

COMPETITION COMMISSION MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

Medscheme's Submission

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Glossary

Word / Phrase	Explanation
Beneficiary	A beneficiary of a medical scheme has access to benefits offered by the medical scheme and can be a principal member or his or her registered dependant (e.g. spouse or child).
Burden of disease	Term used in this report to indicate the level of morbidity or health status of a population of lives.
Case mix	Mix of medical cases and patients.
Closed schemes	Medical schemes that only employees of selected employers may join.
Cost	Used interchangeably with expenditure.
Designated Service Provider (DSP)	A health care provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.
Diagnostic specialists	As per the CMS definition. All specialists except anaesthetists, pathologists, and radiologists.
Efficiency	Providing healthcare services at the lowest claims cost, assuming clinical quality and outcomes are equal.
Expenditure	Amount of money spent, including both price and utilisation.
Input costs	Resources used to achieve a certain output.
Medscheme	Medscheme Holdings (Pty) Ltd.
Open schemes	Medical schemes that anyone may join.
Member	A member of a medical scheme has access to benefits offered by the medical scheme and typically refers to the principal member, but may also include the principal members' registered dependants.
Persal	The SA government's salary system.
Prices	Amount of money charged per unit of an item or service.
Restricted schemes	Medical schemes that only employees of selected employers may join.
Utilisation	Usage or volume of services or items.

PART A – WHO IS MEDSCHEME?

1. Our role and activities

Medscheme Holdings (Pty) Ltd (“Medscheme”) is an accredited medical scheme administrator and managed care organisation in terms of the Medical Schemes Act, 1998 (Act No. 131 of 1998). Medscheme has been offering medical scheme administration services for over 42 years and has been an active participant in the industry during this period. Medscheme is therefore in a position to empathize with medical scheme members experiencing healthcare cost escalations and we thank our client schemes for their continued support.

We trust that the Health Inquiry Panel shall formulate a set of recommendations that will enable all South Africans to join medical schemes at affordable rates while the high standards of private healthcare are maintained. Medscheme recognises that healthcare provision is not purely a commercial activity and that a variety of solutions including consumer and healthcare provider behaviour change, regulatory change and the increasing use of communication technology are essential to ensure competition in an innovative private healthcare sector.

We have been actively pursuing solutions for the medical schemes (and their beneficiaries) under our management to address the rising tide of healthcare expenditure increases and we’ve learnt many valuable lessons. Developing effective expenditure containment solutions for healthcare funding requires a unique combination of actuarial and clinical expertise. Medscheme’s Health Intelligence Unit employs such a blend of expert skills to monitor claims expenditure, fee and 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. This focus on better quality healthcare outcomes has seen Medscheme’s role of active purchaser of medical services on behalf of medical scheme clients expand. *(Note: Certain Medscheme client schemes prefer to engage healthcare providers directly.)*

Medscheme’s active purchasing includes the profiling of healthcare providers (e.g. do some doctors practice medicine in a way that consistently results in higher costs incurred for the same healthcare outcomes), the measuring of quality indicators (e.g. do some doctors’ diabetic patients get hospitalised more frequently than others despite similar health status) and the negotiation of alternative reimbursement models (e.g. per diem or daily rates have been part of our hospital agreements for years; we recently piloted global fees for hip and knee replacements which showed significant financial savings and reduced the patient’s length of stay in hospital without compromising health outcomes).

There are two strategic approaches to managing the health risk of a medical scheme, both of which depend on evidence-based clinical funding protocols and complex risk analyses:

- The first approach is **utilisation and price management**, with the overall goal to balance cost, quality and accessibility in order to ensure affordability of care for a risk pool.
- The other approach focuses on **facilitation of access** to quality and affordable care through the integration of beneficiary-directed care, disease management interventions and healthcare provider network management (based on a healthcare provider strategy).

The future of health risk management will be more and more focused on the facilitative approach, backed by utilisation and price management. Medscheme has embraced the facilitative approach and our focus on healthcare service provider relationships and the use of provider networks is evidence thereof. 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.

Medscheme's network management activities include the following:

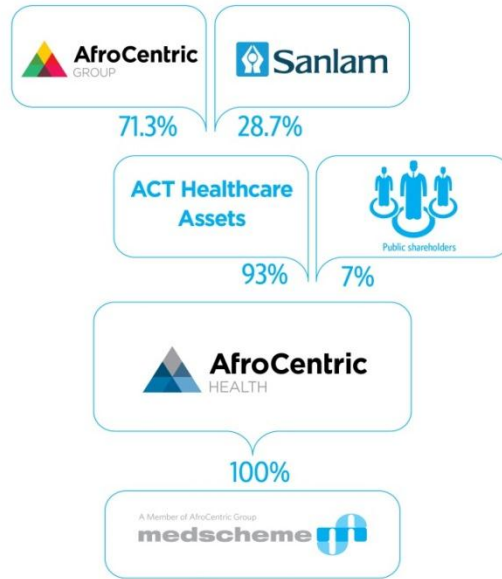
- **Pro-active engagement with healthcare service providers for at least 15 years**, aimed at establishing and sustaining sound relationships.
- **Several leadership and clinical forums** are in place (Independent Practitioners' Associations forum, specialist forum, engagement with the leadership of key societies) in order to foster relationships and develop sustainable funding models.
- **Significant experience with establishing, managing and monitoring GP and specialist networks**. The contracting of a specialist network requires close engagement with the specialist societies due to the influence they have over their membership base.
- **Existing peer management capabilities and a strong relationship with the GP Independent Practitioners' Association (IPA) leadership**. The same principles are being applied in establishing a similar infrastructure for specialists' services.
- Medscheme's **hospital network management** includes quarterly operational and strategic meetings with the various hospital groups:
 - In the operational meetings, **operational inefficiencies** that affect both the scheme beneficiary and the hospital are addressed with viable solutions.
 - Quarterly strategic meetings are also conducted with the hospital groups to address **planning, inefficiencies, funding models and initiatives** that deliver quality, affordable solutions to our medical scheme clients and their beneficiaries.

Medscheme is in the privileged position to have a **single view of a patient's medical care** for a large portion of individuals cared for in the private healthcare sector. Such an overarching perspective allows us to comment meaningfully on issues such as the fragmented care delivered in the private healthcare system as well as the quality of care being delivered.

2. Corporate structure

The AfroCentric Investment Corporation Ltd ("AIC"); indicated as the AfroCentric Group below is listed on the Johannesburg Stock Exchange and is an investment holding company.

The group acquired a majority shareholding in Lethimvula Investments Limited which owned 100% of Medscheme Holdings (Pty) Ltd. Sanlam recently announced their acquisition of 28.7% in the AIC's investment in the healthcare industry housed within ACT Healthcare Assets (Pty) Ltd. ACT Healthcare Assets (Pty) Ltd in turn holds 93% of the shares in AfroCentric Health Limited, which is 93.7% black-owned. The largest asset in the AfroCentric group is Medscheme, a wholly owned subsidiary of AfroCentric Health Ltd.



3. Geography of operations

Medscheme provides administration primarily from its offices in Florida North, Gauteng and managed care services primarily from its offices in Woodstock, Cape Town. In addition, it also offers a branch network to South African clients, namely medical schemes administered by Medscheme, as follows:



4. Geography of services purchased and consumed

Services provided by Medscheme in South Africa are purchased and consumed throughout South Africa.

5. Our experience and observations

Medscheme is contracted to deliver independent administration and managed care services in terms of the Medical Schemes Act 131 of 1998.

Medscheme has, over four decades, provided administration and managed care services to our client medical schemes, with the ultimate objective to ensure the provision of sustainable healthcare funding and quality healthcare outcomes for the three million lives under our care.

We believe that 'sustainability' is a reflection of our commitment to the scheme beneficiaries and our client medical schemes that we already serve, as well as our commitment to continually improving our systems and processes in order to make healthcare delivery more accessible to all, in a way that is financially responsible and cognisant of the needs of the communities we serve.

Our observations regarding the key trends in our section of the industry are contained in our executive summary in Part C and in a more detail in Part D of this submission.

6. Industry associations

Medscheme is a member of several industry and professional associations, and our employees are members of a number of professional bodies. Medscheme's provider management initiatives also results in active engagement with professional societies and associations.

Medscheme is represented on the following professional bodies:

- Board of Healthcare Funders (BHF)
- The Actuarial Society of South Africa

Medscheme's highly skilled and qualified personnel are members of the following professional bodies:

- Health Professions Council of South Africa (HPCSA)
- The Institute of Risk Management (IRM)
- South African Institute of Chartered Accountants (SAICA)
- South African Nursing Council (SANC)
- South African Pharmacy Council (SAPC)

Medscheme is represented on the following industry forums dealing with pertinent industry issues:

- Actuarial Society's Healthcare Committee
- The NHI Research Forum
- Private Health Information Standards Committee (PHISC)
- Industry Technical Advisory Panel (ITAP)
- PMB Costing Project

In addition, Medscheme has established formal discussion forums with several healthcare professional groups. A specific forum has been established for general practitioners, namely the Medscheme IPA Forum. Although Medscheme does not qualify to be a member, it has organised specialist engagement forums with the following societies:

- South African Society of Psychiatrists
- South African Society of Obstetricians and Gynaecologists
- South African Paediatric Association
- Ophthalmological Society of South Africa
- South African Society of Anaesthesiology
- South African Orthopaedic Association
- The Association of Surgeons of South Africa
- Association of Physicians of South Africa

Medscheme has also established interactive forums with the pharmacy, dental and optometry societies. These forums are utilised to address scheme-specific requirements, as well as industry-related issues. Medscheme engages with representative bodies such as:

- Spesnet
- South African Dental Association (SADA)
- Optometric Association
- Iso Leso
- Focus Genius.

PART B – OUR RELATIONSHIPS

A. Stakeholder	B. Nature of relationship (customer / supplier)	C. Name of firm(s) dealt with, where applicable
Medical Schemes	Supplier of administration, managed care, IT services, transaction switching services, HIV management, marketing services.	<p>Administration and managed clients: AECI Medical Aid Society, Barloworld Medical Scheme, Bonitas Medical Fund, Fedhealth Medical Scheme, Glencore Medical Scheme, Horizon Medical Scheme, MBMed Medical Aid Society, Nedgroup Medical Aid Scheme, Old Mutual Staff Medical Aid Fund, Parmed Medical Aid Scheme, SABC Medical Aid Scheme, Sasolmed, University of the Witwatersrand Johannesburg Staff Medical Aid.</p> <p>Selected administration and managed care contracts: Government Employees Medical Scheme</p> <p>Selected managed care and IT system contracts only Medshield Medical Scheme</p>
Brokers	Independent distribution channel for our open medical scheme clients; administrative support services provided.	All of the major brokerages in the healthcare market
Facilities (e.g. hospitals)	Suppliers of services to our medical scheme clients. Hospital networks set up and maintained as part of managed care service for specifically contracted client schemes. Annual tariff negotiations for specifically contracted client medical schemes.	Mediclinic Ltd Netcare Hospital Management (Pty) Ltd Life Healthcare (Pty) Ltd National Hospital Network Clinix Health Group Ltd Joint Medical Holdings Ltd
Pathology	Suppliers of pathology services to our medical scheme clients. Annual tariff negotiations for specifically contracted client medical schemes.	Ampath (Drs Du Buisson, Kramer, Swart, Bouwer Inc) Lancet Laboratories Pathcare (Drs Dietrich, Voigt, Mia & partners)

A. Stakeholder	B. Nature of relationship (customer / supplier)	C. Name of firm(s) dealt with, where applicable
Primary care practitioners (General Practitioner / Dentist)	Suppliers of services to our medical scheme clients. General Practitioner networks set up and maintained as an accredited managed care service for specifically contracted client medical schemes and via Medscheme IPA Forum.	Individual General Practitioners and with national IPA organisations: South African Medical Care Co-operative (SAMCC), Alliance of South African Independent Practitioner Associations (ASAIPA), SP Net, South African Medical And Dental Practitioners (SAMDP) and Emerging Market Healthcare (EMC), Dispensing Family Practitioner Association (DFPA)
Medical Specialists	Suppliers of services to our medical scheme clients. Specialist networks set up and maintained as an accredited managed care service for specifically contracted client medical schemes and via Medscheme Specialist Forum	Individual specialists Specialist associations Spesnet Healthman South African Private Practitioners Forum (SAPPF) Independent Clinical Oncology Network (ICON) South African Oncology Consortium (SAOC)
Allied Professionals (specify)	Suppliers of services to our medical scheme clients.	Documentation Based Care ("DBC")
Pharmacies	Suppliers of services to our medical scheme clients. Pharmacy networks set up and maintained as an accredited managed care service for specifically contracted client medical schemes. Dispensing fees negotiated on behalf of client medical schemes.	Dischem Clicks MediRite Pick & Pay Netcare Optipharm Scriptsavers Pharmacross Individual pharmacies

PART C – EXECUTIVE SUMMARY

EXECUTIVE SUMMARY OF THE MEDSCHEME SUBMISSION IN RESPONSE TO THE MARKET INQUIRY'S STATEMENT OF ISSUES

1. Introduction

On 29 November 2013 the Competition Commission (“the Commission”), in the exercise of its powers under section 43B of the Competition Act, No 89 of 1998 as amended (“the Act”), published a notice that it would conduct a market inquiry into the private healthcare sector (“the inquiry”), as well as the Terms of Reference for the inquiry. The Inquiry published a Statement of Issues on 1 August 2014 and this document represents Medscheme’s response to the Inquiry’s call for submissions.

The purpose of the submission is to assist the Panel by:

- Submitting Medscheme’s position on identified issues, particularly those where regulatory change is proposed.
- Providing relevant information sourced internally by Medscheme in support of the positions proffered.
- Providing related information of a more general nature.

Medscheme, as an administrator and managed care organisation, with more than 40 years’ experience and a meaningful client base, is in a position to provide:

- An integrated perspective on a wide spectrum of issues affecting the healthcare industry.
- A perspective substantiated by rich information sourced at population and at individual beneficiary levels that includes valuable information on stratified health risk status as well as cost and quality healthcare outcomes.
- Integrated clinical, financial, actuarial and health risk management knowledge, skills and experience honed in the South African healthcare environment.

The Medscheme value proposition is not easily commoditised. The services provided by Medscheme are not easy to replicate due to its integrated specialised capabilities such as claims administration, actuarial services, analytical capabilities, and clinical funding capabilities. The strategic purchasing of quality and cost-effective healthcare services on behalf of client schemes and their beneficiaries is complex in a healthcare system and requires such skills.

2. Factors driving cost, prices and expenditure in private healthcare (Refer section 3 of detailed submission)

There is a trend of declining non-healthcare costs relative to healthcare costs, but the increasing healthcare claims expenditure (now up to 87% of total expenditure for open and 90% for closed schemes) has the most significant impact on contribution increases. The often mentioned perspective is that private hospitals account for approximately 40% and specialists for 20% of claims expenditure.

Inefficient and fragmented primary, secondary and tertiary care in an imperfect regulatory environment is an important driver of these high hospital and specialist expenditures.

It is notable that according to the 2012 Towers Watson study, the South African private sector demonstrated a medical inflation (net of CPI) of less than 6%, compared to the majority of comparable sectors in other countries at between 6 and 10%. This indicates a global sustainability issue for private healthcare. Although South Africa has a relatively lower relative medical inflation rate (net of CPI), it is still at an unsustainable level especially considering distortions in South Africa's healthcare service provision which is still driven by demographic factors and exacerbated by a limited growth economic climate.

Current contribution increases are therefore also unsustainable in the South African context and detailed analyses of claims expenditure trends are important to identify areas where innovative solutions should be implemented.

The average increase in claims expenditure (expressed per scheme member per month) has been 10.9% p.a. for all Medscheme client schemes since 2008. Of this average increase:

- 5.5% is explained by CPI inflation.
- 0.5% is explained by ageing (also due to lack of young healthy entrants in the non-mandatory environment, a factor that may be partly addressed by regulatory change towards a mandatory environment) and gender mix changes.
- 2.6% is explained by an increased burden of disease (partly related to the ageing as well as lack of health seeking behaviour). This may be influenced by regulatory change to fund preventative lifestyle related care and rewards for positive clinical outcomes.
- An additional 1.2% is due to buy-down behaviour, i.e. decision to purchase a more affordable medical scheme option with less benefit. This may be partly influenced by proposed regulatory change that allows limited underwriting.
- This leaves a 1.1% residual. The residual is attributed to, for example and in no particular order, market concentration and dominance, anti-selection, PMBs, fragmented inefficient care partly because of information asymmetry, new technology (including the lack of regulation of the prices of medical devices) inefficient and frequent utilisation of healthcare resources including inappropriately high levels of care (such as direct access to specialists) as well as the lack of innovative multidisciplinary healthcare delivery models including the option of employing doctors by funders and firms including but not limited to, administrators and managed care organisations. These factors responsible for the residual increase in expenditure may be influenced by regulatory change.

The portion of medical inflation above CPI could be substantially reduced depending on the Inquiry Panel's findings and ensuing actions.

The breakdown above suggests that medical inflation in the private sector could be approximately 1.1% above CPI if:

- The population were not ageing, such as in a mandatory environment with income cross subsidy where younger members join to help ensure sustainability.
- Buy-downs were reduced, either by (i) using limited underwriting to prevent anti-selective buy-down behaviour, or (ii) ensuring a more affordable healthcare offering or instituting income cross-subsidisation that would result in members being compelled to buy-down due to affordability.
- The population of medical scheme beneficiaries maintained their health status through preventative care, diet and exercise and medical schemes were able to fund initiatives effectively encouraging these healthy lifestyle activities.

The 1.1% residual inflation could be limited if:

- Information asymmetry is addressed. Regulatory change to oblige publication of healthcare cost and quality outcomes will allow greater transparency and therefore empower beneficiaries to purchase more cost effective care. This should be facilitated by the establishment of a central coding authority to manage coding and set an industry reference price list.
- Price regulation of medical devices including surgical and consumable items is regulated in a manner similar to that applying to the single exit price (SEP) of pharmaceutical products.
- There are regulatory amendments of the Prescribed Minimum Benefits (“PMBs”) regulations and guidelines to provide clarity on the definitions, rules and entitlements as well as improve overall affordability by reducing hospi-centric expenditure. It is also proposed that the “in full” payment rule is revised such that medical schemes need only fund PMBs up to scheme rates.
- The Panel investigates any market distortions and inappropriate behaviour due to market dominance and recommends appropriate regulatory change. Inappropriate behaviour may include the unwillingness of providers to provide detailed utilisation data, negotiate regionally, and offer price increases near CPI.
- Selective contracting of providers of healthcare as well as employment of medical practitioners is made possible through regulatory change in order to allow the development of innovative and more competitive healthcare delivery models.

Of course, the above results only analyse the trends in healthcare costs. The base level of claims expenditure may be too high and it is clear that this is the case in many instances. Managed care initiatives, in addition to managing the trend in claims, further aims to lower the base level of claims.

Managed care and waste and abuse identification programmes work within the current imperfect regulatory framework and aim to manage specifically the burden of disease and residual areas, both in terms of expenditure and quality of service.

3. Market power and distortions at various levels of the sector (Refer section 4 of detailed submission)

The South African private hospital market is overly concentrated, particularly due to regional dominance. The hospital provider groups are also unwilling to provide detailed utilisation data and negotiate regionally. On inspection of the hospital groups’ geographical distribution across South Africa, it is evident that it is difficult to eliminate any one of the largest hospital groups from a national network, as each major hospital group has a regional dominance in at least one province with little meaningful alternatives.

The situation is similar for the three major pathology groups dominating the pathology market, also through regional dominance.

The administration market is considered to be concentrated, although mainly due to one administrator, being Discovery, that has a dominant market share.

Medscheme’s position is that it is necessary to investigate any market distortions and inappropriate behaviour due to such distortion.

4. Barriers to entry and expansion by firms at various levels of the sector (Refer section 5 of detailed submission)

Medscheme has identified two main barriers to entry, namely lack of reinsurance approval by the Regulator and lack of funding for loyalty and wellness programmes. Medscheme's position is that the Panel supports reinsurance approval by the CMS and regulatory change to allow schemes to fund lifestyle management with appropriate rewards for positive healthcare outcomes and lifestyle changes.

- **Lack of reinsurance approval by the CMS :**

Reinsurance provides a necessary level of risk cover and expertise for new entrants into a medical schemes market where there is a requirement to meet the statutory minimum 25% solvency ratio (accumulated funds expressed as a percentage of annualised contributions) within a few years. This is practically difficult as a new scheme needs to grow to increase its scale to improve claims stability and offer stable contribution increases. However, this growth in contributions reduces the solvency ratio even if the scheme is profitable. Currently, the legislation allows for reinsurance however the CMS, however, has failed to consistently allow reinsurance for over a decade.

- **Lack of funding for lifestyle management programmes:**

Lifestyle management programmes are not interpreted as relevant healthcare services by the CMS in terms of the Medical Schemes Act ("MSA") definition. The Regulator has thus not approved funding for evidenced-based wellness interventions such as smoking cessation programmes, health and healthcare coaching administered by lay people and subsidised access to exercise facilities. The National Strategic Plan for the Prevention and Control of Non-Communicable Diseases however, advocates the use of screening and evidence-based "wellness" programmes such as mentioned above, for high risk individuals.

Furthermore, research has demonstrated that lifestyle management programmes are more easily accessed when funded by medical insurers and that the application of appropriate incentives significantly increases participation rates in screening tests and lifestyle management programmes.

Medscheme proposes that the definition of relevant healthcare service be expanded to include funding for lifestyle management and rewards for positive clinical outcomes. This would lower the financial barrier to entry into the medical schemes market. From a competition perspective this would facilitate transparency amongst wellness providers who would be forced to publish their outcomes in order to remain competitive, and improve the standards of healthcare as beneficiaries would have increased access and be empowered to make informed choices regarding their care.

5. Factors limiting access by consumers to private healthcare, including affordability (Refer section 6 of detailed submission)

The detail contained in the other sections of the report all present factors limiting access by consumers to private healthcare, including affordability.

In addition, the current inefficient capital requirement of medical schemes requires many larger medical schemes to build unnecessarily high levels of reserves that inflate contributions which then becomes an unnecessary cost driver in the private healthcare market.

Medscheme proposes that risk-based capital techniques are employed to determine the level of reserves required per scheme, using internationally accepted best practice techniques aligned to the short and long term insurance regulations in South Africa.

6. Imperfect information as it affects consumers as well as firms in the sector (Refer section 7 of detailed submission)

It is Medscheme's position that regulatory change to enable mandatory publication of fees, cost and quality of healthcare services will create transparency and consequently greater competition based on quality healthcare outcomes.

Section 6 of The National Health Act 64 of 2003 speaks to the issue of information asymmetry in relation to cost and choice and mandates health care providers to share clinical and cost information with users of their services to enable them to make informed choices.

Information asymmetry in the South African context is however inherently part of most of the issues raised by the Competition Commission:

- Due to a lack of transparency, South African consumers of healthcare services are unable to make informed choices based on a comparison of cost and quality. This suggests that low performing providers could have an uninformed captive market.
- Providers do not always understand their own relative risk-equalised cost and quality status to allow them to improve their behaviour and become competitive in terms of price and best practice
- Publication of provider-specific information on the cost and quality of their services is currently not mandated. Managed care organisations do however play a role in generating and sharing information on behalf of funders to promote competition. This information is used transparently for fee negotiations, strategic purchasing of care, selective contracting and to address waste and abuse.

Medscheme advocates regulatory mandated transparent reporting of cost and quality of healthcare services to consumers to assist in their decision-making. As such, the rates charged by healthcare practitioners and funded by medical schemes need to be clearly defined and easily understood.

The establishment of an independent coding authority to govern coding structures and set an industry reference price list will encourage transparency and enhanced competition:

There is a need for an independent industry coding authority set up by the Regulator. This authority should assume responsibility for the governance of standardised coding structures and the setting of the relative unit values. It should review the coding structures and convene regular multi-stakeholder discussions to ensure that decisions are transparent and fair.

Without the coding authority, the current problems resulting from up-coding, misuse of modifiers, etc. will persist. These problems include consumer out of pocket expenses, medical scheme contribution increases as well as coding driven skewing of claims data that has an effect on utilisation and pricing assumptions.

There are many reasons why an independent industry coding authority would improve the current fragmented situation:

- Each provider association currently owns, maintains and publishes their own coding structures without input from other stakeholders. This situation had led to anti-competitive practices between providers.
- Each provider association or society submits requests for new codes to the South African Medical Association (SAMA). Approved requests are published yearly but without guidelines. This allows providers to unbundle or up-code procedures that were previously incorporated within one specific code. It also allows providers to increase the unit values assigned to codes to gain higher reimbursement without providing transparent reasoning.
- With the advent of new technologies and changed scope of practice of providers as well as the lack of codes to describe such services, providers are compelled to use a combination of existing codes when billing for new procedures.

In addition, the authority should set a minimum reference price list (MRPL). This will provide a reference price list only as a benchmark for the private healthcare industry. Providers' fees and medical scheme benefits need to be defined relative to the MRPL to increase transparency and therefore empower consumers to select providers whose fees best match their benefits.

7. Impact of the regulatory framework on competition in private healthcare (Section 8 of detailed submission)

It is Medscheme's position that the current regulatory framework is incomplete, resulting in increased claims expenditure due to anti-selection. Medscheme recommends that compulsory membership for all employees earning above the tax threshold is implemented, together with income cross-subsidisation.

In the South African environment with limited underwriting and without compulsory membership, the consequences can be summarised as below:

- Perverse incentives are evident.
- Risk management is indirectly, but intentionally extended to benefit design (either including benefits more attractive to the young and healthy and / or limiting benefits more likely to be used by the older and sicker), as well as marketing initiatives targeting the young and setting broker commission levels to favour the attraction of good profile lives.
- Anti-selective behaviour is evidenced, such as people not joining schemes when they are healthy, increasing claims experience.
- Schemes may end up in an 'actuarial death spiral', where contributions are too high, resulting in healthy members leaving which results in even higher contribution requirements. Schemes then need to amalgamate or close.
- Increased claims and expense costs due to the above items.

Administrative complexity and pressure on managed care

It is important that the Inquiry Panel gain an understanding of the increasing pressure on non-healthcare costs due to increasing administrative complexity resulting from the current regulatory framework.

Two examples of the increased administrative burden are:

1. the issues raised around the current implementation of PMBs and
2. the lack of standardised procedure coding in South Africa's private healthcare system.

There is immense pressure on managed care initiatives to offset medical scheme risks intensified by the imperfect regulatory environment as defined in this submission.

The anticompetitive effects of inconsistent interpretation of PMBs regulations

Medscheme recommends that the Inquiry Panel endorses:

- Clear de-lineation of the objectives of PMBs within the government's revised policy to achieve universal coverage.
- Simplification of current PMBs and focus on clear benefit definitions (as has been proposed previously).
- Limiting funding of tertiary and quaternary-type services to established academic teaching units.

The absence of Risk Equalisation Fund ("REF") that encourages competition on the basis of risk selection

Medscheme recommends the introduction of a REF to equalise the cost of providing PMBs across medical schemes, as envisaged in the 2008 Amendment Bill. This must be accompanied by income cross-subsidisation to prevent unintended financial pressure on low income beneficiaries.

The implementation of open enrolment, community-rating and PMBs created an incomplete regulatory environment where medical schemes 'cherry-pick' the healthier lives.

This dynamic occurs because the contributions are set the same for all members in a medical scheme option, but claims are significantly higher for less healthy and older members. Thus, a medical scheme can lower its claims and consequently its contributions simply by attracting the healthiest lives.

The result is that a scheme that doesn't attract the youngest and healthier lives will become uncompetitive and unsustainable. As the medical scheme fails to attract the lower claiming lives, its contributions will increase. As this occurs, the healthier lives leave, exasperating the poorer claims experience and thus competitiveness. Analysis has shown that healthier lives are the first to move schemes, since they do not claim much and are not concerned by the underwriting restrictions that may be applied in a new scheme.

Medscheme therefore recommends that the CMS decision that the REF would not be implemented, as communicated in January 2012, should be revisited. Legislation should encourage competition based on the efficient and quality service delivery, not which scheme can cherry-pick the healthiest lives.

A REF in the medical schemes system is critical to ensure that efficient schemes that provide cover to the less healthy are competitive, irrespective of the age and health of their membership.

Introduction of the REF as a "market intervention", based on a Competition Commission recommendation, will improve competition based on efficiency in the private healthcare market, as well as provide a sustainable model for medical schemes servicing the less healthy portion of the population.

Note that the REF is not a solution by itself, but part of a comprehensive design to encourage appropriate competition and foster sustainability.

Proposed regulation change to improve competition in healthcare delivery models:

Medscheme's experience demonstrates the effectiveness of using provider networks as they enable better co-ordinated care of patients, provide mechanisms to monitor and report quality and cost outcomes as well as allow incentives to be paid to encourage best practice.

Medscheme recommends regulatory change to allow for transparent selective contracting, similar to a tender process.

Employment of medical practitioners:

Medscheme recommends that the Panel consider recommending regulatory change to overcome the systemic flaw posed by the Health Professionals Council of South Africa (HPCSA) adjudication process and ethical rules relating to both who is allowed to employ doctors and under what circumstances are they allowed to do so.

Medscheme's position is that the HPCSA adjudication process be retained but that the limited employment agencies, the criteria for employment of practitioners and those regulating multidisciplinary group practices are changed in order to allow structuring of innovative health co-operatives or affiliations with administrators and managed care organisations.

The rationale for this proposal is that these structures of co-operation and affiliation will encourage more appropriate competition i.e. competition based on quality and efficiency of care.

8. Impact of interventions made by the competition authorities in the healthcare sector (Refer section 9 of detailed submission)

It is Medscheme's submission that the 2004 decision by the Competition Commission around reference pricing created significant complications for pricing in the market. The absence of reference prices created a pricing vacuum causing market forces to drive up prices.

The absence of reference prices has resulted in doctors quoting different consultation fees and different procedure fees for different medical schemes and sometimes even for the different options within schemes. This creates information asymmetry and disempowers the consumer.

The change from collective negotiation to individual negotiations shifted the balance of power to the hospital groups. This created an oligopoly which has largely eliminated the balance of power in price negotiations. The levels of concentration and the geographic distribution of the hospitals of each of the three main hospital groups have resulted in regional or local dominance.

The ruling also impacted negatively on collective trade practices beneficial for the consumer. Examples include the evaluation of new and current technology and drugs resulting in collective principles around the appropriate funding and utilisation of such technology or collective sanctions against fraudulent activities – critical elements in any healthcare system.

The establishment of an independent coding authority to govern coding structures and set an industry reference price list at an industry level between private healthcare providers and private healthcare funders has the following advantages:

- It provides stability in the determination of prices in the private healthcare sector, as well as ensures that the determination is rational and fair.
- Reference price lists can bring about the necessary price transparency in the market and assist with providing clarity to medical scheme beneficiaries on reimbursement and charging rates of medical schemes and providers. Asymmetric information currently hampers members' ability to evaluate the quality and cost of care, and make informed choices.
- It will also enhance budget predictability for healthcare funders and healthcare providers alike.

Medscheme however propose the following qualifications and additions to accompany an independent coding authority structure:

- The output is standardisation of key components that are important to ensure stability and transparency to facilitate competition based on quality and efficiency. The process should be able to accommodate alternative reimbursement models that incentivise cost containment and quality of care and drive competition amongst healthcare providers on this basis.
- A nationally appropriate coding system is adopted to replace the eroded NHRPL or RPL schedules. This links critically into a standard for billing purposes based on robust coding standards in order to implement accurate and reliable measures for price and quality.
- Providers are obliged to transparently report on minimum quality standards and related metrics to address information asymmetry issues.
- A MRPL is established. A list of minimum reference prices (MRPL) should be set by the State at a level equivalent to the State UPFS schedule. This provides a reference price list only as a benchmark for the private healthcare industry.
- PMBs are to be funded at a rate no less than this MRPL.
- A maximum ethical tariff guideline is determined in order to protect the consumer. The process and rate is to be determined by the relevant hospital and healthcare professional regulatory bodies.
- Medical schemes are able to set a Scheme Rate and this will apply to all services including PMBs. This would require regulatory changes such that PMBs are no longer funded open-endedly 'in full' but at the Scheme Rate.
- Healthcare providers are able to charge above Scheme Rates, even for PMBs, but this must be disclosed to members / patients relative to MRPL, and fees above the Scheme Rate will be paid by the member.
- There is (ideally) a significant range between the minimum rate MRPL and ethical rate to allow for flexibility and competition.
- The setting of a reference price list should be at a low level rather than setting it at the current average or maximum levels, or even levels based on cost practice studies in the private sector. If it were set at higher levels, or based on practice cost studies, the reference prices would become the de facto minimum prices in the industry and entrench existing inefficiencies. The State UPFS fees provide a useful benchmark level against which to base the reference price list. There would be differences between the UPFS schedule and the industry coding standard at first, requiring some analysis to target price equivalence. But this may over time converge to a national coding system which would be the ideal.
- There is mandated transparency of price, expressed relative to the minimum reference price MRPL, and quality of care for all healthcare providers. Similarly, hospitals must be compelled to publish their quality measures and their rates, again expressed relative to the minimum reference price MRPL.
- Hospitals should publish the current scope of their licenses as well as explicitly declare any shareholding held by healthcare professionals so as to achieve greater transparency for medical scheme beneficiaries.

- Medical scheme beneficiary empowerment is enhanced by stipulating that the Scheme Rates need to be set relative to the minimum reference price list for ease of comparison, for example 150% of MRPL. In addition, providers are required to stipulate their fees to patients relative to the MRPL.
- There is flexibility to implement alternative reimbursement models (ARMs) / risk sharing arrangements outside of this framework. This will encourage efficiencies within the healthcare system by allowing selective contracting of healthcare practitioners and hospitals by healthcare funders where ARMs and higher tariffs can be negotiated in return for greater overall efficiency (management of waste, utilisation and quality).
- A transparent scientific and structured approach to the licensing of facilities is published by the regulator to ensure appropriate competition and access to facilities.

9. Conclusion

Medscheme is appreciative of the opportunity afforded by the Competition Commission to Stakeholders to submit position statements and recommendations on the Statement of Issues. We see this as an important opportunity to improve regulatory alignment and address anti-competitiveness in the healthcare industry.

PART D – DETAILED SUBMISSION

1. INTRODUCTION

On 29 November 2013 the Competition Commission (“the Commission”), in the exercise of its powers under section 43B of the Competition Act, No 89 of 1998 as amended (“the Act”), published a notice that it would conduct a market inquiry into the private healthcare sector (“the inquiry”), as well as the Terms of Reference for the inquiry.

The Inquiry published a Statement of Issues on 1 August 2014 and invited those wishing to participate in the Inquiry to make submissions on the issues identified in the Statement of Issues, read with the final Terms of Reference.

This document represents Medscheme’s response to the Inquiry’s call for submissions. Medscheme does however reserve the right to submit supplementary submissions should the need arise.

2. APPROACH

Information and data has been sourced externally from publicly available information, including CMS reports and financial statements. Information has also been sourced internally through in-depth analysis and inspection of medical scheme data of Medscheme clients, due to the level of detail and quality of the data, which is readily available to Medscheme. We believe the Medscheme database, representing approximately 3 million lives, represents the private healthcare market well. Medscheme’s clients include both open and restricted schemes, both large and small schemes and both high and low LSM income markets.

Client data has been de-identified and summarised to prevent unintended confidentiality breaches. Best practice actuarial and health economic techniques have been employed to provide a rigorous assessment of the private healthcare sector’s performance, cost drivers and inefficiencies. The results of these analyses, together with decades of experience in both clinical and actuarial fields, have informed the proposals for addressing the industry cost drivers.

It should be noted that the 2013/2014 CMS Annual Report published in September 2014 has *not* been utilised as the 2013 claims utilisation data has been found to be inaccurate as reported by the CMS in Circular 43 of 2014.

It is important to distinguish between cost, price and expenditure in understanding the ‘cost drivers’ in the industry. In this report, the definitions used will be:

Input cost	Input costs of service providers or healthcare providers to deliver a service or product, such as salaries or electricity.
Price	The unit price of a service or product. It may also be referred to as tariffs. Price is the amount charged by firms or practitioners to customers or patients per unit of service or product.
Expenditure	Expenditure incurred includes both price and increased utilisation. Expenditure increases if prices increase, or if utilisation of a service or product increases. Expenditure would be the amount typically accounted for in a firm’s financial income statement. Expenditure may include expense or claims amounts.
Cost	Used interchangeably with expenditure or the amount incurred by a purchaser.

This report, thus, would more precisely be defined as discussing the private healthcare industry's input costs, prices and utilisation.

This detailed submission follows the sequence of issues as listed in the Call for Submissions document issued by the Health Market Inquiry on 1 August 2014, as set out below:

- Factors **driving costs**, prices, and expenditure in private healthcare;
- **Market power** and distortions of competition at various levels of the sector;
- **Barriers to entry** and expansion by firms at various levels of the sector;
- **Factors limiting access** by consumers to private healthcare, including **affordability**;
- **Imperfect information** as it affects consumers as well as firms in the sector;
- The impact of the **regulatory framework** (including various statutes, regulations and rules) on competition in private healthcare; and
- The specific **impact of interventions previously made by the competition authorities** in regard to the healthcare sector.

3. FACTORS DRIVING COST, PRICES AND EXPENDITURE IN PRIVATE HEALTHCARE

This section provides a high level summary of industry and Medscheme client data expenditure, quality and performance metrics in order to provide a high level view of the performance of the private healthcare sector. The aim is to identify potential areas of concern, whilst also highlighting areas that are in fact not of concern but may have been thought to be. The following topics are covered:

- *expenditure in private healthcare;*
- *issues relating to the price of medical goods and services;*
- *issues relating to the basket of goods and services being purchased and*
- *issues relating to utilisation.*

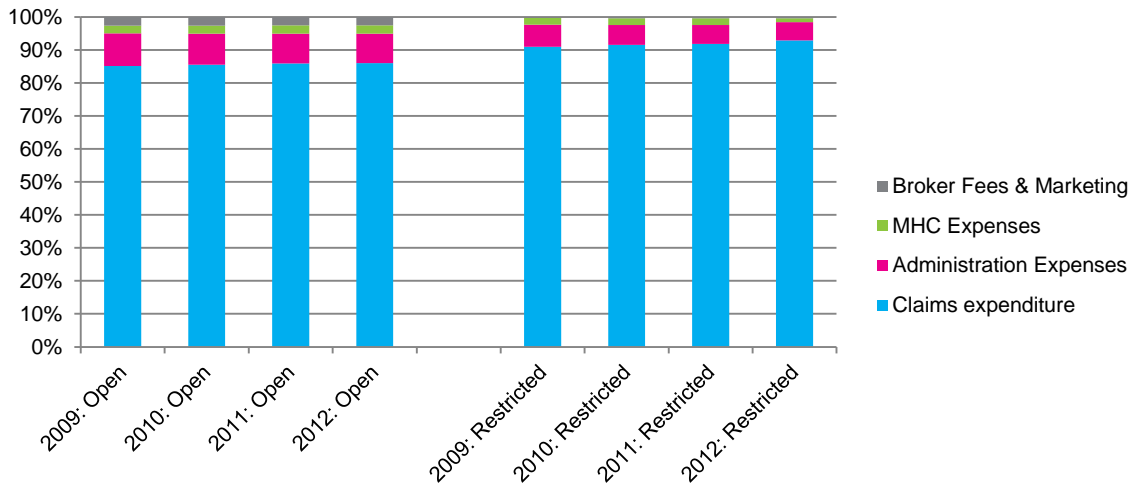
3.1. Expenditure in private healthcare

3.1.1. Split between healthcare and non-healthcare expenditure

This section provides some high level industry healthcare and non-healthcare expenditure metrics to provide context to the discussions in this report.

The figure below summarises the industry expenditure in medical schemes as reported by the CMS Annual Reports. In the case of open schemes, 85% to 87% of total expenditure relates to medical claims expenditure and in the case of restricted schemes, this ratio is 90%. There is a noticeable trend of declining non-healthcare spend relative to claims expenditure, but it is evident that claims expenditure is the predominant expenditure and thus impacts on costs drivers and contributions most significantly.

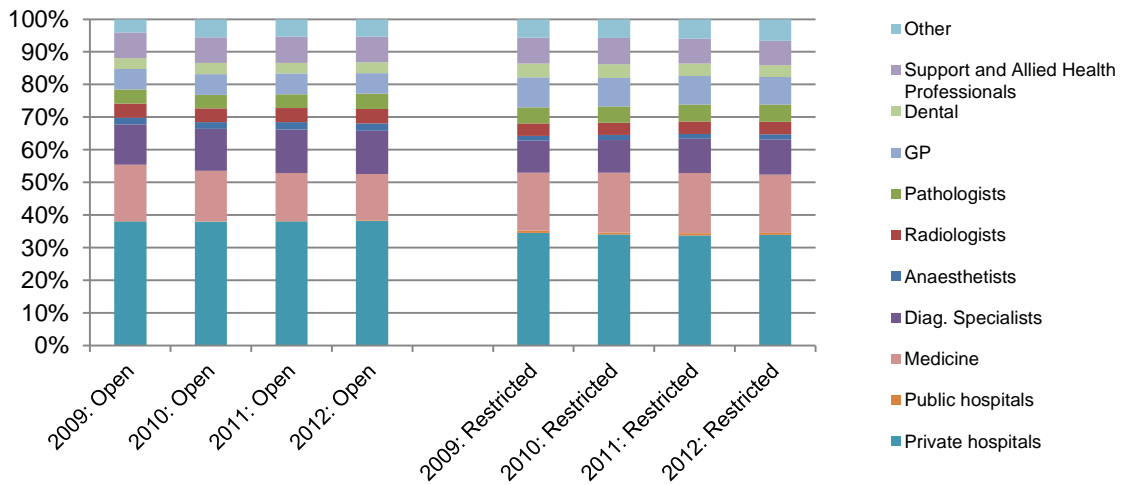
Figure 1 –Healthcare and Non-healthcare Expenditure 2009 to 2012: Open vs Restricted Schemes



Source: CMS Annual Reports 2009/2010 to 2012/2013

The industry claims expenditure is unpacked further below. Private hospitals accounted for nearly 40% of medical claims and medical specialists for approximately 20%. Restricted schemes typically offer richer benefits and this translates into higher out-of-hospital claims percentages as observed in the graph below.

Figure 2 – Medical Scheme Claims Expenditure by Category



Source: CMS Annual Report 2009/2010 to 2012/2013

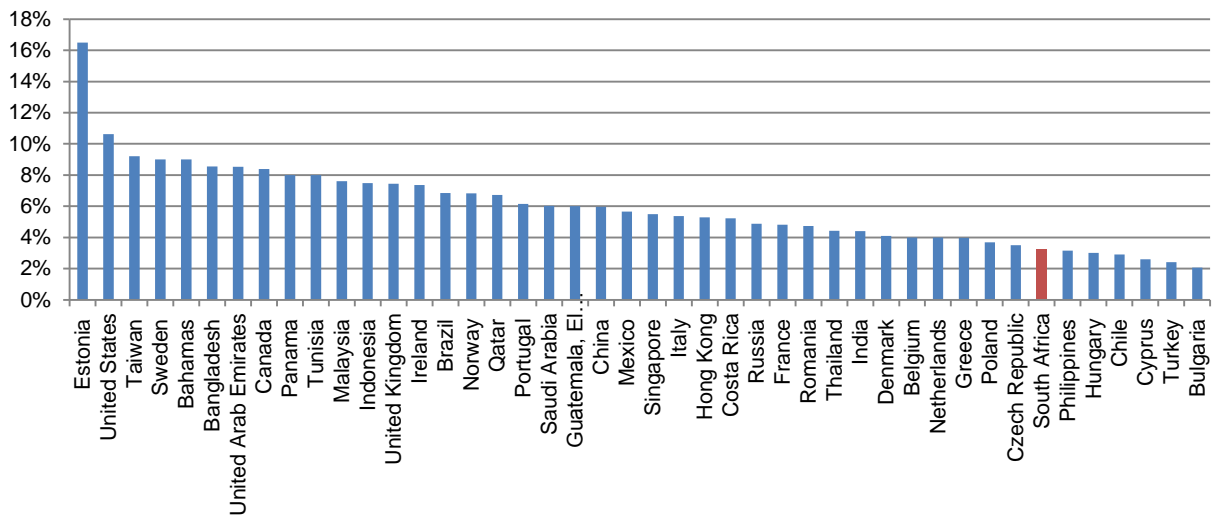
Note that 'diagnostic specialists' include all healthcare specialist practitioners, except anaesthetists, pathologists and radiologists. This is as per the CMS definition.

3.1.2. International Benchmarking

International benchmarking suggests high medical inflation is a global challenge. The South African market compares well and it is postulated that this is due to relatively advanced managed care practices in the larger schemes and administrators, as well as the relatively large proportion of employer based group business. Nevertheless, the South African private market is characterised by few multi-disciplinary group practices and day hospitals; and with admission rates to expensive acute hospitals significantly above international best practice norms.

It is worth considering the experience in the South African private medical scheme market relative to international benchmarks. The figure below, based on a Towers Watson 2012 international private healthcare market survey, shows medical inflation net of CPI (general inflation) across 44 countries.

Figure 3 – International Benchmarking of Net Medical Inflation 2012



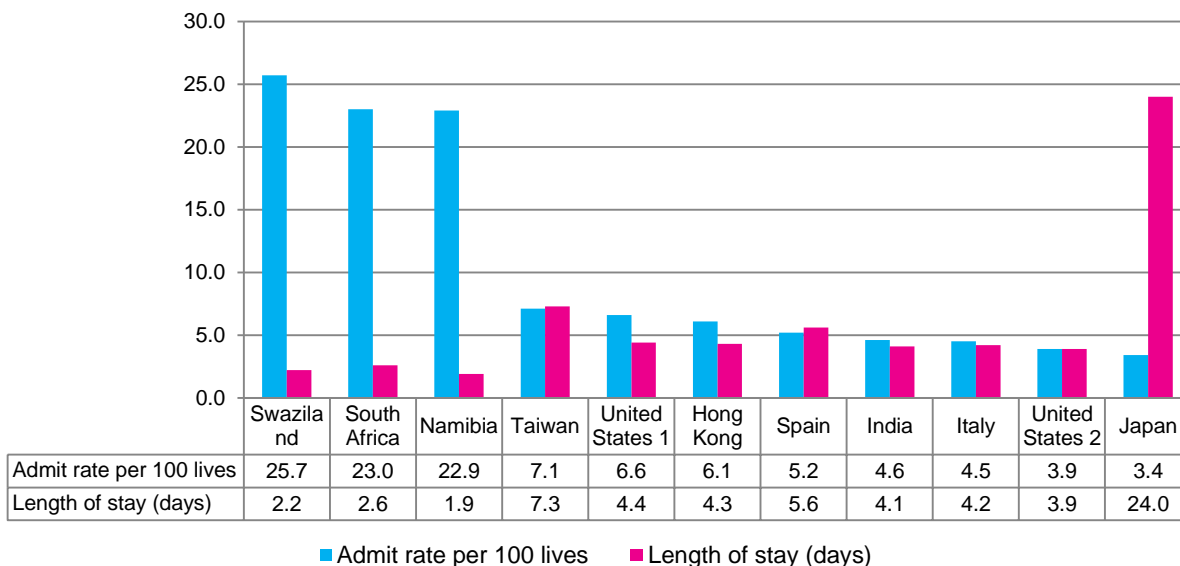
Source: Towers Watson 2012 international private healthcare market survey

South Africa’s medical schemes industry performs relatively well in terms of medical inflation. Clearly, managing healthcare costs is a global phenomenon and challenge. It is postulated that the South African market compares well due to relatively advanced managed care practices in the larger schemes and administrators, as well as the relatively large proportion of group business (group business provides a level of cross-subsidisation in the private healthcare system and helps maintain sustainability through mandatory membership as required by most medium to large employers). The problem is however that South African medical inflation (net of CPI), is still unsustainable especially considering distortions in South Africa’s healthcare service provision which is still driven by demographic factors e.g. an ageing population and exacerbated by a limited growth economic climate e.g. structural unemployment. An analysis of the macro-economic environment is not included in this submission as this is beyond the scope of the enquiry.

South Africa has a systemic issue with delivery of care being provided at the wrong level of speciality and venue. Specialist practitioners are often consulted directly by patients without first being seen by a family practitioner. Similarly, too many patients are admitted to expensive acute hospitals instead of lower level day hospitals. A primary focus of Medscheme’s submission is quality of care and not cost alone. Quality and efficiency data are available to support this argument if required.

The figure below benchmarks the hospital admission rate of male patients aged 40-45 in South Africa to that in other countries:

Figure 4 – International Comparison of Hospital Admission Rates and Length of Stay (LOS)



Source: Males aged 40-45, 2012 Medscheme data and RGA Reinsurance

Certainly the definition of admission does differ across countries and is often difficult to compare precisely, nevertheless the differential is evident and clearly represents a systemic issue across the private healthcare market in South Africa. International best practice points to delivering care by the most appropriate, least costly healthcare practitioner and facility. The South African private market, in contrast, is characterised by few multi-disciplinary group practices and day hospitals.

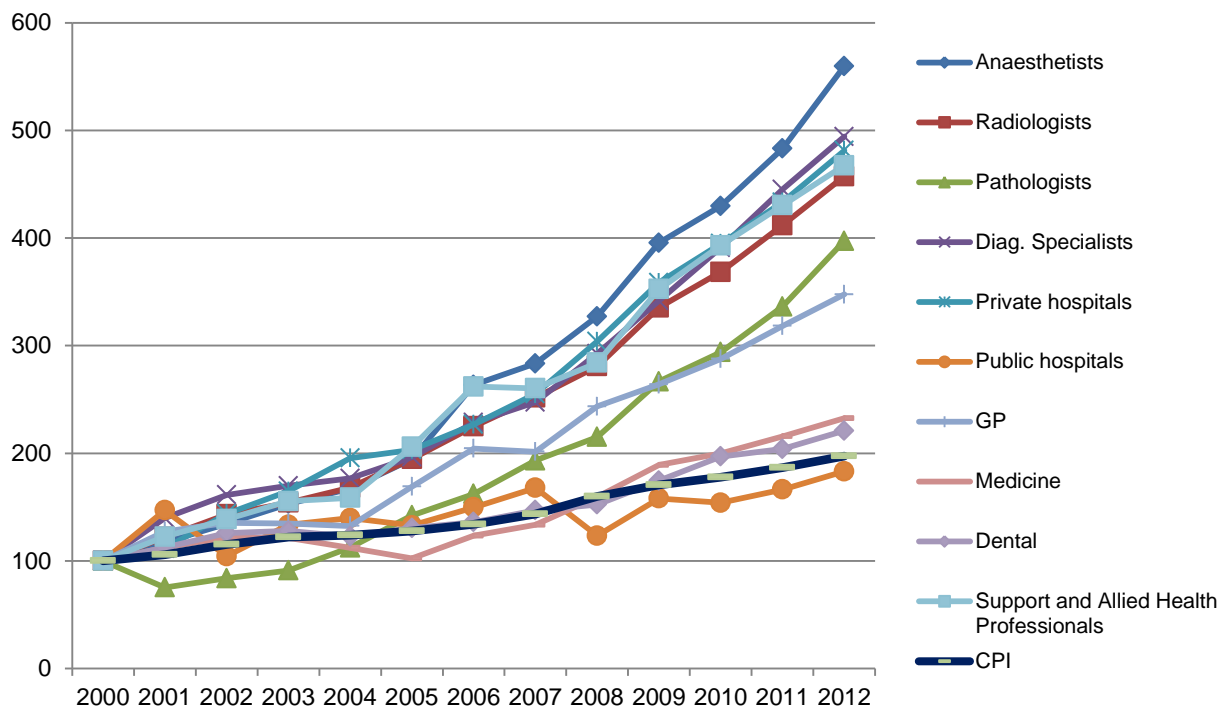
3.1.3. Trends in Expenditure

3.1.3.1 Claims Expenditure Trends

This section provides some high level industry healthcare expenditure metrics to provide context to the discussions in this report.

The figure below sets out the claims expenditure and contribution trends from the CMS annual reports from the year 2000 to 2012.

Figure 5 – Claims expenditure and contribution trends from the year 2000 to 2012



Source: CMS Annual Reports 2000 to 2012

Since the results are indexed to 100, the figure clearly shows the relative increase in hospital and specialist claims expenditure being well above other categories of claims. In particular:

- **Anaesthetists, diagnostic specialists¹ and radiology** costs have increased significantly above CPI in the period 2000 to 2012.
- In the period 2000 to 2005, **hospital costs** increased significantly. This period is also characterised by hospital mergers and by collective bargaining, which stopped in 2004 following a Competition Commission ruling.
- In the period 2004 to 2006, collective bargaining was replaced with reference pricing. It is noticeable that specialist and GP costs increased significantly during this period. **Single Exit Pricing (“SEP”)** regulations for medicines were also introduced in 2004 and medicine costs have remained well controlled since that time. Note that the SEP regulations also allowed for international benchmarking, although this has never been implemented.
- The period 2006 to date has shown consistent increases in **hospital, anaesthetist, diagnostic specialist and pathology costs** relative to other categories. This era is characterised by a fragmented care system, where the GP as co-ordinator of care has declined, specialist care is accessed directly and expensive hospital-based care is more of the norm. In addition, the ‘open-chequebook’ Prescribed Minimum Benefit (PMB) regulations have increased costs, specifically specialist and hospital costs. These increases in costs have been moderately offset with the move towards more managed networks, managed care efficiency controls and reductions in benefits.
- **Support and allied health professional** costs have increased significantly over the period, although this is a smaller claims category. Nevertheless, this is categorised by increasing physiotherapy and psychologist claims.

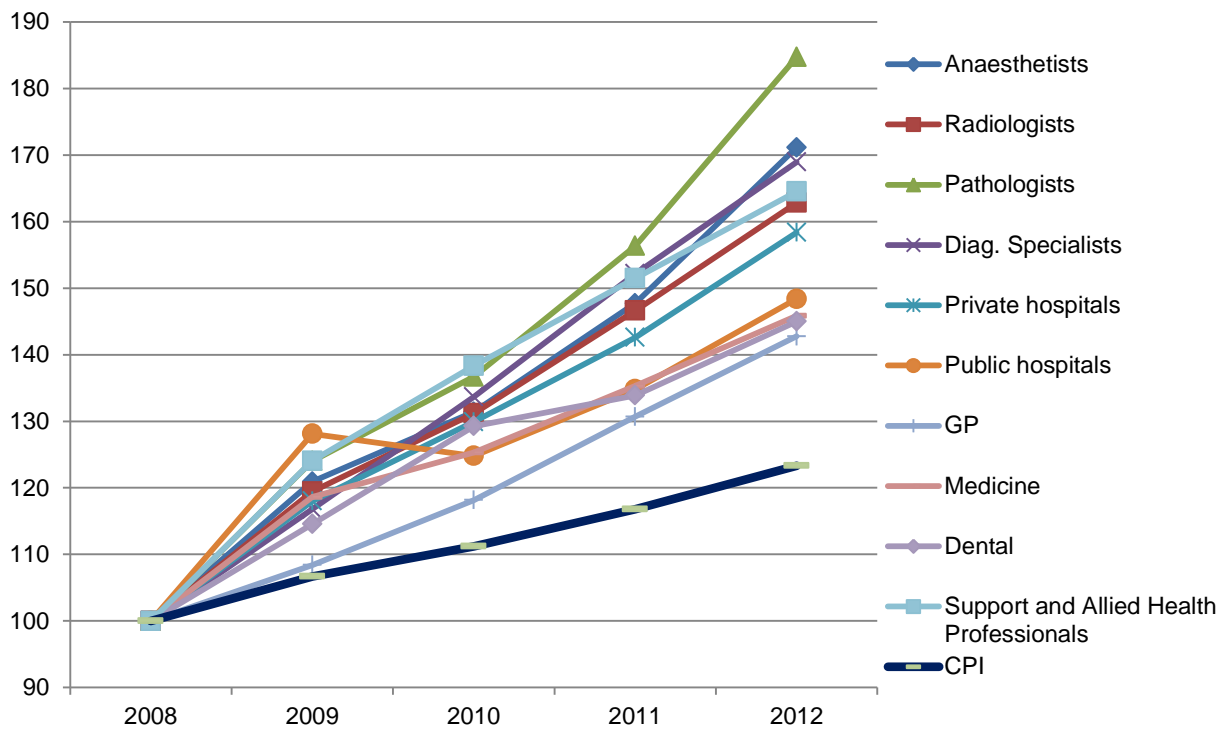
¹ Diagnostic specialists defined as per the CMS definition i.e. excluding anaesthetists, pathologists and radiologists.

Certainly, mental health issues have seen an increase over the last decade, increasing both psychologist visits as well as mental health hospital admissions. This category shows smaller claims for open schemes relative to restricted schemes, indicating the higher benefits typically offered by restricted schemes.

- **Dental benefits** have generally been reduced over the past decade, especially in open schemes where affordability has been an issue. This is also the case for optical benefits. Thus, the dental claims costs have remained near CPI increase levels, but are below CPI for open schemes and above CPI for restricted schemes.

The figure below sets out the claims expenditure and contribution trends from the CMS annual reports from the year 2008 to 2012, to provide a more up-to-date picture of the latest trends.

Figure 6 – Claims expenditure and contribution trends from the year 2008 to 2012



Source: CMS Annual Reports 2008 to 2012

The above figure suggests a similar picture over the 4 years to 2012 relative to the previous 12 year analysis. However, **pathology, anaesthetists and diagnostic specialist costs** have increased significantly more than other categories, especially since 2011. In 2011, the High Court dismissed an application by the Board of Healthcare Funders in respect of the ‘open chequebook’ PMBs and this precipitated an increase in tariffs charged by specialists. An increase in the proportion of claims coded as PMB has occurred over this period, which may indicate a worsening burden of disease (worsening health or morbidity status), but this could be linked to changes in coding practices to ensure claims are paid in full as other non-PMB claims categories have not shown similar trends. Medscheme requests that the panel investigate this issue to confirm causality.

Analysing the Medscheme experience in more depth, it is clear that key contributors include

- an increasing burden of disease,
- changing consumer awareness and demand,
- new technology,
- market dominance by certain suppliers of healthcare services and
- imperfect legislation.

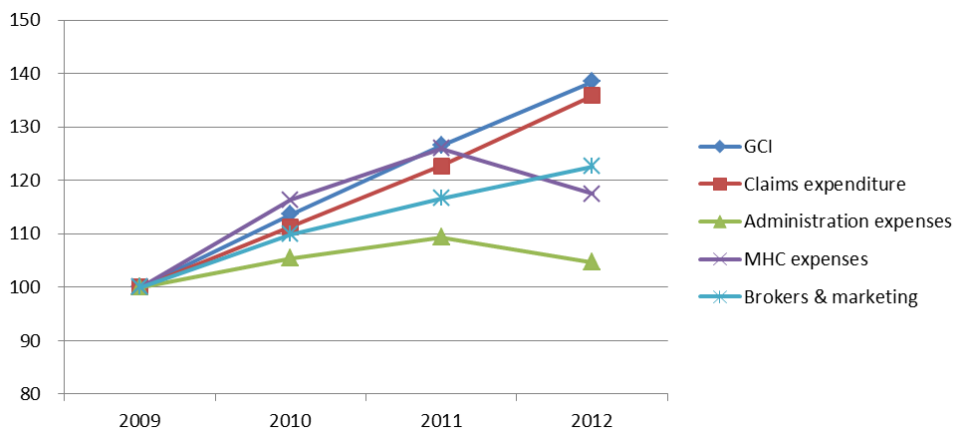
3.1.3.2. Non-healthcare Expenditure Trends

This section provides some high level industry healthcare and non-healthcare expenditure metrics to provide context to the discussions in this report.

The results indicate that healthcare costs are increasing and should be the focus of the Inquiry, whilst administration and managed care expenditure is declining in real terms.

The figure below shows the contribution (GCI), claims, administration, managed care and broker/marketing expenditure since 2009 from the CMS annual reports.

Figure 7 – Claims, contribution and other expense trends



Source: CMS Annual Reports since 2009

The figure highlights the following:

- Gross contributions have increased in line with claims expenditure, which is expected.
- Managed care (MHC) expenses increased similarly up to 2011, although off a lower base. In 2012, the fees declined relative to others (and have continued at this lower level based on Medscheme knowledge). MHC fees are less than broker fees for the first time in 2012.
- Administration fees have increased at the slowest pace relative to the other categories depicted.

As required by the CMS each service within Managed Care is priced separately. This allows the client Schemes to identify the cost of each service and it enables Medscheme to track the value of each service against the fees paid. These fees are itemised in the Scheme contracts.

The current prices charged are based on the initial price set at initiation of contract plus annual increases. The majority of the costs of providing Managed Care services relates to the intensity of the work and hence directly related to the number of resources required to provide the services. Hence the major cost to Medscheme relates to salary costs and related expenses. The staffing required for Managed Care services are mainly from the health professions sector and thus the salary cost per employee is typically expensive.

The fees charged by Medscheme are thus influenced largely by the combination of staffing ratios, team sizes and level of remuneration.

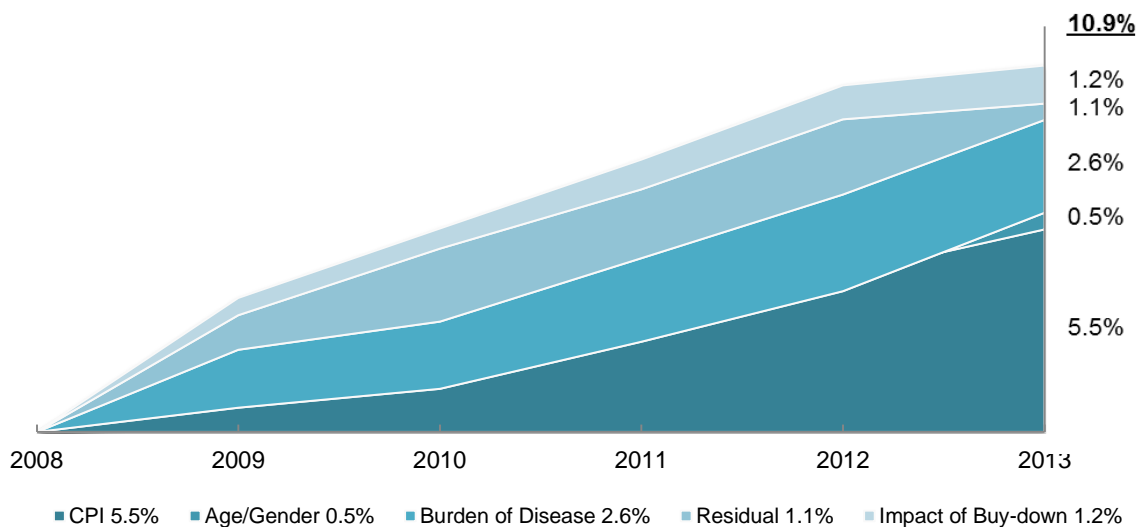
3.1.4. Components driving increased expenditure (difference between price and utilisation)

This section analyses healthcare expenditure since 2008 in the Medscheme client base of more than 3m lives. The analysis provides a breakdown of the major components of healthcare claims inflation.

Within the last decade, increases in claims expenditure have outstripped Consumer Price Inflation (“CPI”) by approximately 4.0%. Since 2008, the average increase in claims expenditure (as expressed per medical scheme beneficiary per month) has been 9.7% for Medscheme schemes. These increases include CPI-related tariff inflation, the impact of increased burden of disease (and the inefficient delivery of healthcare services for these individuals) as well as other cost pressures (new technology, higher than CPI tariff increases). However, the impact of buy-downs, indicative of anti-selective behaviour, in schemes with multiple options have increased claims by an additional 1.2% per annum, resulting in an average increase of 10.9% p.a.

The figure below, based on Medscheme experience, shows the significant impact of the burden of disease on increasing healthcare claims expenditure, as well as the other components of the increase.

Figure 8 – The Impact of the Burden on Disease and buy-downs on the Increases in Claims per life per month (plpm)



Source: Medscheme data, 2,000,000 life years

Of the 9.7% average increase,

- 5.5% is explained by CPI inflation,
- 0.5% by an increase in ageing and gender mix changes,
- 2.6% by an increased burden of disease.
- An additional 1.2% is due to anti-selective buy-down behaviour,
- leaving a 1.1% residual utilisation.

This analysis suggests that medical inflation in the private sector would only be approximately 1.1% above CPI if:

- The population were not ageing, such as in a mandatory environment where younger members are compelled to join and help ensure sustainability.
- Buy-downs were less, either by
 - a. using underwriting to prevent anti-selective buy-down behaviour, or
 - b. ensuring a more affordable healthcare offering or instituting income cross-subsidisation that would result in members not requiring to buy-down for affordability reasons.
- The population maintained their health status through preventative care, diet and exercise and medical schemes were able to fund these.

The 1.1% residual inflation would be attributed to, in no particular order:

- care which is cost inefficient, evident in widely varying cost efficiency and quality outcomes
- a fragmented inefficient healthcare delivery system
- new technology
- patterns of utilisation of inappropriately high levels of care, such as direct access to specialists
- PMBs
- fraud and abuse
- anti-selection in an imperfect regulatory environment
- market concentration and dominance and its impact on prices and utilisation of services.

Managed care and fraud identification programmes aim to influence and manage these residual areas.

Of course, the above results only analyse the trends in healthcare costs, but the base level may be too high and it is clear that this is the case in many instances. Managed care initiatives, in addition to managing the trend in claims, further aims to lower the base level of claims.

3.2. Issues Relating to the Price of Medical Goods and Services

The previous section highlighted the components of the healthcare and non-healthcare expenditure. This section focusses on the price component of healthcare expenditure.

3.2.1. Reimbursing PMBs in Full

Schemes have faced an open-ended liability with respect to PMB claims. Providers are able to charge unlimited amounts for a PMB condition and no ethical or legislated maximum price exists. Many providers will also not contract as a DSP at an affordable price. Consumers are mostly unaware of the fees charged by providers, especially anaesthetists. Thus, PMBs pose a particular problem in respect of price competition. Please also refer to Sections 8.1.2 PMBs – Competitive effects of inconsistent interpretation and impact on benefit design and administrative complexity and 9.1 The matter of collective bargaining.

Medscheme position / recommendations

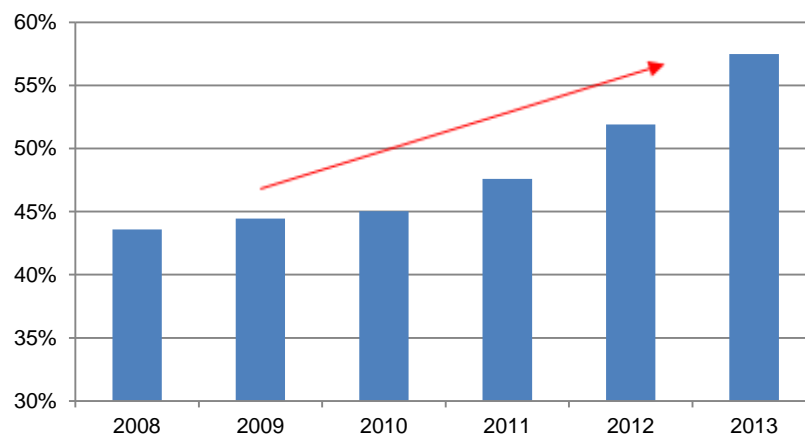
Medscheme proposes that PMBs are only paid in line with scheme rates, as per other benefits. However, the benefits must be clearly defined relative to an industry reference price list and providers must transparently display their billing rates relative to this reference price list.

Further to this, the objectives of PMBs within the government’s revised policy to achieve universal coverage should be clearly de-lineated. The current PMBs should be simplified and focused on clear benefit definitions (as has been proposed previously).

Limiting funding of tertiary and quaternary-type PMB services to established academic teaching units; and the definition of a negative rather than positive disease list should be considered.

Medical schemes are compelled to reimburse PMBs at the invoice price (“at cost” or “in full”) and thus schemes have faced an open-ended liability with respect to PMB claims – in the absence of a designated service provider network, schemes must pay whatever providers charge. This risk is greatest for medical specialists (comprising approximately 20% of claims expenditure).

Figure 9 – Increasing Trend in PMB Claims as % of Total Risk Claims

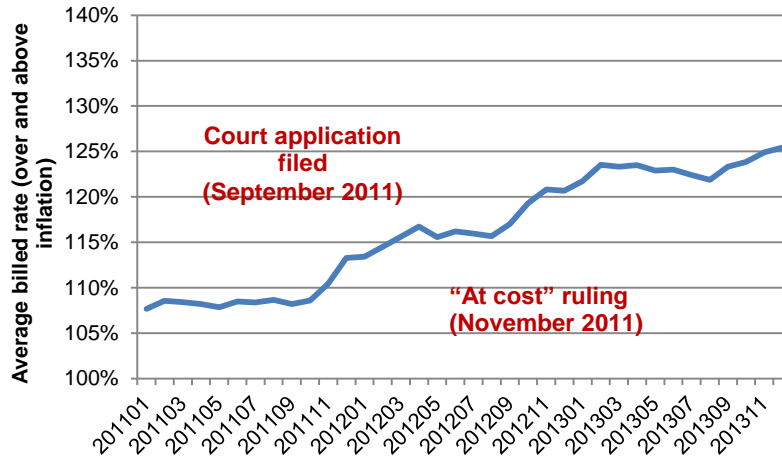


Source: Medscheme data, 2 400 000 life years

The analysis above may reflect better coding and thus a better ability to identify PMBs, however our view is that this represents diagnosis creep and increased charging for PMBs.

Analyses of practice type billing behaviour have further indicated possible changes in provider billing behaviour since schemes were compelled to fund PMBs at invoice price (billed rate) in the latter part of 2011. The figures below show the increasing rates charged by specialists, especially after the court ruling.

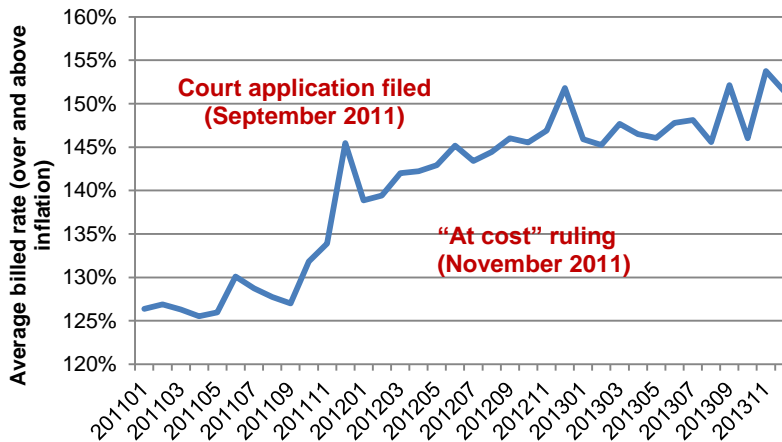
Figure 10 – PMB Tariff Charged by Specialists relative to Scheme Rates: All Specialists Average



Source: Medscheme data, 300,000 life years

The impact of the increasing rates charged for PMBs is most stark in the Anaesthetist speciality, as shown below.

Figure 11 – PMB Tariff Charged by Anaesthetists relative to Scheme Rates: All Specialists Average



Source: Medscheme data, 300,000 life years

Our experience shows that the Anaesthetists are most vocal in their demands for higher pay and least willing to contract into a DSP network, supported by their scarcity of skills in South Africa. Furthermore, the Anaesthetist-member relationship and engagement is often just prior to surgery and the ability of the patient to discuss the possibility of lower fees is not ideal. Lack of certainty of tariffs is of particular concern to patients and members in this environment.

3.2.2. Price Regulation

This section discusses the regulation of prices in the private healthcare sector.

First, the success of SEP for medicines is discussed. Second, the extension of SEP to other medical devices and consumables is motivated. Finally, the expansion of regulated prices is not supported beyond SEP for medicines, medical devices and consumables. Please refer to Sections 7.2. Industry wide tariffs and 9.1. The matter of collective bargaining for further detail.

3.2.2.1 Positive Impact of SEP Regulation on Medicine Prices

The pharmaceutical sector is characterised by a large variety of products (medicines) where price transparency and perverse incentives support the notion of regulated prices. The implementation of SEP prices has been well-controlled and increases have been mostly below average CPI and, thus, its continuation is supported.

The regulation of pharmaceutical products was introduced in South Africa in 2004 with the aim of controlling the price of pharmaceutical items. Regulations included:

- Creating pricing transparency for scheduled pharmaceuticals through the introduction of SEP.
- Removing the perverse incentives associated with discounting.
- Implementing a regulated dispensing fee that would be applied to the transparent SEP.
- International benchmarking of prices to ensure that South Africa was able to obtain pharmaceuticals at an affordable rate (yet to be introduced).
- Regulating the annual increase on pharmaceutical items in order to prevent spiralling costs.

The combination of regulations was intended to promote price transparency of pharmaceutical products. Price transparency is a fundamental component of consumer-driven care as this enables informed decision-making, drives competition and reduces unwarranted price variation.

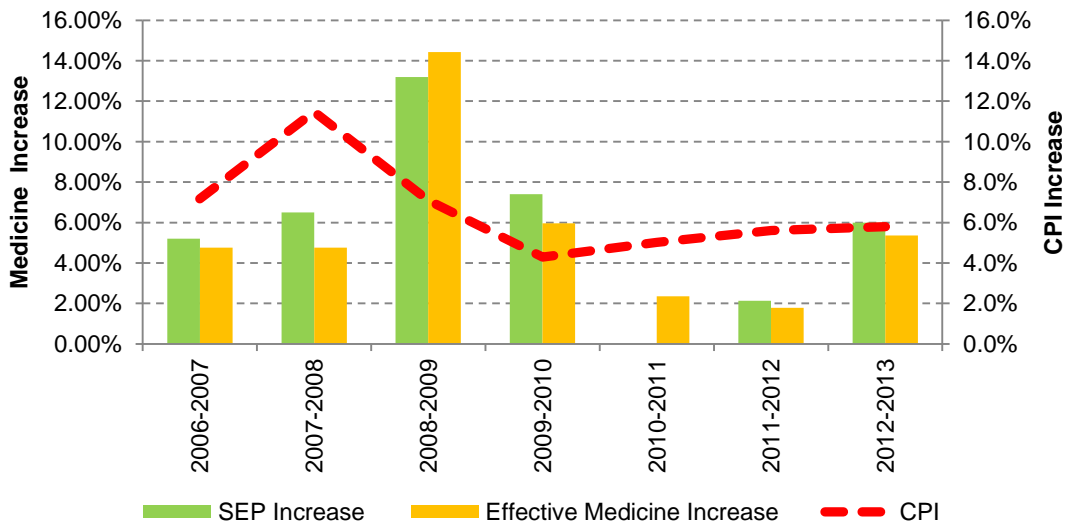
The introduction of medicine pricing regulations was met with strong opposition from stakeholders in the medicine supply chain.

However, as indicated in the figure below, subsequent to the implementation of the regulations, prices have been well-controlled and increases have been mostly below average CPI.

The Department of Health reported that the introduction of price regulation for medicines has reduced medicine prices by an average of 19%, with a 25-30% reduction in generic medicines and 12% reduction in the price of originators (Dr Anban Pillay, <http://www.ipc-undp.org/pressroom/files/ipc144.pdf>, accessed 23 June 2014).

Medscheme data demonstrates that the annual SEP increase has mostly been below the CPI increase, as detailed in the figure below. The 'effective medicine increase' refers to the average price impact across a typical basket of medicines and is typically lower than the published SEP increase.

Figure 12 – SEP and actual Medicine price increase compared to CPI (2006 to 2013)



Source: Medscheme medicine data 2006 to 2013

The introduction of SEP has not affected the availability of pharmaceutical products. Consumers are able to choose therapies based on affordability and their treatment has not been compromised as there has been an increase in the availability of generic products.

Competition has been stimulated as a result of the following:

- Increased consumer choice as SEP pricing structure has allowed Managed Care Companies to introduce formularies and reference pricing structures, thereby reducing out-of-pocket expenses.
- New entrants offering competitive prices have been able to enter the market.
- More generic products have become available, providing greater access and choice.

3.2.2.2. Lack of regulation of the prices of medical devices including surgical and consumable items

The medical devices, surgical and medical consumable sector is characterised by a large variety of products where price transparency and perverse incentives support the notion of regulated prices, similar to SEP.

Medscheme position / recommendations

It is proposed that the price of medical devices, surgical and medical consumable items be regulated in a similar way to scheduled pharmaceutical products.

The absence of price transparency on surgical and consumable items has had a negative impact on the industry:

- The consumer has a very limited view in terms of alternatives and what these items would cost.
- Competition is stifled. For instance, MediKredit maintains a surgical price file that is not available to the general public.

- Suppliers tend to use discount structures to incentivise utilisation of their products by providers, but these discounts are not passed on to the consumer.
- There is no regulated mark-up structure. With the implementation of Net Acquisition Price (NAP) by several hospital groups, most hospitals do not add a mark-up on surgical and consumable items; however doctors do apply a mark-up on items at variable rates. The mark-up is not regulated hence a consumer may pay a different price for the same items in different settings. The resulting differential between doctors and hospitals is approximately 50%.

For instance, a lens to replace a cataract may be priced at R1 500 by a hospital with no mark up. However, if a doctor bills for the same lens, a variable mark-up, unknown to the medical scheme is applied, resulting in an unforeseen co-payment.

- New technologies are entering the healthcare market every day. Without transparent pricing and international benchmarking, the cost effectiveness cannot be accurately determined and this will have a negative impact on the Medical Schemes. As a result, Medical Schemes often simply don't pay for these new technologies which results in out-of-pocket expenses for the consumer. Bearing in mind that the consumer has no access to information on alternatives and their prices so they are totally disempowered.

The introduction of a SEP equivalent structure and a regulated mark-up structure for surgical and consumable items is important to drive competition and transparency in the healthcare market.

3.2.2.3. Regulation of Prices for Services

The pharmaceutical and consumable sectors are characterised by a large variety of products (e.g. medicines) In these sectors perverse incentives are a risk. Regulated prices are an efficient mechanism to manage these costs, especially with international manufacturers. However, in terms of services the Medscheme position is outlined in Section 9.1. The matter of collective bargaining.

3.3. Issues Relating to the Basket of Goods and Services Being Purchased

3.3.1 New Technology, including Biotechnology

Expensive new technologies are flooding the market but unlike pharmaceuticals, there is no regulatory oversight to ensure product quality and transparent pricing.

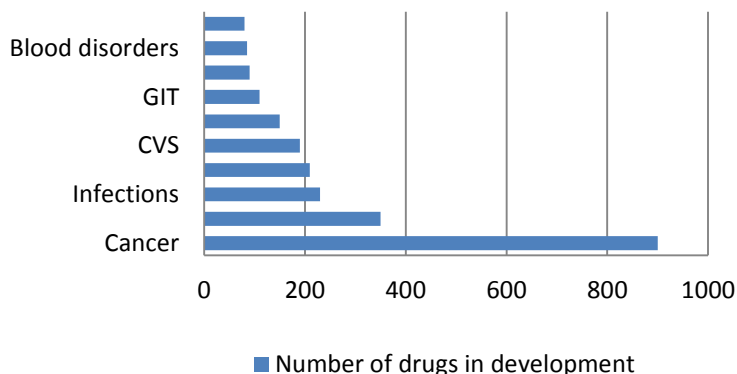
Medscheme position / recommendations

It is proposed that for many highly specialised procedures, care should be confined to Centres of Excellence.

New technologies and advances in the medical sphere are exciting and may offer great hope to many sufferers of modern ills. However, they typically also come at a financial impact.

Globally, drug innovation has shifted from the development of small chemical entities to biopharmaceuticals which are complex molecules with biological activity. Research is focused predominantly on high prevalence diseases and unmet needs, with advances in oncology being of greatest interest.

Figure 13 – Number of drugs in development per type of condition

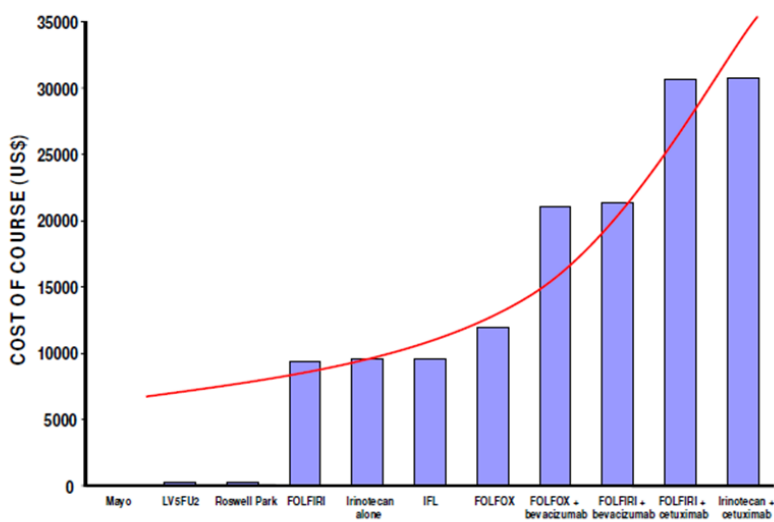


Source: Medco, R&D direction

For products that gain marketing approval, the costs are typically very high. In South Africa, prices of these speciality chronic medicines are typically in the region of R100 000 per patient/per annum or more. In the USA, in excess of 90% of cancer agents approved by the Food and Drug Administration (FDA) during the past four years cost more than US\$20 000 for a 12-week therapy course. Many of these cancer treatment regimens are added to existing treatment approaches, rather than replacing them, and despite the high costs, meaningful benefits to overall patient care are often limited. A study by international consultants Bridgehead demonstrates how marginal improvements in patient outcomes may be mirrored by exponential expenditure increases.

Figure 14 – Price of new therapies compared to additional survival delivered
 Increasing costs of new therapies vs. additional survival delivered

Colorectal cancer treatment costs

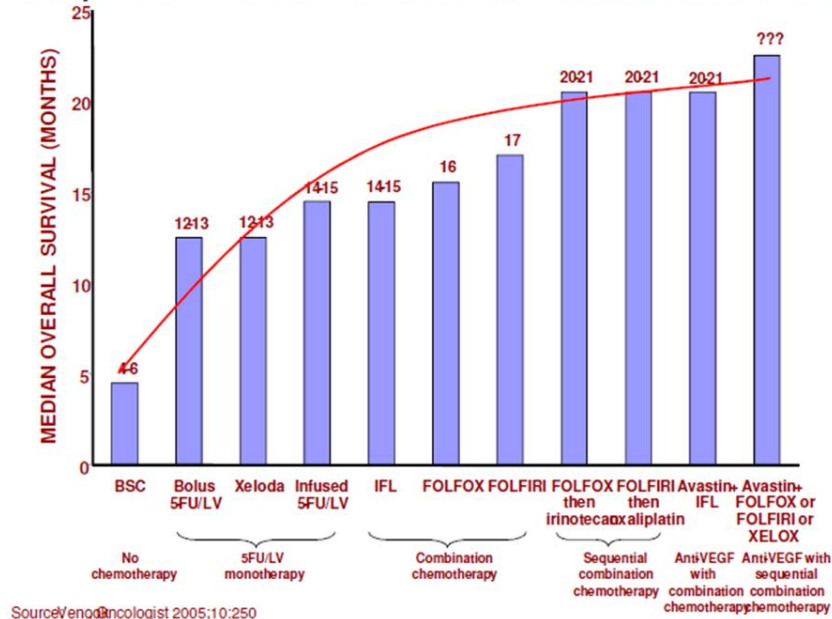


Average patient: 8 mo first line therapy + 4 mo I+C = \$161,000

Source: Schrag, NEJM 2004;351:317-9

Figure 15 – Improved survival in colorectal cancer

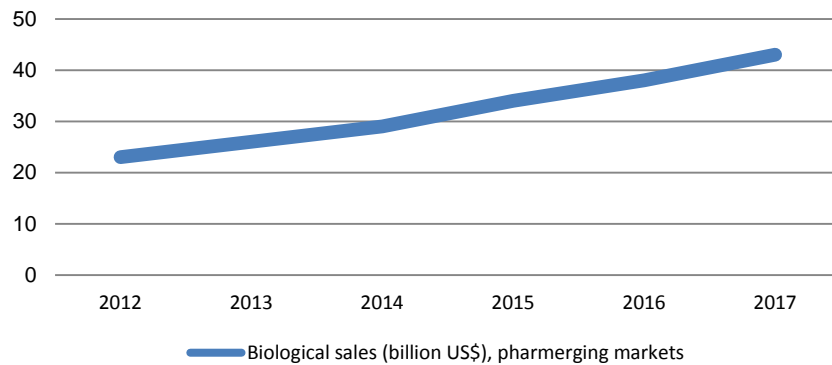
Improved survival in colorectal cancer



Source: Bridgehead International

A report by IMS, published in Nov 2013, predicts that ‘spending growth on newer innovative speciality medicines is one of the single biggest expenditure concerns for developing market healthcare systems’. The predicted rate of growth in markets like South Africa is shown below.

Figure 16 – Trend in biological drugs sales



Source: IMS

Similarly, expensive new technologies are flooding the market. Contrary to pharmaceuticals, there is no regulatory oversight to ensure product quality and transparent pricing.

A particular concern is the trend towards minimally invasive approaches across all surgical disciplines. For example, some heart valves can now be replaced without the need for open heart surgery; prostates can be removed surgically via a keyhole approach. Robots that allow ‘remote control’ surgery within the same operating theatre as the patient are the most recent technological innovation to be introduced in South Africa. Whereas some of these developments have the potential to improve patient care, they pose several challenges:

- The technologies are invariably very expensive. Even in the best of hands, the increased costs are not off-set by the introduction of other potential efficiencies, for example reduced length of hospital stay.
- Prolonged training and special infrastructure may be required to ensure that a new procedure using novel technology is safe. In the absence of a central regulatory authority, distributors of technologies, together with doctors and hospitals, set the standards for training and 'credentialing'. The vulnerability of patients within such a system is described in a case report. <http://www.nytimes.com/2013/03/26/health/salesmen-in-the-surgical-suite.html?pagewanted=all&r=0>. The negative impact on funders speaks for itself.
- Acquiring the skills of a new procedure may be associated with a long learning curve. During this time, the surgeon may spend many additional hours in the operating theatre, adding significantly to the cost of individual cases. Given the structure and demands of the private healthcare system, many specialists are not in a position to leave their practices for any meaningful periods to learn the skills required for the safe use of new technologies. Instead, learning occurs on the job under supervision as patients present.
- For many highly specialised procedures, care should be confined to Centres of Excellence. Such centres are regional sites where high volumes of these interventions are performed by skilled and experienced operators working as part of multifunctional teams, supported by the appropriate infrastructure and focussed on self-audit and peer review to optimise patient care. Regular performance of some highly specialised procedures is important from perspectives of ensuring appropriate patient selection, technical proficiency and early identification and management of complications, all of which are central to ensuring best clinical outcomes. These centres are also important from efficiency perspectives. In the absence of relevant Regulations, establishment of former is, however, not without its challenges. Competition for patients underpins the private sector. Whilst hospitals and doctors do their best to act in the interests of those who are sick, they must also be seen as offering cutting edge care. When a new technology emerges, there is a race to make it available. What may be best for the health system and patient care in general may be overshadowed by the need of healthcare institutions to be associated with the most modern technologies. Suppliers of technologies feed into this as they are interested in expanding markets. As a result, many institutions may start offering a particular service, diluting patient numbers in any single unit with none achieving critical volumes.

By means of example, when trans-catheter aortic valve implantation (TAVI) – a new way of replacing aortic valves in elderly patients – was first introduced in South Africa in 2009, it was stated that units offering the procedure should perform a minimum of 30 procedures per annum for quality of care to be ensured. Established centres abroad were advocating at least one valve replacement per week. Considering the high cost of the procedure and the limited clinical indications, this meant that there should probably be no more than two to three centres across the country performing the procedure (at least until such time that clinical indications for the procedure could be expanded on the basis of supportive data and the price of the valve reduced significantly). Given, however, competition between suppliers, as well as providers in the market, multiple units and teams have attempted to establish themselves as TAVI centres. Other than such trends diluting the number of referrals to any individual centre (undermining their ability to maintain the necessary patient volumes expected from a Centre of Excellence), sprouting of TAVI start-ups under supervision of proctors has the potential to promote poor patient selection. Proctors are experts - selected and funded by suppliers - who supervise individual surgeons during the learning phase. Commonly they travel from abroad to oversee cases.

3.4. Issues Relating to Utilisation

Refer to Section 3.1 Expenditure in private healthcare, for further detail. This section discusses some of the cost drivers associated with 'increasing utilisation' of medical services and its impact of claims expenditure.

3.4.1. Limited Underwriting and Lack of Compulsory Membership

3.4.1.1. Anti-selection in an Imperfect Regulatory Environment

The current regulatory framework is incomplete, resulting in increased claims expenditure due to anti-selection. Refer to Sections 3.4.1.2 Introduction of Compulsory Medical Scheme Membership and Section 8.1.1 Regulatory Environment for the Medscheme position.

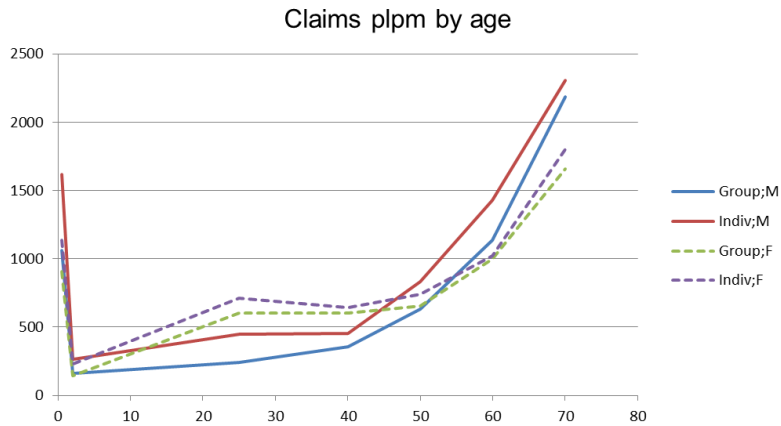
In the South African environment with limited underwriting and without compulsory membership, the consequences can be summarised as follows:

- Perverse incentives are evident and applied to help secure sustainability and growth.
- Risk management techniques are extended to utilise benefit design, marketing and broker commission to attract good profile lives.
- Anti-selective behaviour is evidenced, such as people not joining schemes when they are healthy, increasing claims experience.
- Schemes may end up in an 'actuarial death spiral', where contributions are too high, resulting in healthy members leaving which results in even higher contribution requirements. Schemes then need to amalgamate or close.
- Increased claims and expense costs due to the above items.

McLeod, H., Grobler, P., & van der Berg, S. estimate the following from their work; "prices of minimum benefits [PMBs] are some 17% to 23% more expensive than they could be under... mandatory cover". They claim that approximately 14% is due to simply including the younger lives into the medical scheme pool and the remainder is due to primarily anti-selective behaviour.

If one considers group business, in many respects it approximates a compulsory environment. Comparing the claims experience to that of individual business provides an estimate of the impact of anti-selection. For this purpose, the claims experience of 1,000,000 lives in the Medscheme database was used to assess claims experience by groups vs individual, risk adjusted for factors such as age, gender and Peral status. The graph below depicts the age claims expenditure curve, showing that individual lives consistently claim more than group lives.

Figure 17 – Claims per life per month (plpm) for Mandatory vs Voluntary Membership



Source: Medscheme 2012 hospital claims data, 2,000,000 life years

On average, individuals claimed 25% higher than group lives of the same age, gender, etc. More anti-selection was evident at younger ages and for males.

Two case studies are provided below highlighting the impact of anti-selection.

Case Study 1: Option movements each year on 1 January

Members are able to change options on 1 January each year. This analysis considers the existing member movements, the exits and new joiners over 31 December to 1 January. Age is used as a proxy for expected claims impact. Scheme 3 was a scheme that was considered to be in an actuarial death spiral and amalgamated as a result.

Table 1 – Option Change Selective Behaviour's Impact on Claims

Impact on Claims of Option Changes at 1 January				
Scheme ID	Scheme Type	Year-2	Year-1	Year 0
1	Open	+0.0%	+0.1%	+0.5%
2	Open	+0.0%	-0.1%	+1.9%
3	Open	+0.7%	+0.7%	+1.7%
4	Open	+0.4%	-0.6%	+0.1%
5	Open			+0.0%
6	Closed			-0.5%

Source: Medscheme data

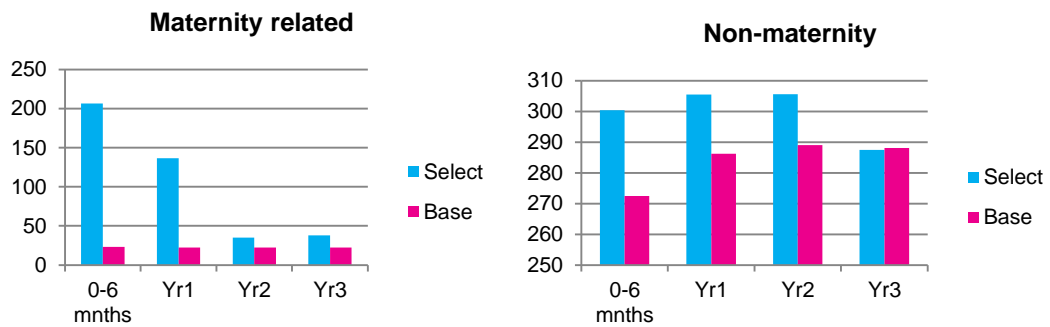
Conclusion: Selective behaviour at 1 January option changes increase claims costs, particularly in specific cases of amalgamations or a struggling scheme.

Case Study 2: Impact of removing entire underwriting for 6 months

In this case study, an open scheme waived all underwriting for a period of 6 months. During this period, 15 300 lives joined, with most joining in the last 2 months as the message spread in the market. Unfortunately, half of the lives left within 3 years; most within the first year. The average member age was 35, which was better than the schemes average, but it increased rapidly as the members left.

The graphs below show the hospital admission rates, of the lives joining during the concession period relative to that of the remainder of the Scheme, split for maternity and other events.

Figure 18 – Case Study Admission Rates: Anti-selective Lives vs Non-selective Base



Source: Medscheme open scheme data

In the first 6 months to 2 years, the admission rates were significantly higher than that scheme’s average. Over time the experience tended to the normal levels. However, in the interim, the financial impact amounted to 10% of contributions over the 3 year period; a 6-month underwriting concession resulted in costs equal to approximately 3 years’ worth of managed healthcare fees (that scheme had paid to try and manage claims costs).

The above comments indicate cost drivers associated with the imperfect regulatory environment. However, approximately 70% of the private healthcare market is employer business. Employer business (corporate employers) mostly have compulsory membership as part of their employee contractual obligation and, thus, anti-selection in this sector of the market is less of an issue and is limited mostly to 30% of the market currently. (There is a concern, however, that the regulations going forward don’t support a sustainable market.)

3.4.1.2. Introduction of compulsory medical scheme membership for employed people earning above the tax threshold

Refer to Section 8 Regulatory Environment for Medscheme position.

Medscheme position / recommendations

It is recommended that medical scheme membership be made compulsory for formally employed lives earning above the tax threshold. Introduction of compulsory medical scheme membership, based on a Competition Commission recommendation, will improve affordability and sustainability of the private healthcare industry. The recommendation should ideally be coupled with affordable income based contributions and the benefit option should be closer to a PMB based package. Failing this, medical schemes should be allowed to risk rate (at least partially) and fully underwrite to ensure a sustainable private healthcare market.

The implementation of open enrolment, community-rating and PMBs requires either (1) a risk rated insurance legislated structure if membership is voluntary, or (2) a compulsory legislative structure, if no risk rating is allowed. This is necessary to ensure a sustainable industry in the medium to longer term.

It is suggested that a risk rated environment is only palatable where the State is able to adequately provide quality and accessible care to the indigent and high risk lives, such as through a government run medical scheme or State providers. In the healthcare sector in its current form, thus, compulsory membership is required.

In addition, a key challenge facing the private sector is the ability to attract young and healthy members. Given the high costs of private medical scheme membership, those without chronic ailments or those at low risk of disease are less likely to prefund healthcare than those with chronic conditions or those at high risk thereof. Young and healthy members are, however, important from perspectives of cross-subsidisation.

Introduction of compulsory medical scheme membership, based on a Competition Commission recommendation, will improve affordability and sustainability of the private healthcare industry.

An expenditure reduction of 9% and an increase of 4,500,000 lives were demonstrated because of the introduction of mandatory membership for *employed people earning above the tax threshold* in a report by actuary H. McLeod et al². This same report alludes to a further 5% saving that could be achieved by removing the anti-selection effect associated with pregnant or chronically ill lives only joining when they need cover.

The simplest method to enforce membership is to utilise the tax system. A simple model may be to apply penalties to employed lives that have not joined a medical scheme. A more complex model may require SARS to collect the contributions through the tax system and allocate these to medical schemes.

3.4.2. Variance in the / Cost of Delivering Care

Claims expenditure and claims increases are partly due to increasing utilisation of healthcare products and services. A driver of costs in this respect relates to technical inefficient delivery of care, as evidenced in the variability of claims per expenditure across providers, after adjusting for case mix and demographic differences.

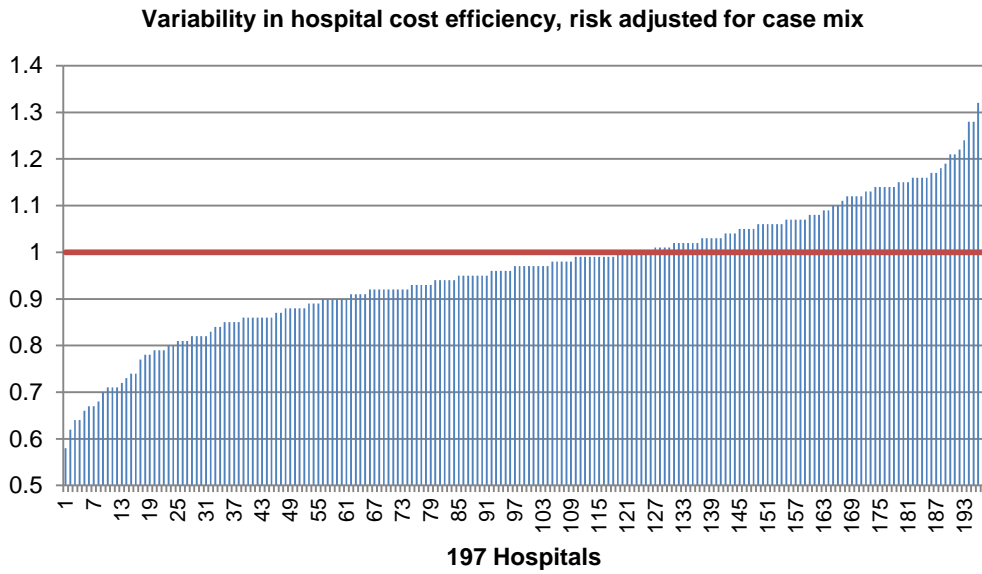
3.4.2.1. Hospital expenditure variability

The analysis below highlights the variance, and thus technical inefficiency, of healthcare delivery by comparing 197 hospitals' claims expenditure efficiency after risk adjusting³ for differing patient and case mix. This clearly highlights the need to improve care delivery by lowering the cost of care of the worse 50% of providers, to the best 50% for example. Hospital reimbursement models are negotiated nationally and this dynamic removes incentives to improve specific hospitals' performance, since the larger hospital groups' cost efficiency overall is often near the industry average.

² McLeod, H., Grobler, P & van der Berg, S. *Preliminary Estimate of NHI Costing in 2009 Rand Terms: McLeod-Grobler-Van der Berg Model Methodology and Assumptions*. 18 February 2010.

³ Risk adjusting is done using regression statistical techniques to adjust for differences in case mix and demographic factors, allowing a like-for-like comparison.

Figure 19 – Hospital claims expenditure inefficiency



Source: Medscheme 2013 data, 2,400,000 life years

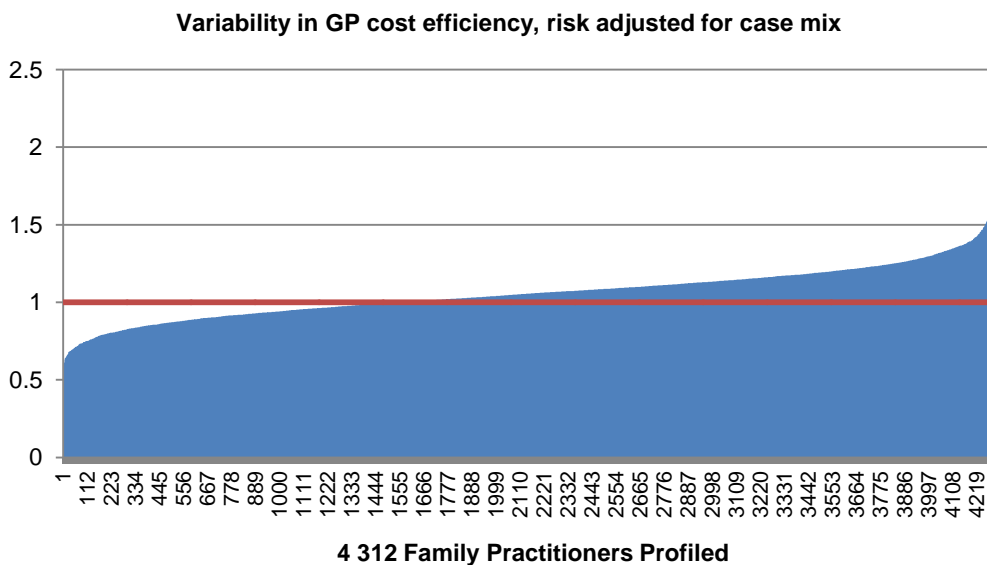
This variability in care delivery is also evident in other healthcare provider or practitioner claims experience outcomes.

3.4.2.2. Fragmented Care

Claims expenditure is partly driven by increased utilisation of products and services. This is evident in fragmented care delivery systems as discussed in this section.

The figure below shows the variation in claims expenditure of 4,312 profiled GP practices after risk adjusting for differing case and patient mix. This variation depicts a level of inefficiency in the delivery of care, translating into higher claims expenditure.

Figure 20 – Family Practitioner claims expenditure inefficiency



Source: Medscheme 2013 data, 2,400,000 life years

A number of practices are at least 50% more claims expenditure inefficient than the average e.g. minor procedures performed in theatre instead of out-of-hospital, albeit a minority. Nevertheless, it is evident that there is a wide variation in costs associated with delivering care.

The provision of healthcare services is distributed across a variety of distinct and often competing entities, often in the absence of a primary care practitioner (PCP). The South African private healthcare sector has many features that contribute to fragmentation of care delivery:

- Independent primary care practices which are focused on acute events and do not have dedicated personnel or an information infrastructure to coordinate care effectively (i.e. few multidisciplinary practices);
- Reimbursement structures and scheme benefit design that do not reward efforts to coordinate care;
- Different healthcare practitioners and facilities competing to render the same or similar services;
- Eroded relationships between different healthcare professionals and facilities and as a result poor quality of referral information; and
- Coordinating care requires effort, time and is labour intensive.

It is suggested that poor coordination of care (fragmentation) not only makes care more expensive than it needs to be – through ineffective, duplicative and unsafe practices – but results in poor outcomes and patient experiences.

Many current proposals to increase the value of health care focus on coordination of care. If designed thoughtfully, targeted coordination of care can improve patient experiences with the healthcare system and their healthcare outcomes as well as reduce wasteful spending in the long run⁴.

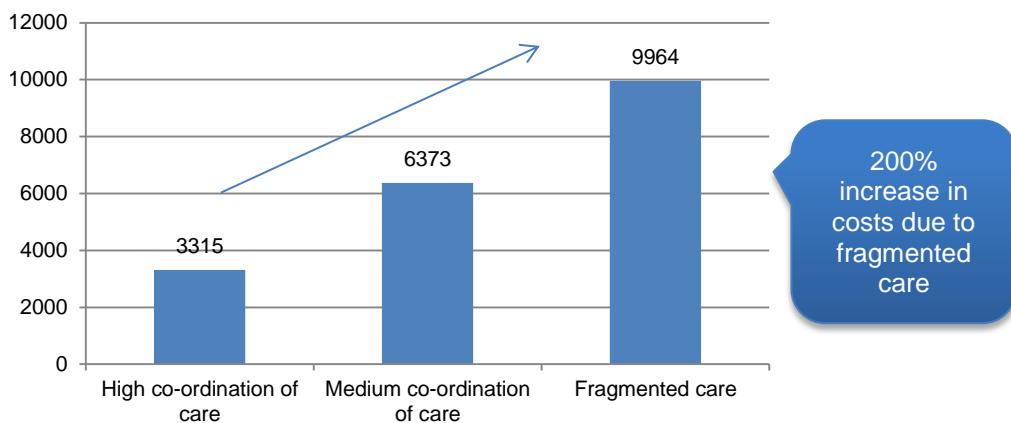
The figure below summarises an analysis of claims costs for Medscheme clients separated by the level of co-ordinated care received by high risk patients, relative to fragmented care. The methodology employs the internationally recognised Adjusted Clinical Grouper (ACG®) of the John Hopkins University in the United States (see ref: <http://acg.jhsph.org/>). The following four markers that make up the ACG Coordination Markers are:

- Majority Source of Care - this marker provides an assessment of the level of participation of those providers that provided care to each individual.
- Unique Provider Count - this marker provides a count of the number of unique providers that provided care to the individual.
- Specialty Count - this marker provides a count of the number of specialty types that provided care to the individual.
- Generalist Seen - this marker indicates whether a generalist is participating in an individual's care.

By combining these markers, coordination risk is determined (i.e. whether a person has a likely, possible, or unlikely coordination issues), categorised as high or medium coordinated care or fragmented care in the figure below.

⁴ Traver A. The Promise of Care Coordination: Transforming Health Care Delivery. Families USA, April 2013

Figure 21 – Claims costs (R) per life per month for high risk patients by the level of care co-ordination



Source: Medscheme’s Health Intelligence Unit

The above analysis highlights the importance of co-ordinated care in ensuring cost effective treatment and the removal of unnecessary duplication of costs, such as pathology tests. Moving from an environment where care is co-ordinated, towards a fragmented care environment, results in claims costs approximately tripling.



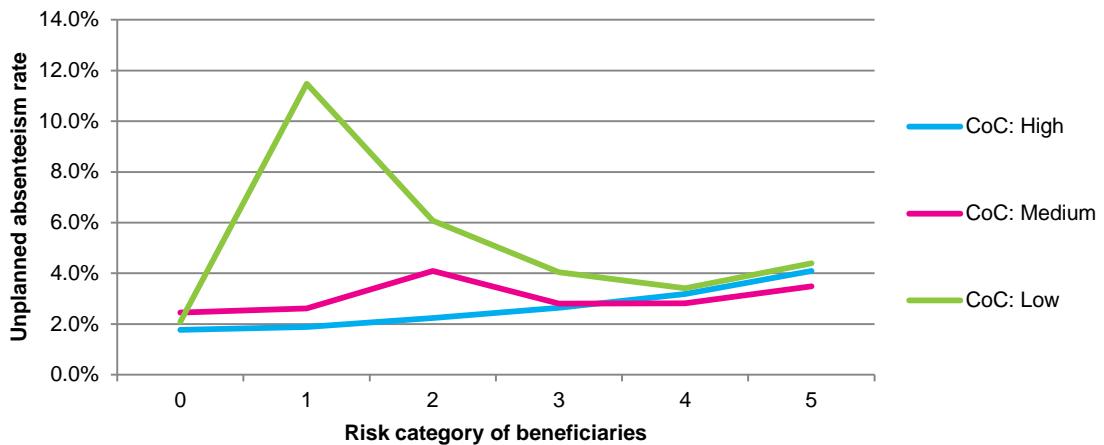
Fragmentation of care is a widely recognised and documented phenomenon associated with poor cost effectiveness and quality of care. Worldwide effort and cost is incurred in order to better ensure co-ordinated care is provided in the correct setting at the correct time. In South Africa it is no different – in fact it is more of a concern in the private healthcare industry following years of market practice where patients can access specialist care without first seeing primary care physicians. Over the past decade, GPs and specialists interacted less and less. Pathology and radiology test results are not shared between healthcare practitioners. Specialists do more primary care and often in the most expensive setting, namely acute hospitals.

Medscheme has identified a lack of co-ordinated care as a fundamental issue and over the years engaged with clinical leadership in efforts to improve the care provided to beneficiaries. The evidence that co-ordinated care provides better health outcomes at lower costs is widely documented internationally, but also evident in analyses performed by Medscheme’s integrated actuarial, statistical and clinical health informatics team.

The analysis in section 3.4.2.2 earlier highlights the importance of co-ordinated care in ensuring cost effective treatment and the removal of unnecessary duplication of costs, such as pathology tests. Moving from an environment where care is co-ordinated, towards a fragmented care environment, results in claims costs approximately tripling.

Co-ordination of care (“CoC”) has also been shown by Medscheme to improve quality outcomes and reduce unplanned absenteeism amongst workers. The figure below highlights the reduction in employee unplanned absenteeism (sick leave) as care co-ordination improves.

Figure 22 – Unplanned Absenteeism by the Level of Care Co-ordination



Source: Medscheme data 1,000 life years, 2013

The above results allow for differences in risk profile of patients and are thus a true reflection of the importance of co-ordinated care.

By improving CoC ; costs, quality and employee productivity are improved. The sections below describe areas, in respect of CoC , that require improvement to support a more effective private healthcare market.

3.4.3. The role and value of networks

Healthcare practitioners and providers have a significant influence on increasing utilisation of services and claims expenditure. Contracting and engaging with healthcare providers has been shown to be of value and requires further Regulatory support. Refer to Section 3.4.4 Inability to Selectively Contract for further detail.

Networks of healthcare providers are essential in delivering cost effective healthcare and are a cornerstone of any co-ordination initiative. In the private sector, there is no incentive for healthcare practitioners to practice co-ordinated medical care. More commonly healthcare practitioners have become sole enterprises working under fee-for-service arrangements.

Fee for service (FFS) payment methodology is the most common reimbursement model in our private healthcare system. The advantages are that it is has been around for a long time, is well understood, flexible for use by any organisation or location and administrative systems are aligned to processing FFS claims.

Conversely movement away from the current FFS system has been a key element of payment reform in most healthcare systems in the world. The FFS system is thought to be a significant contributor to increasing costs in healthcare. The main reasons for this are;

- The FFS payment methodology inherently incentivises volume, not value.
- The FFS system inherently incentivises fragmentation of care. Every service provider submits an independent account based on the volume and type of services they rendered. There is no collective financial responsibility for outcomes and value. The outcome from a beneficiary perspective is the sum of the collective performance of all stakeholders.

- Tariffs remain the same regardless of outcomes. The FFS system delinks cost effectiveness, outcomes, adherence to best practice from the tariff.
- The FFS system does not incentivise innovation in terms of producing better outcomes in a more efficient and cost effective manner.

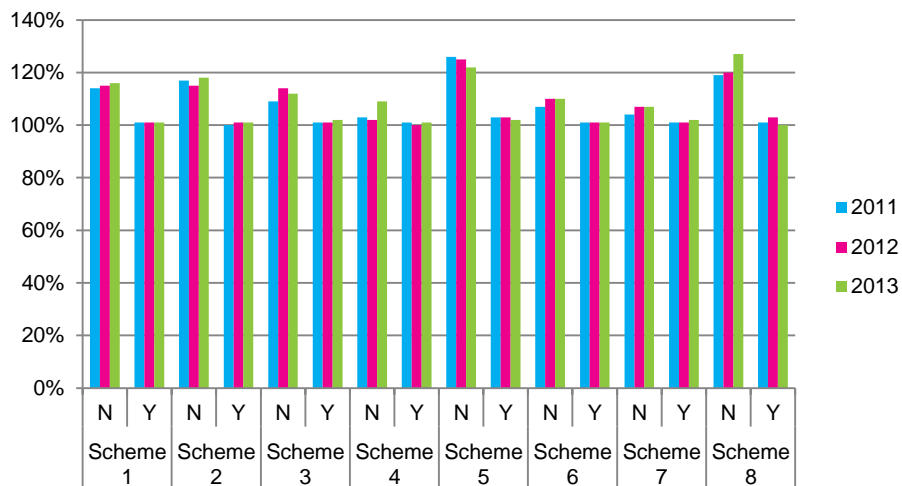
Thus, it is necessary to contract providers into networks in order to facilitate and support the best delivery of cost effective co-ordinated care.

Healthcare provider networks have proven their value in:

- Protecting the scheme (and thus its members) from excessive PMB overcharging and protecting beneficiaries from co-payments for PMB claims.
- Protecting beneficiaries from co-payments for non-PMB claims.
- Ensuring better patient quality outcomes.
- Increasing the utilisation of cheaper generic instead of branded medicines.

The figures below highlight these dynamics for schemes managed by Medscheme. The first figure highlights protection of the scheme from PMB overcharging by comparing the average tariff billed by GPs for PMBs out-of-network (indicator = 'N') to in-network (indicator = 'Y'). Out-of-network tariffs are higher and generally increase at a greater rate than in-network providers.

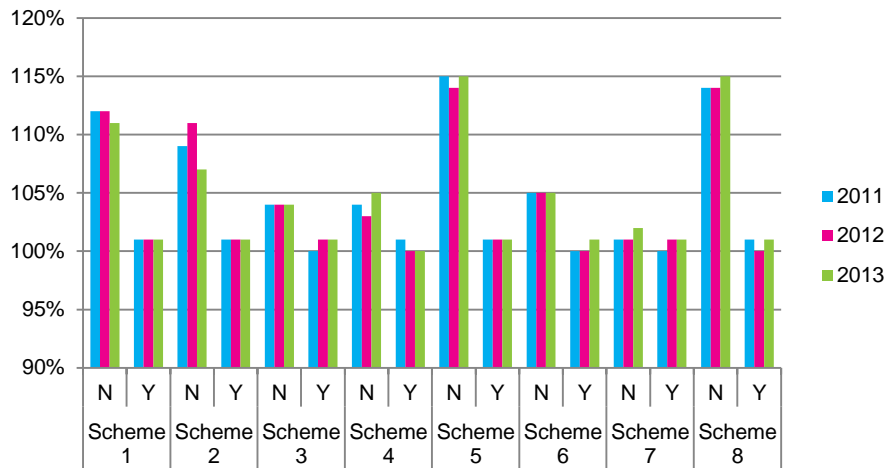
Figure 23 – Average GP tariff rate billed for PMBs out-of-network (N) vs in-network (Y)



Source: Medscheme data 2011 to 2013, 8 schemes with GP networks

The next figure depicts protection of beneficiaries from co-payments for non-PMB claims by comparing the tariff billed by GPs for non-PMBs out-of-network (indicator = 'N') to in-network (indicator = 'Y'). Out-of-network tariffs are higher and imply beneficiary co-payments would be incurred if the network were not in place.

Figure 24 – Average GP tariff rate billed for non-PMBs out-of-network (N) vs in-network (Y)



Source: Medscheme data 2011 to 2013, 8 schemes with GP networks

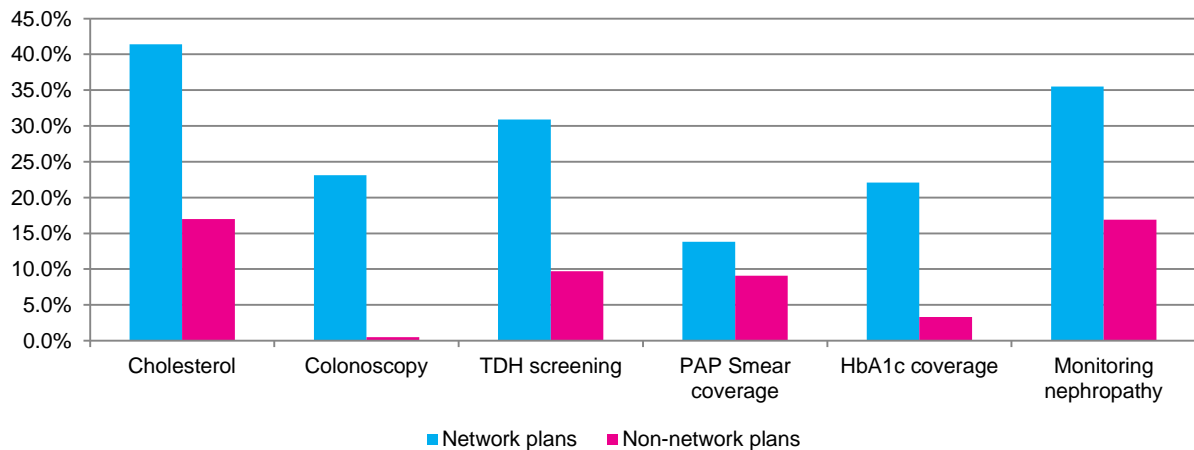
The next figure depicts the quality outcomes of plans with GP networks relative to plans without networks. Network plans consistently show improved quality outcomes relative to non-network plans.

Essentially networks

- encourage better co-ordinated care of patients
- provide mechanisms to monitor and report quality and claims expenditure outcomes and
- allow incentives to be paid to encourage best practice.

Figure 25 – Ensuring better patient quality outcomes in schemes with networks

Percentage improvement in Indicators of Clinical Care from 2007 to 2013: Schemes with GP Networks vs Schemes without GP Networks



Source: Medscheme data 2007 to 2013

Figure 26 – Screening Measures case study for a large scheme with networks

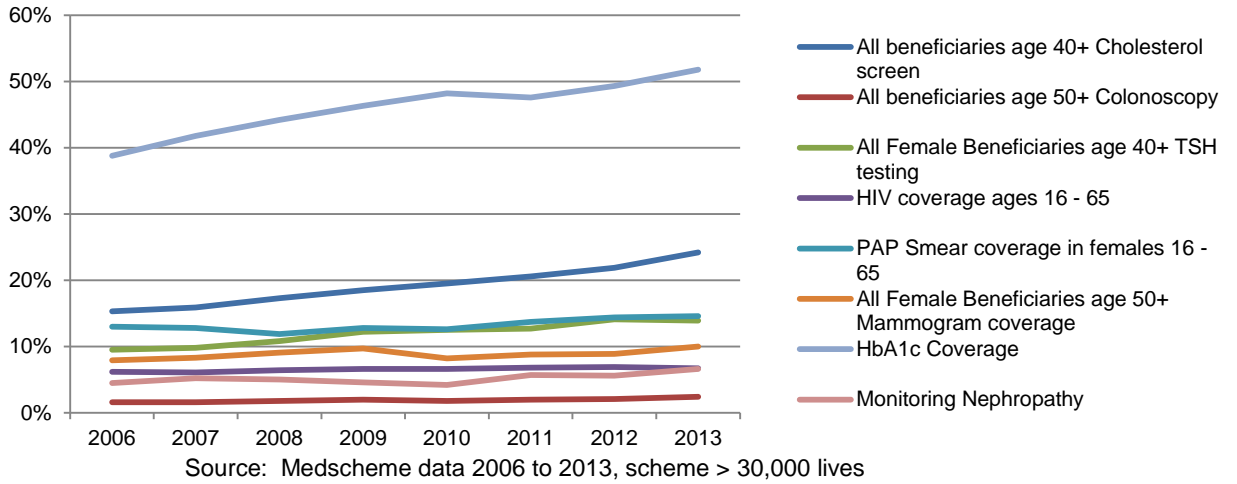
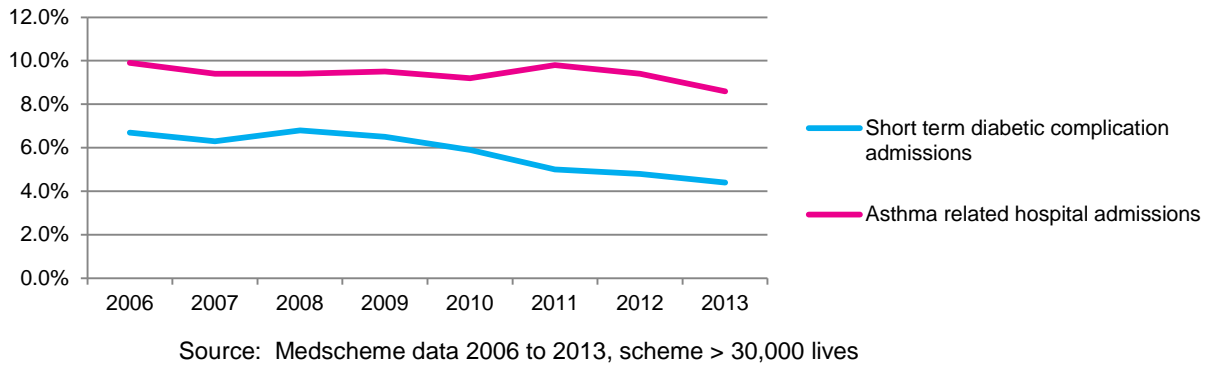
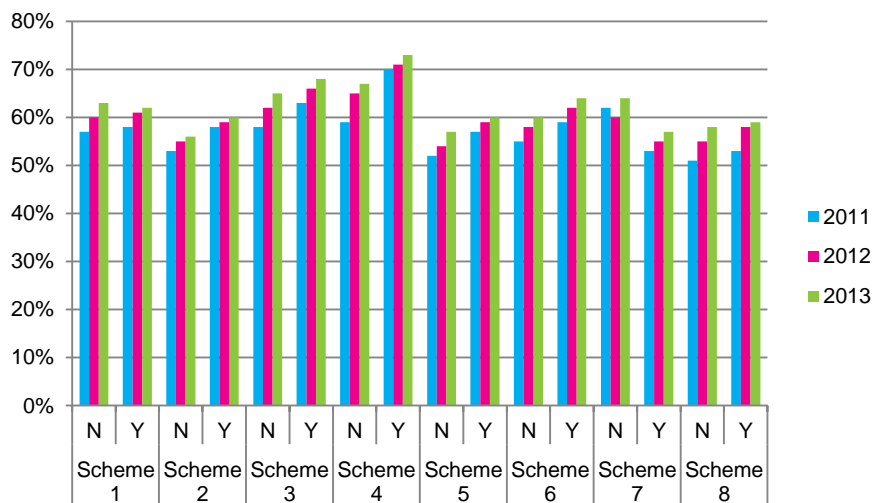


Figure 27 – Outcome Measures case study for a large scheme with networks



The figure below shows the higher and increasing proportion of cost-effective generic medicine utilisation for in-network providers.

Figure 28 – Proportion generic medicine utilisation for out-of-network (N) vs in-network (Y) providers



Source: Medscheme data 2011 to 2013, 8 schemes with GP networks

The evidence above supports the need for contracted networks. It is worth mentioning that the above networks are intensely managed, with detailed risk adjusted profiling and incentivised reimbursement mechanisms employed.

The value of networks is globally supported as a requirement for best practice healthcare systems.

3.4.4. Inability to Selectively Contract

Healthcare practitioners and providers have a significant influence on increasing utilisation of services and claims expenditure. Contracting and engaging with healthcare providers has been shown to be of value and requires further Regulatory support.

Medscheme position / recommendations

It is proposed that the contracting legislation as reflected in the MSA and Health Professions Act be reviewed to create a more balanced environment that will enable health care funders to more easily contract on the basis of cost and quality outcomes. In addition funders should be able to selectively procure healthcare services in a competitive contracting environment where specialists can compete on cost and quality outcomes for a limited number of opportunities (whilst ensuring access to care). This is no different to how any other efficient market would procure services.

The tender process is already one of the mechanisms by which medical funds selectively procure services from other third party service providers. This allows for an ongoing commercial arrangement based on contracted outcomes and service levels.

It is suggested that elements of this process be incorporated into the MSA and Health Professions Act (which should be aligned in their objectives). The rules must ensure that all willing participants have the opportunity to participate in such a competitive process. In addition the criteria for determining reasonable access and for which services it is reasonable to restrict access need to be determined.

Contracting of healthcare providers is an internationally accepted health risk management intervention with the objective of providing beneficiaries of medical schemes access to affordable and quality care.

In order to be an effective intervention the contracting of healthcare providers needs to be done within a framework that balances the needs and rights of the key stakeholders whilst still allowing the intervention to be effective in achieving its objectives. Specifically:

- The beneficiaries right to freedom of choice even if this is at the “price” of a higher contribution,
- The healthcare provider’s right to practice their profession “freely” within the legislative and ethical framework of the relevant governing entity,
- The healthcare funders’ requirement to act as a strategic purchaser of healthcare services for its contributing members. This is to ensure that contributing members have access to affordable and quality care.

The key determinant of this environment is the legislative and ethical framework within the South African private healthcare environment.

Medscheme believes that empowering healthcare funders to selectively contract healthcare providers in certain circumstances (within a fair framework) is critical to achieving the objective of access to affordable and quality care, specifically:

- Driving volume to a limited number of centres where complex procedures are performed will improve outcomes (and cost) as surgeons will have the “numbers” to develop and improve skills.
- Will create opportunities to exchange volume for discount.
- Volume of any specific intervention in specialised centres will create opportunities for process and procurement efficiencies (e.g. prostheses) which will reduce total claims expenditure.
- It is easier to measure, monitor and develop a relationship with a few specialised centres performing large volumes of procedures than individual specialists sporadically performing procedures.
- At an industry level will encourage the more efficient use of scarce specialist resources.
- A limited number of centres within a framework where the contractual relationship is re-evaluated regularly will create competition on outcomes and price between different providers.

It is argued that the current legislative and ethical framework for contracting of healthcare providers is not practically aligned to achieving the objectives above. At the core of the issue is the practical difficulty of selectively contracting with healthcare providers where it would be in the best interests of beneficiaries and healthcare funders to limit access to a limited number of centres that are able to deliver best expenditure and quality outcomes. The reasons for this are unpacked below.

Current status

The contracting of healthcare providers is governed by the current legislation;

The MSA requirements for contracting healthcare providers

Regulation 15E (2) in terms of the Act stipulates the following requirements that need to be adhered to when setting up a healthcare provider network:

“A managed health care organisation or a medical scheme, as the case may be, may place limits on the number or categories of health care providers with whom it may contract to provide relevant health services, provided that—

- (a) there is no unfair discrimination against providers on the basis of one or more arbitrary grounds, including race, religion, gender, marital status, age, ethnic or social origin or sexual orientation; and*
- (b) selection of participating health care providers is based upon a clearly defined and reasonable policy which furthers the objectives of affordability, cost-effectiveness, quality of care and member access to health services.”*

It needs to be noted that although the Act indicates that limits on the number or categories of health care providers is permissible it provides no framework or detail on what would be a “reasonable policy” and who should determine this. In addition the implication of the “Act” seems to be that medical schemes are obliged to contract with any specialist who meets these so called criteria.

No clear provision is made within this framework to accommodate a situation whereby the scheme believes it only requires the services of one “specialised centre” within a region. As an example there may be a number of centres that meet the criteria but the scheme would like to contract exclusively with the centre it believes delivers the best value and outcomes for its members whilst still providing access. The same principle applies when a medical scheme procures managed care services.

In the current environment specialists and hospitals are incentivised to perform any new intervention to increase their income. Providing a fair enabling framework for selective contracting will enable healthcare providers to compete on outcomes (price and quality) which will benefit the beneficiary and medical scheme.

The HPCSA's policy on preferred provider agreements

The Medical and Dental Professions Board (MDPB) of the HPCSA issued a policy statement in April 2004 saying that it is concerned that patients' rights to choose their medical doctor freely, could be severely compromised if medical schemes are allowed to sign agreements exclusively with selected doctors as designated service providers (DSPs).

The MDPB resolved that it had no objection in principle to a medical scheme notifying its members of DSP agreements (preferred provider agreements) entered into with specific doctors, provided that:

- all doctors in the area(s) concerned were informed that they could apply to be preferred providers for the scheme. Furthermore, that no practitioner was unreasonably excluded from being a preferred provider for that scheme;
- the patient was not deprived of his or her right of freedom of choice of a medical practitioner, albeit that it might cost the patients more;
- practitioners who were approached to enter into preferred provider agreements with any organisation were obliged to ascertain that the provision of informing other practitioners had been complied with.

In the opinion of the MDPB, DSP agreements not complying with the aforementioned conditions have the potential of compromising patients' rights to choose their doctor or a particular facility for treatment and will exclude some doctors from the opportunity to become DSPs. A doctor entering into a DSP agreement under these circumstances will transgress the HPCSA's ethical rules with potential serious consequences.

The MDPB noted that the Regulations to the MSA appeared to be in direct contravention with its Ethical Rules. It, however, consequently cautioned doctors against entering into such agreements, without checking that the specified conditions had been met.

At face value it would seem the HPCSA ethical rules are not supportive of a competitive environment where there is competition on the basis on cost and quality outcomes. On the contrary it could be argued that these rules are designed to protect the doctor's access to the benefits of pooled funding rather than accountability for cost and quality outcomes. The policy then goes on to hold doctors accountable for ensuring that other practitioners have been informed of the same offer. This policy appears somewhat collusive, protective and counter intuitive to the establishment of a competitive environment.

Competition Act No. 89 of 1998 – its relevance to networks

Section 4(1) of the Competition Act prohibits an agreement between parties in a horizontal relationship if it has the effect of substantially preventing, or lessening, competition in a market. A "horizontal relationship" is defined as a "relationship between competitors". Specialists located within particular geographic areas are likely to be seen as competitors of each other.

Section 5(1) of the Competition Act prohibits an agreement between parties in a vertical relationship if it has the effect of substantially preventing, or lessening, competition in a market. A “vertical relationship” is defined as a “relationship between a firm and its suppliers, its customers, or both”. In a network arrangement, specialists will probably be regarded as suppliers of services to Medscheme and/or the relevant medical scheme.

Having regard to the foregoing along with the fact that there are a limited number of specialists (and further per discipline) in South Africa, it is necessary to carefully consider the structuring of such specialist network agreements in order not to contravene the Competition Act.

Impact on current status

The current environment and legislative framework has created an environment where it is extremely difficult to contract with healthcare providers.

In the Medscheme environment there have been successes in contracting on tariff (payment arrangements). This is simply a payment arrangement which is put out as an offer in the market and open to any willing specialist. As such the criteria are clear and easy to articulate. The objectives are related to providing a designated service provider (DSP) network for PMBs and members’ access to healthcare providers where there no co-payment is due. The uptake on these contracts appears to be related to the rate offered and the complexity of contracting.

These payment arrangements fall short of addressing the need to contract on cost and quality outcomes and also make it difficult to restrict the size of the network when required. Even in these simple arrangements the contracting process is complex and has been a considerable source of conflict with the professional societies and the contracting medical schemes.

Contracting effectively on cost and quality outcomes within the framework outlined above will significantly improve the ability of medical schemes to manage claim expenditure related cost drivers.

3.4.5. Inability to Employ Medical Practitioners

The MSA should be amended to accommodate alternative healthcare models that will eliminate distortions within the private healthcare market. Legal obstacles inhibiting the development of integrated multidisciplinary healthcare delivery models and preventative care programmes must be defined and addressed.

Medscheme position / recommendations

It is proposed that the ethical and professional rules of the HPCSA that were promulgated in the Government Gazette in 2006 with subsequent amendments be revised to expand the definition of recognised employment agencies and criteria for employment of doctors, in order to allow innovative healthcare delivery structures.

The definition of recognised employment agencies and criteria for employment described in the policy document of the Health Professions Council of South Africa (HPCSA) on undesirable business practices, published on 22 September 2005, limits the possibility of the development of multidisciplinary models that will allow for innovative service delivery models in corporate and managed care settings.

Ownership status and alternative management / reimbursement models have been demonstrated to create a more dynamic environment that stimulate competition and lead to improved quality and efficiencies, especially in less complex hospital and ambulatory environments. Appropriate regulation must however be in place to prevent anti-competitiveness in specific circumstances. For instance, the practice of hospitals employing doctors is not recommended as this has been shown to result in increased expenditure due to unnecessarily higher levels of care, e.g. procedures performed in theatre instead of in doctors' rooms, as well as restricted referrals outside of the specific hospital's environment⁵.

Gains to the funder and consumer are most likely to be achieved in primary and community care settings.

The following objectives are more easily obtained by implementing the aforementioned model:

- Improved performance: Opportunities for high performing corporate business organisations, including managed care and other entities, to employ doctors and other medical staff, have led to turn-around of existing poor quality and cost performance. This drives competition and has been successful in the United Kingdom (NHS).⁶
- Affecting behaviour change: Behaviour change of both doctors and patients have been more successful because of the performance management and reward mechanisms that are unique to the multidisciplinary environment. This led to improved health outcomes.
- Coordination of care: The sharing of information through new technology and team-based care is implicit in this multidisciplinary model, leading to coordination of care with improved quality and efficiencies.
- Selective and strategic employment or contracting is the start of a "virtuous cycle" of increasing performance.
- Comprehensive healthcare offering: The full spectrum of preventative and disease management services is more easily provided by multidisciplinary practices. These services address both short- and long-term quality outcomes.
- A focus on wellness: Mechanisms to promote preventative care and reward compliance with evidence-based clinical pathways are similarly part of the corporate or managed care driven multidisciplinary practice models.

Background

The policy document of the Health Professions Council of South Africa (HPCSA) on undesirable business practices published on 22 September 2005

The HPCSA states under section 2.2.2 of their 2005 policy document (employment of practitioners) that:

"The first question should be whether it must be permissible for any person or body to employ a health care practitioner. If the answer is yes, the matter must be considered on the following basis.

In general the employment of practitioners is a complex issue which in some instances may be beneficial to patients and in others may expose patients to the same risks as referred to under corporate involvement. It is therefore suggested that employment of practitioners be decided on an ad-hoc basis by a committee to which reference will be made later in the document.

As a basis for considering these applications, the motive for the proposed employment should be carefully considered. If the motive is to generate income to the employer, or remunerate the employee on a fee-sharing basis, it should not be approved. A profit motive may also lead to the employee being

⁵ Dash P and Meredith D, November 2010 "When and How Provider Competition can Improve Healthcare Delivery" McKinsey & Company Insights and Publications.

⁶ Ibid supra 1

required to reduce spending and as a result benefit from the savings, which is also not consistent with good practice.

It should however be possible for, i.e., Universities to employ practitioners to render a service to students. Also, in some instances, patients who can afford to pay for treatment received at such institutions as part of the student training programme. In such instances, where treatment is part and parcel of the clinical training of students, funds so generated should be available to the institution.

These aspects should be considered carefully in the case of managed care organisations wishing to employ practitioners.

The following employment agencies would be recognised for the purposes of employing practitioners that are registered under the Health Professions Act:

- The Public Service;
- Universities / Training Institutions (only limited for purposes of training and research);
- All registered persons within the HPCSA may also employ fellow registered practitioners.

Any other agent; institution; person may lodge an application with the HPCSA for the purposes of employment of a practitioner registered with the Health Professions Council save that any other employment which falls beyond the professional practice is not required to lodge an application with the HPCSA.

If employment of practitioners is to be approved, applications for employment should be carefully considered taking the following criteria into consideration:

- Motive or goal: This should indicate the reason for employment.
- Service to specific groups of people: Such as non-profit, charitable and similar organisations.
- Private Hospitals should not be allowed to employ because of a profit motive.
- Training of students: Such as at Universities as set out above.
- Clinical independence of practitioner: Practitioners should refrain from engaging in practices that would compromise patient care or in services not indicated in order to acquire financial or material benefit. No un-due influence should be exerted on practitioner to compromise his clinical independence.
- Method of remuneration: There should be no perverse incentives. This includes undesirable practice enriching a practitioner either financially or in kind at the cost of a payer for professional practice with no evidence based scientific basis or cost effective considerations.

Furthermore, all employing institutions should be accredited by the HPCSA subject to the condition that the practitioner's clinical independence is not violated by the employing body and that the employing body also does not exploit the practitioner or make the practitioner to violate Council ethical rules.

The Government Gazette R717/2006

The ethical and professional rules of the HPCSA were promulgated in the Government Gazette in 2006. (Please note point 3 especially.)

Partnership and juristic persons

- A practitioner may practice in partnership or association with or employ only a practitioner who is registered under the Act and who is not prohibited under any of the annexure to these rules or any ethical rulings from entering into such partnership or association or being so employed: Provided that, in the case of employment, the practitioner so employed either provides a

supportive health care service to complete or supplement the employing practitioner's healthcare or treatment intervention or is in the same professional category as the employing practitioner.

- A practitioner shall practice in or as a juristic person who is exempted from registration in terms of section 54A of the Act only if such juristic person complies with the conditions of such exemption.
- A practitioner shall practice in a partnership, association or as a juristic person only within the scope of the profession in respect of which he or she is registered under the Act.
- A practitioner shall not practice in any other form of practice which has inherent requirements or conditions that violate or potentially may violate one or more of these rules or an annexure to these rules.

Amendments in 2009 to the Ethical Rules of Conduct for registered professionals

On 19 February 2009, the HPCSA issued a media statement regarding the amendments made to the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act, 1974 (HPA), in relation to the employment of medical practitioners.

In essence, it stated that only a medical practitioner may employ a medical practitioner within the same professional category, or one who supplements or completes the employing medical practitioner's health care of treatment.

The media statement also highlighted the amendments relating to medical practitioners' financial interests in hospitals and the prohibition on the sharing of rooms.

The media statement referred to rule 18 of the Ethical Rules that provides that only an employer approved by the HPCSA may employ a practitioner, and that such employment must be in terms of a written contract of employment and made available to the HPCSA at its request.

On 6 August 2012, the HPCSA issued another media statement, requiring all employers of medical practitioners to review their current model of employment of medical practitioners, consequent to the amendment of the Ethical Rules of Conduct for Practitioners Registered under the HPA.

Selective prohibition of the employment of medical practitioners by the HPCSA

The rationale of the HPCSA policy of this type of selective prohibition is that this will prevent the undesirable practices of under-servicing, over-servicing, self-referrals and the risk to the clinical independence of medical practitioners. It will also prevent the unfair sharing of profits with non-medical legal entities.

Notwithstanding the content of the media statements, it should be noted that the legislation does not completely prohibit the employment (selectively or otherwise) of medical practitioners by non-medical legal entities. However, the employment of medical practitioners by non-medical entities requires the approval of the HPCSA.

Furthermore, the HPCSA has at its disposal, the ability to impose harsh sanctions against those medical practitioners who choose to remain employed without its consent.

The position of the South African Medical Association (SAMA)

SAMA is not supporting the employment of doctors in the private sector by any (private) funder (of health care), as in their opinion it does not serve the interests of their patients⁷. This echoes the sentiment of the HPCSA.

4. MARKET POWER AND DISTORTIONS OF COMPETITION

This section uses Medscheme claims expenditure data to measure market concentration in line with economic theory. This allows for an examination of the market power of various sectors and possible distortions in competition this may cause.

Medscheme position / recommendations

It is proposed that the Panel investigate any market distortions and inappropriate behaviour due to such distortion. These may include the unwillingness of providers to provide detailed utilisation data and negotiate regionally.

The graphs below depict the Herfindahl–Hirschman Index (HHI) which is a measure of the concentration of firms within an industry. It is a measure commonly used by economists to reflect market concentration. It is defined as the sum of the squares of the market shares of the 50 largest firms (or summed over all the firms if there are fewer than 50), where market share has been defined as claims paid for this purpose.

A HHI index below 1% indicates a highly competitive market.

A HHI index below 15% indicates an un-concentrated market.

A HHI index between 15% and 25% indicates moderate concentration.

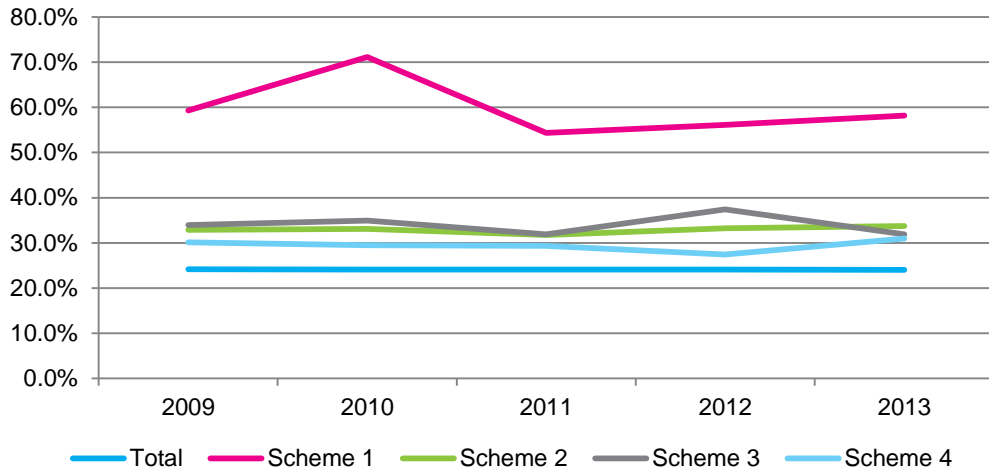
A HHI index above 25% indicates high concentration.

4.1 Hospital Market Dominance and Concentration

The results below show the hospital provider market to be 1% point away from being considered highly concentrated. Additionally, four regionally based medical scheme HHI indices are also shown, indicating high regional dominance of hospital providers.

⁷ South African Medical Association. Discovery Health medical aid and employment of doctor. Electronic communication to SASOM, 23 Oct 2013.

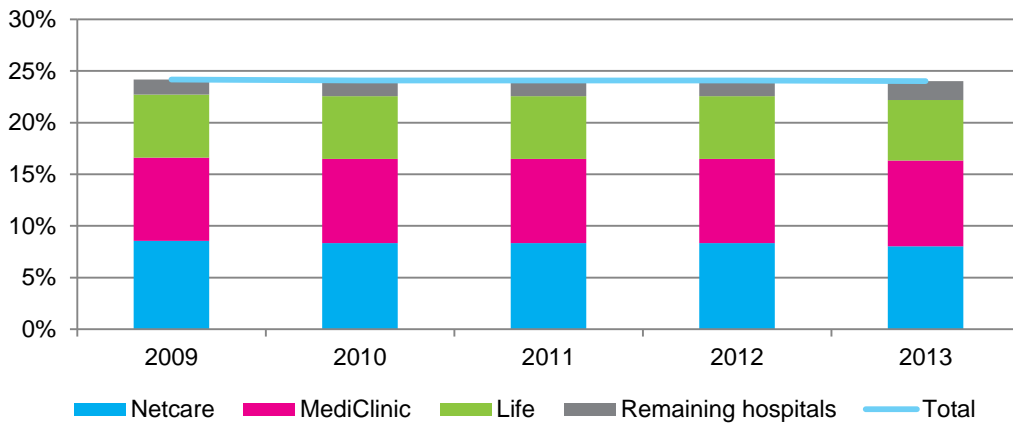
Figure 29 – HHI Market Concentration of Hospital Groups



Source: Medscheme hospital claims data 2009 to 2013, 2,400,000 m life years

The figure below provides a breakdown of the hospital HHI index.

Figure 30 – HHI Market Concentration Split of Hospital Groups

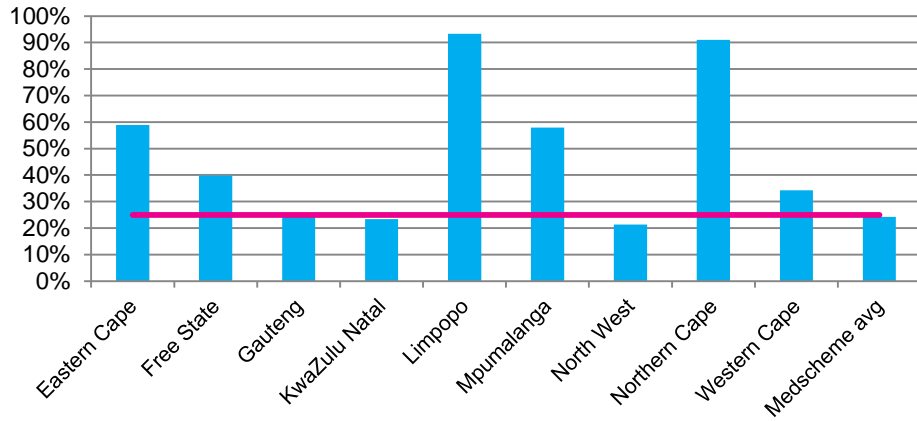


Source: Medscheme hospital claims data 2009 to 2013, 2,400,000 life years

The hospital market concentration is dominated by three large hospital groups, namely Netcare, Mediclinic and Life Healthcare.

Upon inspection of the hospital groups' geographical distribution across South Africa, it is evident that it is difficult to eliminate any one of the largest hospital groups from a national network, as each major hospital group has a regional dominance in at least one province with little alternatives. The figure below clearly highlights that 6 out of 9 provinces are highly concentrated.

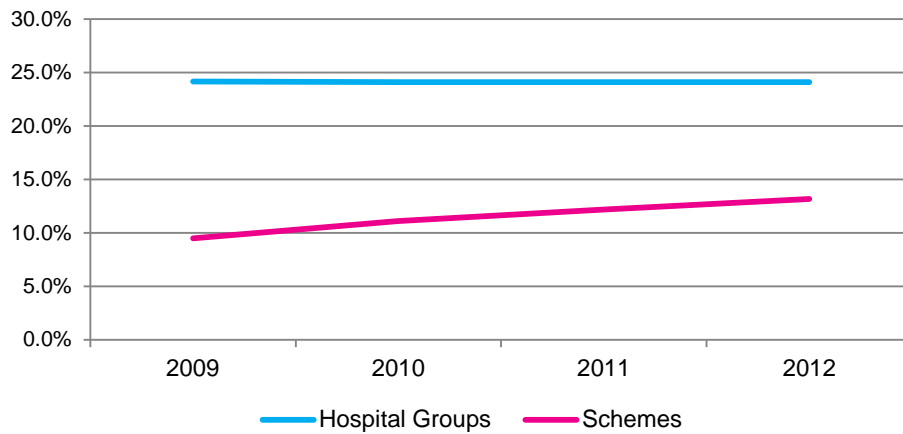
Figure 31 – HHI Market Concentration of Hospital Groups by Province



Source: Medscheme hospital claims data 2009 to 2013, 2,400,000 life years

The figure below shows the HHI market concentration of schemes relative to hospitals. Schemes have been consolidating, although are still considered an ‘unconcentrated’ market. The number of schemes still exceeds 90 (in 2012) and all open schemes are typically nationally based.

Figure 32 – HHI Market Concentration of Hospital Groups vs Schemes

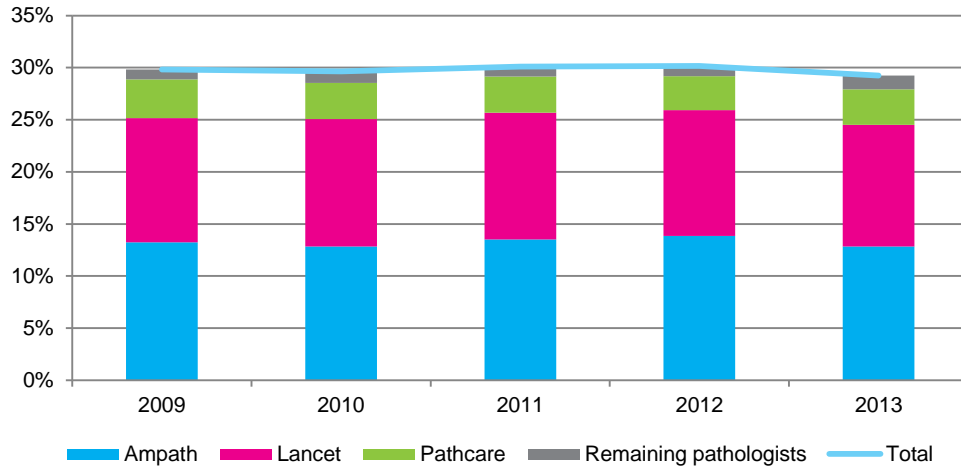


Source: Medscheme hospital claims data 2009 to 2013, 2,400,000 life years and CMS Annual Report data 2009 to 2012

4.2. Pathology Group Market Dominance and Concentration

The figure below includes the HHI index for pathology groups, which is measured as a highly concentrated market.

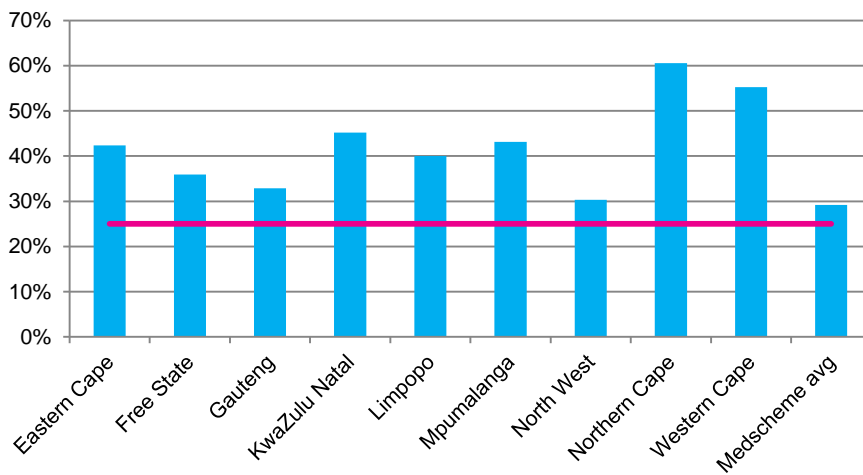
Figure 33 – HHI Market Concentration of Pathology Groups



Source: Medscheme pathology claims data 2009 to 2013, 2,400,000 life years

Three pathology groups dominate the pathology market, with regional dominance as depicted below.

Figure 34 – HHI Market Concentration of Pathology Groups by Province



Source: Medscheme pathology claims data 2009 to 2013, 2,400,000 life years

The Medscheme pathology claims data is dominated by three pathology groups based on claim line volumes – Ampath (34%), Lancet (30%) and Pathcare (20%). Regionally it is clear that certain laboratories do not compete. The table below represents the major laboratories’ market share per province and it is of interest to note that in provinces where Pathcare has a strong presence, Lancet is weaker and vice versa.

In a market where 84% of pathology services are shared between three laboratory groups and where obtaining a competitive price is already a challenge, lack of competition between the three major players on a regional basis further complicates Medscheme’s ability to obtain competitive pathology prices.

Table 2 – Pathology group market share per province

Province	Ampath	Lancet	Pathcare	Van Rensburg	Vermaak	Other	TOTAL
Eastern Cape	60%	1%	34%	0%	0%	5%	100%
Free State	15%	0%	47%	34%	0%	3%	100%
Gauteng	33%	36%	9%	0%	8%	15%	100%
KwaZulu Natal	38%	53%	0%	0%	0%	9%	100%
Limpopo	44%	48%	0%	0%	1%	6%	100%
Mpumalanga	52%	43%	0%	0%	1%	4%	100%
North West	52%	18%	26%	0%	1%	3%	100%
Northern Cape	6%	0%	92%	0%	0%	2%	100%
Unknown	0%	30%	0%	0%	0%	70%	100%
Western Cape	18%	0%	74%	0%	0%	8%	100%

Source: Medscheme January to June 2014 pathology claim line volumes data, 974,000 lives

4.3 Administrator Market Dominance and Concentration

The market share of administrators as reflected in the CMS Annual Reports for 2012/2013 and 2013/2014 reflect a specific anomaly in respect of the percentage market share held by various Administrators in the industry.

Accounting for the Government Employees Medical Scheme (GEMS) has been a challenge for CMS as GEMS has split their administration contracts between different providers. This is not a common practice in the medical schemes industry. We do however believe that by including their membership figures under both Medscheme's and Metropolitan's percentage of market share, the Annual Report is creating an unintentional misperception that may potentially mislead any reader thereof.

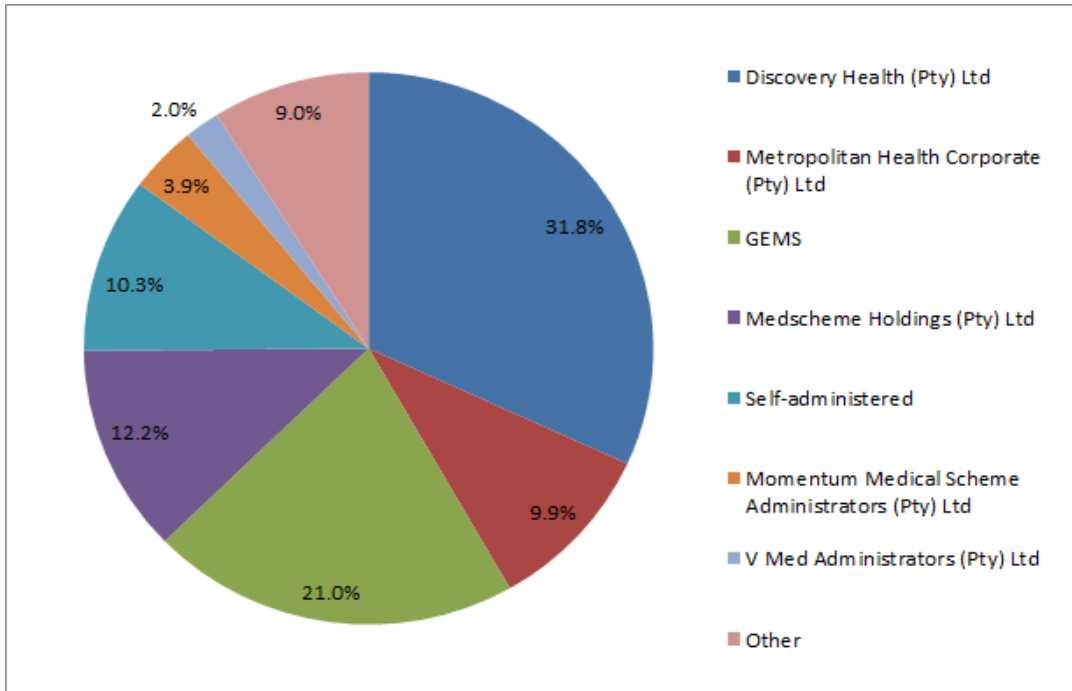
In order to reach a 100% market share distribution for statistical purposes, it is in our view inaccurate to count the GEMS membership base twice.

It is common cause that the Competition Commission will also be focussing on the role of Administrators in facilitating the relationship between healthcare funders and healthcare providers and, in this context it is crucial for the appointed Inquiry Panel to fully comprehend the imbalance of power between Administrators themselves and between Administrators and market dominant healthcare provider groups.

Medscheme believes it would be more accurate to reflect GEMS as a standalone entity, or considered more appropriately as a self-administered scheme. GEMS currently contract all service providers (including hospitals and other healthcare providers) independently and unlike other wholly administered schemes, they have a full staff compliment to manage the day-to-day affairs of the Scheme.

Should GEMS be reflected as a standalone entity, a revised Market Share chart would factually indicate a true reflection of the current market share enjoyed by Administrators as reflected in the chart below.

Figure 35 – Administrator market share 2013



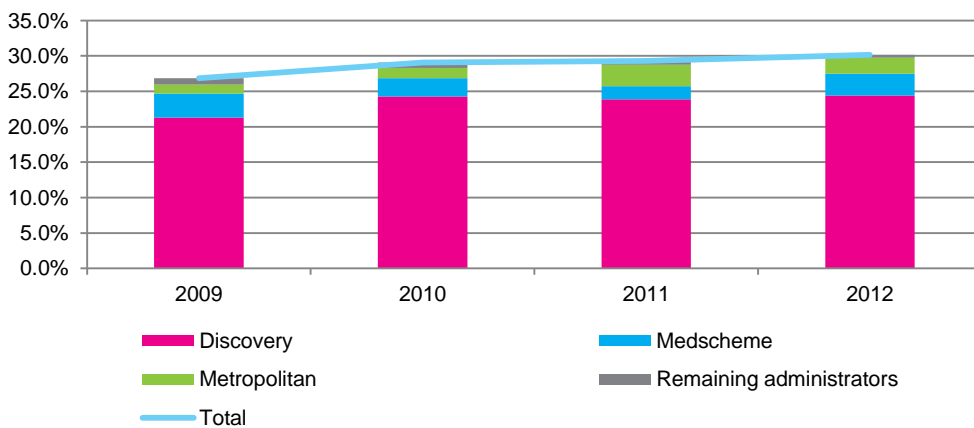
Source: CMS Annual Report 2013/2014 data

When viewed from this perspective, it is evident that factually market dominance is enjoyed by a single Administrator, and the existing market share is not fairly balanced as represented in Figure 58 and Table 74 of the latest CMS Annual Report.

Considering the intention of selected industry stakeholders to strongly attempt to persuade the Competition Commission that all medical schemes negotiate on an equal footing with provider groups as a result of their affiliation to a particular administrator, it is important that the Panel will not be unintentionally misled by such statistical data contained in the CMS Report.

The figure below includes the HHI index for medical scheme administrators and managed care companies. The HHI index is measured using revenue earned, as membership is skewed in the CMS report as discussed above.

Figure 36 – HHI Market Concentration of Administrators



Source: CMS Annual Reports 2009/2010 to 2012/2013, using revenue earned

The administrator market is generally competitive, although a single entity skews the HHI index towards being measured as 'highly concentrated'.

5. BARRIERS TO ENTRY

5.1. Lack of reinsurance approval by the Regulator

The Regulations allow for reinsurance in the private healthcare market, although the Regulator does not approve such transactions. Reinsurance is considered an important component in insurance markets and this stance by the Regulator needs consideration.

Medscheme position / recommendations

It is recommended that the Regulator allow and encourage reinsurance, specifically for new entrants, medical schemes in financial difficulty and smaller medical schemes with volatile claims experience.

Reinsurance is internationally accepted as providing a necessary level of risk cover and expertise for new entrants into a market. Without reinsurance, new entrants are required to meet the statutory minimum 25% solvency ratio within a few years, which is practically difficult. This is especially the case for a scheme needing to grow to increase its scale and thus improve claims stability (claims stability helps with setting of stable contribution rates for consumers and avoids large volatile shifts in financial performance). However, this growth reduces the solvency ratio even if the scheme is profitable.

Currently, the legislation allows for reinsurance, although the CMS is openly against reinsurance and has failed to allow reinsurance for over a decade.

5.2. Loyalty / wellness programmes have become the norm - a new entrant cannot start a medical scheme without significant financial backing outside of the MSA

Loyalty based wellness programmes have become commonplace in the private healthcare market and its role should be considered in unpacking the dynamics in the private healthcare sector.

Medscheme position / recommendations

Medscheme's position is that wellness programmes should be contracted by Medical Schemes in terms of the Medical Schemes Act 131 of 1998 and that the definition of relevant healthcare service should be expanded to include funding for wellness. This would lower the financial barrier to entry, allowing new wellness service providers to enter the market.

From a competition perspective this would facilitate transparency amongst wellness providers who would be forced to publish their outcomes in order to remain competitive. This would also improve the standards of healthcare as beneficiaries would be empowered to make informed choices regarding their care.

For the purpose of this report, the following definitions apply:

Preventative care	Interventions that prevent, identify or manage and improve illness.
Wellness	Lifestyle related behaviour improvement, but limited to health related initiatives or events, and including preventative care.
Loyalty programme	Rewards based system linked to wellness or non-health related activities. Such a programme is not solely linked to healthcare related events.

Loyalty programmes have become the norm for open schemes who wish to attract and retain healthier lives. The MSA does not allow medical schemes to provide loyalty products and a new entrant therefore requires significant financial backing outside of the MSA in order to compete. This places new entrants without links to large insurers at a disadvantage. Whilst some loyalty programmes are considered purely of marketing nature, other loyalty programmes are designed to support wellness and preventative care initiatives.

Consultations with health care professionals and preventative screening are regarded as a relevant health services, but evidenced-based wellness initiatives such as smoking cessation programmes, self-management health coaching by non-healthcare professionals, subsidisation of healthy foods and exercise facilities are not regarded as relevant health services.

Njisane et al (2012), in their paper dealing with competition legislation in the South African healthcare industry, note that “lower barriers to entry... lead to more competition which encourages efficiencies and innovation manifesting in lower prices and greater choice for consumers”⁸. These positive outcomes of competition are applicable to preventive care and wellness initiatives, for which lack of funding acts as a barrier and poor uptake is a negative outcome.

- The benefits of expanded funding (lowering the barrier) for preventive care and wellness are twofold. as a result of early detection beneficiaries and their treating providers would be presented with more treatment options for disease.
- the overall quality of care (and patient experience) would improve through beneficiaries being offered treatment choices by their provider and being able to actively participate in the management of their disease.

Importance of preventive care in South Africa

The importance of increasing access to preventive care in South Africa cannot be underestimated. South Africa is currently facing a quadruple burden of disease, viz. infectious, non-communicable (NCDs), perinatal and maternal, and injury-related diseases. In 2004 NCDs, which are largely preventable and related to unhealthy lifestyles, were responsible for 28% of the total burden of disease in South Africa⁹.

As a result of the increasing burden, the National Minister of Health hosted a summit in September 2011 where it was agreed that broad multi-sectoral interventions were required to reduce the costs associated with managing NCDs.

⁸ Njisane Y et al (2012) Competition legislation and policy – can it cure the perceived ailments in the private hospital market? Paper presented at Sixth Annual Competition Law, Economics and Policy Conference 6 & 7 September 2012

⁹ Prof. B M Mayosi et al. (2009) “The burden of non-communicable diseases in South Africa”, The Lancet, Volume 374, Issue 9693, Pages 934 - 947, 12 September 2009.

Key components of the National Strategic Plan for the Prevention and Control of NCDS include the early identification of high risk individuals through screening programmes (preventive care) and the promotion of healthier lifestyles (wellness). Wellness is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

Loyalty and wellness programmes are, however, not interpreted as relevant healthcare services by the CMS, which has expressed concern relating “to the emergence of loyalty programmes, wellness products and discount ventures which are associated in the minds of the public as adjuncts to membership of particular medical schemes”¹⁰. The CMS response to a request for accreditation of a wellness programme was that the “programme does not constitute managed health care as defined in the Act, but elements thereof could qualify as a relevant health service or could be a supplementary / complementary to other managed care services which meet the requirements”¹¹.

The Regulator has thus not approved funding for evidenced-based wellness interventions as they are perceived to be loyalty programmes and as such a contravention Section 21A of the National Health Act which prohibits conditional selling.

Current legislation permits Medical Schemes to fund the cost of immunisations and screening tests but not the full spectrum of lifestyle interventions that would prevent the onset of disease. Furthermore, beneficiaries who embark on self-funded wellness initiatives and improve their risk status are not permitted to receive monetary rewards or a reduction in contributions upon successful completion of their programme. Research has shown that the application of financial incentives significantly increases participation rates in screening tests and wellness programmes.

Smoking is responsible for 9% of deaths globally and research has shown that seamless integration of smoking cessation interventions¹² for tobacco use with routine clinical care is effective. Furthermore, the provision of free access to evidence-based cessation treatment removes cost and administration barriers and increases participation. Similarly the provision of free confidential cessation counselling (telephonic and on-line) removes time and transportation barriers¹³. The SA National Department of Health (NDoH) has set a target of reducing tobacco use by 20% by 2020, yet the CMS prohibits medical schemes from funding smoking cessation programmes.

Subsidisation of fruits and vegetables combined with targeted taxing of unhealthy foods has been shown to present the greatest opportunity in terms of health benefits¹⁴. The SA NDoH has set a target of reducing the percentage of people who are overweight and/or obese by 10% by 2020.

¹⁰ Council for Medical Scheme Fair Treatment Brochure sourced electronically 9 July 2014 from <https://www.medicalschemes.com/files/Discussion%20Papers/FairTreatmentBrochure.pdf>

¹¹ Electronic communication from CMS Accreditation Manager 27 September 2009

¹² Van Zyl-Smit R.N. et al “South African tobacco smoking cessation clinical practice guideline” S Afr Med J 2013;103(11):869-876. DOI:10.7196/SAMJ.7484 Sourced electronically 16 July 2014 from <http://www.cansa.org.za/files/2014/05/SA-Tobacco-Smoking-Cessation-Clinical-Practice-Guideline-2014.pdf>

¹³ Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs — 2014. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

¹⁴ Nnoaham, Kelechi E., et al. "Modelling income group differences in the health and economic impacts of targeted food taxes and subsidies." International journal of epidemiology (2009): dyp214.

The NDoH strategy is to achieve this through increasing availability and access to healthy foods, yet the CMS prohibits medical schemes from subsidising healthy foods as this is viewed as a loyalty programme.

Self-management evidence-based education workshops, led by health coaches who are non-health care professionals have been shown to be effective in managing a variety of chronic diseases by improving the medical, emotional, and social role management demands of chronic conditions¹⁵. Through limiting the funding of health-coaching to medical professionals, the CMS is driving the cost of these sessions and limiting access to an evidence-based effective intervention.

The benefits of physical activity in preventing a range of chronic diseases are widely acknowledged. However, the financial cost of structured physical activities is perceived to be a barrier to participation, and the most frequency cause of dropping out of sessions. Evidence has shown increased participation in structured exercise groups (gym sessions) when they are free or heavily subsidised¹⁶. Through prohibiting Medical Schemes from subsidising gym membership, the CMS is effectively maintaining a financial barrier to a wellness intervention with proven health benefits.

Research has shown that beneficiaries with known disease who participated in lifestyle management (wellness) programmes experienced significantly higher savings in their medical expenses when compared to those who only participated in disease management programmes¹⁷. Furthermore, the application of financial incentives e.g. loyalty programmes, significantly increases participation rates in screening tests and wellness programmes.

Expanded funding would result in increased participation in wellness programmes and allow for new players to enter the market. Medical schemes could play a significant role in promoting wellness should the definition of healthcare be expanded to include wellness and regulation be amended to enable financial incentives for the lowering of an individual's risk status.

5.3. Low broker commissions encourage perverse incentives and further result in barriers to entry for new medical scheme entrants, since they would require having complementary non-MSA products to pay enhanced commissions

Low medical scheme broker fees relative to competing insurance products have unintended consequences. In addition, the incomplete regulatory environment encourages member selection behaviour, which emphasises the broker's role in attracting member growth.

Medscheme position / recommendations

It is proposed that brokers selling medical scheme business should be able to earn comparable commissions to other insurance markets to level the playing field and remove this barrier to entry for new medical schemes. Medscheme proposes that medical schemes should be allowed to similarly sell loyalty or other insurance products to be able to compete on equal terms with larger co-branded insurance and medical scheme offerings.

¹⁵ Ory, Marcia G., et al. "Successes of a national study of the chronic disease self-management program: meeting the triple Aim of health care reform." *Medical care* 51.11 (2013): 992-998.

¹⁶ Withall, Janet, Russell Jago, and Kenneth R. Fox. "Why some do but most don't. Barriers and enablers to engaging low-income groups in physical activity programmes: a mixed methods study." *BMC public health* 11.1 (2011): 507.

¹⁷ Caloyeras J.P. et al "Managing Manifest Diseases, But Not Health Risks, Saved PepsiCo Money Over Seven Years" *Health Affairs*, 33, no.1 (2014):124-131

Brokers play a crucial role in supporting individuals and corporates to understand their benefits, which is especially relevant in the extremely complex healthcare environment. Medical scheme benefits do not simply include benefit limits and exclusions as typical other insurance products. They have a multitude of limits depending on family size, category of benefit, provider, etc. They also include a multitude of formularies, protocols and network rules. These benefits are many and complex and the broker can play an important role in facilitating member understanding and allowing for informed purchasing.

In private healthcare, brokers earn commission limited to 3% of gross contribution, subject to a maximum Rand value currently set at R71.07 plus VAT. This level is much lower than other insurance products in the South African market, which is typically nearer 20% of premium. The distortion in broker commission between medical schemes and other insurance markets in South Africa may encourage perverse incentives. To encourage brokers to sell their medical scheme, medical schemes have over the years devised insidious methods to try and reimburse brokers more than allowed by the Regulations.

Similarly, insurance companies have co-branded medical schemes under the same name to encourage cross-selling of insurance products together with the medical scheme membership, thereby paying the broker more. Similarly, companies have used so-called 'loyalty products', linked to the medical scheme in terms of marketing and branding, to pay much higher broker commission. These loyalty products typically provide discounted airplane tickets, discounted movies, discounted gym membership, etc. for a small premium. Although publically available details are not easily available, it appears that these loyalty products are not profitable. But companies use these programmes to pay higher broker commission to entice new business and are willing to incur the losses in return for more membership on the medical scheme. More membership on the medical scheme translates into more revenue to the administrator.

This market dynamic, which is widespread, implies a new entrant needs to be linked to a large company (typically a life insurer) with large cash flow reserves, willing to fund a 'loss-leader' in order to attract business and members.

6. FACTORS LIMITING ACCESS BY CONSUMERS TO PRIVATE HEALTHCARE, INCLUDING AFFORDABILITY

6.1. Inefficient capital requirements

Contributions are the primary source of income a medical scheme earns. Thus, members are required to build reserves, which contribute to the affordability consideration in respect of medical schemes.

Medscheme position / recommendations

It is proposed that risk-based solvency be considered as this would result in a more efficient allocation of capital and reduce contributions.

Economic and financial theory suggests that efficient use of capital is an important element in an efficient financial system. As such, healthcare is no different to any other insurance market, both locally and internationally.

Significant reserving regulatory advancement is being undertaken in South Africa under the Financial Services Board (FSB), as well as internationally under so-called 'Solvency II' regulations. These initiatives are major global initiatives aimed at ensuring consistency and latest best practice in setting prudent reserves for insurance products. The regulations, in summary, aim to determine the amount of reserves required based on the risks underlying the product and market, referred to as 'risk-based capital' techniques. Thus, a company (or medical scheme) with more risk would need to hold a higher reserve than a company with less risk. Reserves are typically set to cover 1 in 200 year events and take into account such risks as uncertainty in claims experience, liquidity constraints, investment market uncertainty, operational risks, etc. In the healthcare environment, higher than expected claims are the largest risk, typically followed by investment market risk if the scheme is invested in the equity market.

One clear indicator of risk is the size of the pool of lives being covered. Smaller pools of lives experience more volatile claims experience, whilst larger pools experience less volatile experience. All else being equal, a smaller medical scheme would need to hold a larger reserve as a percentage of contributions, than a larger scheme.

The current medical scheme Regulations require all schemes to hold a minimum of 25% of gross contributions as reserves. This clearly does not allow for any specific risk characteristics of the individual medical schemes. Large medical schemes do not require such high level of reserves. Smaller medical schemes require a larger percentage reserve.

The Industry Technical Advisory Panel ("ITAP") - a body setup by the CMS with collaborative work being done between the CMS, medical schemes, healthcare actuaries, administrators and managed care organisations - conducted some research in risk based techniques in 2012 and presented on 7 March 2013.

ITAP developed a simplified risk-based capital model that allows for three components:

- Pricing risk – setting contributions too low results in a risk of operating losses and thus jeopardising short and long term sustainability.
- Claims volatility risk – future claim levels are unknown and volatile, thus a scheme must hold sufficient reserves to be able to meet its obligations. Typically smaller schemes have more volatile experience which needs to be taken into account.
- Liquidity and other risks – a scheme needs to hold reserves to fund claims and expenses in months where the contributions are insufficient, for expenses in a wind-down scenario, for operational risks, etc.

In essence, the modelled reserve formula = pricing risk * 3 + volatility risk + 10%

where

pricing risk =	operating losses over last three years, weighted towards the latest years
volatility risk =	based on scheme size and modelled using risk based statistical techniques
10% =	allowance to cover liquidity and other risks.

The volatility risk was set at a level to cover the scheme's worst risk event in a 1 in 200 year event. The model assigns a risk category per scheme based on the Capital Adequacy Ratio ("CAR") index, with risk category 1 implying a scheme with more than adequate reserves, whereas a category 4 implies the scheme is at significant risk of financial ruin. The CAR index is calculated by expressing the actual scheme reserves as a percentage of the required reserves under this model. The industry results, based on the latest CMS report (2011 data), is shown below.

Table 3 – Industry Financial Risk Category Results

Risk Category	% Lives	% Schemes	2011 Reserves	Required Reserves	Excess Reserves	Avg CAR for risk category (target = 100%)
1	68.4%	66.3%	30 081.9m	11 400.2m	18 681.7m	264%
2	1.6%	7.4%	492.3m	400.3m	91.9m	123%
3	5.8%	10.5%	1 826.4m	1 921.2m	-94.8m	95%
4	24.2%	15.8%	2 490.9m	4 212.1m	-1 721.2m	59%
Total			34 891.4m	17 933.8m	16 957.6m	195%

Source: CMS Annual report 2011/2012

Approximately 26 schemes are considered to be at financial risk, these being classified as category 3 and 4. As an industry, it is noticeable that the CAR is significantly above 100% - in fact at 195% it implies the reserves are almost twice that considered necessary. (The model assumes most assets are invested in cash or near cash equivalents and that there will be no membership growth. Both these factors would necessitate a higher reserve requirement if a particular scheme were faced with these dynamics.)

The results identified that the medical scheme industry is holding almost twice the required reserves that risk based techniques suggest are necessary to cover 1 in 200 year extreme events. To build up and maintain unnecessarily high reserves is inefficient. To build reserves requires additional contributions from members, as this is the only source of income a medical scheme may receive. This increases the costs to the member and prevents the money from being used more productively or efficiently elsewhere. Building unnecessarily high reserves increases contributions and contributes to the cost drivers within the private healthcare market. It is proposed that risk based capital techniques are employed to determine the level of reserves required per scheme, using internationally best practice accepted techniques aligned to the short and long term insurance regulations in South Africa.

7. IMPERFECT INFORMATION AS IT AFFECTS CONSUMERS AS WELL AS FIRMS IN THE SECTOR

In competitive markets, a cornerstone of any product offered to the public is that adequate information is available to allow the public to consider the product benefits and prices and make informed choices.

7.1. Transparent information enabling improved healthcare efficiency and quality

Medscheme position / recommendations

It is proposed that the Inquiry Panel recommend regulatory change to ensure that transparent reporting of healthcare quality and cost information.

Asymmetric information is the situation in which one party in a transaction has more or superior information compared to another. This happens in healthcare transactions where the seller (of clinical services) knows more than the buyer (the medical scheme beneficiary) or the reverse. It leads to anti-competitive behaviour, adverse selection and fragmentation of care.

In their 2012 paper “The Role of Competition Policy in Healthcare Markets”, written by officials of the Competition Commission at the time in their personal capacity, the following is stated:

“As stated above a key characteristic of this market is the information asymmetry that exists as the consumer of the services is ill-informed and is not in a position to shop around for the best services and prices offered. There is also moral hazard that exists and certain parties within the industry play a key agency role on behalf of the consumers. As such the consumers require protection through regulatory intervention and cannot always be left to the operation of the principles of a free market.

While recognising that healthcare markets do not necessarily function as other normal markets, it does not detract from the role for competition authorities alongside industry specific regulators.”

Effective healthcare systems require transparency of accurate information (health intelligence) on price, utilisation and quality measures:

- Due to a lack of transparency, South African consumers of healthcare services are unable to make informed choices based on a comparison of cost and quality. This suggests that low performing providers have an uninformed captive market.
- Providers must understand their own relative risk-equalised cost and quality status to be competitive in terms of price and best practice. Increased data availability establishes a “virtuous cycle” in which competition increasingly improves the efficiency and quality of care delivered. The South African problem is that superior providers, due to limited supply and increased demand for services, often have limited capacity to increase patient loads.
- Managed care organisations play a role in generating and sharing information on behalf of funders to promote competition. This information is used transparently for fee negotiations, strategic purchasing of care, selective contracting and to address waste and abuse. Strategic purchasing has been proved to be a powerful tool to improve provider behaviour.

Medscheme believes that for healthcare, transparent reporting on quality outcomes, packaged into understandable concepts like star ratings, carries more weight than transparent reporting on cost¹⁸, as it enables informed consumer decision making and influences provider behaviour change.

Medscheme does, however, advocate the transparent reporting of cost to consumers to assist in their decision-making. As such, the rates charged by healthcare practitioners and funded by medical schemes need to be clearly defined and easily understood.

Section 6 of The National Health Act 64 of 2003 speaks to the issue of information asymmetry in relation to cost and choice and mandates health care providers to share clinical and cost information with users of their services to enable them to make an informed choice.

¹⁸ Peters E et al. “Numeracy and the Perception and Communication of Risk”; Annals of the New York Academy of Sciences. 2008; 1128:1-7. (PubMed:18469208)

7.2. Industry-wide tariffs

Medscheme position / recommendations

An independent, multi stakeholder coding authority should be created to develop and maintain coding structures for all provider disciplines, standardising procedural codes within the industry.

As part of this, clear descriptors of codes should be provided, detailing the scope of each code, i.e. what is and what is not covered, as well as which provider type is qualified to use a certain code. Rand Value Units (RVU's), indicators of the relative value of procedures in terms of input time, relative risk, and training required, should furthermore be defined. Without such standardisation, patients are exposed to financial risks and providers and funders alike are burdened by administrative inefficiencies.

It is proposed that the Competition Commission, as a matter of urgency, acknowledge that collaboration on a standardised coding framework and definition of code-specific RVUs is not a contravention of Section 4. The clinical nature of such interaction, which is distinct from negotiations aimed at agreeing on specific prices, should be endorsed.

7.2.1. Implementation of reference tariff rates for healthcare providers to simplify the benefits to members

The dynamics of clinical practice require a multitude of different reimbursement codes for a number of different consultations, procedures and multiple providers. There is thus a need for an independent authority to publish a set of reference tariffs against which healthcare providers can state their prices and medical schemes can define their benefits.

Medical schemes currently make reference to their own 'scheme rates' in their marketing brochures. There is no clarity as to what these rates actually translate into when a member visits a practitioner and how these compare across medical schemes. For example, a medical scheme may describe its benefits simply as 150% of the reference tariff rates for gynaecologists, which is meaningless to the consumer.

In addition, the lack of a reference tariff list complicates administration for medical scheme administrators and profiling of practitioners in terms of cost and quality.

7.2.2. Establishing and implementation of an authoritative independent coding authority

Various coding structures for purposes of classifying and/or identifying healthcare-related information exist in South Africa. From a funder's perspective, unique identifiers and groupers are important for purposes of rendering payment of specific services and analysing healthcare practices and trends. Whereas mechanisms to classify diagnoses, medicines and surgical items are reasonably functional and well-maintained, those defining procedures are problematic. Given historic developments, various provider associations currently own, maintain and publish their own coding structures without input from other stakeholders. Whereas the South African Medical Association (SAMA) is the custodian of procedural codes used by doctors, not all medical practitioner groups form part of this body. For example, Radiology and Pathology Groups operate in isolation. Typically codes used are home-grown and/or an adaptation of the American Medical Association's (AMA) coding structure known as the Current Procedural Terminology (CPT).

For the majority of doctors using SAMA codes, the CCSA (Complete Current Procedural Terminology for South Africa) - a modification of CPT codes published on an annual basis - applies. SAMA has been licensed by the American Medical Association (AMA) to customise and modify the Current Procedural Terminology (CPT) to make it relevant locally. Input is provided by the different specialist societies for evaluation and endorsement by the parent body. Consensus between the two groups is, however, not always reached. By means of example, modifier 0005 is a code that in the presence of multiple procedural codes applied within one treatment session indicates a reduced value of all codes other than the primary one. Whereas SAMA stipulates reduction to 25%, the ENT Association guide only makes provision for a 50% reduction.

For funders, RPL codes still form the basis for payment. Whereas these were negotiated in the past with doctors and maintained by the Board of Healthcare Funders (BHF), the last effective update occurred in 2006. Given fear of retribution by the Competition Authorities for perceived price collusion, all collaborative efforts in this regard have ceased. Instead, individual funds decide which codes to add and what rules to apply. Given increasing concerns about the financial impact of code additions and changes within existing scheme reimbursement structures, however, many amendments included in provider guides have not been implemented by schemes. Since 2011, most medical scheme administrators have not accepted any coding changes from SAMA. For purposes of demonstrating the challenges relating to unilaterally determined codes, the following examples are referenced:

- In 2014, SAMA reviewed the code for hip fractures, which had a RVU of 32. To allow for greater specificity, an additional code - 'repair of a fractured acetabulum' - was advised. Based on CPT, three codes should have been considered, based on the site of the fracture and the associated complexity of the repair.

CPT	RVU
27226	31.32
27227	49.16
27228	55.92

However, contrary to the American system, only the code with the highest RVU was adopted for local use, ignoring the spectrum of procedural complexity and with that legitimising overcharging for simpler procedures. At the same time, the RVU for 'hip fracture' was increased from 32 to 35.45 to bring it in alignment with the CPT structure. Similar practices aimed at maximising providers' ability to bill are common.

- Whereas many surgical procedures can only be performed safely with a surgical assistant, there are others that do not require the attendance of a second doctor. Although such procedures are identified within the CPT system, local provider billing structures fail to list these, endorsing assistant fees if and when requested by the primary surgeon.
- Historically, code 0146 could only be billed in instances when the patient presented as an emergency and was required to be seen immediately without an appointment. An emergency is defined by CMS as a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy. However, in 2013 SAMA amended such rule, indicating that such code could be used for any unscheduled visit, irrespective of the reason.

The current status quo whereby individual provider groups decide their own coding rules and individual funders implement varying hybrids of RPL and SAMA codes, including heterogeneous interpretations, has many negative consequences:

- It exposes medical scheme beneficiaries to significant financial risks as codes used by providers are not endorsed by funders.
- It creates major administrative inefficiencies within the private healthcare system, for funders, providers and patients alike.
- Given that many new procedures based on technological advances are not accommodated adequately within the coding structures of funders, providers are forced to submit creative hybrids of funder-accepted codes, in an effort to ensure payment at a rate deemed reasonable by the provider. As such, funders do not have clear oversight of the financial impact of changes in medical practice.
- It has the potential to disadvantage certain provider groups unduly, especially where their scope of practice has changed. For example, these days sonographers not only perform sonars, but also interpret them; specialists from different groups can acquire the skills of new procedures, e.g. both neurosurgeons and radiologists may acquire the skills to perform neuro-interventional procedures. However, because coding structures may differ across different provider groups, some specialists can work with more appropriate codes than others.

8. THE IMPACT OF THE REGULATORY FRAMEWORK ON COMPETITION IN PRIVATE HEALTHCARE

8.1. Regulation of Medical Schemes

8.1.1. A Critical Review of the Private Market Regulatory Structure vs Best Practice

The current regulatory structure was implemented with the view of moving towards a sustainable social health insurance system. However, critical regulatory aspects were not implemented and the current regulations are incomplete and out of line with best practice.

Medscheme position / recommendations

It is recommended that compulsory membership with income cross-subsidisation would provide a sustainable regulatory structure and support the private healthcare sector towards the NHI future.

Failing this, limited risk rating and increased underwriting is required to provide a sustainable regulatory framework.

Insurance based systems, such as medical schemes in South Africa, are typically regulated according to one of two designs; namely 'mutuality' or 'solidarity'.

Mutuality is the common design for *voluntary* insurance products, such as the life assurance or car insurance industries. These industries apply underwriting rules and charge premiums that reflect the policyholder's risk of claiming. This design allows them to remain sustainable given the risk of anti-selection by policyholders given the voluntary nature of the business. The regulators are primarily concerned with consumer protection in these environments.

Solidarity based systems are more common for health insurance, where the healthy subsidise the sick and higher earners subsidise the lower earners. These systems typically charge a standard contribution

for all lives (community rating), apply no underwriting and require compulsory membership to remain sustainable and avoid the risks associated with anti-selective behaviour.

The table below compares some of the characteristics of the two regulatory designs for insurance-based industries:

Table 4 – Mutuality vs Solidarity Systems

Mutuality and risk rating	Solidarity and community rating
Risk rated premiums, by age, etc.	Community rated premiums, preferably differentiated by income level
Full underwriting allowed	No underwriting
Renewability not guaranteed (i.e. cover can be denied after the 1 st year)	Guaranteed renewability
Voluntary participation	Mandatory participation
Consumer protection	Risk equalisation
	Minimum common benefit package

Source: David Wilkie, 1997, "Mutuality and Solidarity: Assessing Risks and Sharing Losses"

In social security systems the entitlements to benefits and the degree of risk-pooling are described in terms of pillars:

- Pillar 1:** Universal benefits for all citizens. Funding is typically from general taxes, but may include earmarked health taxes.
- Pillar 2:** Contributory environment above Pillar 1 or as a substitute for Pillar 1. It is characterised by strong mechanisms to ensure social solidarity: income-based cross-subsidies; risk-related cross subsidies; and mandatory participation.
- Pillar 3:** Discretionary social security over-and-above minimum levels regarded as essential. Individuals are left to make decisions completely at their discretion. Government is, however, still required to ensure that basic consumer protection is in place.

The current healthcare system design is one of a Pillar 1 state system (government clinics and hospitals, etc.) with a substitutive Pillar 2 private medical schemes environment. Pillar 1 applies an income means test above which patients need to pay and the medical schemes (Pillar 2) receive a tax subsidy. Thus, the means test and tax subsidy imply a regulatory design where medical scheme cover is a substitute for State cover.

In mature NHI or NHS systems, the design would include the universal access through Pillar 1 and voluntary cover in Pillar 3. Pillar 1 would ensure cover for the vulnerable, allowing Pillar 3 to be top-up cover or complimentary cover, such as having access to specialists earlier than would be allowed under the national Pillar 1 structure.

Prior to the 1990's, the medical scheme environment was governed by solidarity principles (Pillar 1+2). In the 1990's, the regulations moved to a mutuality design (Pillar 1+3), whereby the guaranteed minimum benefits and community rated contributions were replaced by risk based premiums and underwriting.

An analysis by the Department of Health iro the 1990's environment stated the following:

“the history of the medical schemes movement and its regulation shows a drift from solidarity principles which defined the original schemes, to individualising health cover ...**benefits declined** and the **older and sicker membership were excluded** from cover to a greater extent ...by 1999 **no open scheme was permitting anyone over the age of 55 to join as an individual member**. Virtually all open schemes applied **life-time exclusions for pre-existing conditions** ...schemes **age-rated and/or experience rated** their membership without restriction ...as such, by 1999 the majority of medical scheme membership was in an environment which **excluded vulnerable groups from cover** (e.g. the old and those with chronic conditions), where medical costs continued to rise (due to the retention of fee-for-service reimbursement) and ...where **non-medical costs were driven up** (through profit taking and hidden commission costs).”

In an environment such as the 1990's, a “Pillar 1+3” design, it is not uncommon to see the above characteristics. In fact, internationally these are typical characteristics and are a consequence of the need to ensure sustainability. The Pillar 3 design effectively replicates the characteristics of a normal commercial insurance industry. What is critical, however, is that the Pillar 1 state system needs to provide adequate cover for the remaining population and especially for the vulnerable. Where the state does not provide this, the Pillar 3 voluntary business will be subject to criticism.

Hybrid Designs

In practice, across the globe, hybrid designs are often found. These markets display mutuality and solidarity principles, such as:

- Limited risk rating is allowed
- Limited underwriting is allowed, such as:
 - Portability (i.e. members are able to move schemes without a new waiting period)
 - Open enrolment
 - Guaranteed renewability
 - Waiting periods and pre-existing conditions may be extensive
- Minimum prescribed benefits are uncommon, but may be encouraged through tax subsidies especially for benefits not covered in the national health system, e.g. dental.

The medical schemes environment in South Africa is effectively a hybrid design at present, not by design but due to an incomplete process towards a social health insurance system. However, item 1 and 3 above place the South African medical schemes industry at a disadvantage and contribute to an increased risk of increased costs and failure (unsustainability).

Underwriting Best Practice in a Risk Rated Environment vs the MSA

The following underwriting is allowed by the MSA in South Africa:

- 3 month general waiting period
- 12 month condition specific waiting period / pre-existing condition exclusion
- Late joiner penalty (although insufficient to cover the additional risk for such late joiners)
- Only change plans at 1 point in the year (or, reworded, schemes must allow option changes once per year without underwriting).

The above would be considered very limited underwriting if compared against the underwriting best practices in a mutuality, risk rated environment as shown below:

Table 5 – Best Practice Underwriting

Group Business	Individual Business
Premiums are priced on the group's risk / claims experience (Experience rating, using credibility theory)	Premiums are priced on the individual's risk. At least age based.
No underwriting, if <ul style="list-style-type: none"> • Participation is acceptable, e.g. >90% join • Profile is acceptable 	Full underwriting applied; Medical tests, questionnaires on health status and history, family history, age, etc.
Limited underwriting is applied for small groups	Testing requirements differ by age and level of cover to ensure affordability of testing
Waiting periods and re-existing condition exclusions do not apply	Waiting periods and pre-existing condition exclusions do apply, usually for all lives
Underwriting applied for lives not joining at 1 st opportunity, e.g. 1 st joining company or spouse joining late, or child registered late Limited underwriting may be applied if change cover / policy conditions	Actions: <ul style="list-style-type: none"> • Decline • Restrict benefits • Apply pre-existing condition exclusions (min 12 months; for rest of life) • Apply general waiting periods (min 3 months) • Apply loading to premium • Accept at standard terms

It is clear that the current legislation only allows for a very limited set of underwriting and pricing actions. In practice, the South African market does not always apply even the limited set of underwriting in order to increase membership or avoid declining membership.

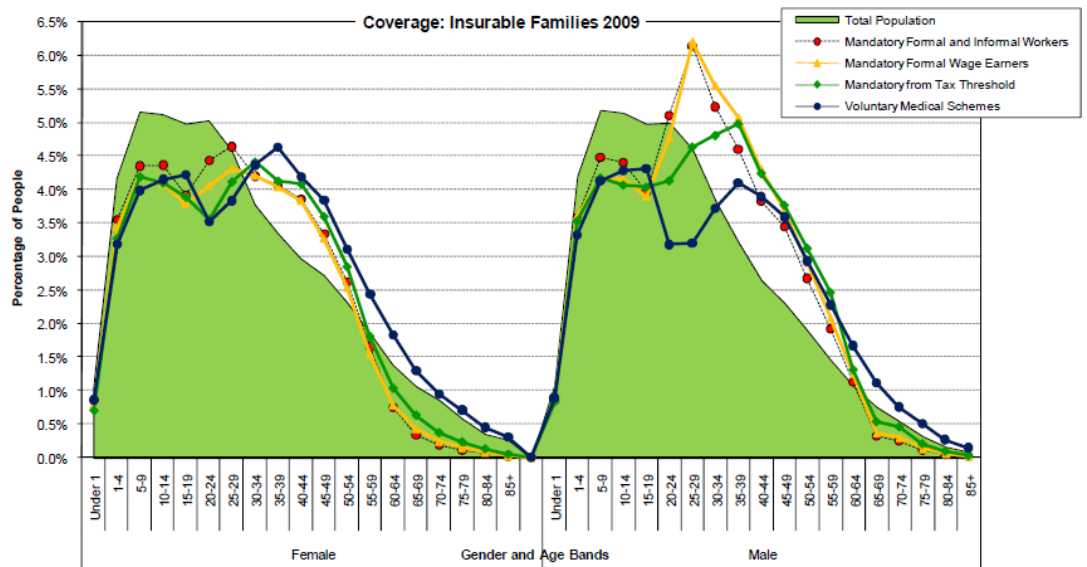
Consequences of Limited Underwriting

In the South African environment with limited underwriting and without compulsory membership, the consequences can be summarised as below:

- Perverse incentives are evident and applied to help secure sustainability and growth
- Innovation
- Growth of managed care expertise
- Risk management techniques are extended to utilise benefit design, marketing and broker commission to attract good profile lives
- Anti-selective behaviour is evidenced, such as people not joining schemes when they are healthy, increasing claims experience
- Schemes may end up in an 'actuarial death spiral', where contributions are too high, resulting in healthy members leaving which results in even higher contribution requirements. Schemes then need to amalgamate or close.
- Increased claims and expense costs due to the above items.

The graph below is an extract from a paper by McLeod, H., Grobler, P., & van der Berg, S. in 2010 entitled “Preliminary Estimate of NHI Costing in 2009 Rand Terms”. This paper used the industry REF data and explored the impact of anti-selection in its derivation of NHI costing estimates. The green shaded areas reflect the population distribution, compared against the blue line representing the medical scheme population. The green and other line graphs show how the medical scheme membership would increase as membership became compulsory for people that earn above the tax threshold, for formal wage earners and informal workers, respectively. It is clear that males, in particular, opt out of medical schemes in their twenties and thirties and present anti-selective behaviour.

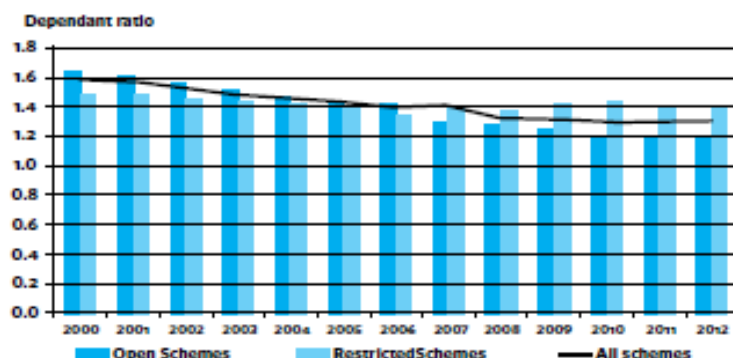
Figure 37 – Impact of Mandatory Cover on Increasing Membership



Source: McLeod, H., Grobler, P., & van der Berg, S. (2010). Preliminary Estimate of NHI Costing in 2009 Rand Terms

The graph from the CMS 2012/2013 Annual Report also highlights the anti-selective behaviour of families in open schemes, where fewer dependents are being registered over time.

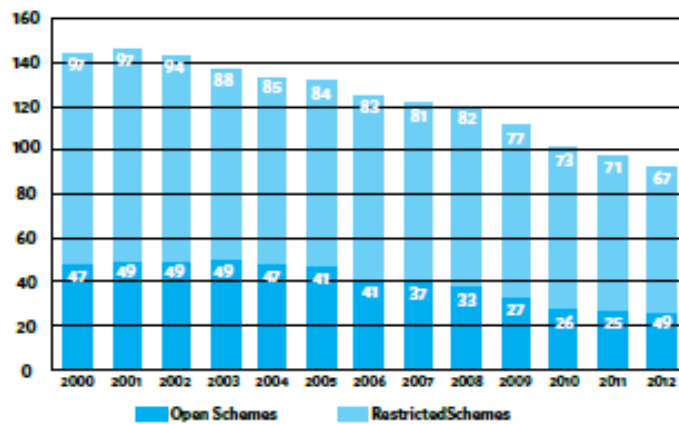
Figure 38 – Declining Dependant Ratios



Source: CMS Annual Report 2012/2013

The CMS Annual Report also highlights the declining number of schemes. Three of the last 4 open schemes that amalgamated showed evidence of being in an ‘actuarial death spiral’ prior to merging.

Figure 39 – Declining Schemes



Source: CMS Annual Report 2012/2013

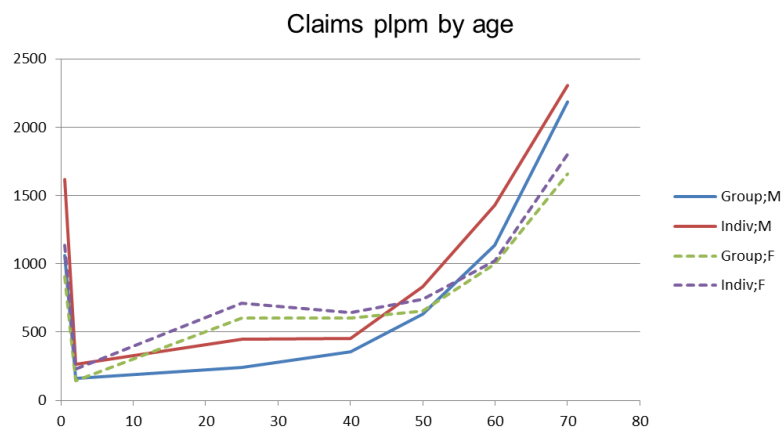
Consequences of Limited Underwriting: Increasing Claims Experience

Full underwriting should result in claims for all lives, both individual and group, being similar. Sufficient evidence exists to show the impact of the regulatory environment and limited underwriting on increasing claims. Some evidence is provided in the next sections.

McLeod, H., Grobler, P., & van der Berg, S. estimate the following from their work; “prices of minimum benefits [PMBs] are some 17% to 23% more expensive than they could be under... mandatory cover”. They claim that approximately 14% is due to simply including the younger lives into the medical scheme pool and the remainder is due to primarily anti-selective behaviour.

If one considers group business, in many respects it approximates a compulsory environment. Comparing the claims experience to that of individual business provides an estimate of the impact of anti-selection. For this purpose, the claims experience of 1m lives in the Medscheme database was used to assess claims experience by groups vs individual, risk adjusted for factors such as age, gender and Persal status. The graph below depicts the age vs claims expenditure curve, showing individual lives consistently claim more that group lives.

Figure 40 – Claims per life per month (plpm) by Age: Mandatory vs Voluntary



Source: 2012 Medscheme data, 2,000,000 life years

On average, the individuals claimed 25% higher than group lives of the same age, gender, etc. More anti-selection was evident at younger ages and for males.

The review above suggests the imperfect regulations are driving costs and need to be reviewed to ensure the private healthcare system remains sustainable and competitive. It is recommended that compulsory membership with income cross-subsidisation would provide a sustainable regulatory structure and support the private healthcare sector towards the NHI future.

8.1.2. Prescribed Minimum Benefits (PMBs) Competitive Effects of Inconsistent Interpretation, and Impact on Benefit Design and Administrative Complexity

Refer to Sections 3.2.1 Payment of PMBs in Full and 8.1.2 PMBs the competitive effects of inconsistent interpretation, and impact on benefit design innovation and 9.1 The matter of collective bargaining.

Medscheme position / recommendations

Medscheme proposes that PMBs are only paid in line with scheme rates, as per other benefits. However, the benefits must be clearly defined relative to an industry reference price list and providers must transparently display their billing rates relative to this reference price list

Further to this, the objectives of PMBs within the government's revised policy to achieve universal coverage should be clearly de-lineated. The current PMBs should be simplified and focused on clear benefit definitions (as has been proposed previously).

Limiting funding of tertiary and quaternary-type PMB services to established academic teaching units; and the definition of a negative rather than positive disease list should be considered.

The PMBs refer to a minimum set of legislated benefits to which all beneficiaries of medical schemes are entitled, irrespective of benefit option. They are provided for in terms of section 29(1)(o) of the Medical Scheme's Act 131 of 1998 which states that schemes must make provision in their rules for the scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed. Such scope and level of minimum benefits is defined in the applicable Regulations, first promulgated on 20 October 1999, and effective since 01 January 2000. The Regulations define which healthcare services have to be paid in full from risk benefits. Although PMBs when first published in 1999 were relatively clear in terms of coverage, there has been increasing lack of clarity as they have evolved, with significant differences in interpretation amongst stakeholders as to what is in fact included. Most relevant has been the expansion of the DTPs (270 Diagnosis-Treatment pairs that are defined in broad terms and that refer to pairing of diagnoses and treatments that may qualify for PMB entitlement) to include not only hospital-based but also ambulatory care¹⁹. A formal review to be conducted every two years by the Department of Health to ensure inter alia consistency with developments in health policy, correction of inconsistencies or flaws in the current regulations and adjudication of impact on medical scheme viability and its affordability to members has furthermore not occurred. Some clinical protocols have become outdated as a result (for example, the published algorithm for hyperlipidaemia is based on an outdated cardiovascular risk calculator and follows a different treatment approach to that proposed in the Essential Drug List, applicable to State facilities).

¹⁹ Taylor B, Taylor A, Burns D, Rust JD, Grobler P. Prescribed Minimum Benefits – quagmire or foundation for social health reform? SAMJ 2007; 97: 446 – 450

At the time that PMBs were first introduced, government was pursuing social health insurance as a vehicle to increase equitable access to health care. For all earning above a given threshold, income-based medical scheme contributions towards a minimum package were to become compulsory. Reform was aimed at increasing prepaid revenue earmarked specifically for healthcare, as well improving cross-subsidisation of healthcare services (where the young and healthy cross-subsidise the healthcare costs of the sick and elderly, and where the rich cross-subsidise the care of the poor). PMB's were the envisaged basic ('social health insurance') package common to all those contributing. Other legislative enablers of social health insurance included open enrolment and community-rating. To ensure that no individual scheme would carry a greater financial burden as a result of PMB's than another, a REF was to be introduced. Such fund would allow for transfer of money from one medical scheme to another for purposes of equalising the financial risk relating to PMB's. A medical scheme with older members and/or many chronically ill members would have to pay out more on PMB's than a scheme with mainly young and healthy members. Not only would this unfairly compromise the competitiveness of former further, but it would act as an incentive for schemes to attract low-risk members and avoid those at high risk. This would undermine the intention of policy reform which was aimed at incentivising schemes to compete on the basis of efficiencies rather than membership risk.

Given amongst other factors political developments, however, key determinants of the proposed model of social health insurance have not been introduced and PMB legislation has not been reviewed as mandated by the Regulations. Instead, the government is pursuing a model of national health insurance and universal coverage. The role of PMBs within such model, if any, has not been defined.

The current status quo is problematic from perspectives of competition law for the following reasons:

- For schemes to compete effectively on the basis of efficiencies, all funders must follow the same interpretation of PMB's. The lack of clear benefit definitions allows for significant differences in stakeholder interpretation of the law.
- Given the vague description of PMBs, administrative processes have become increasingly inefficient. Although State level of care is defined as the benchmark against which PMBs are adjudicated, State protocols do not exist for most conditions. Instead, administrators try and obtain an understanding of 'prevailing State practice' by contacting individual public institutions. This process is labour-intensive for public facilities, as well as private administrators. Often it is futile, as information is not shared readily or is contradictory, depending who provides the former. For consumers, there is no transparency. Not only are PMBs highly complex and thus difficult to understand, but treating providers tend to overstate PMB entitlement (in an effort to obtain benefits for treatment recommended). This results in many complaints that are time-and labour-intensive to administer.
- In the absence of financial subsidies, the current PMB package is too expensive for lower-income earners. Not only is this hampering the introduction of innovative medical scheme options that could broaden access to private healthcare services, but the sustainability of lower-contribution options is threatened as a result of potential buy-down.
- As PMBs become less affordable, schemes - as a cost-cutting measure - are inclined to reduce non-PMB benefits. This results in members with certain important diagnoses not having access to any benefits relating to their care. As such, PMBs have created a barrier to health insurance cover for those with non-PMB diseases.

Based on the above considerations, it is important that the concept of minimum entitlement is reviewed. Although the government's strategic framework for health reform, in particular financing thereof, remains obscure, PMBs are likely to play a role.

8.1.3. Absence of REF Encourages Competition on the Basis of Risk Selection

Legislation should encourage competition based on the efficient delivery of the service, not which scheme can cherry-pick the best lives. In this context, risk equalisation is typically implemented in healthcare markets to avoid this distortion.

Medscheme position / recommendations

Medscheme recommends the introduction of the REF to equalise the expenditure of providing PMBs across medical schemes, as envisaged in the 2008 Amendment Bill.

The implementation of open enrolment, community-rating and PMBs created an environment where medical schemes 'cherry-pick' the healthier lives.

This dynamic occurs because the contributions are set the same for all members in a medical scheme option, but claims are significantly higher for less healthy and older members. Thus, a medical scheme can lower its claims and, thus, its contributions simply by attracting the healthiest lives.

The result is that a scheme that doesn't attract the youngest and healthier lives will become uncompetitive and unsustainable. As the medical scheme fails to attract the lower claiming lives, its contributions will increase. As this occurs, the healthier lives leave, exacerbating the poorer claims experience and thus competitiveness. Analysis has shown that healthier lives are the first to move schemes, since their claims expenditure is lower and they are not concerned by the underwriting restrictions that may be applied by a new scheme.

The CMS decision that the REF would not be implemented, as communicated in January 2012, should thus be reviewed.

Legislation should encourage competition based on the efficient delivery of the service, not which scheme can cherry-pick the best lives.

A REF is, thus, critical to ensure that efficient schemes that provide cover to the less healthy are competitive, irrespective of the age and health of their membership.

Introduction of the REF as a "market intervention", based on a Competition Commission recommendation, will improve proper competition based on efficiency in the healthcare market, as well as provide a sustainable model for medical schemes servicing the less healthy portion of the population.

Note that the REF is not a solution by itself but part of a comprehensive design to encourage appropriate competition and foster sustainability.

8.2. Regulation Limiting Innovation in Healthcare Delivery

Please also refer to Sections 3.4.4.2.1 Fragmented Care Delivery for further detail.

Medscheme recommends the use of provider networks as they enable better co-ordinated care of patients and provide mechanisms to monitor and report quality and cost outcomes and allow incentives to be paid to encourage best practice.

8.2.1. Employment of Medical Practitioners

Please refer to Section 3.4.4.2.3 Employment of Medical Practitioners for further detail.

Medscheme position / recommendations

It is proposed that the ethical and professional rules of the HPCSA that were promulgated in the Government Gazette in 2006 with subsequent amendments be revised to expand the definition of recognised employment agencies and criteria for employment of doctors, in order to allow innovative healthcare delivery structures.

9. IMPACT OF INTERVENTIONS MADE BY THE COMPETITION AUTHORITIES IN THE HEALTHCARE SECTOR

9.1. The matter of collective bargaining

Medscheme position / recommendations

Medscheme proposes the establishment of an independent coding authority to govern coding structures and set the industry MRPL is proposed to encourage transparency and empower consumers, enhancing competition.

We believe that it will make a substantial contribution towards curbing the rising costs of healthcare if a MRPL is published. Healthcare practitioners and providers, as well as medical scheme benefits should be mandated to publish their rates relative to this MRPL. The MRPL should be set at State UPFS fee levels and would represent the minimum rate of payment for PMBs.

In initiating the Market Inquiry the Commission stated that it has reason to believe that there are features of the private healthcare sector that prevent, distort or restrict competition in the market.

It is Medscheme's view that the 2004 abolishment by the Competition Commission of collective bargaining between healthcare providers and healthcare funders at an industry level had unintended consequences that distorts and restricts competition in the market.

Although the price of a healthcare service is but one of a number of "cost risks" such as utilisation, intensity and severity, it is an important contributor to the rising costs of healthcare which is why the evaluation of the nature of price determination in the private healthcare market was identified as one of the main objectives of this Market Inquiry as set out in the Commission's TOR.²⁰

²⁰ Terms of Reference for Market Inquiry into the Private Healthcare Sector – Government Gazette no 37062, 29 November 2013, page 86

It is Medscheme's submission that an industry body with participants from healthcare providers and healthcare funders should be allowed but on a qualified basis.

These qualifications we see as necessary in order to allow for innovation such as alternative reimbursement models that incentivise performance to stimulate competition between healthcare providers and to accommodate other matters of importance to the industry such as the establishment of an industry coding standard for billing purposes.

Unintended consequences of the Competition Commission's 2004 decision

In their 2012 paper "*The Role of Competition Policy in Healthcare Markets*"²¹ written by officials of the Competition Commission at the time in their personal capacity, the following is stated with reference to the 2004 decision and the rising costs of healthcare:

"With regard to role of the Commission's decision in contributing to this situation, we are of the view that this cannot be seen as the only factor which has led to the increase in healthcare costs. The Commission's position has always been informed by legislation and the realisation that the collective negotiation created a platform for collusion which itself leads to varying anti-competitive effects to the detriment of consumers. However, it is important to understand that in a "second best" world, normally sound interventions can have unintended consequences. With this in mind, a healthcare inquiry could seek to better understand the dynamics at play in these negotiations. Ultimately, however, the solution to the issue is likely to involve some form of government or regulatory intervention."

"The major concern in the healthcare market is over rising prices. We believe the inquiry should analyse the current pricing regime by considering the implications of past Government and Commission decisions. As discussed above, there are proponents of a view that the abolishment of collective bargaining and the dismissal of the NHRPL in the industry has resulted in the current impasse over prices in the market. An inquiry should consider if the reference price list is justified and whether it potentially encourages anti-competitive behaviour."

It is our submission that the 2004 decision by the Competition Commission created significant problems for prices in the market.

- The absence of reference prices created a pricing vacuum causing market forces to drive up prices.

Medical schemes were theoretically required to negotiate general reimbursement prices with every single medical service provider. Assuming the logistical problem of negotiating the fees could be overcome, this resulted in a situation where doctors quote different consultation fees and different procedure fees for different medical schemes and sometimes even for the different options within schemes.

- The change from collective negotiation to individual negotiations shifted the balance of power to the hospital groups.

Hospitals consolidated into three major groups, which generated a negotiation imbalance with the less concentrated medical schemes and administrators. This placed the hospital groups in an oligopoly position which has largely eliminated price competition.

²¹ "The Role of Competition Policy in Healthcare Markets" - Pamela Halse, Nonkululeko Moeketsi, Sipho Mtombeni, Genna Robb, Thando Vilakazi and Yu-Fang Wen, 2012, page 16.

The levels of concentration and the geographic distribution of the three main hospital groups have resulted in regional or local dominance. This affects the ability to negotiate competitive prices due to schemes' requirement of comprehensive geographical coverage. Hospital groups may adjust their rates in return for greater volume and the assumption of greater efficiencies, however where geographic dominance exists, members of medical schemes are balance billed by the hospital where the medical scheme and hospital group are unable to reach agreement on rates.

- The ruling also impacted on collective trade practices the likes of which include the evaluation of new and current technology and drugs resulting in collective principles around the appropriate funding and utilisation of such technology, or collective sanctions around fraud – critical elements in any healthcare system.

In their October 2010 document "*Discussion Document on the Determination of Health Prices in the Private Sector*" and in particular Annexure A to it "*Draft Policy Framework for Price Determination in the Private Health System*"²² the National Department of Health and the CMS stated the following (our underlining):

"Many of the prices charged in the market are also not formally negotiated, and merely set unilaterally by suppliers of health goods and services. In conventional markets unilaterally determined prices that are excessive will be penalised through reduced demand leading to reduced profits. Within health care markets, where demand is sustained by insurance, excessive prices are not penalised and unilaterally determined prices will result in the achievement of super-normal profits.

Unilateral pricing essentially only works in markets facing normal competitive conditions where the consumer has substantial discretion to avoid the purchase if over-priced. Importantly, the prices are sensitive to household budget constraints, even though the relationship is indirect. Within healthcare markets, given that demand is sustained regardless of the price, the relationship to medical scheme and household budget constraints is broken, and needs to be re-constituted.

Achieving balance therefore requires that a direct link be established between scheme and household budget constraints and supplier prices. This can only be achieved by requiring that all prices for private health goods and services be pre-negotiated, even where they are paid for on an out-of-pocket basis. However, as bilateral negotiations are not always practical or feasible, a framework has to be established for negotiations that are not bilateral. These can only be collective or multi-lateral in nature and all affected parties need to reasonably participate in the process.

"However, just as unilateral price determinations in a market "distorted" by insurance can prejudice final purchasers, there is some risk that providers could be unfairly penalised where colluding purchasers are in a position to "monopsony" price, i.e. excessively drive prices down. Such an outcome is recognised as undesirable and needs to be avoided by ensuring that the process is fair to all parties.

Aside from prices, there is a need to agree on technical issues relating to code structures and billing rules. As these have material effects on costs and behavioural incentives they also need to be properly and fairly negotiated."

An industry wide reference price list has the following advantages:

²² "Discussion Document on the Determination of Health Prices In The Private Sector, Annexure A, Draft Policy Framework for Price Determination in the Private Health System" – NDOH & CMS, October 2010, page 14.

- It provides stability and simplicity in the determination of prices in the private sector, by reference to a benchmark reference price list.
- It promotes competition to take place in the realm of efficiencies and healthcare outcomes and not technicalities around coding and interpretation of tariffs.
- Limited information hampers members' ability to evaluate the quality and cost of care, hence the common perception that medical scheme membership is a grudge purchase. Consumers are ill-informed due to the information asymmetry that exists and are thus not in a position to shop around for the best services and prices offered.

A reference price list can bring about the necessary price transparency in the market by assisting with providing clarity to members on reimbursement and charging rates of medical schemes and providers, expressed clearly with reference to a standardised industry reference price list.

- When a healthcare benefit is provided as a regulated benefit for the public such as by medical schemes, the price at which the benefit is procured from the service provider needs to be transparent to assist access to the benefit.

We do however propose the following qualifications and additions to a coding authority structure:

- We support a multi-stakeholder coding authority where the output is the standardisation of key components that are central to ensuring stability and transparency to facilitate competition based on value.

The process should thus be able to accommodate alternative reimbursement models that incentivise cost containment and quality of care and drive competition amongst healthcare providers.

- A nationally appropriate coding system should be adopted to replace the less than ideal NHRPL or RPL schedules. This links critically into a standard for billing purposes based on robust coding standards in order to implement accurate and reliable measures for price and quality.
- In order to improve measures on price and quality, providers should be obliged to transparently report on minimum quality standards and related metrics.
- Establishing a minimum reference price list (MRPL). A list of minimum reference prices (MRPL) should be set by the State and set at a level equivalent to the State UPFS schedule. This provides a reference price list only as a benchmark for the private healthcare industry.
- PMBs should be funded at a rate no less than this MRPL.
- A maximum ethical tariff guideline in order to protect the consumer should be determined. The process and rate is to be determined by the relevant hospital and healthcare professional regulatory bodies.
- Medical schemes should be able to set a "Scheme Rate" and this will apply to all services including PMBs. This would require regulatory changes such that PMBs are no longer funded 'at cost without restriction' but at the scheme rate.

- Healthcare providers are able to charge above Scheme Rates, even for PMBs, but this must be disclosed to members / patients relative to MRPL and fees above the Scheme Rate will be paid by the member.
- Ideally there should be a significant range between the minimum rate MRPL and ethical rate to allow for flexibility and competition.
- Setting a reference price list at a low level is required rather than setting it at the current average or maximum levels, or even levels based on cost practice studies in the private sector. If it were set at higher levels, or based on practice cost studies, the reference prices would become the de facto minimum prices in the industry and entrench existing inefficiencies. The State UPFS fees provide a useful benchmark level against which to base the reference price list. There would be differences between the UPFS schedule and the industry coding standard at first, requiring some analysis to target price equivalence. But this may over time converge to a national coding system which would be the ideal.
- Mandated transparency of price, expressed relative to the minimum reference price MRPL, and quality of care for all healthcare providers. Similarly, hospitals must be compelled to publish their quality measures and their private rates, again expressed relative to the minimum reference price MRPL.
- In terms of achieving greater transparency for members, hospitals should publish the current scope of their licenses as well as any shareholding from healthcare professionals.
- Member empowerment is enhanced by stipulating that the Scheme Rates need to be set relative to the MRPL for ease of comparison, for example 150% of MRPL. In addition, providers are required to stipulate their fees to patients relative to the MRPL.
- There should be flexibility to implement alternative reimbursement models / risk sharing arrangements outside of this framework. This will encourage efficiencies within the healthcare system by allowing selective contracting of healthcare practitioners and hospitals by healthcare funders where ARMs and higher tariffs can be negotiated in return for greater overall efficiency (management of waste, utilisation and quality).
- To ensure appropriate competition and access to facilities, a transparent scientific and structured approach to the licensing of facilities should be published by the regulator.

PART E – SUMMARY OF RECOMMENDATIONS

Statement of Issues (listed as per Call for Submissions 1 August 2014)	Medscheme Position / Recommendation	Cross References
1. Factors driving costs, prices, and expenditure in private healthcare	<p>Medscheme proposes that PMBs are only paid in line with scheme rates, as per other benefits. However, the benefits must be clearly defined relative to an industry reference price list (MRPL) and providers must transparently display their billing rates relative to this reference price list.</p> <p>Further to this, the objectives of PMBs within the government's revised policy to achieve universal coverage should be clearly de-lineated. The current PMBs should be simplified and focused on clear benefit definitions (as has been proposed previously).</p> <p>Limiting funding of tertiary and quaternary-type PMB services to established academic teaching units; and the definition of a negative rather than positive disease list should be considered.</p>	Section 3.2.1. 8.1.2 9.1
	It is proposed that the price of medical devices, surgical and medical consumable items be regulated in a similar way to scheduled pharmaceutical products.	Section 3.2.2.2
	<p>The establishment of an independent coding authority to govern coding structures and set the industry reference price list (MRPL) is proposed to encourage transparency and empower consumers, enhancing competition.</p> <p>We believe that it will make a substantial contribution towards curbing the rising costs of healthcare if a MRPL is published. Healthcare practitioners and providers, as well as medical scheme benefits should be mandated to publish their rates relative to this MRPL. The MRPL should be set at State UPFS fee levels and would represent the minimum rate of payment for PMBs.</p>	Section 3.2.2.3 7.2 9.1
	It is proposed that for many highly specialised procedures, care should be confined to Centres of Excellence.	Section 3.3.1
	It is recommended that medical scheme membership be made compulsory for formally employed lives earning above the tax threshold. Introduction of compulsory medical scheme membership, based on a Competition Commission recommendation, will improve affordability and sustainability of the private healthcare industry. The recommendation should ideally be coupled with income based contributions and the benefit option should be closer to a PMB based package. Failing this, medical schemes should be allowed to risk rate (at least partially) and fully underwrite to ensure a sustainable private healthcare market.	Section 3.4.1.2

Statement of Issues (listed as per Call for Submissions 1 August 2014)	Medscheme Position / Recommendation	Cross References
	<p>It is proposed that the contracting legislation as reflected in the MSA and Health Professions Act be reviewed to create a more balanced environment that will enable health care funders to more easily contract on the basis of cost and quality outcomes. In addition funders should be able to selectively procure healthcare services in a competitive contracting environment where specialists can compete on cost and quality outcomes for a limited number of opportunities (whilst ensuring access to care). This is no different to how any other efficient market would procure services.</p> <p>The tender process is already one of the mechanisms by which medical funds to selectively procure services from other third party service providers. This allows for an ongoing commercial arrangement based on contracted outcomes and service levels.</p> <p>It is suggested that elements of this process be incorporated into the MSA and Health Professions Act (which should be aligned in their objectives). The rules must ensure that all willing participants have the opportunity to participate in such a competitive process. In addition the criteria for determining reasonable access and for which services it is reasonable to restrict access need to be determined.</p>	Section 3.4.4
	<p>It is proposed that the ethical and professional rules of the HPCSA that were promulgated in the Government Gazette in 2006 with subsequent amendments be revised to expand the definition of recognised employment agencies and criteria for employment of doctors, in order to allow innovative healthcare delivery structures.</p>	Section 3.4.4.2.3 3.4.5 8.2.1
2. Market power and distortions of competition at various levels of the sector	It is proposed that the Panel investigate any market distortions and inappropriate behaviour due to such distortion. These may include the unwillingness of providers to provide detailed utilisation data and negotiate regionally.	Section 4.0
3. Barriers to entry and expansion by firms at various levels of the sector	It is recommended that the Regulator allow and encourage reinsurance, specifically for new entrants, medical schemes in financial difficulty and smaller medical schemes with volatile claims experience.	Section 5.1

Statement of Issues (listed as per Call for Submissions 1 August 2014)	Medscheme Position / Recommendation	Cross References
	<p>Medscheme’s position is that wellness programmes should be contracted by Medical Schemes in terms of the Medical Schemes Act 131 of 1998 and that the definition of relevant healthcare service should be expanded to include funding for wellness. This would lower the financial barrier to entry into this market, allowing new players to enter the market.</p> <p>From a competition perspective this would facilitate transparency amongst wellness providers who would be forced to publish their outcomes in order to remain competitive. This would also improve the standards of healthcare as beneficiaries would be empowered to make informed choices regarding their care.</p>	Section 5.2
	<p>It is proposed that brokers selling medical scheme business should be able to earn comparable commissions to other insurance markets to level the playing field and remove this barrier to entry for new medical schemes.</p> <p>Medscheme proposes that medical schemes should be allowed to similarly sell loyalty or other insurance products to be able to compete on equal terms with larger co-branded insurance and medical scheme offerings..</p>	Section 5.3
4. Factors limiting access by consumers to private healthcare, including affordability	It is proposed that risk-based solvency be considered as this would result in much more efficient allocation of capital and reduce contributions.	Section 6.1
5. Imperfect information as it affects consumers as well as firms in the sector	<p>It is proposed that the Competition Commission Inquiry Panel recommend regulatory change to ensure the transparent reporting of healthcare quality and cost information.</p> <p>An independent, multi-stakeholder coding authority should be created to develop and maintain coding structures for all provider disciplines, standardizing procedural codes within the industry.</p> <p>As part of this, clear descriptors of codes should be provided, detailing the scope of each code, i.e. what is and what is not covered, as well as which provider type is qualified to use a certain code. Rand Value Units (RVU’s), indicators of the relative value of procedures in terms of input time, relative risk, and training required, should furthermore be defined. Without such standardization, patients are exposed to financial risks and providers and funders alike are burdened by administrative inefficiencies.</p>	Section 7.1 Section 7.2.

Statement of Issues (listed as per Call for Submissions 1 August 2014)	Medscheme Position / Recommendation	Cross References
	It is proposed that the Competition Commission, as a matter of urgency, declare that collaboration on a standardized coding framework and definition of code-specific RVUs is not deemed to be a form of price collusion. The clinical nature of such interaction, which is distinct from negotiations aimed at agreeing on specific prices, should be endorsed.	
6. The impact of the regulatory framework (including various statutes, regulations and rules) on competition in private healthcare	It is recommended that compulsory membership with income cross-subsidisation would provide a sustainable regulatory structure and support the private healthcare sector towards the NHI future. Failing this, limited risk rating and increased underwriting is required to provide a sustainable regulatory framework.	Section 8.1.1
	Medscheme recommends the introduction of the REF to equalise the expenditure of providing PMBs across medical schemes, as envisaged in the 2008 Amendment Bill.	Section 8.1.3
	Medscheme recommends the use of provider networks as they enable better co-ordinated care of patients and provide mechanisms to monitor and report quality and cost outcomes and allow incentives to be paid to encourage best practice	Section 8.2 3.4.4.2.1
	It is proposed that the ethical and professional rules of the HPCSA that were promulgated in the Government Gazette in 2006 with subsequent amendments be revised to expand the definition of recognised employment agencies and criteria for employment of doctors, in order to allow innovative healthcare delivery structures.	Section 8.2.1 3.4.4.2.3
7. The specific impact of interventions previously made by the competition authorities in regard to the healthcare sector	<p>Medscheme proposes the establishment of an independent coding authority to govern coding structures and set the industry MRPL as this will encourage transparency and empower consumers.</p> <p>We believe that it will make a substantial contribution towards curbing the rising costs of healthcare if a MRPL is published. Healthcare practitioners and providers, as well as medical scheme benefits should be mandated to publish their rates relative to this MRPL. The MRPL should be set at State UPFS fee levels and would represent the minimum rate of payment for PMBs.</p>	Section 3.2.2.3 7.2 9.1