Industry Snippets

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This document highlights the most salient industry developments for the first Quarter of 2015 (as at the time of writing). It does not aim to provide a detailed analysis of the events, but rather an overview of the key events. Should the reader require further detail on any of the aspects discussed, please feel free to contact NMG Healthcare.

Demarcation Debate

National Treasury and the Department of Health (DOH) have postponed the publication of the final Demarcation Regulations until the 2nd Quarter of 2015. The postponement is as a result of the time required to consider the extensive public comments. Over 446 submissions have been received.

The Regulations will specify which types of health insurance policies will be permissible under the Long Term Insurance Act and the Short Term Insurance Act and are therefore excluded from regulation under the Medical Schemes Act.

All new health policies written after the Regulations come into operation, must be aligned with the requirements of the Regulations. Existing health insurance policies will be expected to comply upon renewal of the health insurance contract. The effective date of operation / implementation will be within 90 days after the Regulations are published – which is expected in June 2015.

Supplementary Levy for Medical Schemes

The CMS proposed a supplementary levy for medical schemes for 2015 / 2016. This levy is intended to help the CMS to meet increased regulatory and administrative costs as well as tasks carried out by the

Registrar of Medical Schemes. Medical schemes will be expected to pay an extra R1.70 per member per year. The period for the submission of written comments ended in January 2015.

With non-health expenses constantly being on CMS' radar, it is important to note that any supplementary levy for schemes will potentially increase the non healthcare expenditure costs further.

CMS publication – Categorisation of Assets

The CMS issued draft guidelines on the categorisation of assets in terms of Regulation 30 of the Medical Schemes Act 131 of 1998 read in conjunction with Annexure B to the Regulations. The draft guidelines provide (as at 31 December 2014):

- a listing of registered banks and subcategorise these banks
- a listing of listed instruments on the Bond Exchange of South Africa and sub categorise these
- a listing of all listed instruments on the JSE and further subcategorises these into property, shares, debentures and other assets
- a listing of all registered insurers as per the FSB website
- a listing of registered financial service providers as per the FSB website

It is expected that these would aid improved investment performance. Commentary has been invited.

CMS publication – Guidelines for introduction of a Low Cost Benefit Option (LCBO)

The Council for Medical Schemes (CMS) issued Circular 9 of 2015 on 13 February which invites comments on the proposed introduction of a Low Cost benefit Option (LCBO) Framework. The purpose of the framework is to provide schemes with the requirements which could lead to the establishment of low cost benefits for approximately 6 million people who are in formal employment, but who do not have medical scheme coverage.

In Circular 9, the Council provided some of the broader principles for consideration by the industry when formulating its response:

- Risk-pooling: The principle of risk-pooling and its maintenance is a cornerstone of the Act. The framework aims to ensure that the existing medical scheme risk pool is not undermined
- Benefit design: The Act currently requires that all registered options include prescribed minimum benefits (PMBs). The proposed framework envisages a partial departure from the current requirement, but intends maintaining the content and objective behind PMBs to the extent to which affordability is not compromised.
- Continuation of care: The intention of the framework is to ensure continuation of care in a setting that may be "out-of-network", based on the proposed coverage of the LCBOs. These products are typically developed on the basis of contracted networks of primary healthcare providers.
- Solvency protection: The Statutory solvency requirement in terms of the Act is a principle that the framework intends maintaining as the requirement is intended to protect the financial integrity of a scheme.

- Non health expenditure: In evaluating the value proposition of any suggested product, the affordability of the proposed contribution must also ensure that the benefits provided are optimised.
- Marketing: The purpose of the framework is to expand coverage to the persons not previously belonging to medical schemes (referred to as previously uncovered market). It is important to ensure that marketing of the LCBOs should be targeted at the previously uncovered market and that they are not misled into believing that they are purchasing a more comprehensive product than is actually the case.
- Underwriting: Late joiner penalties should not be applied - The very rationale for exemptions is that these people were excluded from risk-pooling opportunities by virtue of economic disadvantage.
- The framework provides for the opportunity to be responsive to the needs of the environment, while at the same time wishes to ensure that the policy objectives of open enrolment, community rating, consumer protection, non-discrimination and expanding risk-pooling objectives are demonstrably furthered with each exemption.

CMS Indaba feedback

On 12 March 2015, CMS held an Indaba in Cape Town to discuss Circular 9 (see previously) and the introduction of a Low Cost Benefit Option (LCBO). Medical Schemes and other healthcare providers presented their proposals as to how they believe a LCBO could be structured.
The main points highlighted as the need of a LCBO are:

- Affordability
- Meeting the needs of the uncovered population
- Provision of quality of cover

The common theme in all the presentations was that a LCBO should offer at the very minimum primary care benefits with potentially some flexibility to include some additional benefits. Benefits should be exempted from PMBs with a focus on capitation arrangements for the primary care benefits, coupled with a simple and clear benefit design.

Some of the key themes presented by the various stakeholders at the Indaba could be summarised as follows:

> **Discovery Health:** Proposed a cost of approximately R250-R300 per member per month provided the framework in place prevents anti selection and restricts cover to employer groups bigger than 35 and for employees with incomes between R2000 and R6000. It will also need to be mandatory for such employees to prevent anti-selection against the product/ scheme option This also allows that payroll of companies act as administrator and ensures correct income is disclosed. In the absence of these criteria, the proposed option could cost between R396 and R800 depending on the level of anti-selection. Discovery proposed a structure of primary care benefits with mandatory risk pools, tight networks and formularies, with no PMB and a consideration of not enforcing a reserve requirements.

- **Carecross and Primecure**: Based on the Carecross experience, the following success factors of a LCBO were highlighted: strict contracting with providers such as GPs, risk sharing with GPs, preventative care, low cost delivery platform to minimise claims and processes, quality guarantee and co-operation with state. The benefits proposed consist of GP, acute and chronic medicines, basic radiology and pathology, dentistry, optometry and a referral to secondary care with care covered by state. Carecross stated this package could cost R200 pbpm.

  Carecross highlighted certain structural challenges:

  - benefit construction,
  - exemptions from PMBs,
  - exemptions from having self-supporting options (allow cross subsidies between options),
  - underwriting to prevent option changes and
  - contributions for such low cost options not to be based only on income and family size.
  - Income based contributions for increased income cross subsidies.

CMS confirmed that the LCBO framework and implementation is in support of NHI.

The way forward:

1. CMS will host more workshops and consultations with industry and stakeholders, with the next meeting scheduled for late April or early May in Gauteng.
2. CMS will review all the comments before they prepare guidelines for adoption.
3. Publication of guidelines and start of LCBO application process.

<u>CMS Circular 20 of 2015 – Notice of intention to publish Undesirable business practice declaration</u>

It has come to the attention of the Registrar that some 3rd party service providers contracted to medical schemes promote their businesses in a manner that leads the public to believe that such service providers carry on the business of a medical scheme. The CMS specifically referred to 3rd party service providers that brand their communication to members under the brand of the scheme and abuse the resources shared with medical schemes to promote their own commercial interests. In essence the relationship between medical schemes and 3rd parties should be more at arm's length. Stakeholders have until 8 April 2015 to comment.

<u>NHI update</u>

Health Minister Aaron Motsoaledi drew parallels between SA and the NHI system in the UK and advised that the shortage of doctors in SA coupled with how to incentivise doctors in the private sector to perform work for the NHI is one of the biggest challenges of NHI. Many areas of NHI are still grey as there is no clarity about how doctors will be remunerated to join the system, but incentives are definitely needed if the shortage of doctors is to be addressed.

Patients in the public sector already wait for a long time to get medical attention and if the shortage of doctors is not addressed then with the increased demand as a result of NHI, the queues will be longer.

Key focus areas were highlighted as:

- the NHI need to be adequately funded (probably the most controversial aspect)
- the public sector hospitals need to be adequately resourced – the rapid decline of public health services need to be reversed
- a process of monitoring quality of care should be implemented

So far, only 175 doctors have been contracted to work in state clinics in 10 of the 11 districts (considering the target was 900 by the end of March). The sign up rate has been so slow that the Treasury cut the funding for the NHI pilot programmes through the National Health Grant by R767m over the next 3 years. According to South African Medical Association SAMA the GPs who own independent practices did not sign up – mostly newly qualified doctors took these posts.

More recently, Minister Motsoaledi stated that Treasury was preparing the Financing Paper on NHI whilst the National Department of Health has been working on revising the White Paper on NHI (taking into account the 150 written submissions from various stakeholders). Due to the strong links between the two papers, it is envisaged that they would be published and tabled together in the National Assembly before the end of December 2015

Competition Commission Inquiry
(Summary of feedback provided by Cliffe Dekker Hofmeyr)

On 5 February 2015 the Panel of the Market Inquiry into the Private Healthcare Sector (Inquiry) presented an information session on the status of the Inquiry. The Panel summarised the major themes that emerged from the submissions, being:

- that private healthcare expenditure is high and that private healthcare inflation is higher than general inflation;
- concerns about the regulatory environment in the private healthcare market;
- concerns about lack of information available to patients, highlighting a general lack of transparency in accessing private healthcare information, in particular on pricing costs and quality of services; and
- the challenges of reconciling recommendations relating to the private healthcare sector and the development and implementation of long-term public healthcare policies.

Stakeholders were invited to comment on these submissions to address material issues that appear from the submissions made by other stakeholders. Going forward, the Panel will engage with various stakeholders on the content of their submissions and will issue written requests for information where needed. The Panel may also request meetings with relevant stakeholders (which is likely to take the form of site visits). Due to the Inquiry's timeline, this process will have to be completed by Tuesday, 31 March 2015.

Following the stakeholder engagement, public hearings will be conducted. Pre-hearing meetings with stakeholders will be scheduled to work out a timetable for the public hearings. It is anticipated that these pre-hearing meetings may take place at the beginning of April, but the exact date is still to be announced. The Commission has published an invitation for stakeholders to participate in the public hearing and the deadline for registration is 31 March 2015.

Following the public hearings, the Panel will publish its provisional findings. Stakeholders and the public will then have further time to comment on these provisional findings and recommendations. The Panel will then present its final recommendations. The deadline for the completion of the Inquiry is November 2015, however, if the need arises this deadline can be extended.

Bonitas Medical Fund

Bonitas Medical Fund is being probed by the CMS over allegations that include irregularities in the election of Trustees and a steep rise in non healthcare expenditure. Allegations relate to the administrator, the marketing company and certain employees of Bonitas who shared details of members with 3rd parties in order to influence who should be elected. There is also a question around the commercial relationship between some of the trustees and some service providers. Bonitas has appealed and the inspection has been suspended pending on the council's decision on the appeal. The matter remains unresolved.

Budget Speech 2015

Medical scheme tax credits have increased by approximately 5% from R257 to R270 per month for the member and the first dependent and from R172 to R181 per month for every additional dependent in respect of whom the member is paying contributions for.

Some expressed disappointment that so little was said about NHI. There is a sentiment that Minister Nhlanhla Nene could have tabled the white paper on financing the NHI which has long since been promised. If anything, the NHI budget cut announced (through the National Health Grant by R767m over the next 3 years) pointed to the opposite direction.

Draft National Policy on Intellectual Property published by the Department of Trade and Industry (DTI)

The Draft National Policy on Intellectual Property has been circulated for comment and the plan is for the final policy to go to Cabinet for approval "soon".

The patent system forms a key part of intellectual property and gives inventors who are granted patent rights a period to make and sell their products without competitors being allowed to copy them. Once a patent has expired, competitors are then entitled to copy.

In SA, patents are granted by the Patents Office – now the Companies and Intellectual Property Commission (CIPC) – and remain in force for 20 years from the date of an application being lodged. In the health sector, most patent applications are made by foreign pharmaceutical corporations or their South African subsidiaries.

The DTI through its National Policy on Intellectual Property aims to reduce drug prices by shortening the patency period and allowing for more competition through generics.

The tactic by which drug companies extend the patents on medicines likely to become available as cheaper generics, is called "evergreening" and in SA, these tactics often succeed. However DTI proposed that this be replaced with a substantial examination system to determine whether a "new" drug really is new. Those applying for patents in South Africa towards the end of 2015 will no longer have applications rubber stamped as in the past. Rather, all applications are to be subjected to extensive research and examination – making it more difficult to obtain patent rights.

Discovery

Discovery takes Vitality to the US: An unnamed US Insurer, will launch a suite of products similar to those of Discovery Life in SA. This is in line with Discovery's strategy to look for established partners in a country to enter the country. This proved very successful in entering China through the Discovery – Ping An joint venture.

Discovery increases participation in credit card: Discovery plans to raise R5bn in the form of a rights issue - R3 bn will be used to expand its UK insurance business and 40% of the funds will be used to buy an extra 55% (from 20% to 75%) of Discovery Card for R1.35 bn. The intention is to build a much bigger financial services business with the card potentially being expanded into other financial services products. According to Adrian Gore, the balance of a further R800m will go into "building up financial services opportunities".

Regulation 8: Payment of PMB in full

The DOH is currently reviewing Regulation 8, which requires all PMB related benefits to be paid in full by medical schemes, regardless of what the provider chooses to charge. BHF is also actively engaging the DOH and has expressed concern that providers can charge whatever they choose for PMB related conditions and schemes are obliged to pay in full. BHF argues that a scenario that gives providers a blank cheque is untenable and unsustainable. It is estimated that PMB's can cost the medical scheme up to R800 per member per month.

Samwumed and Genesis Medical Scheme have taken the Minister of Health, Aaron Motsoaledi, to court to have the regulation struck down but Samwumed has decided to withdraw from the High Court application in order to allow the Minister an opportunity to amend Regulation 8. A Task Team has been established by the DOH – of which Samwumed is a participant.

There is an open invitation for you to please contact your NMG Healthcare consultant or myself on tkouskos@nmg.co.za, should you wish to raise any matter relating to the contents of this document, the NMG Benefits service offering or pertaining to the healthcare industry in general.