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Discovery Health Note to Investors on recent regulatory developments

Universal health coverage

Discovery Health continues to support the objectives of transforming the national health system in order to achieve the goal of universally accessible, high quality, affordable health care for all South Africans. Although the provisional report of the Competition Commission's Health Market Inquiry (HMI) notes that between the means-tested public system and regulated private system, South Africa has a system of almost universal coverage, there is little doubt that the vast majority of South Africans do not have access to quality health services when they need it. There remains a lot of work required to improve access to quality and affordable health services.

There are significant challenges in both the public and private sectors. In the public sector there is a dire need for operational revitalization and improvement in service delivery. This is a mammoth task as a number of recent reports have substantiated. In the private sector there is significant scope for improving efficiency, reducing over servicing and other 'waste' that drives claims inflation, and aligning incentives for quality of care. The HMI has made a number of critical recommendations in this regard.

The NHI System as outlined in the NHI Bill

The publication of the NHI Bill and the establishment of the NHI Fund can be seen as a significant step towards the achievement of universal healthcare for all South Africans. The proposed NHI system outlined in the Bill, is pragmatic and workable. The Bill proposes the establishment of the NHI Fund and its associated governance and advisory structures. It indicates that for the next several years (at least until 2022, and in our view, most likely for far longer), the NHI Fund will focus on funding critically-needed services for defined vulnerable groups, including school children, the elderly, mental health patients and cancer patients. The private sector has an important collaborative role to contribute in terms of expertise and experience to assist with these programmes. In fact the Department of Health has issued a tender requesting medical scheme administrators to bid for a contract to utilize the R4bn allocated to the NHI for the next three years to procure a defined set of high priority services for specified vulnerable public sector patient groups from private providers. Discovery Health will be participating in this tender. In our view, this indicates a potential future area of collaboration between the public and private sectors which could be of significant mutual benefit.

One of the critical elements of the NHI system will be the benefits it funds. The Bill provides no detail on these benefits, and these details are expected to be developed through a Benefits Advisory Committee, which will be appointed by the Minister of Health; and who will develop proposals for the NHI benefits over the next few years. It is critical for stakeholders from across the public and private sector to be part of this process and Discovery Health will be pressing for participation in this process.

The Bill indicates that in order to qualify for NHI benefits at no cost, patients will need to follow the NHI's referral pathways and use its contracted providers. Those patients who elect not to do so, will not be able to claim from NHI, and critically, will be able to fund their services directly, or via medical schemes or other forms of health insurance. This is an important point – as it confirms that medical schemes will continue to exist alongside the NHI system and that patients with medical scheme cover will retain freedom of choice in which doctors and hospitals they wish to use. This also makes it clear that for an extended period into the future, it will be critical for employers to make provision for the healthcare of their employees, either through a medical scheme, or through a primary care product that provides adequate day to day cover for employees and their dependents.

The Bill provides no detail on the funding of the NHI system, as this is a function of the National Treasury. In our view, funding for NHI will remain constrained for the foreseeable future, due to the weak macro-economic conditions in the country, and the other fiscal pressures on government. In the last Budget speech, the Minister of Finance allocated R4.2 billion to the NHI Fund for the 2018 to 2020 period. This will be used to fund the high-priority services outlined above.

The role of medical schemes in the context of the NHI system

It appears that for an extended period into the future, the benefits covered by the NHI will expand very gradually, and will be focused on high-priority services for defined vulnerable populations. While the services covered by NHI will expand, those who belong to medical schemes will still have the choice of bypassing NHI referral pathways and the choice to use their own providers, and will also then be able to claim from their medical scheme. It is therefore clear that medical schemes will continue to operate alongside the NHI system, and will be able to cover all services currently covered. In our view, this situation is very likely to be a permanent one – very much as occurs in other systems which have universal access publically financed systems, but still allow citizens who can afford it to purchase additional private sector cover. Well known examples include the UK, Australia and most European countries, as well as various countries in Asia and Latin America.

The Medical Schemes Act (MSA) Amendment Bill indicates that medical schemes will not be permitted to allow co-payments where a member requires a treatment that is part of a basket of still-to-be-defined “mandatory benefits” (or “comprehensive service package”) which will replace the existing Prescribed Minimum Benefit (PMB) package. This package is expected to be aligned with the ultimate benefits of the NHI Fund. The MSA Bill also makes provision for simultaneous membership of a medical scheme and the NHI.

Other proposed amendments to the Medical Schemes Act

The MSA Amendment Bill indicates that co-payments will not be permitted only in relation to the mandatory benefits (or comprehensive service package) offered by schemes. There is no restriction proposed on applying co-payments to the balance of benefits. This is in fact no different to the current situation, where schemes are not allowed to have co-payments for Prescribed Minimum Benefit (PMB) conditions.

We therefore expect that this situation will remain much as it is, except that the PMB definitions will be modified over time.

No details on the proposed comprehensive service package have been included and this will need to be developed ensuring that the total cost of mandatory benefits is more affordable than the current level of PMBs.

With respect to brokers, the key change relates to the requirement for explicit consent from members and the disclosure of the amount included in contributions for broker fees. It appears that the proposal is that broker fees would still be paid by the medical scheme to brokers in respect of those members who have provided such consent and other members would pay a reduced contribution.

There are a number of other technical changes including proposed changes to underwriting rules of medical schemes and how scheme premiums should be calculated and disclosed. Discovery Health will be quantifying the financial consequences of these proposals as part of our submission.

There are no changes in the regulation of scheme solvency contemplated in the draft Bills. However, the Minister has indicated that he has instructed the CMS to accelerate the development of a new capital regulation approach that will ensure that capital requirements for schemes are more closely related to their actual risk profile. This would be a very good development as the current rigid 25% (of total premium) solvency requirement means that many schemes are overcapitalized, while others are undercapitalized. This development will significantly benefit Discovery Health Medical Scheme, as it requires far lower reserves than current levels, due to its large size and stability. At this point, we have no clarity on the timing of new solvency regulations, but would expect these to be in force by January 2020, and not before.

The Health Market Inquiry

The HMI has published important findings regarding inefficiencies in how health care services are accessed in the private sector and has made a number of recommendations to address supplier induced demand and to encourage innovation in delivering quality, affordable care. Not least of these is the need for better measurement (and publication) of health outcomes in order to assess the value of health expenditure.

Discovery Health welcomes the publication of the provisional findings of the HMI. The HMI has completed a massive task in assessing several complex markets, analysing extensive data and incorporating detailed stakeholder comment, and we believe that the findings and recommendations will ultimately strengthen the private healthcare system for the benefit of its consumers.

The HMI has identified the need for improved competition in all sectors of the private healthcare market and has made wide ranging recommendations encompassing a variety of factors and stakeholders. The HMI has also identified a number of the key drivers of rising healthcare costs and has correctly concluded that the high rates of cost inflation are due more to factors such as utilisation (driven by factors such as supplier induced demand and technology) rather than simply, an escalation in prices.

We support the principles of ensuring maximum consumer information and transparency, through the collection and publication of much more relevant information, and most importantly, a focus on ensuring high quality outcomes of treatment. Discovery Health has initiated such a process with Hospital Efficiency Scores being made available to members.

We also support the recommendations regarding the urgent need to revise the ethical rules of the HPCSA so as to promote competition, and efficiency in the delivery of care through multi-disciplinary teams and global fees. Our submissions to the HMI have stressed the importance of developing alternative reimbursement models as a way to align incentives for delivering quality, affordable care, and we have consistently pointed out that the HPCSA's rules are an obstacle to these important developments.

We support the recommendation to address the fragmentation of regulation on the supply side, and the recommendation that there be more careful evaluation of need and evidence to be applied in the licensing of hospital and other facilities. We made extensive submissions to the HMI on this point and welcome the references made to this input.

We also support the proposals to allow for maximum fee for service tariffs that professionals charge for Prescribed Minimum Benefits to be determined through an organized tariff determination process. It will be critical that this process is carefully designed to ensure full participation by all relevant stakeholders, and support the recognition by the HMI that bilateral negotiation remains critical in the case of large corporate providers such as hospital and pathology groups.

We share the HMI's concerns regarding the complexity of benefit options, and we noted in our submission that the fee for service environment and complexity of PMBs are key contributors to this option complexity. We do not agree with the HMI finding that there is any deliberate attempt at making benefits complex, quite the opposite.

We note the recommendation regarding the introduction of a base benefit option across all schemes that should be risk equalized across schemes and also the recommendation that schemes can offer supplementary benefits on a risk rated basis. These are interesting and workable proposals, and we are looking forward to working with the regulators to ensure that these changes are implemented in a workable fashion that benefits medical schemes and their members.

We also welcome the concept of risk equalisation on the basic benefits and the acknowledgement that a key challenge for medical schemes has been the incomplete implementation of the social solidarity regulatory framework.

We note the references to Discovery Health (DH)'s sustained profitability, and our strong market position. We disagree strongly that the medical schemes market lacks competition. There are 22 open medical schemes which compete intensely with each other for new members, and Discovery Health competes actively with its main competitors in the market for restricted scheme contracts. We have participated in 17 such tender competitions in the past 10 years, and have won 16 of these.

Discovery Health has always worked hard to ensure maximal transparency on both the fees we charge our medical scheme clients, and on the profits we earn as a result. We are proud of the continued growth and success of our business over the past 26 years and believe that this reflects an outstanding business which has been grown life by life on an entirely organic basis.

It is critical to note that DH's profitability is not due to DH charging higher fees to its medical scheme clients than its competitors do, but rather due to a number of business factors including continuous innovation and greater operational efficiency driven by management excellence, and by large investments in advanced systems and customer service technologies.

This is confirmed by publicly available data which clearly demonstrate that the weighted average administration expenses and managed care fees incurred by the open schemes administered by our major competitors are very similar to those incurred by DHMS. Public data also confirm that the administration expenses and managed care fees incurred by DHMS are almost exactly the same as the weighted average of all 22 open schemes when measured as a percentage of Gross Contribution Income ("GCI"). The fees charged to DHMS are in fact the 14th lowest out of 22 open medical schemes when measured on a Rand per beneficiary per month basis, or 10th out of 22 open schemes when measured as proportion of contribution income. Similarly, the expenses incurred by Discovery Health's 18 restricted scheme clients are very close to the average expenses incurred by schemes administered by our competitors, and the weighted average fees charged to DH's restricted scheme clients are almost identical to the weighted average fees charged by our two major competitors.

The impact of DH's expertise and systems is acknowledged by the HMI as part of the explanation for its sustained success, and also in the observation that DH is the only administrator that has been able to use countervailing negotiating power to achieve lower hospital tariffs for its client schemes.

We fully agree that scheme trustees should hold administrators accountable for delivering value to the scheme and its members. This is the basis on which we contract with DHMS and our 18 restricted scheme clients, and we continually measure the value created for these schemes and report on this regularly. The true yardstick for consumers to assess the value they receive from their medical scheme administrator is the scheme premiums, which is the actual 'exit' price paid by consumers for their benefits and services. When compared on a like for like basis, Discovery Health Medical Scheme (DHMS) premiums are on average 16.4% lower than the next eight competitor open schemes. This is due to a combination of effective procurement, claims and fraud risk management by Discovery Health.

In 2012, Deloitte developed a methodology to quantify the value derived by scheme members of DHMS in Rand terms. The assessment takes account of value added from providing administration services, managing claims costs, making members healthier, attracting and retaining members, product innovation

and additional services offered. In 2017, this analysis shows that for every R1.00 spent by DHMS on administration and managed care fees, the members of the scheme received R2.10 in value from the activities of Discovery Health.

Similarly, Discovery Health's 18 restricted scheme clients benefit materially from the full range of services provided by Discovery Health, including major claims risk savings which result in lower premium increases over time.

Finally, it is important to note that the HMI made no specific recommendations in respect of Discovery Health.

The HMI will issue a final report in late November 2018. This report has the status of recommendations only, and any specific recommendations can only be implemented if these are included in forthcoming legislation and regulations. This is likely to be an extended process, with only a subset of the recommendations finally reaching the statute books, and many unlikely to be implemented due to their complexity and/or objections from affected parties.

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