HFA Matters

HEALTH FUNDERS ASSOCIATION

Working with our members for their members

Welcome to the Spring edition of HFA Matters!

Events in the industry over the past few months have brought into sharp focus the need for an industry body that is able to be a collective voice and a platform for collaborative industry activities. One such example is where, at a Consultative Forum on Fraud, Waste and Abuse in July, members came together to discuss the establishment of a collective, member-driven fraud management initiative which will be established under the banner of HFA. Another relates to the HFA submissions on the NHIB, the MSAB and the HMI Provisional Report which must reflect the views of our members but at the same time must take a step towards greater collaboration between HFA and policymakers. Yet a third example is the recent application by pharma manufacturers for an interim increase on SEP in 2018 and the subsequent requirement for a collective industry response by HFA.

The 'silly season' for schemes has, this year, been exacerbated by the required commentary on the two important Bills and the HMI Provisional Report. To assist members in planning and formulating their submissions, HFA convened a workshop on the 27th July where experts, Roseanne Harris, Health Policy Actuary at Discovery Health; Barry Childs, Joint CEO of Insight Actuaries and Consultants; and, Elsabe Klinck, CEO of EKA shared their expertise and insights into the contents of the documents and the impact that the policy changes may have on the industry.

Please see pages 2-7 for summaries of HFA's submissions on these documents.

HFA's membership of BUSA provides an inroad to the NEDLAC process where both the NHI and the MSA Bills will be interrogated further once the period for comment is closed. BUSA's contribution to the NEDLAC process will be informed by its members, which in effect provides HFA with yet another opportunity to provide input on these important policy documents.

We are delighted to report that HFA continues to grow and welcome our newest members, Anglo Medical Scheme and Genesis Medical Scheme, into our fold. HFA now represents 76% of open scheme lives, 21% of restricted schemes and approximately 54% of total medical aid membership.

Congratulations go to Mr André de Koker; Ms Barbara Duffy; and Dr. Tebogo Phaleng who were elected on to the HFA Board at its AGM on the 29th May. Our deep gratitude goes to outgoing directors, Graham Anderson and Dr Jonathan Broomberg for their invaluable contribution and commitment to the organisation.

Dr Tebogo Phaleng

Barbara Duffy

André de Koker

Happy reading!
Lerato Mosiah, CEO

HFA's submission to the HMI Report

HFA has submitted detailed commentary to the Competition Commission (CC) on the HMI Report. The submission covers a number of aspects raised in the report and where relevant, provides possible solutions. HFA has also pledged to provide technical and other expertise where necessary to assist in realising some of the recommendations.

One of the main points of concern for HFA is the proposed extended powers of the Registrar and Council for Medical Schemes, and to this end our submission emphasises the need for an appropriate balance of power between Parliament, the National Department of Health, the Council and the individual schemes and their trustees.

HFA's submission asserts that the incomplete implementation of a social solidarity framework is the driving factor for many of the failings within the industry, including the lack of efficiency-based competition between schemes. It suggests that some of these could be addressed through a risk equalisation mechanism, mandatory cover for those earning above a certain threshold and the revision of the PMBs. HFA cautions, however, that risk adjustment is a highly complex mechanism and serious regard must be given to how it is implemented, including which entity should be responsible for overseeing this process.

The HFA submission disputes that the limited innovations in the industry are due to lack of effort on the part of funders but rather reflect the environmental barriers. HFA is of the view that the proposed amendments to the Health Professions Council of SA (HPCSA) rules are an urgent requirement for innovations that have been worked upon, to be implemented.

On the recommendation by the HMI that schemes should be taking more responsibility for containing supply induced demand and for developing and implementing effective ARMs, HFA submits that the fee for service environment, HPCSA rules and lack of negotiating powers on the part of medical schemes (particularly following the 2006 Competition Commission ruling with respect to the National Health Referencing Price List (NHRPL) inhibit these developments.

HFA's submission supports the concerns cited in the HMI Report around the effectiveness of ARMs because of carve outs and suggests that this is a symptom of imbalanced negotiations.

There has been extensive historic debate regarding the merits of for-profit insurance versus mutual entities with respect to efficiencies and cost. The HFA states its support for the current social solidarity framework noting that there are several key protective measures for risk pools that are required to ensure that this framework operates optimally. These include that risk equalisation and mandatory membership are necessary to be in place with the principles of community rating and open enrolment inherent in the current medical scheme framework.

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HFA's submission to the HMI Report, cntd.

> ***'… the incomplete implementation of a social solidarity framework is the driving factor for many of the failings within the industry.'***

On the issue of anti-selection, HFA states its concern at the understating of the importance of this phenomenon by the HMI. The HFA also raises concerns that the lack of importance assigned to anti-selection will be used to support the proposed relaxation of waiting period requirements in the Medical Schemes Amendment Bill which will have dire consequences on the costs of cover, affordability and hence levels of coverage.

HFA's submission addresses the issue of mandatory cover and suggests that, despite the high levels of unemployment, the introduction of mandatory membership above a specified income band will have significant benefits in terms of affordability and that progressive introduction of income-based mandates will increase access to those who are unlikely to see the benefits of the NHI Fund for some time.

The submission notes the flawed approach by the HMI in relying on ICD10 codes to identify PMBs and suggests that the findings that the PMBs are not a primary driver of cost escalation is incorrect, particularly as PMBs are found to be an increasing component of medical scheme expenditure.

Finally, the HFA submission addresses concerns around the pharma and consumables market and highlights the fact that the HMI has not considered the issue of cover for lower income earners and points out the valuable work done in this regard in 2006.

In total, 47 submissions have been received by the CC, with further submissions expected from stakeholders who have requested an extension on the due date for submissions.

In a notice published on the 6 September in Government Gazette No. 41893, the CC has postponed the date for the release of the final report and recommendations to the 30 November 2018. According to the notice this postponement is due to the data access process and extensive engagements that are required in respect of the provisional report.

The notice also states that all submissions will be considered and that the report will be revised, if necessary.

Should you wish to submit an item for inclusion into HFA Matters, please send it to Maureen Litchfield at maureenl@hfassociation.co.za

A summary of HFA's submission to the NHI Bill

At a broad level, the HFA submission stresses the need for a concerted and coordinated approach to achieving the major regulatory reforms which are required to address South Africa's burden of disease and to achieve Universal Health Coverage (UHC), and emphasises that medical schemes have a key role to play as part of the NHI framework.

The submission points out that the implications of the provision which allows the Registrar (in consultation with the Minister) to limit the benefits that medical schemes may offer with reference to the NHI Fund are impossible to assess without much greater clarity on the details of the NHI benefit package, and without clear definitions of the terms "duplicative costs" for the "same benefits". In addition, it stresses that this provision is inconsistent with the draft NHI Bill and with the definition of a beneficiary in the Medical Schemes Amendment Bill, both of which provide for medical scheme cover to co-exist with the NHI Fund.

HFA makes the point that there is no precedent for countries that have prohibited the purchase of voluntary health insurance in the context of NHI or other systems of universal health coverage

HFA's submission also raises concerns with regards representation in the various committees and stresses that expertise to address the tasks in the terms of reference of the various committees should be incorporated, with adequate reporting to the Stakeholder Advisory Committee. The Stakeholder Advisory Committee should include representatives of the healthcare practitioners through their various professional bodies as well as the funders through their industry bodies including the HFA.

The HFA submission stresses that the establishment of the NHI Fund as a Schedule 3 entity in terms of the Public Finance Management Act (PFMA) is not sufficient to afford the Fund adequate protection and transparency as a major funding entity. The NHI Fund should be registered as a major entity under Schedule 2 of the PFMA.

The submission raises the point that the NDP cautions against centralised control due to lack of accountability at local level and against a blurring of accountability lines due to Ministerial prerogative on key appointments for statutory bodies in the health sector. The authority awarded to the Minister and the opportunities for interference in the day to day operations of the NHI Fund are a problematic and worrying feature of the NHI Bill.

In view of the lack of information on the approach to financing of the NHI, it was not possible provide commentary on this aspect, save to say that there is international consensus that the consequence of avoiding a costing projection is that benefits are not made explicit to the public, and therefore there is no clarity on what the realisation of UHC will actually look like.

The HFA submission suggests a detailed assessment on the feasibility, costs and risks of shifting from the current model of government funds flows to a system of procurement based on contracting between the NHI Fund and each individual provider. It is not at all clear that the proposed model is feasible, or that it is the most cost-effective approach to building a system of UHC.

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HFA's submission to the NHI Bill, cntd.

HFA points out in its submission that the NHI Bill does not appear to recognize the numerous and serious current limitations in the supply of healthcare providers in South Africa. The problems in delivery of accessible, adequate healthcare services for the majority of the population are well known and well documented. While financing and purchasing are essential elements of reform towards UHC, there is a material risk that the situation will become worse, rather than better, if most if not all, of government's focus in the next decades is dedicated to the development of a vast new financing infrastructure, rather than the improvement of the current delivery system. It is also critical to ensure that there is adequate resource planning and investment in training and development. HFA's submission points out that a comparison between SA and OECD on average visit rates for primary care gives a clear indication of the large deficit in terms of health professionals. The submission stresses that there is no quick fix for addressing this deficit due to the lengthy training period required for medical professionals, but that there is opportunity to engage with private sector facilities to assist in the training process (in terms of practical training elements rather than higher education elements).

HFA recommends that a detailed feasibility study is undertaken to develop a workable framework around the procurement process and reimbursement framework for contracting services from the private sector and public sector under the purchaser provider split, referred to in the Bill.

The HFA welcomes the phased implementation but cautions that it may not be realistic. It also recommends that there be parliamentary/judicial oversight of the reform process, given the magnitude and complexity, adding that the Inter-Ministerial Committee for NHI as established by the President in August may fulfil this role.

Finally, HFA emphasises that there are immediate opportunities for efficiency improvements in the private sector that could have a material effect on improving access to affordable cover for low income earners. These include the implementation of risk equalization (so that medical schemes compete on efficient management of risk rather than selection of risk) and mandatory membership which can be implemented in a phased way based on income.

NEWS FLASH

CMS Circular 42, released on the 19th September 2018 invites input and comments by the 30th November 2018 on its 'Draft Framework for Medical Schemes Consolidation'. This framework follows an impact analysis on medical schemes consolidation conducted by an actuarial firm on behalf of the CMS.

Click here to view Circular 42 of 2018

HFA's submission to the MSAB

HFA submitted detailed commentary on the MSAB, which included both high-level observations as well as commentary on specific aspects of the Bill. Where possible, recommendations and proposals for alternative solutions were included.

High level observations include:

A number of the proposed amendments will have severely negative implications on the cost, and hence affordability of medical schemes. This could lead to a reduction in the covered population and an increase in beneficiaries relying on public provision of care.

Some of the proposed changes prioritize the interests of individual members (e.g. applicants with pre-existing conditions and members whose membership has been terminated due to fraud or non-disclosure) above the interests of the collective pool of contributing members who will be required to pay increased contributions to cover these additional costs. An important principle of risk pools structured on the basis of social solidarity is the fair treatment of all participants to ensure that the integrity of the pool is preserved and that individuals do not benefit disproportionately.

Some amendments will result in a material increase in the powers of the Registrar, in many cases resulting in the usurping of the current powers of the Council as well as that of Parliament. These changes may also undermine the powers and duties of the trustees of schemes and pose risks to their ability to fulfil their fiduciary duties to govern schemes effectively.

The socio-economic impact assessment system (SEIAS) document on the Bill does not include any quantification of the implications of proposed amendments, nor does it appear to consider the factors of affordability and sustainability of medical scheme risk pools. While the stated intentions in the SEIAS include improved protection of members and affordability, many of the proposed amendments seem to have the opposite effect.

The amendments which provide for increased powers of the Registrar create a material risk to medical schemes in the event that the Registrar takes inappropriate actions due to lack of information, bias or other untoward intent. Some of these amendments may be open to challenge on the basis that there has been an unlawful delegation of powers to a body (in this case the Registrar) by Parliament, to the extent that the exercise thereof is unfettered or unlimited by any constraints imposed by Parliament.

HFA's commentary and recommendations related to specific amendments include:

The proposed new definition of dependant coupled with the proposed amendments on waiting periods will have significant cost implications for all medical schemes.

The requirement to hold and manage funds from medical savings accounts separately imposes significant additional non-healthcare costs on medical schemes which are borne by members. The intentions of this amendment can be achieved by incorporating the necessary protection with regard to liquidation into Section 64 of the MSA.

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HFA's submission to the MSAB, cntd.

The publication of tariffs agreed between service providers and schemes will undermine competition and will adversely affect schemes and their interests. Transparency in tariffs will harm those schemes and their members who obtain better tariffs and will drive all tariffs towards a standard level which may well be higher than current average tariffs. There is no justification for this anti-competitive amendment.

The provision in the draft Bill that where a provider appears on the provider register, schemes are obligated to pay the provider directly is not justified. It is critical that schemes retain the ability to retain the use of direct payment arrangements to encourage providers to enter into DSP arrangements where members are protected from co-payments. If this negotiating lever is removed from schemes, they will lose the ability to develop DSPs and will not be able to comply with PMB requirements without undermining the affordability of the medical scheme cover.

In addition, schemes need to retain the ability to limit payments from providers who have committed fraud or abused the scheme and/or its members in any other way. This is an important protection mechanism for medical scheme members.

The management of non-healthcare expenses, like all other key elements of scheme governance, is a duty of trustees and it is not appropriate for the Registrar to be able to override the operational decisions of the trustees

With reference to the NHI Fund, the proposed amendments to Section 34 which provide for the Registrar (in consultation with the Minister) to limit the benefits that medical schemes may offer are difficult to assess in the absence of clarity on the NHI benefit package and a clear definition of the term "duplicative costs". It is premature for such a provision to be included in the Medical Schemes Act until the NHI benefit package has been clarified.

The amendments relating to changes in definition of waiting periods will have a significant negative impact on medical scheme costs for both open and restricted membership medical schemes. This was confirmed in the HMI provisional report (p. 87 "Partial regulatory framework for medical schemes") which states that underwriting mechanisms such as late joiner penalties and waiting periods are critically necessary in the absence of mandatory membership to mitigate against adverse selection. Further the HMI report recommends that the level of underwriting may need to be reconsidered and increased, if necessary, to dis-incentivize anti-selective behaviour. If the already weak underwriting requirements are further weakened, as proposed, this will lead to even greater adverse selection than is already the case. This will further weaken scheme risk pools and drive up contributions.

It is estimated that the removal of waiting periods could increase the cost of cover by 10 to 15% which would lead to a loss of beneficiaries in the order of 800 000 from the risk pool due to affordability. Losing the lower claiming lives will have further cost implications.

The proposed requirement to re-admit members whose membership has been terminated for these reasons is contrary to the interest of the honest majority of contributing members and renders the sanction of termination ineffectual. It is vital to the integrity of medical scheme risk pools that there are adequate disincentives against dishonest behaviour and anti-selection.

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HFA's submission to the MSAB, cntd.

Schemes should retain the right to permanently terminate membership where there is clear evidence of fraud or material dishonesty and also if amounts owing to the scheme remain unpaid or if (re)payment arrangements are not being adhered to. HFA recommends that the requirement for re-admission is subject to a delay of at least 24 months, which will create a sufficiently strong disincentive against members behaving with *mala fides* against a scheme.

HFA disagrees strongly with the proposals regarding stipulated levels of contributions for child and young adult dependents for a number of reasons, including that the proposed discount for young adults will undermine the age cross subsidy inherent in the social solidarity risk pool since these beneficiaries will not be making a contribution to the risk pool in terms of a cross subsidy. Analysis of current costs indicates that the proposed structure will lead to large increases in contributions for older couples, countering existing age cross subsidies. Young adults would also face an increase of 150% on turning 30 which may cause them to exit the risk pool and only re-enter on an anti-selective basis. This change will therefore worsen the already serious problem of adverse selection faced by many medical schemes.

The process for defining the Comprehensive Service Benefits needs to be consultative and inclusive. The provision for such significant changes to be published in the Gazette appears to bypass a consultative process and is dictatorial in nature. This is inappropriate for privately funded, voluntary membership medical schemes. The requirements associated with assessing the impact of changes to benefits and developing accurate and responsible costing and ensuring that risk management processes can be put in place requires a significantly longer period than 30 days. HFA suggests that a period of at least 90 days is provided for notifying schemes of proposed changes to the Comprehensive service benefits.

HFA's fraud intervention strategy

The HFA has been invited by the CMS to participate in its newly established Fraud Steering Committee. This is timeous as it coincides with the establishment of HFA's industry prevention and investigation initiative which is in the process of being set up.

At a Consultative Forum for HFA members held during July, it was agreed by members present that a collective approach to fraud is the most efficient way for investigation and prevention, and that combatting fraud should not be perceived as a competitive issue but rather as a collaborative issue.

It was also acknowledged at the forum that several good forensic management tools have been developed by the industry, but that these are being used in a fractured way and that an evaluation on these various assets should be conducted in an attempt to build a collective approach. Such a collective approach would prevent duplication of efforts and provide an opportunity for the industry to develop shared industry processes for investigation and prosecution.

HFA will be convening a Fraud Forum during the first week of November where the proposed HFA initiative will be discussed and where members will be requested to provide input in preparation for the CMS Fraud Summit scheduled for later in November

HFA engages NDoH Medicines Pricing Committee over possible further SEP increase

Following media reports that the pharmaceutical manufacturing industry is lobbying for a further increase to the 2018 SEP, HFA has met with the NDoH Medicines Pricing Committee to emphasise the impact this increase will have on medical schemes and their members.

According to reports, an increase to the level of CPI is being requested by the manufacturing industry.

According to claims data from HFA member schemes, if an interim single exit price increase to the level of CPI were to be allowed, as proposed by the pharmaceutical industry, medical schemes would incur an additional cost of at least R260-million over the remaining four months of 2018 (considering projected volume growth). The annualised impact of this increase would be over R1-billion in 2019, even before next year's single exit price adjustment.

HFA believes that medical schemes and the South African healthcare consumer simply cannot afford to shoulder the burden of this additional medicine price increase during the current cycle.

Based on data from member organisations, medical schemes have experienced significant cost inflation during the first half of 2018, a trend which is expected to continue through the rest of 2018 and into 2019. Overall cost inflation of medicine is driven not only by the SEP adjustment but by volume growth as well, which compounds annual medicine price increases. HFA data shows that, despite this year's regulated SEP increase of 1.26%, during the first half of 2018 overall cost inflation for chronic medicines has increased by up to 6%, and up to 8% in the case of cancer medicines for some medical schemes.

This increase has been compounded by the VAT increase from 14% to 15% which was not factored into medical scheme budgets for 2018. HFA estimates that this factor alone has imposed an additional R875-million unbudgeted expenditure on schemes.

HFA also voiced concerns to the Pricing Committee over the fact that the funders of medicines have been excluded from adding their input to the SEP adjustment process.

Click here for the full press release

Results from the HFA member survey

In order to gauge whether HFA is delivering on its strategic objectives and thereby adding value to members, we conducted a survey earlier this year which was sent out to all our members.

A response rate of 40% was received, which is considered adequate for an accurate sample.

An overwhelming majority of our members believe that constructive engagement with policy makers and other key influencers, and being able to influence policy at the soft pencil stage is the most important role for HFA at a strategic level.

Drilling down further, members believe that HFA should continue to demonstrate thought leadership and in order to be in a position to provide input to policies and legislation through engaging experts and consulting with members through workshops and other such forums.

On the question of prioritising focus areas, in addition to playing a meaningful role in the policy and legislative environment, members agree that HFA provides a platform where non-competitive issues can be addressed, such as an initiative to combat fraud, waste and abuse within the system.

The final question asked respondents to provide general comments on their experience as members. Most respondents believe that HFA represents the values and ethics of its membership, is a partner to its members and is on the right track in terms of its strategic objectives and focus areas,

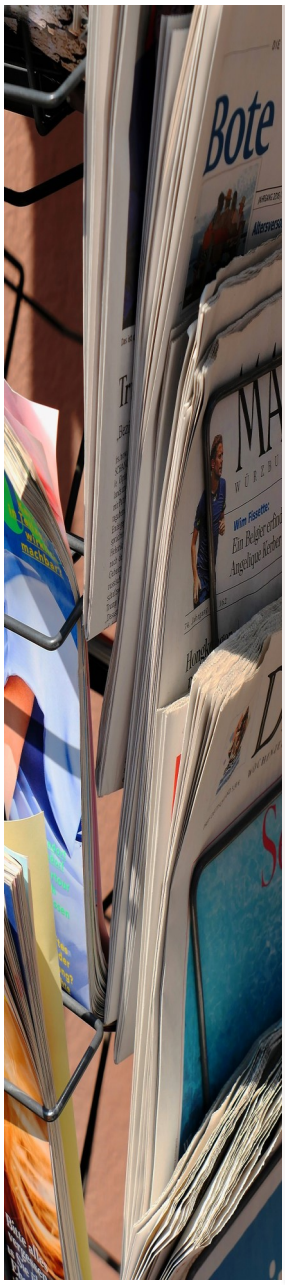
These results have been extremely valuable in assisting us in prioritising our objectives for the year and we will continue to engage members in this way in future.

HFA
HEALTH FUNDERS ASSOCIATION

WHO WE ARE

The HFA is a **representative organization** committed to serving the **best interests of its members** by being **responsive, relevant** and **dynamic** in addressing issues pertinent to the private healthcare funding. The HFA stands for **equitable, rational** and **cost-effective** representation of its member organisations. It will act as the **'voice'** of its members to **diligently** and **respectfully** carry out their mandate. The HFA will conduct itself with **integrity**, upholding high **ethical** and **professional** standards, in support of the **development** and **viability** of the private healthcare funding industry.

Click here to become a member



IN THE NEWS

Council for Medical Schemes suggests single scheme for public servants
By Tamar Kahn: Business Day, 21 September 2018
https://www.businesslive.co.za/bd/national/health/2018-09-21-council-for-medical-schemes-suggests-single–scheme-for-public-servants/

Findings of private health inquiry to be dumped?
By Amy Green: Health-e News, 10 September 2018
https://www.health-e.org.za/2018/09/10/findings-of-private-health-inquiry-to-be-dumped/

Medical schemes in price plea after drug companies seek second increase
By Tamar Kahn: Business day, 29 August 2018
https://www.businesslive.co.za/bd/national/2018-08-29-medical-schemes-in-price-plea/

Pharmaceutical makers push for extra price rise
By Tamar Kahn: Business Day, 21 August 2018
https://www.businesslive.co.za/bd/companies/healthcare/2018-08-21-pharmaceutical-makers-push-for-extra-price-rise/

Ousted board want Samwumed curator, Duduza Khosana, gone
By Laura du Preez: Business Day, 26 August 2018
https://www.businesslive.co.za/bd/companies/healthcare/2018-08-21-pharmaceutical-makers-push-for-extra-price-rise/

Will NHI and Medical Schemes Amendment Bills offer appropriate response to healthcare crisis?
By Lucy Gilson, Jane Goudge, Uta Lehmann & Helen Schneider:
Daily Maverick, 22 August 2018
https://www.dailymaverick.co.za/article/2018-08-22-will-nhi-and-medical-schemes-amendment-bills-offer-appropriate-response-to-healthcare-crisis/