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Competition Commission of South Africa

The Health Market Inquiry Panel

Via email: paulinam@compcom.co.za

7 September 2018

Dear Sir / Madam

COMMENTARY ON THE HEALTH MARKET INQUIRY PROVISIONAL FINDINGS AND RECOMMENDATIONS REPORT ("Report")

Universal Healthcare Administrators (Pty) Ltd ("UHA") is an accredited administrator and has been providing a broad spectrum of administration services since 1974. UHA values the opportunity to comment on the recommendations made by the Health Market Inquiry Panel ("Panel").

Please note that this commentary only pertains to certain aspects of the Report. Matters not addressed or commented on must not be construed as either approval or disapproval of such matters. The comments below relate to the items addressed in the Report that UHA found most pertinent. Comments have been made with reference to the relevant paragraph numbers as indicated in the Report.

1 **Ad Paragraph 17** - ***Overall, the HMI finds that competition in the funders market is neither as vigorous nor as effective as it could, or should, be. This is true of both administration services and medical schemes***:

1.1 This is largely due to the imbalance in supply and demand, where the supply side is typified by a shortage of providers in certain disciplines e.g. specialists or where supply is dominated by the three large hospital groups. Medical schemes, particularly smaller schemes, are at a disadvantage and tend to be price takers. As a result, administrators,

particularly the smaller ones, have limited ability to negotiate on behalf of of all schemes and rely on personal relationships to negotiate from an inequitable distribution of negotiating power.

2 **<u>Ad Paragraph 18</u>** - ***In both the administration and open scheme markets, one large player (Discovery Health in administration and DHMS in open schemes) leads the market, especially in terms of growth, innovation and profitability. Other players largely follow its lead. Restricted schemes, by their very nature, do not compete with open schemes nor do restricted schemes compete with each other. The HMI found that there is limited competition between schemes on factors that increase the value of medical scheme cover (in terms of both cost and quality) and limited evidence of efforts to design and implement alternative reimbursement models to contain expenditure and encourage value-based contracting. The HMI believes that there are failures in regulation, governance and adverse incentives associated with the current market structure that contribute to this lack of competition and innovation:***

2.1 Innovation in terms of benefit design and alternative reimbursement models is often stifled by restrictions from the Council for Medical Schemes "CMS"), certain provisions of the Medical Schemes Act 131 of 1998 ("MSA") and the HPCSA Ethical Rules.

3 **<u>Ad Paragraph 19</u>** - ***At the heart of the failure of funders to deliver better value to consumers lie multiple problems: a profound lack of transparency (including on scheme options and quality of outcomes), a lack of accountability of schemes to members, and a failure of governance that align scheme interests too closely with that of administrators. The lack of incentives operating at scheme level weakens schemes' resolve to hold administrators to account for delivering value to members. Health care costs and administration costs fees are increasing and benefit packages cover less care:***

3.1 UHA does not agree with this finding. Scheme governance is best of breed for most schemes, with policies, charters etc to guide scheme activities. The quality of outcomes is extensively reported on and demanded of the administrators by the well governed schemes. This statement is a high-level generalisation.

3.2 Administration costs increase in-line with inflation, despite a larger than inflationary increase in administrator costs due to increased legislative and compliance requirements, specifically in terms of requirements from the CMS such as reporting and data submission.

4 **Ad Paragraph 20** - ***The Inquiry has also found that all schemes have failed to adequately manage supply induced demand. Given that supply-induced demand is known to exist in healthcare markets (and has been shown to exist in South Africa too), we would expect medical schemes to force their administrators to actively manage this in the interest of protecting scheme members' health and the financial sustainability of the scheme. The ability to effectively manage SID should also be a competitive differentiator for administrators. The widespread inability to manage and supply-induced demand suggests a lack of effective competition in the market for administration:***

4.1 This is largely due to the discontinuation of NHRPL. Without these guidelines suppliers can charge what they want. Furthermore, Prescribed Minimum Benefit ("PMB") legislation has exasperated healthcare costs in a fee for service provider billing regime.

4.2 Insofar as the management of supply induced demand ("SID") is concerned, UHA agrees that further steps need to be taken to improve the negotiating powers of healthcare funders in the industry. Administrators and managed care organisations use best efforts to negotiate preferred fees, but the outcome of these negotiations is still very much dependent on the size of the scheme in question.

5 **Ad Paragraph 21** - ***With respect to the lack of transparency, consumers simply do not know what they are purchasing and cannot hold funders accountable. There are too many plan options, very little understanding of what they cover, how the plans compare, and no measure of the value that consumers are receiving. In the absence of such information, consumers may simply choose what they can afford:***

5.1 UHA concurs that scheme options are complex and that members do not always have a clear understanding as to how these options work.

5.2 According to UHA this is the result of a very complex regulatory environment, particularly the PMB legislation. Managing risk in innovative ways leads to the design of complex options e.g. network options.

5.3 Schemes and their administrators go out of their way to make benefit options comparable and easy to understand through members booklets, brochures and website information. The role of the broker plays a key role in providing advice to the member although the regulated commission makes this uneconomical for brokers to do this effectively for individual members.

5.4 UHS thus encourages the simplification of the proliferation of options in the industry.

6 <u>Ad Paragraph 22</u> - *Ideally the trustees of schemes should be interceding on behalf of members to ensure that they receive value for money and that administrators are delivering the best possible value to scheme members. But, the governance of schemes is problematic:*

6.1 Schemes with poor governance are the exception to the rule, not the rule.

7 <u>Ad Paragraph 23</u> - *There are few incentives to ensure that scheme employees, trustees and principal officers always act in the best interest of consumers. And even if they tried, administrators generally have far more analytical capacity and 'know how' than schemes and generally make decisions on behalf of schemes, even on key issues of strategy. The 'separation' between schemes and administrators often seems artificial, particularly in the case of large open schemes. This failure in governance is severe and is a major concern for the Inquiry:*

7.1 UHA provides the analytical capacity and "know how" to the schemes it administers, to empower such schemes to make these decisions.

7.2 UHA is required to account to the boards of trustees on scheme performance, contract adherence and value. Contractual penalties and remedial processes are in place where there are breaches in performance of UHA.

8 **Ad Paragraph 26** - ***However, even if restricted schemes exert some pressure on administrators, nonetheless administrators face insufficient pressure from schemes. Non-healthcare costs for the 10 largest schemes in South Africa range from 5% to 13.4% of gross contribution income compared to only 3% of GCI on average for OECD countries. Additionally, during annual negotiations it seems that trustees are generally satisfied with CPI-linked increases in member contributions year after year:***

8.1 There seems to be confusion in this point between administration fee increases and contributions. Administrator fee increases are generally contracted to CPI and the smaller administrators can demonstrate where they have brought down NHE. NHE includes ALL non- risk cost including trustee fees and marketing fees.

9 **Ad Paragraph 27** - ***We find no evidence that schemes demand information on the costs saved by administrators related to, for example, managed care or fraud control and whether the related savings are passed on to scheme members:***

9.1 This statement does not apply in all cases.

9.2 UHA reports to its schemes on all cost savings in various reports. All savings are passed on to the members, as any savings will have a direct impact on the bottom-line of the scheme – which will have a positive effect on the basis for the following year's budget. Savings are indicated in the managed care report at BOT meetings on a quarterly basis.

10 **Ad Paragraph 29** - ***Therefore, the panel recommends measures to strengthen governance to ensure that schemes place greater pressure on administrators to deliver value to members, that members place greater pressure on schemes to improve value for money, and measures that enable the regulator (the CMS) to exercise more effective oversight over funders:***

10.1 UHA disagrees that its medical scheme clients demand no accountability from it to manage healthcare costs and demonstrate value. UHA experiences significant (and appropriate) pressure from all our scheme clients to mitigate claims inflation.

10.2 In addition, due to the highly regulated environment, various reports have to be submitted to the CMS. Further overview is supported by on-site CMS evaluations, routine CMS compliance inspections, as well as audits by external auditors; both on the scheme as well as the administrator and its systems, processes and procedures. All these governance measures have value to the schemes and its members as a key focus area.

11 **Ad Paragraph 31.1** - ***The introduction of a stand-alone, standardised, obligatory 'base' benefit package that all schemes must offer. The package must include cover for catastrophic expenditure, i.e. the current Prescribed Minimum Benefits (including making provision for treating PMBs out of hospital) and; additionally, include, primary and preventative care. The base option would include a standard basket of goods and services and will thus be easily comparable across schemes*****:**

11.1 Currently all schemes must offer PMBs (thus the base package), and the cost thereof has been crippling. If this package is to be extended this will have a direct impact on health care costs, and subsequently on contributions.

11.2 An essential pre-condition to the introduction of a base benefit package by schemes will be the prior establishment of an appropriate tariff setting mechanism. It is therefore imperative that the SSRH be established as a matter of urgency, which will assist with managing the costs.

12 **Paragraph 31.2** - ***The introduction of the base package must be accompanied by a system of risk adjustment (see below), which will remove schemes' incentives to compete on risk factors such as age, and will instead encourage schemes to compete on value for money and innovative models of care*****:**

12.1 Kindly provide more clarity on how the risk adjustment will work, as schemes have been waiting for the risk equalisation fund, which has not transpired, despite submitting data to the CMS to enable the forming and implementation of such fund. How will this be administered and governed?

13 <u>Ad Paragraph 31.4</u> - *That administrators must report publicly on the value and outcomes of all ARMs, PPNs and DSP arrangements they have entered into on an annual basis. These reports must be presented in a simple and accessible way, so that it allows consumers to see how much administrators have saved from these arrangements*:

13.1 The term "consumers" may be construed to mean members. It is doubtful if members will have the ability to understand these concepts. We would rather propose that reference is made to medical schemes.

13.2 Please also take note that it is the schemes who save on these arrangements and not the administrators.

13.3 Whereas UHA agrees with this in principle, it would be necessary to specify which outcomes are to be measured and the methodology for calculating value, and schemes would need to conform to these specifications. This would ensure that the results are comparable. Proverbially speaking apples need to be compared with apples.

14 <u>Ad Paragraph 32.1</u>: That the remuneration packages of employees of schemes, particularly that of trustees and Principal Officers, be linked more explicitly to the performance of schemes. Performance will be measured in terms of the value delivered to members. Presently, the remuneration of Principal Officers and Trustees is poorly connected to performance. We propose that the remuneration of Principal Officers and trustees be set at a minimal base level and that the rest of their package be linked to clearly-defined quantitative objectives of the scheme such as reductions in non-healthcare costs, administration costs etc.

14.1 Measuring should not be based on financial performance only, as this can lead to fewer benefits to members to improve financial results. The balance should be between affordability, access and quality of care and outcomes.

15 <u>Ad paragraph 32.7</u>: *That the broker system is an active opt-in system so that the interests of brokers and scheme members are more closely aligned. Members will be required, on an annual basis, to declare if they want to use the services of a broker. For those that do, the scheme will facilitate the payment to the broker. Members who chose not to use the services of a broker will pay proportionally lower scheme membership fees:*

15.1 The need for explicit member consent, should be practical and feasible.

15.2 An annual declaration would be administratively onerous and will lead to an increase in non-healthcare expenditure. It does not make sense to require that consent be obtained every year – consent should be obtained once, and a member can then withdraw their consent at any time thereafter.

15.3 A workable solution for consent in the corporate environment, where it will not be possible to obtain consent from all current employees should be proposed.

16 <u>Ad Paragraph 56.1</u> - *The highly concentrated structure of the facilities market. At a national level, the three largest hospital groups have a market share of approximately 90% based on hospital admissions and 83% based on registered beds.8 Also, in the majority of local markets, concentration levels are alarmingly high according to several recognised metrics commonly used to screen for concentrated markets. One of the challenges of this, from a competition perspective, is that it affords the three biggest hospital groups "must-have" status in bargaining for contracts with funders which reduces funders' countervailing power*:

16.1 UHA strongly agrees with the statement that the biggest hospital groups have "must-have" status in bargaining for contracts with funders and it is our ongoing experience

that this unequal bargaining power is to the significant disadvantage of medical schemes and to smaller schemes in particular. As the big hospital groups base their fees and fee increases (in part) on "volumes", small medical schemes are adversely affected when it comes to negotiating favourable fees or fee increases.

17 Ad Paragraphs 110 – 111 - *Regulated pricing:*

17.1 Of the two tariff setting mechanisms proposed by the Panel, the regulated option of tariffs being set by the SSRH after input from a multilateral forum is preferred and more pragmatic. The alternate multilateral price setting mechanism where stakeholders conduct tariff negotiations under a framework and with conditions determined by the SSRH, may be open to abuse as a result of the market dominance of the service providers and facilities.

17.2 UHA welcomes the fact that tariffs for PMBs will be binding and that the tariffs for non-PMBs will have the status of reference tariffs, which may only be exceeded if the patient's informed consent has been obtained, or as a result of negotiations between service providers and funders.

17.3 More detail is required in respect to how the arbitration process will work.

18 Ad Paragraphs 137 – 140 - *Establishment of an independent supply-side regulator for healthcare (SSRH):*

18.1 UHA supports the establishment of a SSRH and the proposed structure and urge that this be set up as soon as possible, preferably sooner than the suggested five years from date of publication of the final Inquiry report (Paragraph 138).

19 <u>Ad Paragraphs 147 – 151</u>: *Coding systems*

19.1 UHA considers the setting up of a central, standardised coding system under the control of an independent body, an urgent priority given the current situation where codes are being manipulated, unbundled and used inappropriately and inconsistently – all of which contributes to ever-rising healthcare costs.

19.2 However, whilst UHA agrees with the recommendation for the SSRH to outsource certain parts of its work on coding systems to independent experts, we do not necessarily agree that this should be academics per se. The criteria for appointing independent experts should include considerable prior experience of working with codes and coding within the private sector funding environment in South Africa.

19.3 This highly specialized area requires extensive practical experience in the successful implementation and maintenance of coding systems as well as a successful proven track record of the application of the coding system within the healthcare system. In this regard, the NAPPI coding system is an example of a system that has been tried and tested in the private healthcare sector and has successfully met all of the requirements of this sector for almost two decades.

19.4 The success of the NAPPI coding system is also attributable to the NAPPI Advisory Board, which consists of various stakeholders across the industry, who give practical input on specific requirements of the industry.

19.5 Whilst the recommendation of a central, standardised coding system under the control of an independent body is supported, a mechanism will be required to ensure that input from various stakeholders are considered and implemented where appropriate. For a coding system to work, it needs to be robust and policy decisions need to be made quickly to ensure that appropriate requirements of the industry are met.

20 Conclusion

UHA wishes to commend the Panel on the execution of this mammoth task in a succinct manner. The adoption of the appropriate recommendations will greatly improve competition, innovation and accessibility in the sector and lead to reduced costs, provided that the recommendations are implemented properly and timeously.

Yours faithfully

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MARK BAYLEY

Managing Director