Seminar:
Funders' Market Concentration and Countervailing Power

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Issues for Funders Market Concentration and Remedies Seminar

- **What are the competition issues raised due to significant funder concentration**
  - "**Buyer**" power in negotiations with hospital groups and
  - **Market power** with regard to competition for members; consumer benefits
  - Profitability

- **With regard to facility concentration – not highly concentrated; market conditions are not conducive to significant facility bargaining power**
  - Dynamic competition, entry, alternative providers for funders.

- **Do funders have tools to address issues raised by HMI on utilisation, investment, and capacity?**

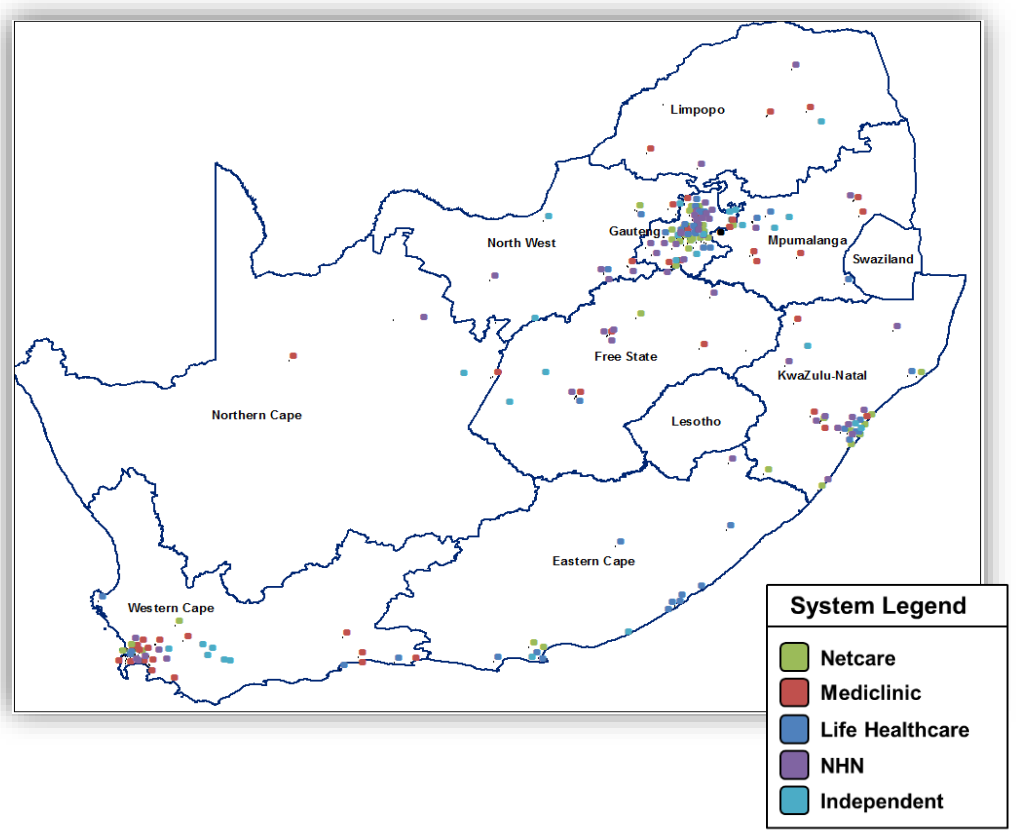
- **Selected recommendations for review in seminar:**
  - Can HMI recommendations be improved to replicate optimal effects of competition?
  - Are DSPs (networks) starting to reduce inefficiency? How can they be made more effective?
  - Reference pricing.

Data show strong national and local competitive alternatives that support effective bargaining and competition

- **NHN created a strong 4th national health group to bargain collectively with funders and presents an effective competitive alternative to the larger 3 groups;** large competitive fringe exists to provide access and additional services. Significant entry by NHN/independents.

- **Schemes and patients have <u>many competitive</u> alternatives for healthcare services** – locally and nationally –**conditions are conducive to effective bargaining and competition**.

Private Hospitals by group (2016)



Funders have sufficient alternatives – HMI note overstates claims of must-have hospitals and facility market power

- **Funders can exercise effective bargaining and use of alternatives.**
  - **Hospital alternatives have increased over time** – especially with NHN growth.
- Economic and competition literature supports conclusion funders do not need to drop an entire hospital group to exert competitive discipline.
- Several examples of schemes successfully using strategies other than network to reduce tariffs. According to HMI data and Netcare data, funds with network and non-network options negotiate tariffs down for both types.

- **Whereas funders have numerous options to substitute among hospitals groups - hospitals risk losing significant volumes and large share of revenues if they fail to contract with the largest funders.**
- **Funder concentration increased significantly over time [HHI over 3000.]**

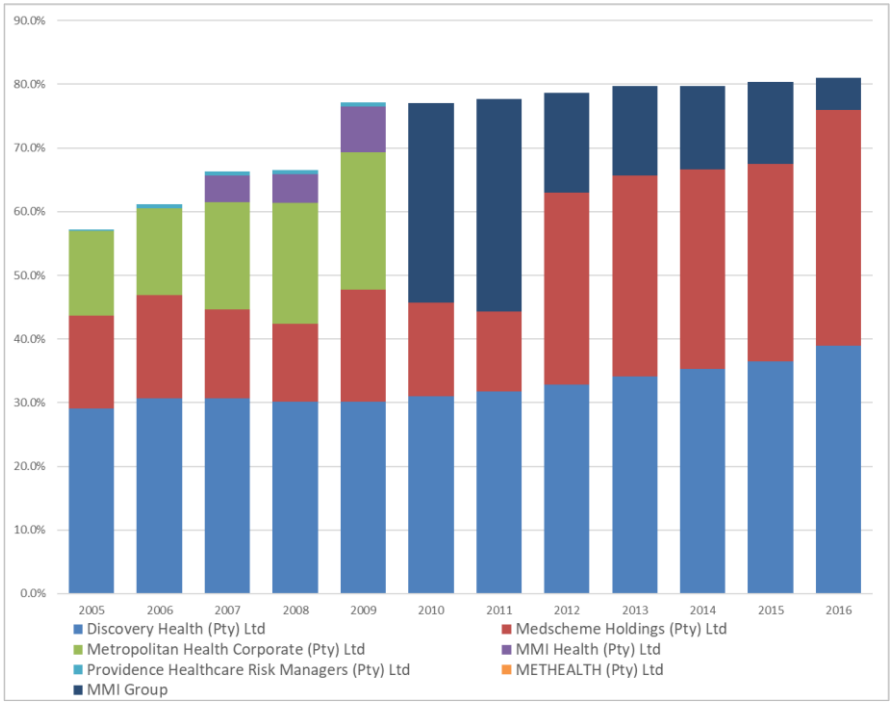
The HMI raises competitive concerns on funder concentration

"*The HMI nevertheless remains concerned with the potential anti-competitive outcomes arising from such [funder] concentration, where a lack [of] effective competition amongst funders on the downstream markets prevent the lower prices achieved upstream to be passed-on to consumers. Which then results in significant and persistent administrator profitability. ….increasing competition on the downstream market of funders is [pf concern].*" – Funder Seminar Note at Par 27

- Medical scheme markets as defined by HMI show high shares for top two firms:
  - According to the HMI, GEMS has 47% of the restricted medical scheme market. – PR, p 82
  - Discovery has 55% of open medical scheme market. – PR, p 80
- According to the HMI's own findings, Discovery Health and GEMS represent "*51.3% of the market in terms of [all] beneficiaries*." – Davis, 2018, p 15
  - Discovery represents 30.9% and GEMS 20.4%. – PR, p 154
- These suggest funders have a significant ability to constrain pricing with competing hospital alternatives; raise HMI's potential market power concerns.

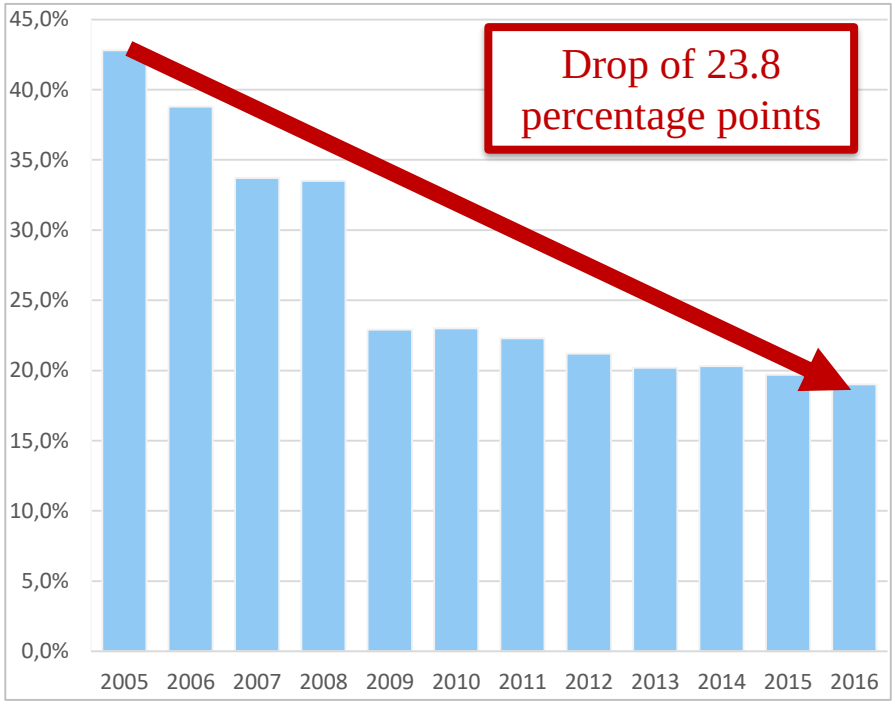
Increasing concentration of administration sector

Share of Largest Administrators



Source: Table 5.6 of HMI Provisional Report

Share of All Other Administrators



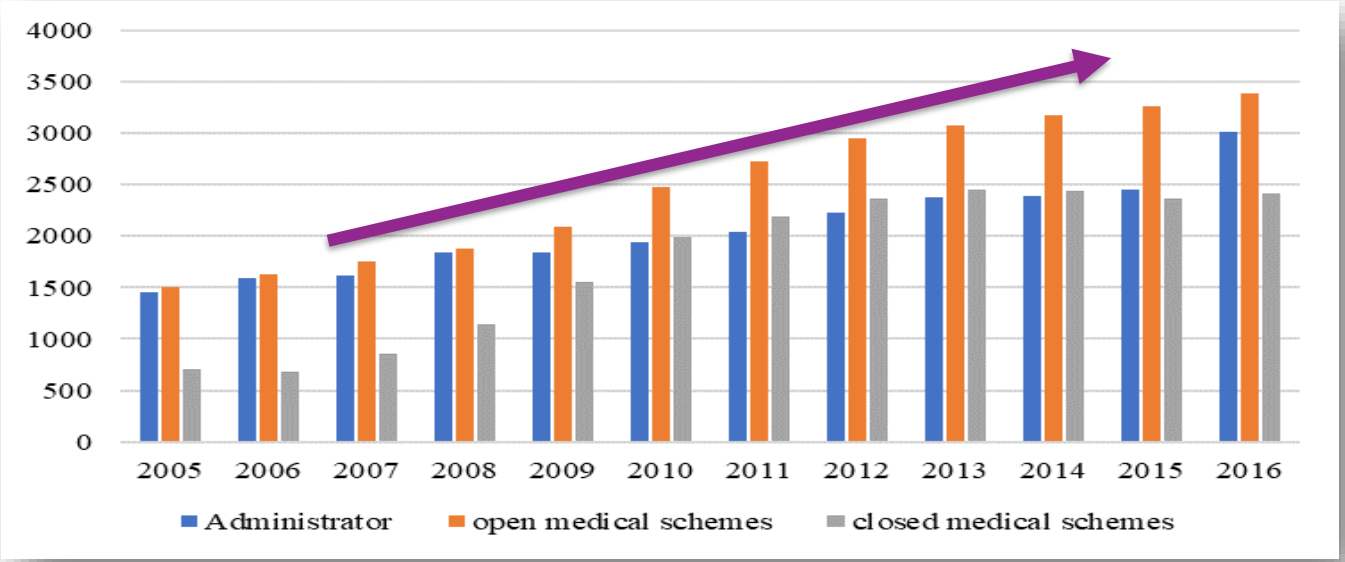
Source: Table 5.6 of HMI Provisional Report

- Trend of increased concentration (HHI) is due to increased shares of the largest two firms (from 45% to 77%) and a decline in all other administrators to 19%.
- Discovery Health notes in its most recent annual report that its market share is now well over 40% suggesting an even higher HHI today.

Increasing concentration of funders sector; little entry

- The HMI's funder concentration analysis shows **concentration levels have increased** substantially for administrators, open medical schemes and closed medical schemes – with limited entry.

Funders HHI Trends



Source: Table 5.3 of HMI provisional report

- In 2005, HHIs in the administrator and closed scheme markets **were below 1500 (non-concentrated)** and the open schemes HHI **was just above 1500**.
- **By 2016, HHIs in administrator and open were both above 3000 (highly concentrated),** and the closed scheme HHI increased **substantially to 2422.**

Update: Actual networks show market functions competitively

- In addition to 9 April Seminar examples (below), Discovery Health excludes several significant Netcare hospitals from some of its large networks. E.g.: Netcare hospitals are only selectively included in Discovery's Smart Hospital Network (10 facilities) and Delta Hospital Network* (6 facilities).

Numerous Representative Examples (2017-2019) – Based on Netcare Information

One or more Hospital Groups excluded:

- **Health Squared Medical Scheme: Life Health excluded**.
- **Medshield DSP – Network: Mediclinic** generally excluded.
- **Selfmed DSP:** DSP Option reinstated with Netcare; **LifeHealth excluded**.
- **Medipos DSP – Hospital Network: All Netcare facilities** excluded from DSP; all scheme options for 2019.
- **Umvuzo EDO/Filler Hospital: All Netcare facilities** excluded - new EDO Ultra Affordable Option & DSP Proposal for Activator Option.
- **Fedhealth EDO "Elect" Option – Hospital Network: All Netcare facilities** excluded from new very limited EDO which has Government, LifeHealth, Mediclinic and NHN hospitals except for Ceres Hospital.
- **GEMS – Emerald EDO Option:** Value Option (EVO). Netcare and LifeHealth plus 10 NHN hospitals. **Mediclinic** excluded from the EVO.

Anchor hospitals, selective adds, exclusions:

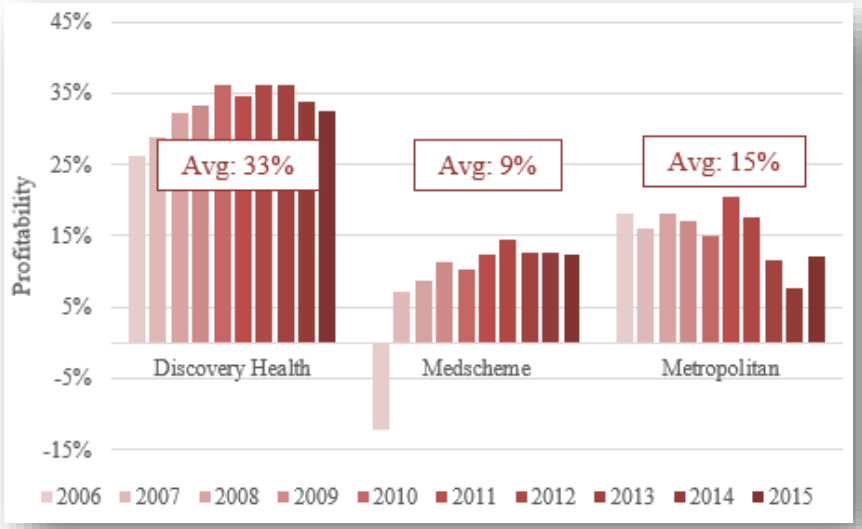
- **Polmed DSP – Filler Hospital: Netcare excluded** as anchor DSP status for scheme;17 Netcare facilities added as filler sites. 14 Same Day facilities; 11 Psychiatric Facilities.
- **Profmed Savvy EDO – Filler Hospital:** Mediclinic and Life Health as anchor network. 16 Netcare as fillers (16 acute; 12 psych;15 same day facilities).
- **Keyhealth DSP – Options awarded to Netcare as anchor:** Equilibrium, Essence Silver, Netcare and Life Health were awarded the DSP contract. **Mediclinic and NHN** excluded with exception of specific regions.
- **Bonitas – DSP Network:** DSP Network inclusive of all Netcare hospitals for options which do not have own EDO network. **Excludes 14 LifeHealth facilities** in major metro areas.
- **Fedhealth EDO Options –** Netcare as anchor: Benefit Options Included **Mediclinic, LifeHealth** excluded with exception of some specific regions.

*According to data from the Council for Medical Schemes, Delta (EVO) represented ~11% of Discovery beneficiaries in 2017.

HMI findings on profitability of administrators

- The HMI redacts most data on funder profits. It does find that the funders profitability analysis shows **"persistent"** profits for top funders.
- The PR also indicates need for increased competitive pressures on top funders for more vigorous competition and particularly to assure benefits are passed to consumers.*
- These HMI findings are inconsistent with a conclusion that funders lack bargaining power in negotiations.

"Over time, there has been a clear upward trend in Discovery Health's [return on sales]" and "the observed level of profits for Discovery Health point to a degree of market power on the downstream market." – Provisional Report, p 144 & 146



Source: Table 5.6 of HMI provisional report

***"Medical scheme administrators with a substantial market share that persistently earn excess economic profits over a prolonged period of time, without the realistic threat of competitive entry, may have a degree of market power and be able to charge prices above the competitive level."** – Provisional Report, p 140

Funders have effective tools to constrain capacity and utilisation

- **Funders' bargaining power has been used to deter or limit bed expansion; added investments in new hospital capacity; and to limit utilisation of excess capacity or redundant services in an area of the specific funder.** (Medscheme, Discovery ex.)
  - **Economic theory: hospitals with "excess capacity" have incentives to respond competitively.**

- Funders also have **market-based solutions** to address utilisation. Starting in 2016, GEMS has been actively working to reduce what they believe is unnecessary utilisation.
  - Independent claims review; hospital event utilisation, associated hospital provider utilisation; claims management program; early warning system to track hospital authorisation rates
- DH developed strategies **to reduce utilisation** -on-site case managers; pre-authorisation.

Ryan Noach: "Out of this pre-authorization process, we're (declining) 20 percent of admissions" and "We're seeing a 31 percent decline by the onsite case manager of the admission rate."

GEMS: Demonstrated "significant positive results for the Scheme"

Discovery: "[Discovery] has been effective in managing supplier induced demand to some extent." Discovery saved 26.6B Rand between 2013 and 2017 from managed care and wellness initiatives.*

*Discovery Health, *Submission on the Provisional Report of Findings of the Health Market Inquiry of 5 July 2018*, 15 October 2018.; GEMS, *Claims Management*, Appendix 4 and 5; DH Presentation 10 April

Review of HMI Recommendations Regarding Pricing

Price Regulation and Reference Pricing

- **<u>Price regulation is without any foundation</u>. There is no basis for concluding that prices are excessive or that funder and private hospitals cannot effectively negotiate prices.***
- **Price regulation is not proportionate or easy to implement.** Setting prices is complex and time-consuming process, even when there are fewer tariffs or reference prices for specific services. Reference pricing requires establishing a specific price for each service for all hospitals, that can change as market conditions change and that provides sufficient return.
- Government regulation of healthcare prices is fraught with complexities that make it unlikely that results will approximate equilibrium prices that would be established in a competitive market. The market is likely to achieve greater efficiency without government price intervention, particularly with effective competition and bi-lateral negotiations.
- **CMA rejected price regulation in favor of bi-lateral negotiations: "***… a price control regime would be very difficult and costly to set up …and to update, to take account of both the introduction of new treatments and procedures, and movements in costs over time. We therefore decided that a pricecapping regime would not be effective in the long term.. not proportionate."**
- If the HMI's price control proposals are meant to encourage greater adoption of ARMs, remedies designed to minimise any existing costs/barriers to the adoption of ARMs may be sufficient and would be far less onerous than price controls. The HMI has not considered such possibilities.

*No evidence of price-concentration linkage/causality – controlling for funder mix, procedure mix, and patient acuity mix, there is no evidence that tariff or revenue/admission vary with concentration (Davis, 2014).

HMI should consider timing and choice of recommendations and conduct further assessment

- The HMI notes potential significant benefits from mandatory membership in reduced anti-selection risks and reduced costs – and a general stakeholder consensus on these benefits.
- The HMI **defers** recommending mandatory membership based on findings of alleged SID, high and increasing costs, and alleged contracting issues between funders and facilities **and** its view that these issues require significant and immediate regulatory interventions.
- **The HMI should reconsider the proposed recommendations with benefit of comments**:
  - Neither the PR nor the underlying data demonstrate SID, bargaining power, excessive pricing, or excessive facility profits, nor do they demonstrate significant issues from facility concentration.
  - There is no need for proposed extensive regulatory interventions for share, divestiture, CON, price regulation, or entry restrictions to address issues; there are market-based alternatives if necessary.

"We note that stakeholders submitted that mandatory membership of all people earning above a defined income threshold would reduce anti-selection risk. This is true and though the inquiry supports the principle of mandatory membership, we do not believe that it should be implemented within the current flawed system. At this stage, mandatory membership would simply add more beneficiaries into a system with high and rising costs, significant SID, limited competition and no incentives to create value for members." – Provisional Report, p 461

"[M]andatory membership does not change the current contracting with providers or over utilisation of healthcare services in the system (See Chapter 7 and 8 on Practitioners and Facilities as well as Chapter 9 on Supplier Induced Demand). – Provisional Report, Annexure 5.1

HMI should re-evaluate the balance of recommendations and consider further assessment of mandatory membership

- **The HMI has some evidence from comments on benefits of mandatory membership that can be used in assessing benefits and evaluating options.**
  - Netcare experts quantified significant potential benefits from mandatory membership: "Assuming a 10% saving for the market overall, in line with published SHI estimates and more recent work, mandatory membership would result in a saving per capita that would equate to a R12.4 bn saving per annum. This significantly outweighs other remedies put forward in the Provisional Report." (Barry Childs, Insight Actuaries, p 5)
- The HMI could also consider further evaluation of supporting policies and cost/benefit.
  - Additional and supporting policies could include, e.g., review of PMBs every two years, solvency measures for medical schemes, and a risk equalisation mechanism. Areas for further study could include demographic analysis and evaluation of minimum tax thresholds.

On a per-member basis, the cost of providing PMB benefits reduce under mandatory membership, in a once off step change…. [T]here may be an initial decrease in the real average age of medical scheme members, and with that, a decrease in expenditure on PMBs…[G]iven the substantial poverty which exists in South Africa, and the fact that many middle and high-income earners support large numbers of impoverished dependents, careful attention would need to be paid to the ultimate net social equity effects of any mandatory membership regulatory reform. While mandatory membership thus remains an interesting and potentially extremely useful policy option, the pre-conditions for implementing it are probably not yet in place. – Provisional Report, Annexure 5.1

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