Discovery Health

Discovery Health

DISCOVERY HEALTH (PTY) LTD Response to Published Stakeholder Submissions

Compiled in accordance with Supplementary Guideline No.1 of 5 February 2015.

Table of Contents

Section 1. Preferred Provider Networks

DH has developed hospital, health professional and pharmacy networks which have been implemented by DHMS and by some of the restricted schemes under DH administration. Networks are preferred provider arrangements set up between schemes and providers. Schemes enter into network contracts with providers based on agreed tariffs. By encouraging members to use network providers, schemes are better able to manage healthcare costs and members are protected against co-payments.

The development of networks, which is catered for in the Medical Schemes Act, is an essential tool used by medical schemes to provide financial protection for members against potentially significant out-of-pocket payments, and for the Scheme against the potential high cost of PMBs.

Provider participation in all networks is completely voluntary, and contracts are entered into by mutual agreement. No provider is under any obligation to join DH's network and, even if on the network, the provider may freely do business outside the network. Any provider who wishes to terminate the contract may do so with one month's notice.

The following sections identify key themes in the 'allegations' or factual inaccuracies in various submissions followed by DH's responses to these.

1.1 Health professionals (GPs, specialists, and all allied health professionals) networks

1.1.1 Direct Payment Arrangements (DPA) give funders an advantage over providers when contracting

"[DSP] contracts are also examples of market power wielded by medical schemes insofar as these contracts are unilaterally developed by schemes and marketed on a "take it or leave it" basis." ***SAPPF page 58***

"Medical funds that pay directly to doctors at the various plan rates still practice price fixing (of doctors' fees) if the payment depends on the doctor charging the fund rate only." ***SAPPF page 136***

"*If a doctor wishes to stay in business, he/she has no alternative but to do whatever the medical scheme requires in order to receive direct payment."* ***SAMA page 37***

"For professionals the acceptance of, for example, DSP and/or preferred rates is a "take it or leave it" choice, with the risk that if one "leaves it" the scheme will actively direct patients to other practices." ***SAOA page 11***

It is submitted, at the outset, that (i) scheme members are not compelled to use the services of network providers. Members have the choice to use providers outside of the network, but this has a cost implication (described below); and (ii) providers are free to exit the network (on one month's notice) and to provide services outside of the network. Therefore, to the extent that a provider offers a service for which members are willing to pay, this is not prevented by the network arrangements.

Section 3.2.2 of the DH submission details the manner in which health professional networks are developed, structured and implemented. As discussed in the submission, DH's health professional networks with the feature of Direct Payment Arrangements (DPAs), were developed in order to manage the risk that tariffs charged by health professionals are significantly in excess of Scheme tariffs, particularly with regards to PMBs, which schemes are liable to settle in full. DPAs are arrangements in terms of which DH offers health professionals higher direct payment in return for no balance billing.

These networks are structured such that the primary criterion for inclusion on the network is based on the health professional's acceptance of the DH tariff rate as **full reimbursement.**

Should a health professional join the Scheme's network, their invoices are paid directly and in full by the Scheme, regardless of whether or not it is in respect of a PMB or not. Health professionals that do not join the network may charge as they wish, but the scheme will reimburse the member who will then be responsible to settle the invoice with the doctor. In this case, members will be reimbursed in full for PMBs if they used a non-network doctor on an involuntary basis (such as in an emergency). However, for non-PMBs and for PMBs in the case of voluntary use of non-network providers, the scheme will reimburse members at tariffs typically close to NHRPL rates, requiring a co-payment from the member to cover the shortfall between the doctor's actual tariff and the scheme reimbursement rate.

The direct payment mechanism is a deliberate feature of the network as direct payment is the *only* negotiation tool available to schemes when contracting with health professionals, especially for PMBs. Given that the scheme would still be liable to cover the bill irrespective of the tariff charged in the case of PMBs, without this direct payment arrangement there would be no incentive for the health professional to agree to scheme tariffs. This would result in high co-payments to members and high costs to the Scheme in respect of PMBs.

1.1.2 Network tariffs offered to health professionals are unsustainably low

> *"Where guaranteed reimbursement is on offer, providers are generally satisfied to enter into an understanding with schemes at its pegged rates. In the past, SAMA agreed to charge lower rates if funders guaranteed payment"* ***SAPPF page 59***
>
> *"Doctors have, for want of a better word, been blackmailed into accepting this status quo. The majority of doctors who adhere to the direct reimbursement at scheme rate model do not necessarily agree that [network tariffs] are appropriate, or reflective of the reality of practice costs. It is the devil they know"* ***SAPPF page 135***

Again it is pointed out that providers are not compelled to join a scheme's network. To the extent that a provider offers services outside of the network for which members are willing to pay, this is not prevented by network arrangements.

The DH tariff rates are determined by DH and are set at a level to accommodate the affordability constraints faced by members and their schemes. Every scheme administered by DH can choose to implement DH tariffs or may decide to use a different set of tariffs. The tariffs are acceptable to the majority of doctors, and are set at rates higher than the inflation-adjusted National Health Reference Price List (NHRPL) industry tariffs. For instance, DH 2015 GP network tariffs are around 24% higher than the inflation adjusted NHRPL rates. As discussed in chapter 2 of the DH submission, tariffs for GPs and specialists in fact exceeded CPI due to the deliberate decision by DHMS to offer higher tariff increases to

GPs and specialists to ensure high levels of participation in contracted networks and to minimise member co-payments. This provides members with wide access to care without co-payments.

It must be noted that despite DH network tariffs being significantly higher than industry tariffs, a number of health professionals exercise their choice not to enter into direct payment arrangements with medical schemes. In the case of DH, 14% of GPs and 10% of specialists choose not to contract in these arrangements.

1.1.3 Networks restrict patients' freedom of choice

"A doctor has a relationship and responsibility towards their patients irrespective of whether or not such patients have health insurance. Restrictive networks however are changing this benevolent paradigm by forcing patients against their will to see network aligned doctors resulting in the following negative consequences:

- *A patient's right to choose the best doctor has been removed, or at the very least, interfered with.*
- *Access to care has been compromised because many times medical schemes contract with restrictive networks that do not have any clinics or doctors in or close to the poorer communities, forcing these financially challenged patients who can least afford it, to travel vast distances at huge cost to access care that was recently provided by their local doctor, but who is now excluded from the restricted network. Despite the fact that many excluded doctors are willing to sign contracts for the sake of continuing to care for their existing patients, restricted network contracts refuses them this right.*
- *Newly qualified doctors are not even considered for membership of the restricted networks."* ***SAMA page 37***

Although patients on low cost plan are limited to DH networks, these networks *increase* patients' freedom of choice relative to what would otherwise be accessible to them, as network plans increase affordability to many members who would otherwise not have been able to join a medical scheme.

Moreover, scheme members are not compelled to use the services of network providers. Members have the choice to use providers outside of the network, but this has a cost implication.

Members are afforded the freedom to choose the benefit package that best meets their needs and budget constraints. Networks are critical to ensure that low cost plans remain affordable, and are a feature of health insurance plans globally, with clear recognition that these restrictions are a vital mechanism to contain healthcare costs. When selecting amongst the benefits packages available, members weigh up the benefit of the lower premiums associated with networks with the limitation that this will have on providers. In this way, members are able to exercise real choice, with provider networks making it possible for patients to belong to a medical scheme in instances where it might otherwise not be affordable. Wherever possible, DH attempts to provide a large doctor network with wide geographic coverage, so that members/patients are still able to exercise a degree of choice of providers. But, in general, the greater the choice offered, the higher the cost.

DH disagrees that access to care is compromised by lack of access to doctors in poor or rural communities. DH ensures that doctors are contracted *wherever* DHMS or other client scheme members live or work. DH is not aware of gaps in coverage in rural areas or in poor communities.

The duration of practice is not taken into account when constructing networks.

1.1.4 Clinical protocols adopted in networks do not adhere to best practice

> *"In addition to the price setting referred to above, the medical schemes prescribe treatment protocols and formularies which must be adhered to by DSP's. These treatment protocols and formularies do not necessarily adhere to best clinical practice and may be regarded as interference in the clinical management of patients by the medical scheme."* ***SAMA page 36***

All treatment protocols and formularies developed by DH are based on best available international evidence-based guidelines, and are regularly updated. In the majority of situations, these are reviewed and approved by relevant local specialist associations and/or independent panels. The use of protocols and formularies is standard managed care practice in all public and private healthcare systems globally. With the ever increasing demands for healthcare coupled with rising healthcare costs, managed care is increasingly being adopted by healthcare systems to contain healthcare expenditure.

1.1.5 Poor weighting is given to quality outcomes in the profiling of health professionals

> *"Many contracts impose the conducting of "practice profiling" on the doctors. In terms of this process, the doctor's performance is evaluated on financial criteria (how much money is saved) and not on clinical outcomes. Those who save money are rewarded with preferential reimbursement rates. This practice profiling is the most overt evidence of the financial focus of these contracts and that doctors, above all else must ensure the lowest cost exposure to the medical scheme."* ***SAMA page 37***
>
> *"For DSP contracts to be completely fair, they should also reward quality over quantity, and senior practitioners at a rate that is commensurate with their experience."* ***SAPPF page 59***
>
> *"The very absence of quality measurement in all fixed-payment arrangements in South Africa results in their "unethicality". Such contracts are based on a fixed price and purported cost savings, a portion of which is then passed on to the doctor who has agreed to the price-fixing which is wholly unethical."* ***SAPPF page 136***

Whilst the primary criteria for inclusion on the network is based on the doctor's acceptance of the DH tariff rate, once on the network, DH does take into account aspects of quality of care provided through various initiatives, such as the IPA Foundation GP peer review process, and several other initiatives . With these tools, doctors engaging in malpractice or fraudulent activities are easily identified and, on occasion, removed from the network.

DH practice profiles are based on a number of criteria, including admission rates, use of pathology and radiology investigations, as well as quality metrics where available. While the current practice of profiling is weighted towards cost-efficiency, this is due to the lack of data on health outcomes and quality of care, which would need to be provided by treating health professionals and hospitals, as medical schemes and their administrators do not have any other

source of quality of care data. DH is working hard with various professional groupings and hospitals to improve quality of care as well as availability of data on quality of care. DH takes all available and relevant information into account in determining relevant profiling measures, and discusses and agree these with professional societies. However, cost is and will remain an important factor, as it enhances affordability and therefore access.

However, the lack of quality of care data in some profiles does not undermine the validity of the profiling practice in identifying outliers in terms of cost per patient, after suitable risk adjustment. Provider profiling is therefore an important mechanism for encouraging health professionals to practice in a more cost effective manner, thereby enhancing affordability to members.

1.2 Hospital networks

1.2.1 There are no objective criteria in developing hospital networks giving funders an advantage in negotiations

> "*Designated Provider Networks based on cost considerations only, without due consideration to quality metrics is a shortcoming. Inclusion on the network is dependent on the providers' cost efficiency based on cost per event analysis or, most often, an agreement with a provider for a lower tariff.*" ***Mediclinic page 101***
>
> *"[T]he parties to a DSP have an interest in excluding other competitors and thus no objective criteria is set out to decide who may be a DSP provider."* ***NHN page 39***
>
> *"Netcare hospitals have been excluded from hospital networks formed by schemes and where Netcare has had to agree to terms which are favourable to the schemes in order to be included in particular network options."* ***Netcare Page 34***
>
> *"Although about half of Mediclinic's hospitals are included in the Keycare hospital network, most of the Mediclinic hospitals included are hospitals in remote areas where there are no other surrounding competitor hospitals to choose from such as Newcastle and Welkom. In more populated areas such as Johannesburg and Stellenbosch, none of Mediclinic's hospitals are included on the Keycare network."* ***Mediclinic page 102***

The objectives of hospital networks are different to healthcare professionals' networks, as hospital tariffs are agreed via negotiation and contract.

As discussed in Section 3.1.1 of the DH submission, the objective of hospital networks is to give members a cost-effective alternative option with lower premiums in return for use of selected network hospitals. Cost efficiency is therefore the main consideration in the hospital network selection process, with the inclusion of a hospital on the network primarily dependent on the hospital agreeing to lower tariffs, and providing care at lower total cost. The lower tariffs obtained from the hospitals thus enables the scheme to offer plans with lower premiums (such as the DHMS's Delta and KeyCare range of plans) to members who are willing to accept these network restrictions.

If the "any willing provider" principle was applied to hospital networks, this would eliminate any incentive for hospitals to compete with each other on grounds of cost-efficiency, and would limit the ability to manage costs.

The location of the hospital is also an important consideration in network selection, to ensure a comprehensive geographic footprint of network hospitals. Further selection is based on quality outcomes using claims data and patient

satisfaction scores from DH surveys. There is currently very limited quality of care data available to funders, as providers are only obliged to submit IDC10 codes on claims, and do not provide any clinical information, including discharge summaries etc.

However, as DH moves towards value based purchasing, where value is a function of both cost and quality, DH is becoming increasingly sophisticated in measuring quality outcomes. It is intended that these quality metrics will play a greater role in future network construction. A change to regulations requiring providers to submit clinical outcomes data for quality measurement would greatly aid the quality measurement process.

Hospital networks have thus not only proved to be an innovative benefit design feature increasing access to care, but have intensified price competition amongst hospital groups. As DH moves towards value based purchasing, provider competition will also increasingly focus on providing quality care in the most cost-efficient manner.

1.2.2 Networks impair the financial viability and sustainability of non-network participants

> *"[Network] arrangements have negative impacts on the market by impairing the financial viability and sustainability of non-contracted healthcare facilities"* ***NHN page 39***

Medical schemes and their administrators have obligations to comply with the Medical Schemes Act and to ensure that schemes provide adequate benefits at affordable premiums. Schemes and administrators do not have an obligation to ensure the financial sustainability of providers who do not participate in networks. Having said this, roughly 24% of DHMS members are part of hospital network plans, and non-network hospitals therefore still have access to a large portion of the membership of DHMS and of other schemes' non-network plans.

1.2.3 Networks have the effect of raising prices for the uninsured

> *"[Network] arrangements have negative impacts by potentially raising prices to the uninsured."* ***NHN page 39***

DH has no information on whether its network arrangements have the effect of raising prices for the uninsured. However, anecdotal evidence suggests the contrary – that many providers charge lower prices to uninsured clients than they do to scheme members.

DH is of the view that, *if* hospitals do in fact raise prices to non-insured patients, that this cannot be the result of network arrangements. In particular, (i) the pricing of the network arrangements is fair to the relevant hospitals (in that they are making a reasonable return, even at these lower rates); (ii) the expected increase in volumes from network patients results in economies of scale; and (iii) the network revenues comprise an insignificant portion of hospitals' total revenues. Therefore, the hospitals cannot plausibly argue that the network arrangements cause them harm, which forces them to raise prices to non-network customers (whether insured or uninsured).

Further, it is unclear how networks would cause the prices for the uninsured to increase as providers would still seek to compete on price to increase volumes from the uninsured.

1.2.4 Networks are anti-competitive

> *"[N]either the member nor the excluded service provider have insight into how these benefit agreements have been designed, or on what basis price has been agreed…Investigating powers of the panel may bring a degree of transparency as to whether exclusionary provisions exist in these agreements which result in anti-competitive restriction on non-contracted healthcare providers to the detriment of the consumer… and whether DSP arrangements may be pro-competitive tool if appropriately, uniformly and fairly applied by healthcare funders in an adequately regulated environment."* ***NHN page 40***

Neither DH nor its schemes are under obligation to provide details of DSP contracts to non-contracted providers. The terms of these contracts are confidential and are commercially sensitive.

DH believes that the establishment of DSP contracts is clearly pro-competitive. These contracts protect schemes and their members from high claims, and they allow schemes to comply with the Medical Schemes Act.

In the case of hospitals, they promote competition by selecting one or two hospitals in each region, on the basis of efficiency and price negotiations. Hospital networks are constructed by DH based on internal data on the relative cost efficiency of each hospital, analysis of regional hospital supply patterns, the availability of the appropriate range of treating specialists in the hospital, as well as on negotiated contractual arrangements including tariffs. It is worth noting here that NHN has disproportionately high representation in DH's KeyCare network and Delta networks, as NHN makes up a higher percentage of the network plans than their overall market share.

1.2.5 DHMS's KeyCare Network is exclusionary

> *"[The KeyCare] DSP agreement has been in place before Emalahleni was established and that Discovery has an obligation towards Cosmos Life in terms of which it cannot appoint a second DSP in the Witbank area unless their KeyCare membership base is enjoying substantial growth."* **Emalahleni page 4 par 4**

A narrow hospital network with one hospital per region ensures the affordability of KeyCare to lower income households. As discussed above, these hospitals are selected on the basis of cost-efficiency and price negotiations. Cosmos Life hospital has been on the KeyCare network for 11 years and has performed well in terms of cost-efficiency. Including another hospital within the Witbank area on the KeyCare network would undermine the agreement with Cosmos, and result in higher KeyCare premiums, as it would result in less efficiencies and higher admission rates. There are therefore compelling reasons for retaining only the current hospital in the network. Nevertheless, there have been extensive discussions with Emalahleni on network inclusion, and the possibility of advanced reimbursement models and

different delivery models, and therefore the network is not cast in stone, but may change depending on the efficiencies offered by either of these two hospitals or any other hospitals in the area that may enter negotiations in future.

1.3 Pharmacy Networks

1.3.1 Pharmacy networks favour large groups

> *"[M]edical schemes tend to favour pharmacies that belong to large groups because of ease of contracting with one entity, preferably with a national footprint, rather than a number of smaller individual pharmacies confined to one location."* ***PSSA page 3***

Similar to health professionals, DH has offered pharmacies (including community pharmacies) an opportunity to voluntarily join its pharmacy networks, on the basis that DH will reimburse at the agreed dispensing fee and that the network pharmacies will not charge more than the agreed dispensing fee to ensure members are not levied with any co-payments.

Any pharmacy may elect to join the DH Network provided they are willing to accept the DH dispensing fee. Independent community pharmacies in particular are better off should they join the network, because the dispensing fee paid to independent pharmacies is higher than the dispensing fee agreed between DH and corporate pharmacies. There are currently 1,651 community pharmacies participating in DH's pharmacy network, but only 600 pharmacies from large companies on the network.

Further selection that may be required will be based on criteria such as location to ensure a comprehensive geographic footprint of network pharmacies. The DH tariff rates and eligibility criteria to belong to the networks are transparent, standardised and applied in a consistent manner across all pharmacies. The selection of pharmacies to the networks is therefore done on a fair and unbiased manner, giving all pharmacies an equal opportunity to participate, irrespective of size, ownership status or location. These networks are therefore not selective, exclusive or discriminatory and membership is primarily dependent on the pharmacy's will.

1.3.2 The appointment of DSPs for non-PMB care is illegal

> *"In addition to appointing DSPs for the provision of PMB conditions to their beneficiaries, certain schemes are also appointing DSPs for the provision of acute medication. The latter practice is unlawful. Regulation 7 allows medical aid schemes to appoint DSPs to provide to its members services in respect of one or more prescribed PMBs, but not for acute medication."* **ICPA page 4**

PMBs are the minimum benefit package that must be covered in full by all medical schemes in terms of the Medical Schemes Act. The Act also states that schemes may implement DSPs in order to protect the Scheme against the potential high cost of this mandatory PMB package.

Schemes have no legal obligation to provide additional benefits to members above this minimum PMB package. Schemes add on additional benefits (such as acute medication) to benefit packages subject to the affordability constraints of members. There is nothing in the Act prohibiting Schemes from using DSPs for non-PMB benefits. By also using managed care tools such as formularies and DSPs to better manage the cost of non-PMB benefits, rising healthcare costs are better contained, benefitting members in the form of richer benefit packages and/or lower contributions, or through the avoidance of co-payments.

1.3.3 Schemes abuse the co-payment mechanism in DSP arrangements

> *"[I]t is evident that schemes abuse the co-payment mechanism by charging an additional punitive "penalty" co-payment when a beneficiary uses a non-DSP to obtain medicines… [T]he "penalty" co-payment is unreasonable, not in the best interests of beneficiaries/the public and has no justifiable basis for its implementation."* **ICPA page 7**

As discussed in Section 1.3.1, any pharmacy may elect to join the DH Network provided they are willing to accept the DH dispensing fee applicable to PMBs and non-PMBs as full reimbursement. Co-payments serve as a fundamental feature of any network, including the DH pharmacy network, to channel patients to preferred providers. It allows the Scheme to promise higher patient volumes to contracted pharmacies in return for their acceptance of the network dispensing fee as full reimbursement. Without suitable co-payments, networks would be ineffective in managing pharmacy expenditure, be it for PMBs or non-PMBs.

Section 2. Product Differentiation

2.1 Product standardisation will simplify consumer choice

"Over and above such Basic Benefit Package, all schemes should only be allowed to sell three or four more standardised and defined Supplementary Benefit Packages. This increased standardisation of products would drive competition to a more productive activity; namely the cost and quality of healthcare delivery, as opposed to the current focus of risk selection. With a Basic Benefit Package across all schemes, members will be able to make price comparisons between options within a scheme and between schemes, with less reliance on brokers to assist members to choose an option. It will also make it easier for members to switch between schemes, increasing the level of competition within the industry." ***Mediclinic page 98***

"Medical schemes do not offer homogenous products. In other words, there is little uniformity between schemes and the various options in terms of what benefits offered; how those benefits are structured and the different price points. This can sometimes make it difficult for a member to conduct comparisons in order to determine the schemes and benefit options that best suit their health needs, taking into account levels of affordability." ***Fedhealth page 19***

A further factor complicating the comparison is the fact that benefits vary substantially and that there is no single standard benefit available for comparison. This makes it very difficult to assess the different benefits and compare these in an incontestable manner. The discussion above shows that it is almost impossible for consumers to make rational choices in respect of scheme membership unless a standard benefit package is developed and a system of risk adjustment is introduced. ***Metropolitan page 26***

While product standardisation may simplify consumer choice, standardisation would come at the cost of innovation, competition,, affordability and consumer choice. Innovation has enabled DH to create product solutions to enhance affordability and to increase access to healthcare. The novel benefit design of DHMS's KeyCare range of plans is an example of such innovation, which has expanded healthcare cover to lower income households, covering more than 400 000 beneficiaries, who could not previously afford private healthcare cover.

DHMS's Delta series is a further example of product innovation addressing affordability constraints. The Delta series are network plans at a 10-20% discount to their "parent" plans, providing the same benefits as the parent plan but with a restricted network of service providers. The Delta series has experienced considerable growth, from 83 000 beneficiaries in 2010 to more than 219 000 beneficiaries today, giving consumers a cost-effective alternative that would otherwise not have been available in a market governed by standardisation.

As shown, product differentiation allows for greater choice, allowing members to choose a plan with a lower premium but with network restrictions. It also creates increased competition between providers who compete to participate in network and other arrangements developed for these plans.

Product differentiation also enables medical schemes to tailor benefit packages suitable to their own circumstances. For example, members on a restricted scheme in a mining town may have specific healthcare needs and may value certain benefits more than others. There may be ways on which occupation-based healthcare could complement medical scheme cover and hence offer better value to such members. Similarly, a scheme may wish to set up a preferred provider network to match their specific geographic footprint. Product standardisation would remove these opportunities.

Product differentiation has intensified competition between schemes, encouraging schemes to compete not just on premium levels and service standards, but also on tailoring innovative product features to match the unique characteristics of their members.

Further, product differentiation stimulates competition in the provider market. For example, the development of provider networks has intensified price competition in the provider market. Similarly, DH's Day Hospital Network has enabled new healthcare delivery models to enter the market, stimulating the market for day hospitals and creating a significant element of competition with existing acute care hospitals. Many of these have responded by reducing rates for day surgery, which clearly demonstrates the pro-competitive and pro-consumer impact of innovative plan design. Standardisation would therefore stifle competition in both the funder and the provider markets, to the detriment of consumers' access to care in the long run.

In a market where choice is abundant, an agent is pivotal to enable the consumer to make informed decisions. This is particularly the case in the healthcare market, where benefit designs may be unfamiliar and future healthcare needs unknown. This is where brokers play a critical role in independently assisting members with navigating through the range of products available until the most suitable product has been identified.

Any uncertainty of benefit design stems not from the range of plans available, but rather from the fact that medical scheme rules have to cover a very wide range of conditions and many different types of doctors, treatments and service providers. If premiums and benefits are modified to accommodate standardisation, *all* existing members will face complex decisions, as they would then have to make choices on which new and different plan to join. Standardisation would lead to significant risks of anti-selection for schemes, and significant risk for members, who may end up not having the cover they need for future healthcare requirements.

Finally, there is already some degree of product standardisation in the industry. All medical scheme products have to cover PMBs, in full, from risk benefits. This typically covers more than 50% of claims.

DH is therefore of the view that the introduction of legislated, standardised scheme benefit designs would:

- Force many members to choose different benefits and premiums to what they are familiar with
- Reduce competition between schemes in the market
- Reduce competition between hospitals and other healthcare service providers
- Prevent schemes from introducing products which increase affordability and improve access to care; and
- Prevent schemes from introducing innovations in the service provider market, which ultimately deliver better value and quality to members of medical schemes.

Section 3. Wellness Programmes

3.1. Wellness programmes provide schemes with an unfair marketing advantage

> *"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."* ***Medscheme page 69***

It is difficult to understand Medscheme's competitive concerns with the Vitality programme. Vitality is not a loyalty programme: it does *not* offer rewards for duration of membership of DHMS. Instead, it offers rewards for engagement in wellness activities, and for improved member health, which has nothing to do with loyalty.

Medscheme has alleged that DH makes more revenue from offering an innovative programme to its members. This is, in DH's view, pro-competitive. Be that as it may, Vitality is a wellness programme aimed at promoting the health of its members, which in turn reduces healthcare costs. Thus, in addition to being pro-competitive, it is an important commercial tool that reduces healthcare costs of members and, in turn, reduces premiums for all members and enhances affordability for all members.

Vitality was launched by DH in 1997 as the first incentivised wellness programme in the South African market. Its main aim was, and remains, to encourage members to improve their own health by living a healthier lifestyle. Since then, competition in this market has intensified with similar products on offer by competitors such as Liberty Life's *Own Your Life Rewards* programme, Sanlam's *Reality* programme, Medihelp's *MultiSport Club* and Momentum's *Multiply* programme.

There are no specific barriers to entry to the wellness programmes market, evident by the number of products available today. Further, any medical scheme (irrespective of its size, open or restricted status or whether it self-administers or not) is able to offer such products through a third party. Medical schemes that choose not to offer such products do so at their own will.

Similarly, medical scheme members are under no obligation to belong to wellness programmes, with membership on a voluntary basis that may be terminated at any time. Vitality premiums are separate and additional to medical scheme contributions. The financial results of Vitality are a matter of public record and it is clear from the financials that Vitality is priced to cover its costs and generate a small profit. It is true that a substantial proportion of Vitality premiums are used to fund discounted access to gym and other health promoting activities, and to reward those who look after their health. As noted above, the fundamental objective of Vitality is to make its members healthier, and it is therefore rational that its premium income is devoted to incentivising health improving behaviour in various ways.

Vitality was not established to pay higher broker commission for medical scheme members, but for the reasons outlined above. Given that Vitality is a separate and entirely voluntary, it is appropriate that brokers are remunerated for selling the product. Furthermore, it is not a requirement for Vitality members to belong to DHMS – they can also access Vitality through the purchase of other Discovery products, and there are many Vitality members who do not belong to DHMS.

The primary purpose of wellness programmes is to encourage members to adopt healthier lifestyles; translating into direct savings for the scheme, as healthier members incur lower healthcare expenditure. Data from DH indicates that increased engagement in wellness activities significantly reduces our client scheme's claims costs.

Figure 5-4 in the DH submission shows how fitness-related activities are associated with lower healthcare costs. The results provided in this graph have been adjusted for other relevant risk factors. The studies demonstrate that the claims costs of people with the same (or similar) age, chronic conditions, socio-economic status, geographic location and other demographic factors differ if they exercise, compared to those who don't. DH observes a significantly lower claims cost for people who do engage or exercise, relative to those that don't, adjusted for their other risk factors.

The natural implication is that over time the positive impact of engagement in Vitality that DH has observed in these studies would result in a positive health impact regardless of the starting health position of the individuals. This hypothesis has been tested subsequent to the publication of these studies through longitudinal analyses conducted on a cohort of 1.4 million Vitality members for the period 2008 to 2013.The results provide an insight into the impact of Vitality on members who may already be exercising when they join Vitality and take account of this factor to determine the impact of Vitality on a "select" or prior-engaged population. The results are summarised as follows:

a. 70% of the observed population started with a minimal level of engagement, or with no engagement. After 4 years in the programme, approximately 30% of them had improved their level of engagement. Those that improve their engagement, starting at a low level, have claims of between 3% and 15% lower than those who don't, and who stay at a low level of engagement throughout.
b. Approximately 6% of the group entered the population with a low level of existing engagement. Their healthcare costs were initially between 4% and 13% lower than those who exhibited no initial level of engagement. By year 3, approximately 48% of this group had increased their engagement levels, resulting in a further healthcare cost reduction of between 2% and 11% compared to those members of this segment who maintained their engagement at the initial low level.
c. The balance of the population, being approximately 24% of members, joined with an already high level of engagement. At entry, their healthcare costs were between 15% and 22% lower than those who did not exhibit any levels of engagement. By year 5, approximately 28% of these members had increased their engagement levels *even* further. Their healthcare costs were between 3% and 9% lower than those who simply maintained their high level of engagement throughout the period.
d. All of these results have been adjusted for all other known risk factors, including age, gender, socio-economic status, chronic conditions and overall level of health at the outset.

Overall, the Vitality programme over time does lead to a general improvement in population engagement. Over the period 2008 to 2013, indexing the population's level of engagement to 2008 levels, we observed 12.5m additional gym visits in years after 2008, and an additional 8 physical exercise sessions per year for those who did engage. In other words, more people are encouraged to engage in wellness activities over time, and for those that do, we see a net increase in exercise levels over time, and subsequent to that, a further decrease in their healthcare claims.

Increased engagement is also associated with lower lapses amongst engaged members. A higher proportion of healthier lives within the medical scheme risk pool enables greater cross-subsidisation from healthy to sick, benefiting all members in the scheme with lower contribution rates, due to community rating.

Wellness programmes are also a means for schemes to promote preventative care in a medical scheme market focused on covering PMBs which are largely curative. Active engagement in preventative care not only results in lower healthcare costs for the scheme, but significantly improves members' health.

The maturity of the wellness programmes market has added a new dynamic of competition in the medical schemes market, encouraging medical schemes to innovate and differentiate in order to make people healthier and to retain those that engage in wellness activities in the Scheme. The effects of these products is evident at an industry level, as the medical scheme members make healthier lifestyle choices, which reduces healthcare consumption. Wellness programmes have thus proven to be an innovative mechanism to intensify competition in the market, enhancing the sustainability of medical schemes and, more importantly, having a real impact on members' health and wellness.

Section 4. Cross-selling

4.1 Insurance companies cross sell medical scheme cover with insurance products

> *"[I]nsurance 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."* ***Medscheme page 69***

Although there are a variety of Discovery branded insurance products on offer, they are marketed and sold separately. Brokers earn commission on each product sold: a broker will earn a commission for the sale of a medical scheme product to a customer, and a separate commission if he/she sells a life insurance or short-term insurance product to the same customer. The broker therefore earns "more" commission because he/she sells more products. The broker could achieve the same result by selling DHMS medical scheme products and life or short-term products of another insurer.

The ability to offer clients a range of products enhances client choice and increases competition in the market for all of these products. Discovery's motivation has never been to design products to increase broker commission, but rather to design products that enhance value for its clients.

Section 5. Collective negotiation by administrators

5.1 Administrators practice collective negotiation in provider contracting

> *"In Mediclinic's experience, administrators who act for several schemes, negotiate very similar tariff increases and service level conditions, for all of the schemes under their administrator, with little or no product differentiation."* ***Mediclinic page 94***
>
> *"The NHN is unaware of whether these administrators have applied for, or intend applying for a competition law exemption to collectively negotiate on behalf of competing medical schemes. We defer the question as to whether such conduct falls foul of section 4 of the Competition Act to the market inquiry itself."* ***NHN page 10***
>
> *"At the same time it is also necessary that the role of the administrators should be carefully examined. Popular belief is that a series of vertical (Section 5) agreements exist between administrators and schemes that would take such agreements outside of the ambit of section 4 of the Act."* ***NHN page 48***
>
> *"Administrators that administer more than one scheme negotiate tariffs with doctors on behalf of all their member schemes. An investigation into the tariffs that these schemes pay doctors will show that they are almost exactly the same, which is by definition anti-competitive."* ***SAMA page 35***

DH has been independently appointed as the third party administrator of DHMS (an open medical scheme) and fifteen restricted medical schemes. One of DH's contracted functions as an administrator is to represent the medical schemes administered by it in the negotiation of various reimbursement arrangements with service providers.

Section 4 of the Competition Act applies only to parties in a horizontal relationship, namely competitors.

DH and the medical schemes administered by it are not in a horizontal relationship (Section 4.3 of the DH Submission provides further details):

a. DH is a medical scheme administrator and does not compete with the schemes that it administers;
b. The schemes administered by DH do not compete with one another. DHMS is the only open medical scheme administered by DH, competing in the open market. The other medical schemes administered by DH comprise employer-based restricted medical schemes, which by definition do not compete with DHMS. Moreover, since these restricted schemes service only a particular employer or group of employees, they do not compete with one another for members.

Not all schemes have the same tariffs for doctors

DH does not negotiate tariffs with doctors on behalf of the schemes it administers as it is impossible to negotiate with every single doctor individually. In general, DH publishes a list of reimbursement rates for each billing code or procedure. The doctor is then free to set his / her own billing rate. The difference between the reimbursement rate and the billing rate is the co-payment paid by the member - the size of which is dependent on plan choice, and which differs considerably amongst the different medical schemes administered by DH. There have been some variations from this approach, in particular, where Direct Payment Arrangements, networks and alternative reimbursement models for hospitals have been established and negotiated by DH. However, it is up to schemes administered by DH as to whether

they adopt these arrangements. The majority of DH's restricted scheme clients do not participate in these arrangements.

In the case of hospitals, DH uses its sophisticated data and negotiation skills to procure the best rate for each of the medical schemes it administers

DH engages in separate annual negotiations with each hospital group and individual independent hospitals for the benefit of the medical schemes under its administration.

DH uses its own negotiating methods (namely, its intellectual property, analytic methods and skills, honed over the years to derive alternative reimbursement models and risk sharing arrangements) to procure what it believes is the lowest possible rate for each of the medical schemes administered by it. These negotiating methods based on an investment in experience and expertise, are unrelated to scale or to the number of members of the schemes that DH administers. These methods are necessary to counterbalance the market power of hospital groups (who each represent on average a quarter of the market). DH began achieving better negotiating results through the use of its methods when DHMS was significantly smaller than it currently is and when only one other restricted membership scheme was administered by it.

Following the negotiations, each medical scheme has an independent election to participate in or opt out of the agreements concluded with the hospitals.

Certain schemes administered by DH elect to retain different tariffs with certain hospital groups for specific reasons. Each scheme's election depends on its own circumstances. Each scheme makes this election independently, without any co-ordination with the other medical schemes administered by DH.

DH's negotiation on behalf of client schemes is pro-competitive and pro-consumer

In addition to the above, it is clear that DH's active negotiation on behalf of its client schemes has had significant positive effects. The members of all of these client schemes have benefited significantly from reduced hospital tariffs and costs. In addition, this arrangement overcomes the relative weakness of the bargaining power of individual restricted schemes against the significant power of the major hospital groups, creating a greater balance of power for these schemes and their members. If administrators such as DH were not able to negotiate on behalf of restricted scheme clients, this would greatly increase the already strong market power of the hospital groups, which would undermine competition and be to the detriment of these schemes and their members.

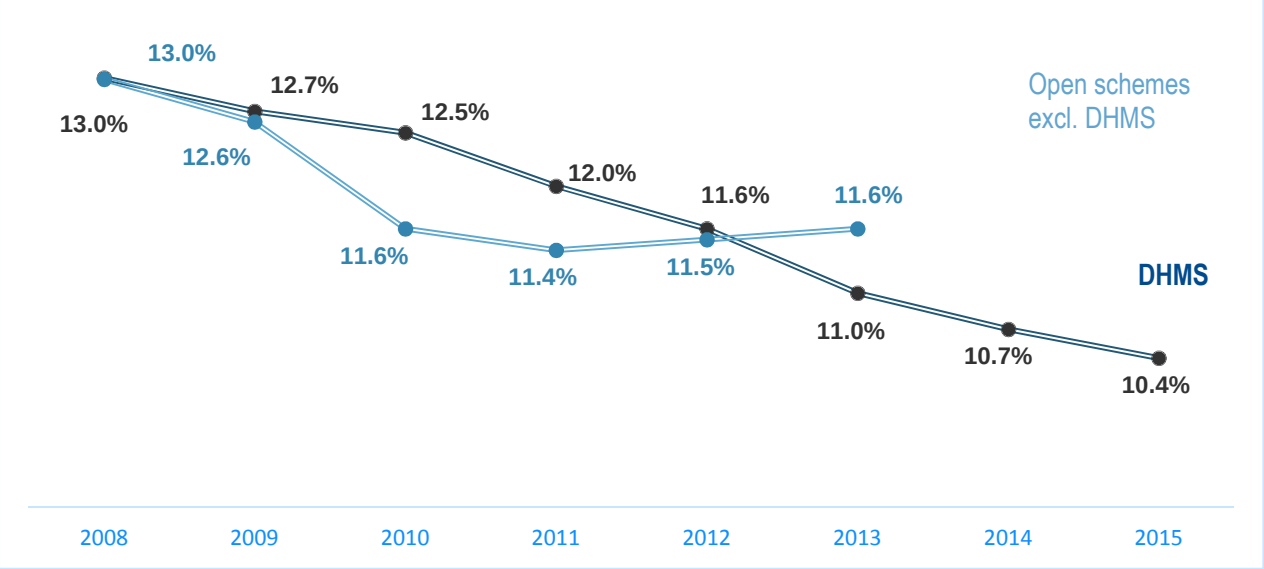
Section 6. Non Healthcare Expenditure (NHE)

6.1 NHE has grown substantially as a percentage of contributions

> *"The biggest beneficiary however of medical scheme risk pool expenditure is however non-healthcare overheads which grew by 68% from 7.5% to 12.6%, meaning that in 2013 schemes spent R14.1 Billion on not providing healthcare to their members."* ***SAMA page 33***

Firstly, whilst NHE has grown over the entire period, it has been associated with a gradual decline in real terms since 2005[1]. This is evident in SAMA's graph where NHE peaked in 2006 at 16.3% but has since been on a downward trend. This is also evident from DHMS' own data which shows that administration and managed care fees have fallen sharply when expressed as a percentage of gross contribution income (GCI), falling from 13 percent of GCI in 2008 to 10.4 percent of GCI in 2015. This is shown in the Figure 1 below.

Figure 1: Administration and managed care fees as a percentage of GCI [2]



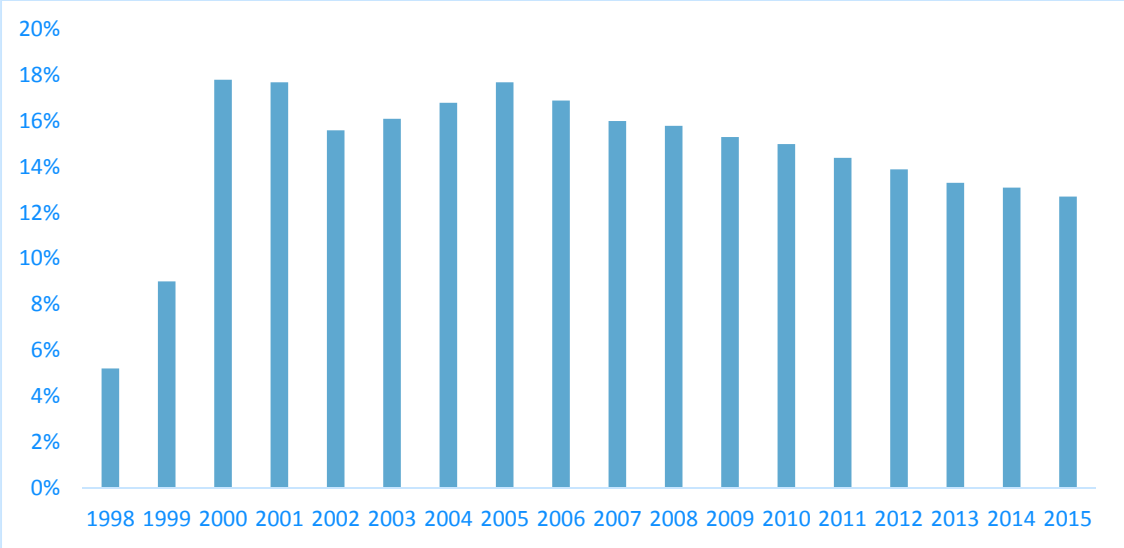
Source: DHMS and CMS

In addition, as a percentage of GCI, DHMS' *total* NHE (including broker fees, trustee fees, etc) has fallen from of 18% in 2000 to 12.7% in 2015. This is illustrated in Figure 2, which provides the historical NHE for DHMS from 1998 to the present.

[1]CMS press release 16 of 2013, Available online at:
http://www.medicalschemes.com/files/Press%20Releases/PressRelease16Of2013.pdf

[2] CMS data unavailable for 2014 and 2015

Figure 2: DHMS administration, managed care and broker fees as a % of GCI[3]



Source: CMS and DHMS data

The downward trend in NHE has been driven by a number of factors, including the consolidation in the funder industry and pressure from CMS to contain NHE. While the CMS does not prescribe the fees paid by schemes to administrators, it does monitor them closely. The Tribunal has previously noted that: "*[m]edical scheme administrators do not have carte blanche to set prices, since the Registrar for Medical Schemes monitors fees and regulates the relationships between the schemes and the administrators*[4]."

Data issues aside, the initial steep increase in NHE in 2000 was also the result of the implementation of the Medical Schemes Act in 2000, when a number of new regulations were introduced which added complexity to the industry. For example, the introduction of PMBs added considerable complexity to the system, requiring increased administrative functions. In addition, as membership shifted from restricted to open schemes there was an increased need for brokers and marketing, with average fees increasing for higher broker fees and marketing expenses. This has subsequently stabilised. Thirdly, since 2000, there have been considerable developments in the sophistication of the managed care industry, in contracting and in the administration business. The massive investments required in data warehousing, technology and analytical skills initially contributed to higher NHE but have since produced a number of benefits both in quality, efficiency and cost savings. In particular, currently DHMS has a total of 84 managed care interventions (increasing almost 3 fold over the past 5 years), which have produced considerable savings to the scheme (Chapter 5 of the DH Submission provides further details on DH's managed care initiatives). As mentioned in section 4.4.2. of the DH submission, an independent study was performed by Deloitte on the value for money obtained by DHMS from the

[3] DHMS did not report managed care and broker fees for 1998 and 1999 in their AFS. This was probably due to different reporting requirements prior to the implementation of the Medical Schemes Act in 2000. Data points prior to 2000 would not be comparable to NHE figures thereafter, as standard industry practices were only introduced at that point.

[4] *Momentum/African Life Health*, para 15(c)

various managed care and other services delivered by DH, and it was found that the Scheme saves between R1.77 and R2.02 for every R1 spent on administration and managed care services.

Section 7. Relationship between the scheme and the administrator

7.1 Lack of independence between the scheme and the administrator

> *"The distinction between the not-for-profit scheme and the administrator has become blurred. Due to the complex nature of the industry, all of the intellectual property, in the form of systems, knowledge (both clinical and actuarial) and contracting acumen lie with the administrator. The Board of Trustees become entirely dependent on this skill set/expertise of the administrator. In the interest of greater transparency, the maintenance of the not-for-profit status of medical schemes, and the separation between administrators and medical schemes should be questioned."* ***Mediclinic page 90***
>
> *"In the "administrator model", the administrator effectively "controls" and "manages" the scheme. The BoT and Principal Officer are not independent of the administrator. This impacts on the governance of the scheme as a third party is, in effect, in control of the scheme. BoTs might, as a result, not have all the relevant information for purposes of decision-making. This results in the administrator also being in "control" of the decision-making of the BoT and therefore the management of the trust funds. This model has inherent conflicts of interest between the administrator's own interests and those of the medical scheme members. It is questionable whether decisions are always made in the interests of members. It is submitted that this model is not aligned with the objectives of the MSA."* ***Profmed page 16***

Whilst DH cannot comment on the relationships between other administrators and the schemes they administer, it can comment on its relationship with DHMS and the fifteen restricted membership schemes under its administration.

Medical schemes and their administrators operate in a highly regulated environment with the CMS effectively policing the industry and the relationship between schemes and administrators. The Medical Schemes Act was introduced to regulate medical schemes and related entities and ensure the protection of medical scheme members. The CMS actively enforces the Act and its regulations, and in so doing, ensures a formal, arms-length relationship between schemes and administrators and managed care organisations, as well as encouraging a careful balance of power between these entities.

Key elements of this active regulation by CMS in terms of the Act and its regulations include:

a. Compulsory accreditation of administrators and MCOs (typically granted for a 2 year period);
b. Active regulation of all market behaviour of medical schemes, administrators and MCOs to ensure ongoing compliance by these entities with all aspects of legislation, and enforcement of compliance where required;
c. Active oversight of contracts between schemes, administrators and MCOs;
d. Active review of all tender processes in which schemes appoint administrators and/or MCOS;
e. Frequent issuing of circulars instructing and guiding schemes and administrators/MCOs on key issues of interpretation of the legislation and conduct of stakeholders;
f. Frequent meetings with representatives of schemes and administrators/MCOs;

g. Inspections of schemes and administrators/MCOs to investigate specific complaints or issues;
h. Management and adjudication of disputes against schemes or administrators/MCOs lodged by scheme members or other stakeholders;
i. The appointment of a curator where governance by the scheme's trustees has failed for whatever reason.

Relationships between schemes and all service providers, including administrators and MCOs are governed by formal contracts which can be terminated at any point. All medical schemes must enter into written agreements with administrators in which the scope, duties and fees of the administrator are outlined in a very detailed Service Level Agreement. This agreement details the metrics to be measured for each service, penalties for breach of service levels, as well as the basis on which the administrator will be remunerated. Agreement on the fees payable follow intensive negotiations. Contracts are continuously negotiated, updated and reviewed and may be terminated within three months' notice, which means that the power in the contractual relationship ultimately resides with the scheme, rather than the administrator.

DHMS has in place a very effective set of governance structures and processes that are regularly subject to external audit as well as regulatory review by CMS. DH's client schemes all have formal governance arrangements in place that comply with all aspects of the Act. (DHMS explains its governance arrangements in detail in Section 4.2 of their submission.) These arrangements ensure comprehensive and effective oversight of DH's administration and managed care operations by the Principal Officer, each Board of Trustees, and Board Sub-Committees. This strong and effective set of governance arrangements for DHMS was endorsed by Deloitte in the Deloitte Review[5] which concluded that the Scheme is led by a strong and competent independent Board, with no governance failures.

While DHMS outsources all its operational functions to DH, DHMS maintain a strong oversight and management of the performance and scheme operations through several committees chaired and run by DHMS Trustees and the Principal Officer and Management of DHMS. Over the years, there has been a significant increase in the number of DHMS Board committees to enhance the scheme's oversight of all scheme business transacted on its behalf by DH. DH provides detailed reports on every aspect of the scheme's operations to empower the scheme's decision making and is invited to these committees where required and appropriate, to provide input and make recommendations.

In certain instances and where required, DHMS and most other DH client schemes make use of external, independent actuarial and other advisors to review the information and advice provided to it by DH. The Principal Officer and Management of DHMS also participate in all relevant DH operational meetings and executive level structures, allowing DHMS full insight into all key discussions and decisions.

Lastly, there is no conflict of interest between the administrator and the scheme with respect to members' welfare. Schemes wish to provide the best possible value for money to their members with the richest possible scheme benefits and as a result maintain a competitive position in the market and ensure membership growth. An administrator's interests are fully aligned with these objectives since, to the extent that these objectives are satisfied, the scheme will grow, which directly benefits the administrator earning revenue through the fixed monthly administration and managed care fees per member, payable by the scheme.

[5] DH Medical Scheme Operating Model and Governance Review. Deloitte. June 2013.

Section 8. DH Administration Fees

8.1 DH has the most expensive administration fees

> *"As in the private hospital sector, the medical aid sector has become more concentrated and is now largely carved out between the top three administrators in South Africa –Discovery, Metropolitan Health (MMI) and MEDSCHEME. They account for over 80% of all medical scheme administration. The largest, Discovery, is now the most expensive on a per beneficiary basis. This concentration has occurred through takeovers of smaller closed medical schemes, …"* ***Cosatu page 13***

It is misleading to compare administration fees across administrators and scheme types. This is due to the highly differentiated service offering that administrators provide to schemes. Some schemes pay significant amounts to other third parties which is sometimes not included in the total for administration and managed care fees. This skews the results because DH performs all the administrative work for DHMS and charges one comprehensive fee. As such, it is more consistent to view fees paid by schemes than fees received by administrators.

It is also critical to assess the combination of both administration and managed care fees as different administration companies provide different levels of services. Further it is more appropriate to assess administration and managed care fees as a percentage of GCI as it costs more to administer schemes with richer benefits.

Given these qualifications, the fees paid by DHMS to DH are not the highest in the industry, as the following table clearly shows:

Table 1: Administration and Managed Care Fees by Scheme

Name of medical scheme	PABPM Administration	% GCI	PABPM Administration and Managed Care	% of GCI
Community Medical Aid Scheme (COMMED)	288.85	17%	324.67	19%
Pharos Medical Plan	210.49	15%	243.96	18%
Selfmed Medical Scheme	181.86	12%	205.60	14%
Spectramed	186.00	12%	204.99	14%
Compcare Wellness Medical Scheme	144.07	10%	191.48	13%
Liberty Medical Scheme	148.90	11%	185.40	14%
Fedhealth Medical Scheme	133.64	9%	168.29	11%
Resolution Health Medical Scheme	119.71	11%	150.83	14%
Discovery Health Medical Scheme	**113.77**	**9%**	**150.18**	**11%**
Keyhealth	119.08	6%	149.64	8%
Medihelp	122.76	9%	148.70	11%

Name of medical scheme	PABPM Administration	% GCI	PABPM Administration and Managed Care	% of GCI
Hosmed Medical Aid Scheme	111.89	9%	142.14	12%
Sizwe Medical Fund	111.88	8%	140.78	11%
Bestmed Medical Scheme	114.09	7%	139.19	9%
Bonitas Medical Fund	100.96	8%	137.73	12%
Topmed Medical Scheme	105.50	9%	135.60	12%
Genesis Medical Scheme	117.06	13%	117.06	13%
Momentum Health	89.66	8%	112.89	11%
Medshield Medical Scheme	79.60	7%	102.85	9%
Cape Medical Plan	100.87	12%	100.87	12%
Suremed Health	83.47	9%	98.72	11%
Thebemed	65.85	10%	89.11	14%
Makoti Medical Scheme	80.64	12%	80.64	12%
Medimed Medical Scheme	64.65	8%	78.43	9%

Source: CMS Annual Report, Annexures 2012/13

It is not clear whether the COSATU comment cited above refers to administration fees of medical scheme premiums. To the extent that it refers to premiums, its assertion is also incorrect. Our analysis shows that, on a plan for plan basis, DHMS premiums are approximately 14% lower than the average of competitor open medical schemes.

Amalgamations with certain restricted schemes have been at the behest of schemes approaching DHMS to amalgamate, and the decisions of the schemes have been based on a variety of factors. In any event, incremental increases as a result of such amalgamations have been small in the context of DH's overall business. All of the amalgamations that have been notified to the Competition Commission (either voluntarily or not) have received the requisite approval.

Section 9. Income differentiation in premiums

9.1 There is no income differentiation in premiums

> *"Lower income medical schemes members pay a larger percentage of their income in medical scheme contributions than higher income members. This is because a flat rate (or fixed Rand value) contribution is charged by medical schemes rather than an income-related contribution."* ***Cosatu page 12***

This statement is clearly wrong, given that the contribution rate structure of DHMS's KeyCare range of plans is deliberately designed to offer lower income households lower premiums. The table below illustrates that all KeyCare contributions are income differentiated, enhancing access to lower income members.

Table 2: KeyCare 2015 monthly contributions

Plan and income band	Main member	Adult	Child*
KeyCare Plus (10 001+)	R1 592	R1 592	R426
KeyCare Plus (7 051 – 10 000)	R1 069	R1 069	R300
KeyCare Plus (361 – 7 050)	R764	R764	R276
KeyCare Plus (0 – 360)	R330	R330	R330
KeyCare Access (10 001+)	R1 556	R1 556	R420
KeyCare Access (7 051 – 10 000)	R1 036	R1 036	R292
KeyCare Access (4 401 – 7 050)	R718	R718	R258
KeyCare Access (0 - 4 400)	R538	R538	R235
KeyCare Core (10 001+)	R1 176	R1 176	R265
KeyCare Core (7 051 – 10 000)	R762	R762	R187
KeyCare Core (0 – 7 050)	R611	R611	R158

Section 10. MedSaver benefit

10.1 The collaboration between Clicks, DHMS and Vitality is unlawful

> *"Incentive schemes on the sale of medicines are strictly prohibited in terms of the Medicines and Related Substances Act…Discovery Health Medical Scheme is also contravening Section 26 (5) of the Medical Schemes Act since it is directly or indirectly providing rebates to members by enticing them to purchase Schedule 1 and 2 medications from Clicks Pharmacies. The 25% discount of Schedule 1 and 2 medicines further contravenes Section 22G(3)(a)."* ***ICPA page 23***

DH is of the view that ICPA's complaint in essence raises issues about legality and not competition issues, despite its claim that these contraventions ultimately distort competition. Note also that MedSaver is not a DHMS benefit but a Vitality benefit.

In respect of MedSaver, Clicks is required to pay Vitality a fee in return for marketing services rendered by Vitality to it (based on a percentage of Schedule 1 and 2 products purchased by all members of schemes administered by DH). These marketing services entail email campaigns, sms campaigns, online advertising, social media, competitions, print advertising, radio and posters. The MedSaver benefit also entails Vitality paying cashbacks to persons who register/join MedSaver and the quantum of such cashbacks is dependent on meeting other requirements (i.e. completing a personal health assessment) which Vitality considers beneficial to its business.

MedSaver does not foreclose the pharmacy market to pharmacies that are not part of Clicks. This is because

a. there remains a large number of prospective customers outside of Vitality and DHMS (including members of other medical schemes, non-insured customers and customers seeking medication on all Scheduled Classes) who are unaffected by the existence of MedSaver .
b. pharmacies outside of Clicks can and do continue to attract the custom of Vitality/DHMS members if they can convince such members that they provide a valuable offering in general, as well as in connection with purchasing medication in other classes i.e. not just Schedule 1 and 2.

For these reasons, ICPA's competition complaint is unfounded. To the extent that this allegation concerns potential legal issues and alleged contraventions of applicable legislation, this has been extensively canvassed and addressed with all the relevant regulators and MedSaver has been successfully operating with regulatory approval for more than 3 years.