these issues. We have identified some of the main issues which have drawn comments and inputs from a number of stakeholders as a preliminary guidance to the seminar. The HMI hopes to profit from a robust exchange of views between stakeholders during the seminar.

\(^{19}\) See HMI provisional report, page 239