MAKOTI MEDICAL SCHEME
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Competition Commission of South Africa
The Health Market Inquiry Panel
Via email: paulinam@compcom.co.za

Dear Sir / Madam

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

Introduction

Makoti Medical Scheme ("the Scheme") appreciates the opportunity to comment on the recommendations made by the Health Market Inquiry Panel ("Panel").

The Scheme is an open medical scheme which was founded in 1976 and is registered in terms of the Medical Schemes Act 131 of 1998, as amended.

The Scheme has accumulated over 40 years of experience in the provision of medical benefits to a number of employer groups as well as individuals, and has come to understand what South Africans want from a medical scheme. The Scheme currently offers two benefit options, namely the Comprehensive Option and the Primary Option through a full risk transfer agreement. The Scheme provides cover to approximately 4 500 members.

Comments provided are the opinion of the Scheme on matters that we believe will affect the operations of smaller, open schemes and relate to the items addressed in the Report that the Scheme found most pertinent and would like to comment on with references to the relevant paragraph numbers indicated in the Report.

Comments on the Report

Paragraph 18
Although restricted schemes do not compete with each other, as membership to these schemes are usually a condition of employment, they do however compete with open schemes as the spouses of these employees could be members of an open scheme and employees are exempted from joining the restricted scheme based on proof of registration to their spouse's medical scheme.

The Scheme is in full support of the recommendations for the improvement of healthy competition in the industry through improved accountability and transparency measures.

Paragraph 19
The Scheme supports the Inquiry's proposals that transparency and governance in medical schemes should be improved. It should however be noted that governance standards are generally high in the medical scheme environment as most schemes have implemented various governance tools such as Codes of Conduct, Remuneration Policies, etc.

Paragraph 20

On the matter relating to the management of supply induced demand, the Scheme agrees that further steps need to be taken to improve the negotiating powers of funders in the healthcare industry. Outcomes of negotiated preferred fees is unfortunately dependent on the size of the scheme. The limited number of service providers in the industry also significantly restricts the negotiating powers of all schemes.

Paragraph 21

With regards to the lack of transparency, the Scheme does not agree with the fact that consumers do not know what they are purchasing and that they cannot hold funders accountable. Members receive comprehensive benefit guides, which is supplied at a substantial cost to the Scheme. The onus is therefore on the consumer (member) to familiarise themselves with the content. The Scheme also only has two benefit options.

Paragraph 22

The Scheme does not agree with this recommendation. The Makoti Board of Trustees is interceding on behalf of its members to ensure that they receive value for money and that the administrator (and managed care company) is delivering the best possible value to members on the Scheme. We also disagree on the statement that governance of schemes is problematic as the medical schemes industry is a highly regulated industry and that most schemes have implemented various governance tools such as Codes of Conduct, Remuneration Policies, etc.

Paragraph 23

The Scheme does not agree with this recommendation. There is a definite separation between the Scheme and the administrator. The administrator definitely has the analytical capacity and "know how", but the Board of Trustees use these analytical tools and "know how" to ultimately make decisions that impact the Scheme and its members. The Scheme has not delegated its authority and decision-making responsibility to the administrator.

Paragraph 27

The Scheme places a lot of pressure on the administrator and managed healthcare organisation to deliver value to members. Cost savings are presented and reviewed at Board level. This is one of the main reasons that the Scheme can provide affordable cover for first time entrants to the market.

Paragraphs 31 and 39

The Scheme appreciates the HMI's proposal for the introduction of a stand-alone, obligatory 'base' benefit package, which would include an extended range of Prescribed Minimum Benefits (PMB) across all schemes. The Scheme is of the opinion that this can only be successfully implemented if a standardised tariff schedule has been introduced. In the absence if this, it will have the same cost implication of the current situation with PMBs where service providers inflate their costs to the Scheme as medical schemes are obliged to pay in full.

The establishment of a Supply Side Regulator of Healthcare (SSRH) will assist to curtail the exorbitant costs even further. The Scheme therefore supports the recommendation of the establishment of a supply side regulator, which will assist with managing the costs. Clarity needs to be provided on how

this body will be financed as this could result in an increase in non-healthcare expenditure if this is another body that schemes have to contribute to.

Paragraph 32

The Scheme agrees with the proposal that the remuneration packages of the trustees and Principal Officer be linked to the performance of the Scheme. The quantitative objectives however need to be clearly defined. Further clarification is required on the competencies and it would be suggested that a window period be allowed for current trustees to improve their current competencies where there are gaps to ensure a retention of institutional knowledge.

Paragraph 32.4

The Scheme agrees with the proposal to include the CMS' telephone number on the medical scheme card.

Paragraph 32.7

Further clarity is required on the "opt-in" recommendation. It is not clear whether existing members will automatically be opted in with their current, active broker selection and will have to opt out.

Paragraph 34

The Scheme does not agree with this recommendation as this will be unfair towards smaller, existing medical schemes where the pressure from CMS is on a minimum requirement of 6 000 principal members and the requirement of 6 000 members to register a new scheme. This is also against the strategy from CMS to consolidate schemes and reduce benefit options.

We also do not agree with the principle of reinsurance as this will also be unfair to other existing schemes who are not allowed to have reinsurance.

Paragraphs 40-45

The proposal of a legislated system of risk adjustment will be challenging to implement as was evident with the efforts in the past with regards to the introduction of a risk equalisation fund. Further clarity is required on the relevant risk mechanism to be used.

Paragraphs 51 - 53

Anti-selection will unfortunately remain a reality as long as membership to a medical scheme remains voluntary. The Scheme also welcomes the idea of an incentive to encourage younger members to join schemes. Such incentives much however be implemented in a responsible manner. Depending on the current age profile of the scheme, this may not allow for risk adjustment where the younger and healthier help to fund the older less healthy in the scheme. The result would be an adverse effect where older members are being charged much more and younger beneficiaries less and so it may encourage younger members to join but it may make it unaffordable for pensioners to stay.

Paragraphs 54 to 55

The practice of members declaring whether they want to continue to make use of broker services on an annual basis is also impractical. The Scheme agrees with the proposal that members should be free to choose any broker, but the broker has to have a contract with the Scheme in order for the Scheme

to pay the legislated broker fees over to the broker. The Scheme currently reports broker fees separately.

Paragraph 110-136

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

In the event that there is no agreement on a tariff, the proposal is that the decision of an arbitrator will be final and binding on the parties. More clarity is required on who such an arbitrator will be and which guidelines they will be required to follow in the resolution of a dispute. More detail is required in this regard.

Paragraphs 137 to 140

The Scheme agrees with the recommendation of the establishment of a Supply Side Regulator for Healthcare (SSRH). The proposed timeline of five years is unfortunately not desirable as urgent intervention is required to reduce the rapidly increasing costs of medical care. This is foreseen to continue to increase in the absence of a SSRH and will be further be improved by the introduction of a regulated tariff determination process.

Paragraphs 157 to 171

The Scheme supports the recommendation of an outcomes measurement reporting system. Funding of this needs clarification as this will result in an increase in non-healthcare expenditure should this be funded by medical schemes.

Conclusion

The Scheme appreciates the efforts that have gone into the production of this extensive Report. The adoption of the appropriate recommendations will greatly improve competition in the sector and lead to reduced costs, provided that there is a will to implement the recommendations properly and timeously.

Kind Regards,

H. MAKGOPELA
Principal Officer