The Council for Medical Schemes' submission on the Health Market Inquiry (HMI) Seminars (9 – 12 April 2019)

2 May 2019

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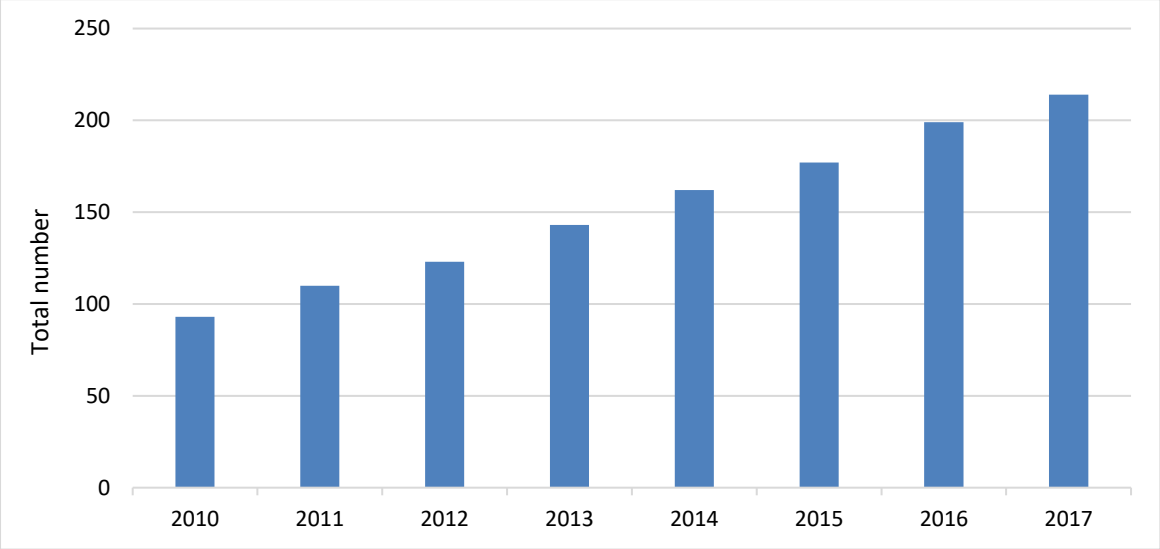
1. Facilities Market Concentration and Remedies

The Council for Medical Schemes (CMS) has for many years observed and reported on concentration issues within the private hospital market. This concentration has increased substantially over the past years although there has been a notable increase in the number of National Hospital Network (NHN) affiliated hospitals, especially from 2010 until recently (see Figure below).

Figure 1: Growth in number of facilities between 2010 and 2017



Source: NHN data (2017)

Although improving over time, NHN members continue to have limited bargaining power compared to other big hospital groups. The approval of the NHN exemption application from Section 10 (1) (b) of the Competition Act has been one of the mechanisms that has enabled this hospital network to gradually grow its national footprint.

This footprint has enabled NHN hospitals to be contracted through Designated Service Provider arrangements including within Efficiency Discounted Options (EDO). We have noted a slight diversification within EDO contracting where other hospital groups like Clinix and NHN have been contracted. This was not the case in the past since most of the EDOs contracts preferred Netcare, Life and Mediclinic due to the three hospital groups' national footprint.

The EDO framework as approved by Council is geared towards incentivizing medical provider competition, based on "efficient factors". To realise the efficiency gains, which medical schemes ultimately pass-through to members in the form

of discounted contributions, medical schemes must only appoint cost-efficient medical providers as their designated service providers. The intended beneficiaries of the discounted contribution rate are a group of beneficiaries with an adverse risk profile, mainly the sick and elderly. The ultimate aim of the EDOs exemption framework is to bring down the cost of healthcare by permitting medical schemes to offer premium discounts to beneficiaries who voluntarily opt for more cost-efficient service provider arrangements. The Medical Schemes Amendment Bill 2018 proposes the regularisation of the EDO arrangement by allowing schemes to extend a uniform percentage discount to members who choose to have healthcare services provided by a designated service provider.

As at 31 March 2018, there were 12 (nine open and three restricted) schemes offering efficiency-discounted options (CMS,2018). The schemes include Momentum Health; Discovery Health Medical Scheme (DHMS); Fedhealth Medical Scheme; Bonitas Medical Fund; Thebemed; Compcare Wellness Medical Aid Scheme; Medihelp; Bestmed Medical Scheme; Resolution Health; Government Employees Medical Scheme (GEMS), MotoHealth Care and Old Mutual Staff Medical Aid Fund. Overall, EDOs have a significantly lower average age compared to non-EDO packages (CMS,2018). Similarly, claims ratio for EDOs was lower than that of non-EDOs. The financial performance of EDOs was better than that of non-EDOs, with EDOs contributing 32.3% of the total surplus, even though these options accounted for only 20% of the total membership (CMS,2018). We believe that there are valuable lessons to be learned in terms of coordinated care and value-based contracting within EDO contracting.

As an illustration to the above, Table 1 and 2 below provides a case study on EDO contracting by two large medical schemes between different hospital groups in 2017. A comparison of these schemes shows that for Scheme B, the preferred provider was NHN facilities whilst Scheme A preferred Life and Mediclinic hospital groups and other hospital providers were only included as “fillers”. Fillers are often considered in cases where the preferred hospitals do not have sufficient coverage.

In certain instances, we noted that NHN was appointed on an anchor status for acute and psychiatric services by a few schemes while some NHN day clinics were also selected to participate in network arrangements since 2016. These appointments served to improve the NHN footprint to satisfy access requirements for schemes, while at the same time responding to competition and cost-effective service delivery. Notwithstanding this slight improvement, we are aware that several other small hospitals continue to struggle, since some of them are appointed on an anchor status, with a majority of the appointments being that of a ‘filler” status within network arrangements and reimbursement determination.

It needs to be acknowledged though that whilst some medical schemes might consider to enter into contractual relationship with other hospital groups as opposed to the three big ones, they also need to satisfy access requirements as per Designated Service Provider (DSP) legislation, this is where a well-established national footprint becomes an advantage for the big hospital providers. This context has been well articulated by one of the small independent hospital groups, which stated the following*"…when DSP arrangements are limited to few big providers it often leads to non-DSP providers exiting the market in the long term." when these service providers exit the market, the private healthcare delivery space becomes more concentrated which will lead to more challenges with regards to health inflation in absence of the statutory pricing authority." (Independent hospital group CEO, 2015)*

Table 1: EDO contracting from Scheme A (2017)

Region	Clinix Group	Life	Mediclinic	Netcare	NHN	Other	Total
Eastern Cape		9 (100%)		1 (25%)			**10 (67%)**
Free State		1 (100%)	3 (100%)		1 (14%)		**5 (36%)**
Gauteng		18 (90%)	11 (100%)	1 (3%)	4 (13%)		**34 (34%)**
KwaZulu-Natal		8 (80%)	4 (100%)	3 (25%)	2 (29%)		**17 (49%)**
Limpopo			2 (67%)				**2 (33%)**
Mpumalanga	1 (100%)	3 (100%)	5 (100%)		1 (33%)		**10 (77%)**
North West		2 (100%)	2 (67%)				**4 (29%)**
Northern Cape			3 (100%)		1 (100%)		**4 (100%)**
Western Cape		7 (100%)	16 (100%)		3 (30%)		**26 (62%)**
Grand Total	**1 (17%)**	**48 (92%)**	**46 (96%)**	**5 (8%)**	**12 (17%)**		**112 (46%)**

Table 2: EDO contracting from Scheme B (2017)

Province	Clinix Group	Life	Mediclinic	Netcare	NHN	Other	Total
Eastern Cape							
Free State				1 (33%)			**1 (7%)**
Gauteng	2 (50%)	9 (45%)	3 (27%)	4 (13%)	16 (50%)		**34 (34%)**
KwaZulu-Natal		3 (30%)		1 (8%)	1 (14%)		**5 (14%)**
Limpopo							
Mpumalanga		1 (33%)					**1 (8%)**
North West							
Northern Cape							
Western Cape		1 (14%)	3 (19%)	1 (13%)	2 (20%)	1 (100%)	**8 (19%)**
Grand Total	**2 (33%)**	**14 (27%)**	**6 (13%)**	**7 (11%)**	**19 (28%)**	**1 (14%)**	**49 (20%)**

Reflection on proposed remedies

Improvement of the hospital licensing system for the private sector is one of the major issues requiring regulatory intervention. The CMS therefore supports the recommendation on the implementation of the Certificate of Need provisions of the National Health Act. We also recommend a review of the Australian model in this regard, where the licensing process is clearly linked to needs based data submission and annual reporting on trends. In this way, the Certificate of Need will also provide necessary basis for the National Department of Health to address inequitable distribution of health facilities.

Diversification of the hospital ownership market through the licensing system will also help in addressing market barriers for new hospitals especially the introduction of private not for profit facilities, subacute facilities, day clinics and centers of excellence where there is a need. The ideal is to have some hospital licenses held by non-profit hospital groups and other cost-effective hospital types.

The Health Market Inquiry (HMI) panel also needs to ensure that there is a clear link between the Outcomes Measurement and Reporting Organization and the proposed licensing framework. This will ensure that healthcare resources are matched to the population needs to address factors such as mortality and morbidity patterns, demands and utilisation.

2. Designated Service Provider Contracting

Medical schemes are empowered by the Medical Schemes Act, 1998 (Act No. 131 of 1998) to implement several innovative contracting and payment methods aimed at incentivizing competition and efficient delivery of healthcare, especially the prescribed minimum benefits (PMBs). Whilst we agree that there are regulatory gaps and some industry factors that can constrain application of a full spectrum of active purchasing models, there are a significant number of big schemes and some medium schemes who are able to negotiate favorable contractual terms through contracting.

The experience provided in this submission is based on the CMS' observations from the medical scheme rules, a review of the tariff assumptions data as well as the complaints database. We have noted the following factors as barriers to effective contracting within DSPs:

- Provincial market concentration and provider scarcity (especially within rural provinces). This has a direct impact on competition).[1]
- Where market concentration exists, some providers face little incentive to switch to less favorable terms of contracting (i.e. use of alternative reimbursement methods or quality health outcomes driven contracting) given that they are guaranteed income and volumes.
- Guaranteed payment for all PMB related care, including challenges with up-coding and unbundling of codes to maximize income by some providers.
- Some providers refuse to enter into DSPs or any other contractual arrangements because of their dominance in the market.
- And, as illustrated in Section 1 above, for some hospital groups, there are significant barriers of entry which can only be addressed through regulatory changes.
- Regulatory gaps also distress competition within the industry.

Medical Schemes Act and DSP regulatory gaps:

- Limitations within the Medical Schemes Act with respect to monitoring and evaluation of the appointments of network providers. For example, whilst Section 15 D (c) articulates the importance of transparency and criteria informing the decisions affecting funding of care by managed care providers Section 15 E (b) does not oblige the medical scheme to use transparent criteria for selection and review of contracts.

[1], Some of these factors arise due to market structure conditions within the supply side, provider behavior and regulatory gaps

- There are also issues with regards to arm's length relationships between certain providers and medical schemes. Whilst these were identified by the HMI in the Cross-ownership and Cross-directorships Research Note, CMS has also observed several issues with regards to conflict of interest between a provider group, administrator and the medical scheme where the medical scheme has a DSP contract with the provider who hold shares within the administrator. This is the same administrator who would be expected to continually negotiate favorable contractual conditions including tariff increases on behalf of the members.
- Some medical schemes exist because they were initially established by the administrators who have been providing administrative services towards those schemes. The same schemes would be expected to assess and review those contracts according to the legislation.
- The DSP nomination legislative provision also assumes fairness in the nomination process even though a few cases have been presented to CMS and the Competition Commission about limitations with regards to pricing and lack of transparency in the bidding process.
- The Medical Schemes Act does not map a process that can be followed by non-nominated providers in instances where they have reasonable grounds of unfairness. This issue also relates to issues of competition such as the removal of barriers to entry for certain providers, and oligopoly by some.
- While the Medical Schemes Act require that managed care organisations should use clinical appropriateness, evidence-based medicine and cost effectiveness and affordability criteria for service delivery decisions; the same requirement is not properly articulated for DSPs even though it is applicable. It appears that the Act assumes that providers will always provide care in a clinically appropriate manner with the consideration of cost and quality health outcomes.
- Whilst Section 4, 5 and 6 of the Medical Schemes Act seek to encourage medical schemes to improve on their efficiency and effectiveness in healthcare funding as it relates to delivery, and the use of clinically appropriate treatment; it does not outline principles which should inform healthcare delivery for DSPs and other arrangements. Section 7 articulates the need to report on quality health outcomes although the framework to measure such is currently under review.

Proposed remedies

The CMS supports the recommendation for the establishment of the Supply Side Regulator for Health (SSRH) to undertake regulatory oversight over DSPs to ensure transparency in the selection and open tender process. This is potentially a co-regulatory function between SSRH and the CMS. CMS has made a submission to the HMI panel on this regard.

3. Single comparable base scheme option with a Risk Adjustment Mechanism

It is not uncommon for multiple payer health insurance systems like the medical schemes industry to be constrained by problems associated with risk selection, pooling challenges and/or fragmentation, cost escalation, adverse selection and moral hazard. These challenges necessitate a move towards the development of a pragmatic health financing policy to encourage effective risk pooling, firstly within the entire national health system in the context of the implementation of universal healthcare coverage system through the National Health Insurance.

As an interim measure which is also identified within the National Health Insurance White Paper, some form of risk adjustment mechanism is required to improve the stability of the medical schemes during the development and implementation phases of the National Health Insurance. Paragraph 422 of the NHI White Paper states *that "…in Phase 2 (2017/2018 to 2019/2021), as part of the amendment of the Medical Schemes Act a consideration for the establishment of an interim* ***single 'virtual'*** *pooling arrangement for schemes not funded through the State shall be made…" (DoH, 2015).* CMS therefore encourages the HMI panel to engage the National Department of Health further, including making a submission to the published Medical Schemes Amendment Bill and the National Health Insurance Bill. As we have indicated in our initial submission, Risk Adjustment forms part of the stewardship responsibility by the National Department of Health, where CMS is expected to play a supportive role.

Proposed remedies

The Council for Medical Schemes agrees with the proposal on the Single Comparable Base Scheme Option. The PMB review work currently underway seeks to move the industry towards that direction. This proposal is also partially in line with the research that CMS has commissioned on Risk Pool Consolidation. We believe that the simplification and standardisation of benefit options forms part of our current regulatory work.

We are also aware of the differences in opinion between HMI, CMS and National Department of Health with regards to policy options to address risk pool fragmentation. As indicated to the HMI panel, CMS regulatory work is expected to always be in line with Section 7 of the Medical Schemes Act as well as other policy directives emanating from the National Health Insurance Bill and Medical Schemes Amendment Bill.