COUNCIL FOR MEDICAL SCHEMES

Health Portfolio Committee

15 September 2010

Structure of the presentation

- Introduction – CMS functions
- Review of the Medical schemes industry
- CMS Budget and Finances
- Strategic priorities
  - REF
  - Pricing
  - Other important matters
- Conclusions

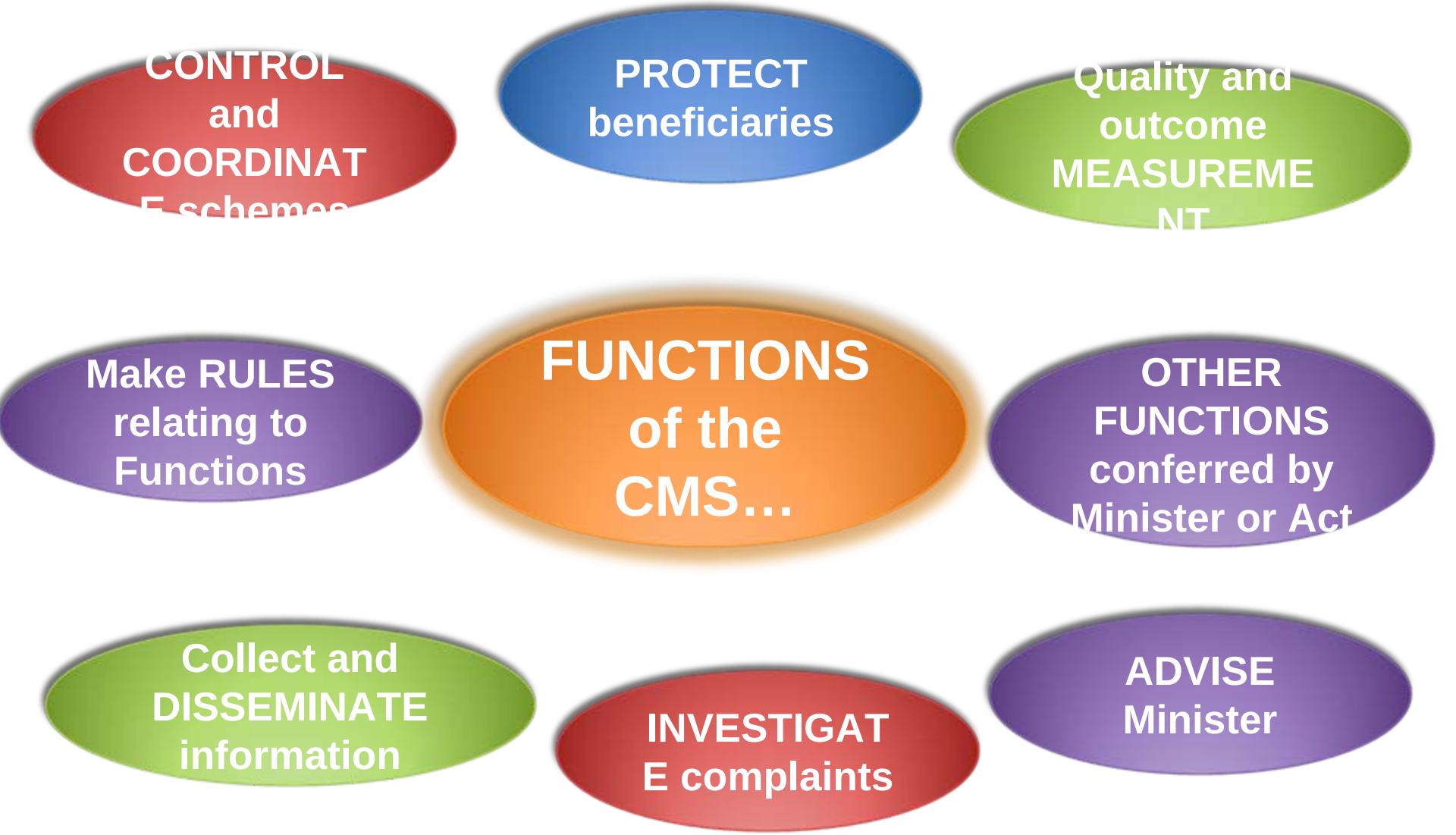
INTRODUCTION – CMS FUNCTIONS

The Council for Medical Schemes…

- Regulates medical schemes with the purpose of
  - Protecting Beneficiaries
  - Maximising access to coverage
  - Protecting the public interest

Without adequate regulation only private interests would prevail, reducing access and accountability

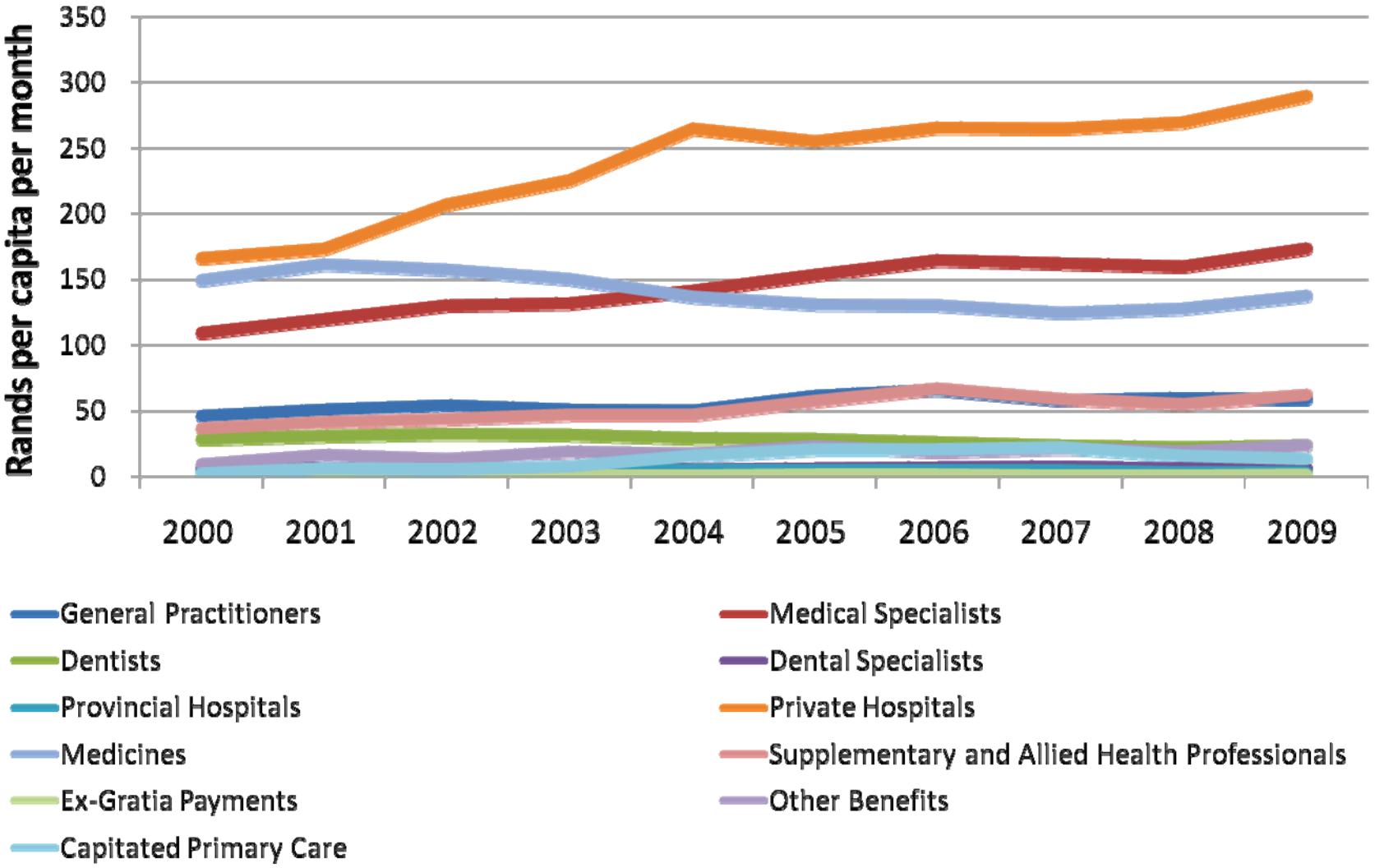
Section 7 outlines the …



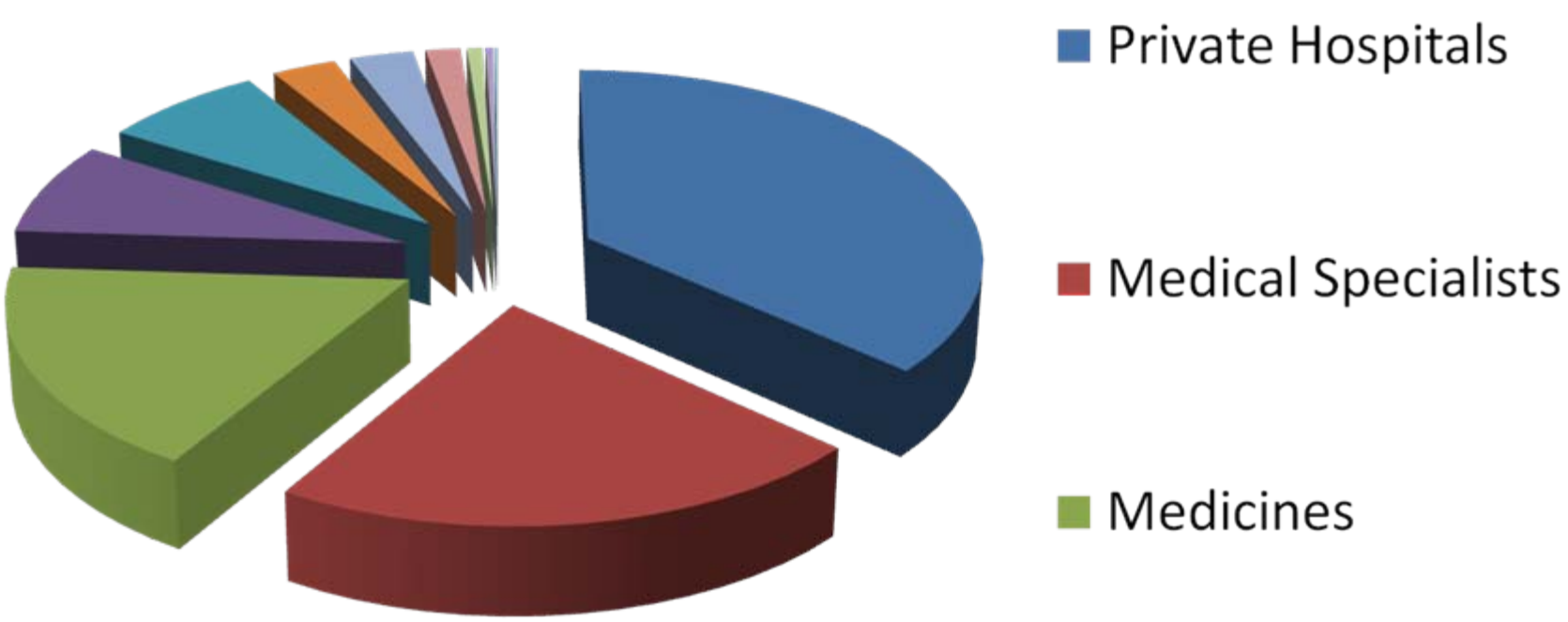
COUNCIL FOR MEDICAL SCHEMES

REVIEW OF THE MEDICAL SCHEMES INDUSTRY

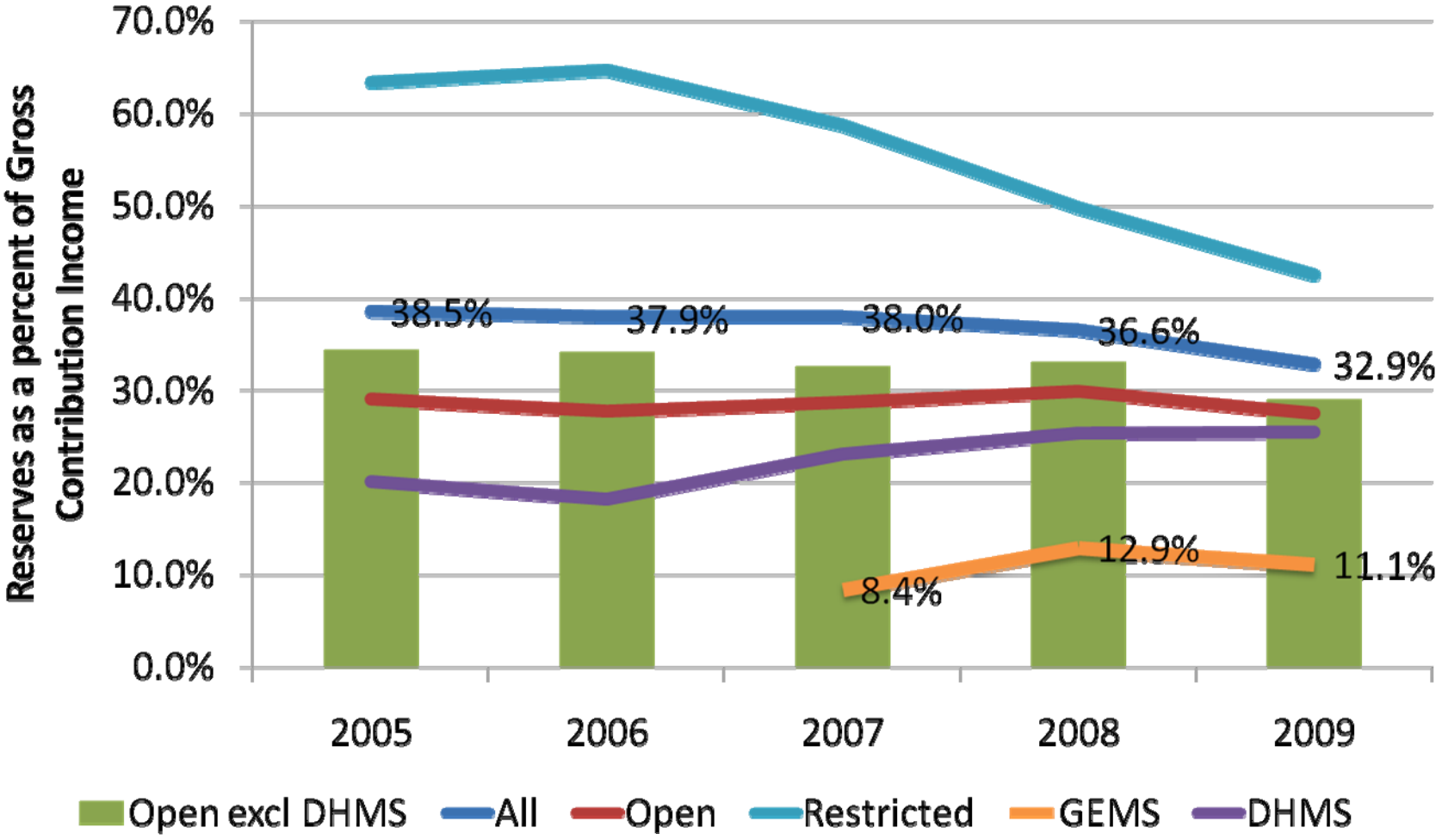
Claims costs increased significantly for the first time in a number of years…



…with hospitals, specialists and medicines costing the most….

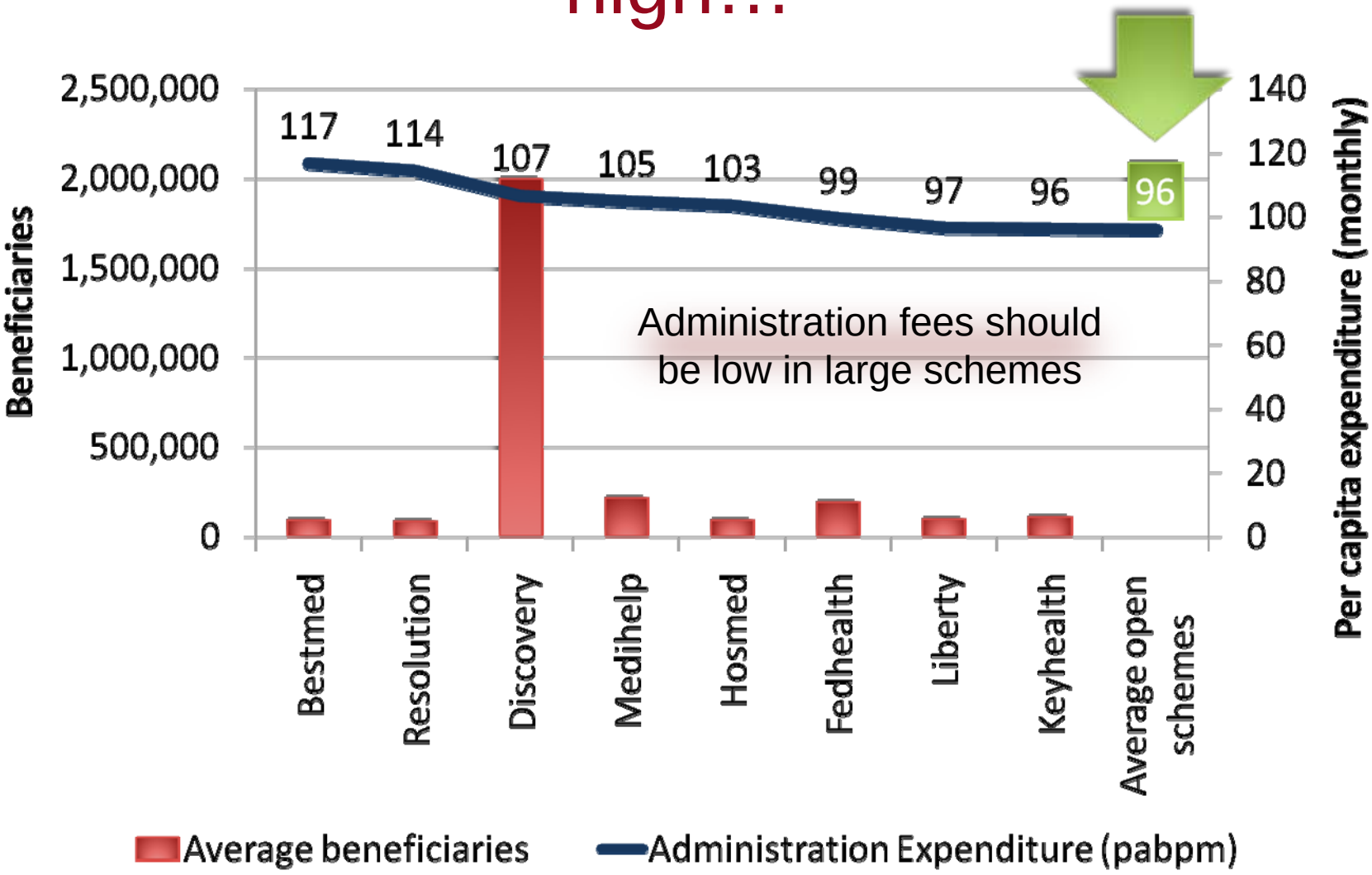


Solvency trends have been affected by GEMS…

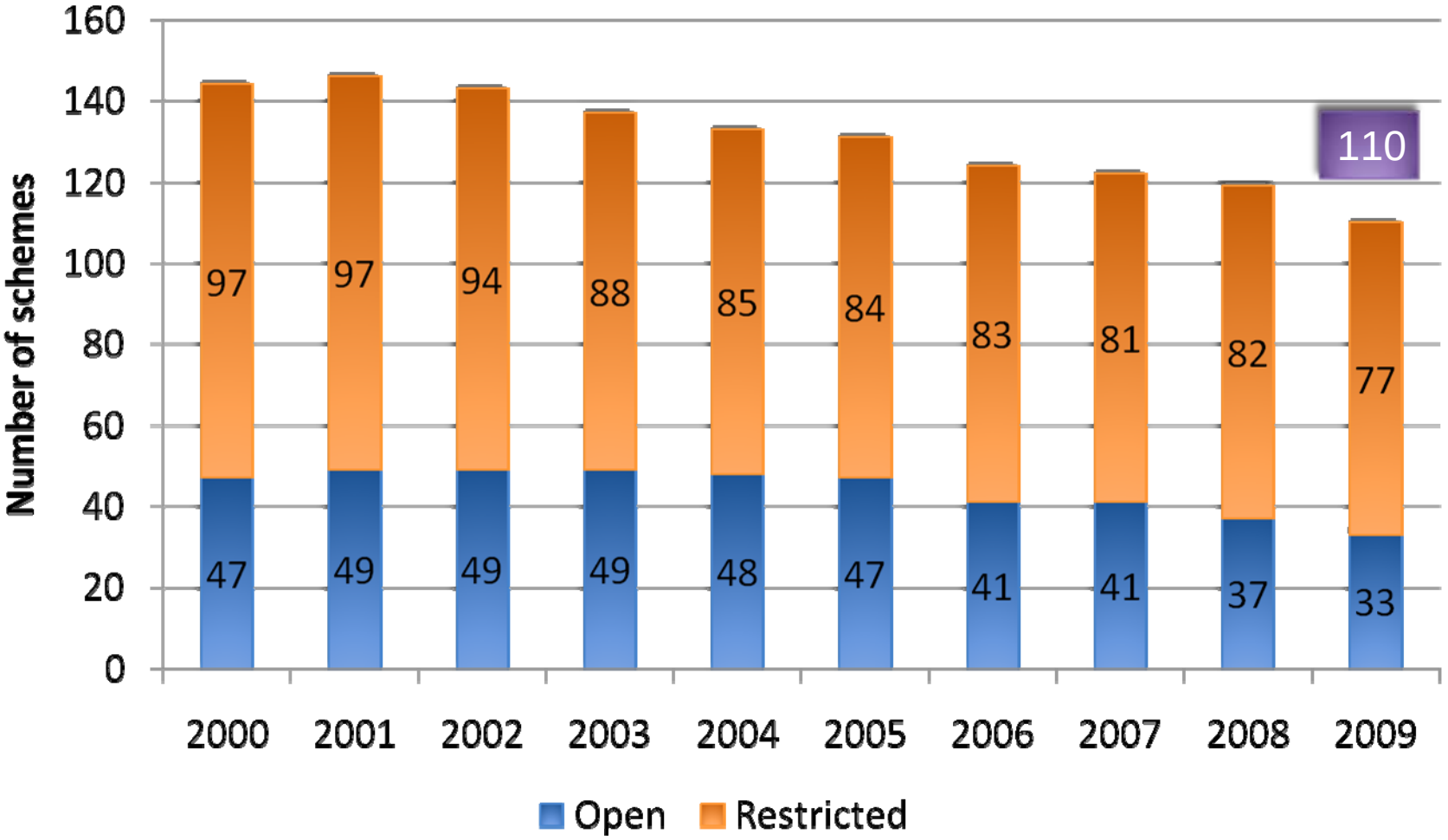


But system remains solvent and health

Some administration fees are very high…

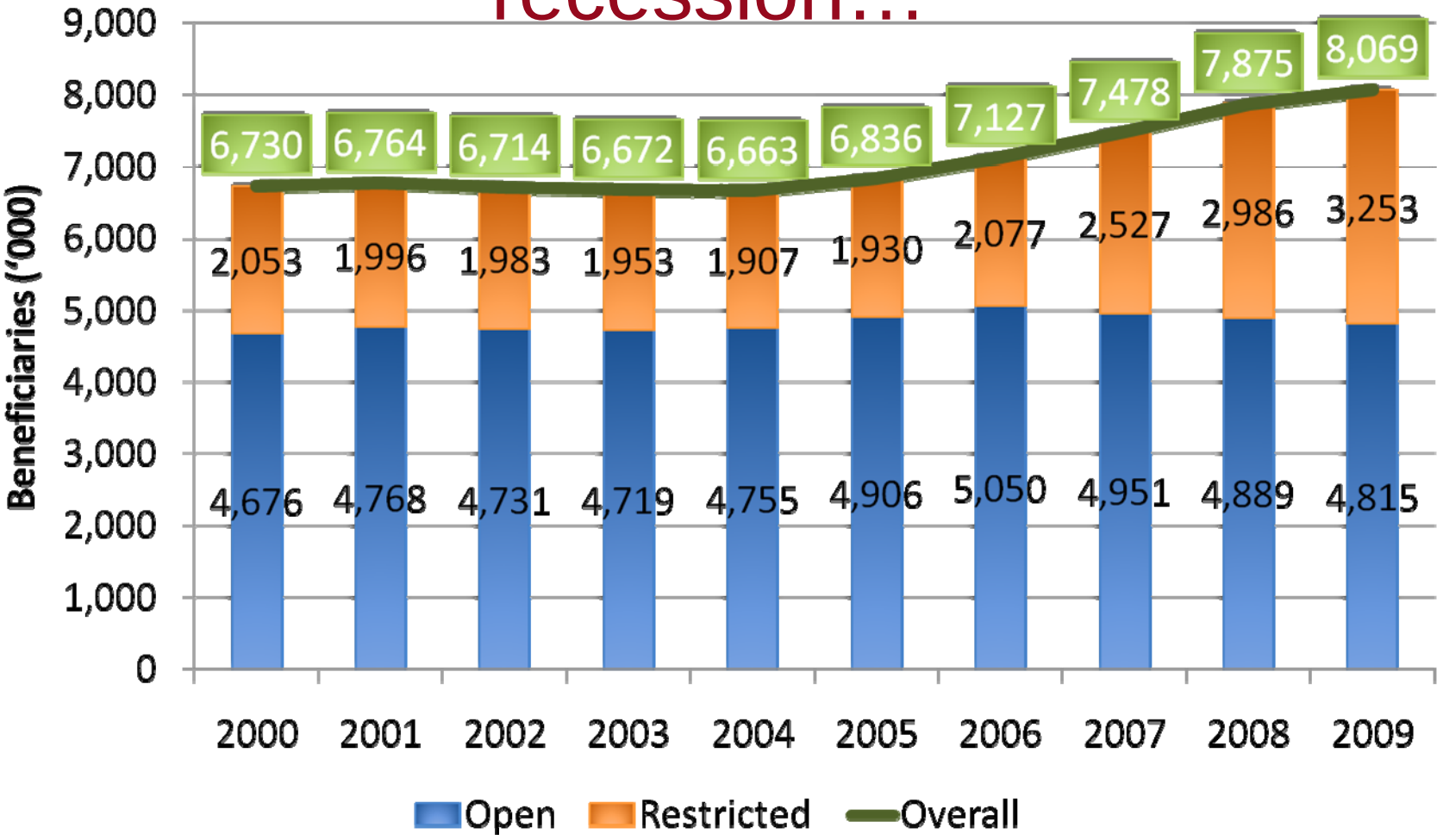


Schemes are continuing to consolidate…



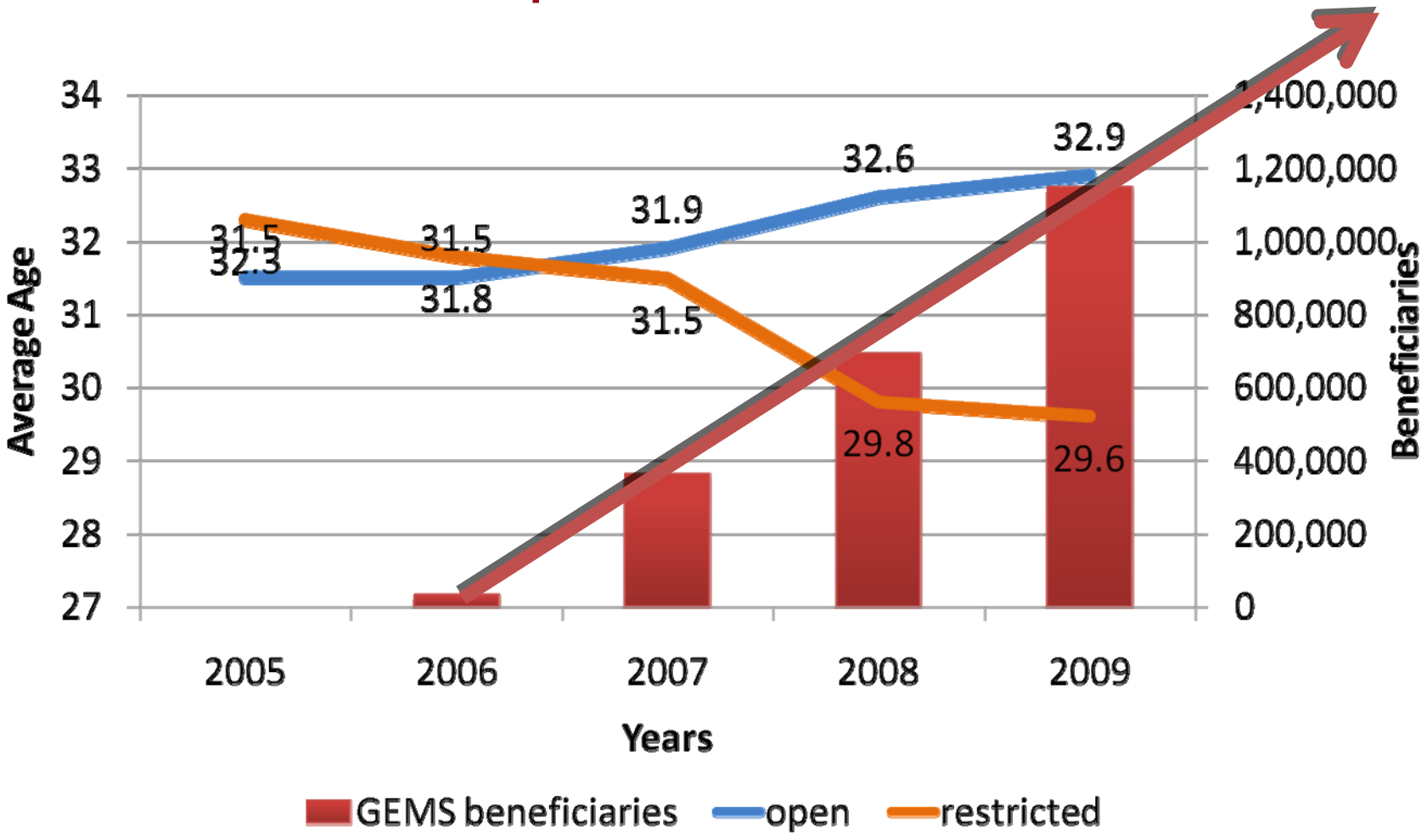
This is not a problem, but if taken too far will reduce competition…

Beneficiary numbers continued to grow in 2008 and 2009 despite the recession…



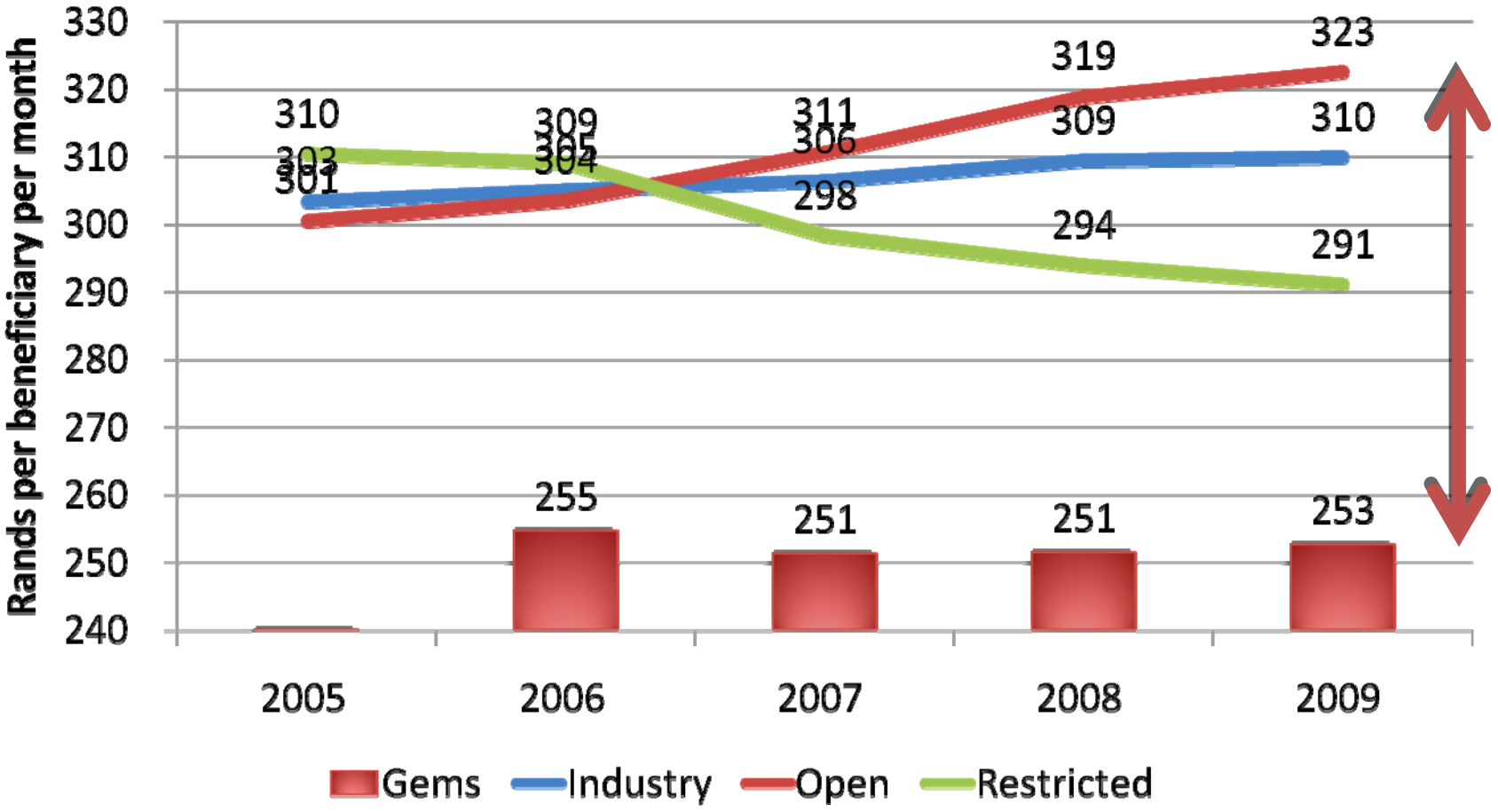
demonstrating how slight structural adjustments (GEMS) to the system can grow participation…

However, the effects of GEMS are not all positive…



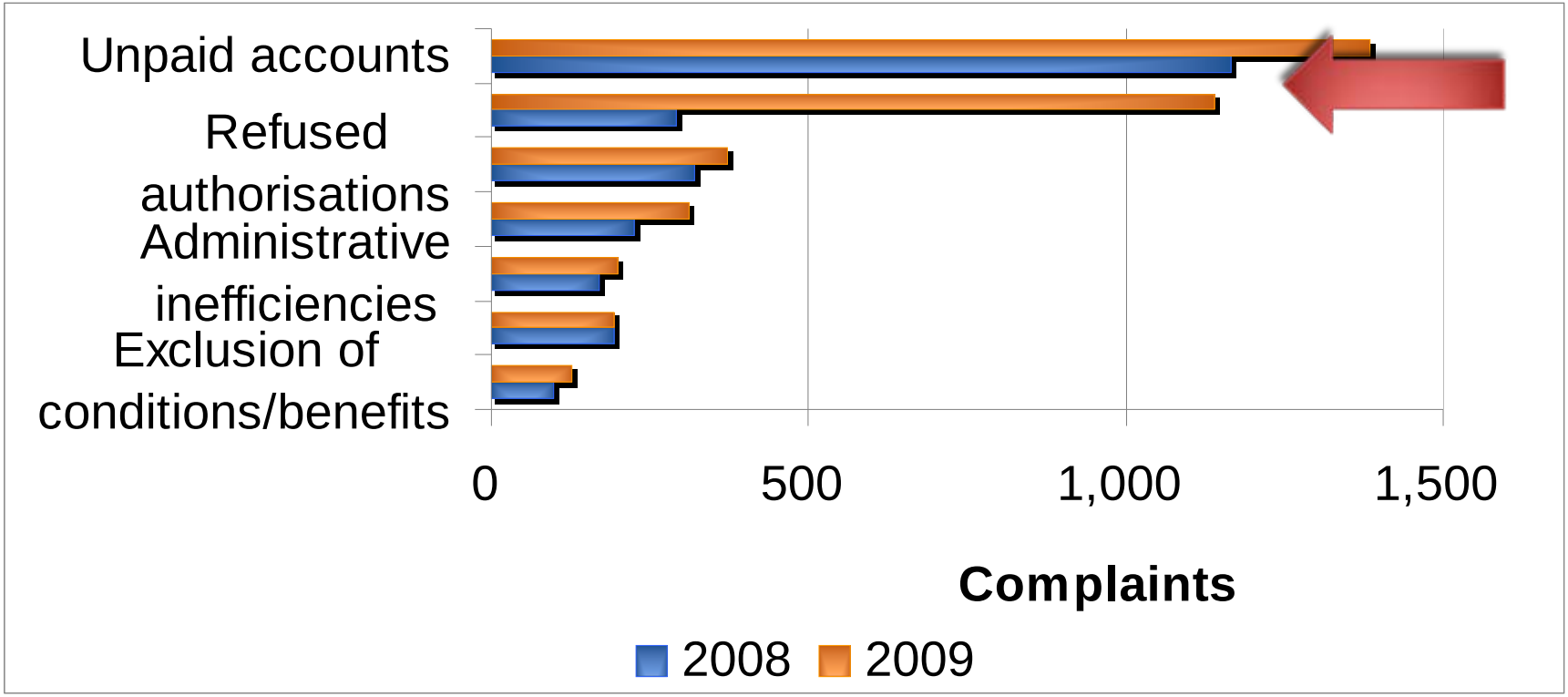
GEMS is expected to grow ultimately to around 3 million beneficiaries...

GEMS is impacting on the cost of open schemes...



A risk equalisation fund would have mitigated this impact…

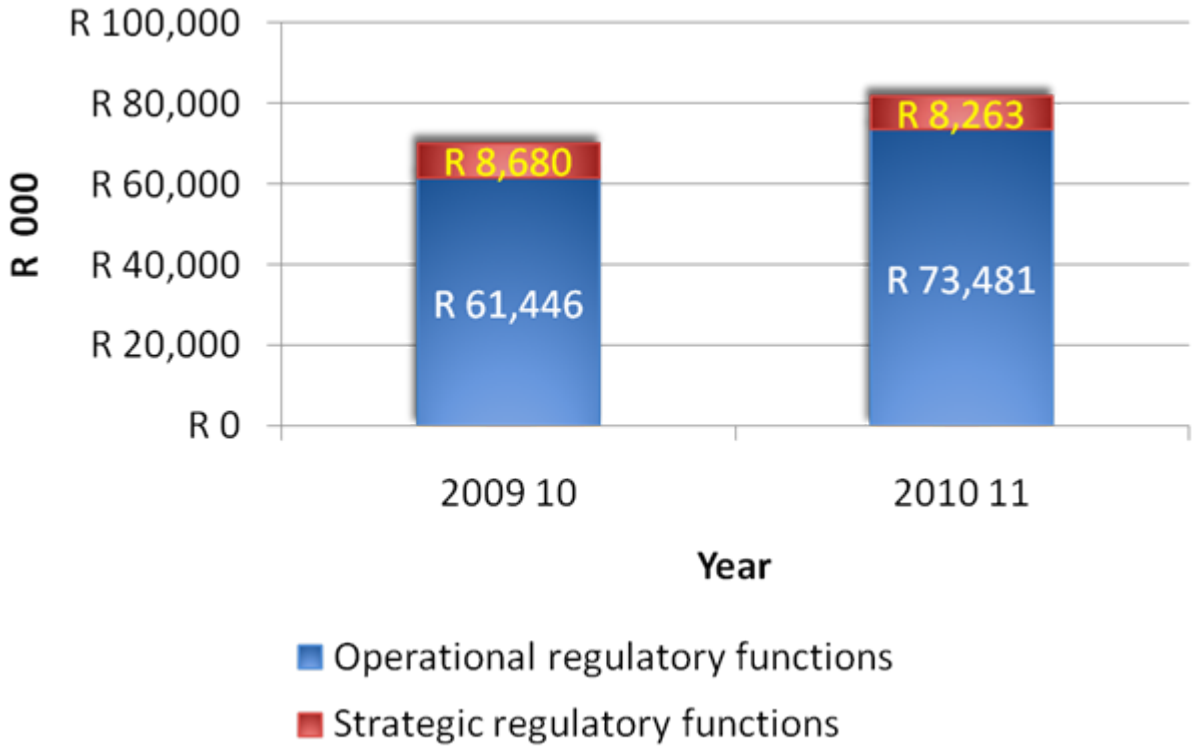
Complaints for non-payment of Prescribed Minimum Benefits increased dramatically in 2009…



Unpaid accounts continues to generate the most complaints…

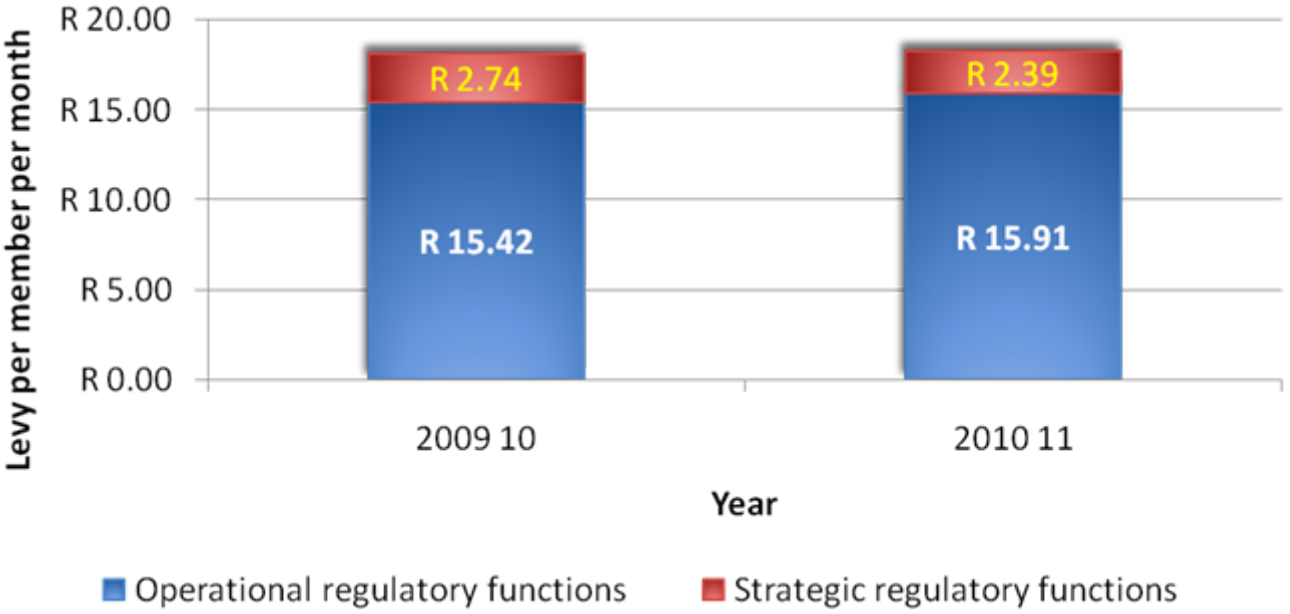
BUDGET AND FINANCES

A nominal budget increase from R70.1 M to R81.7 M (17%)...



...and the decision to fund strategic functions from levies rather than general taxes...

...resulted in a 18.6% levy increase from R15.42 (plus R2.74 for REF + Strat) to R18.49 per member per year...



...impact on members kept smaller because of an R11.5M cash surplus and an increase in the number of members...

... performing specific tasks conferred on the CMS by the Minister in the interest of medical scheme beneficiaries...

	2009 10	***2010 11***
Operational regulatory functions	*R 61,446*	*R 73,481*
*Strategic regulatory functions**	*R 8,680*	*R 8,263*
REF and Strategic projects		R 5,059
BI Mining tool		R 1,704
SEP System		R 1,500

* Strategic regulatory functions previously funded by transfer from the Department of Health, since 20010 11 this is funded through levies

High cost budget items

- Salaries
- Rent
- Legal fees
- Trustee training

... total salary bill increased by 11%up to R51.8M due to new positions and market demands...

- 8 new positions created
  - Increase in complaints
  - Maturing of accreditation function
  - Additional requirement on strategic projects
  - More capacity in research and monitoring
- 8% general increase
  - Inflation was much higher in February when budget was considered
  - Compete with the industry for specialised skills

… to accommodate extra staff an additional part of the building was rented..

- The rent increased by 29% from R3.4M to R4.4M

..budget for legal fees increased by 17% from R3.2 M to R3.7M

- To ensure compliance with the Act expert legal advice and litigation is required to protect members

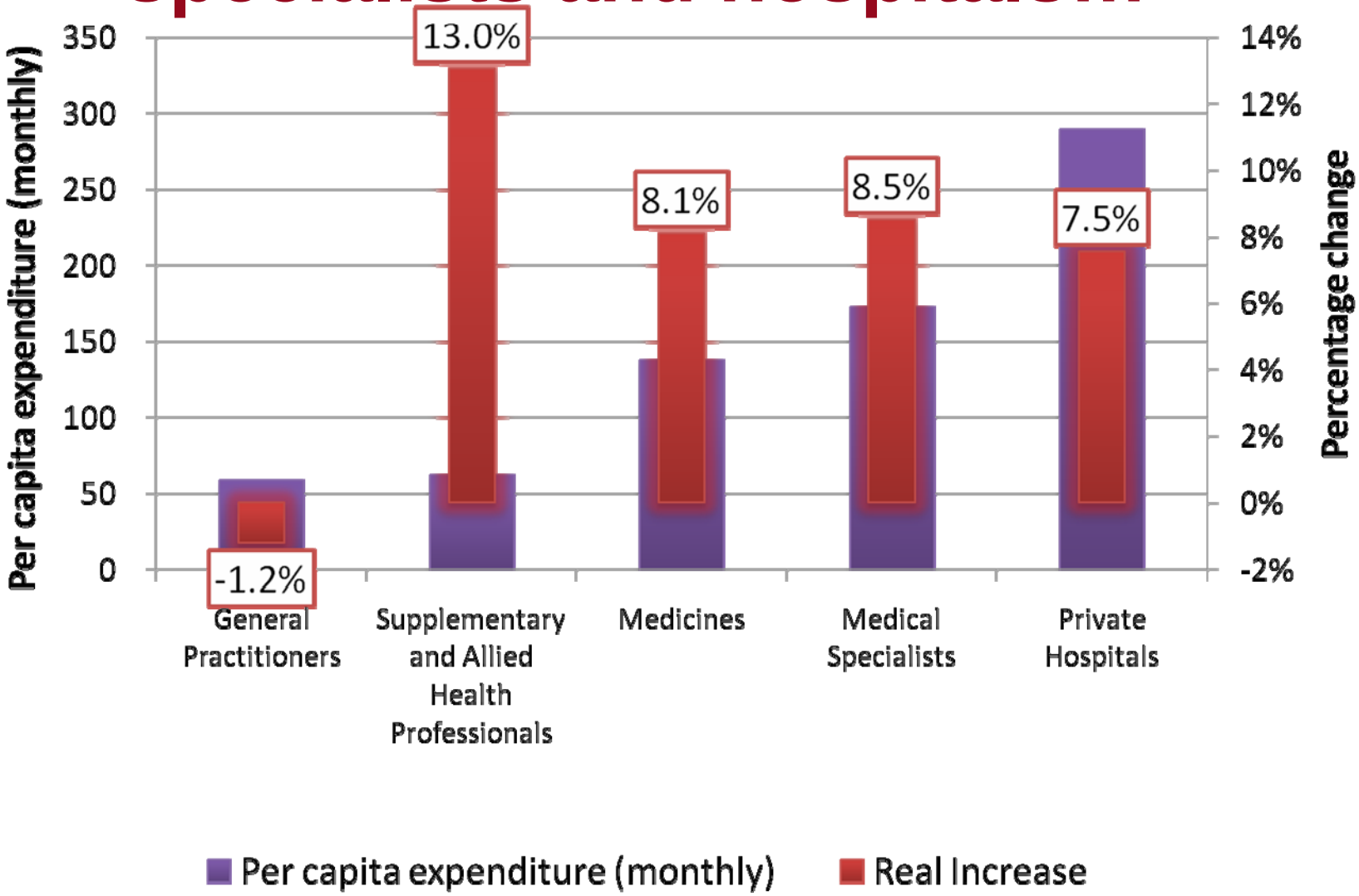
...trustees have a fiduciary duty to manage the R80 Billion industry in the interest of members

- Trustee training budget increased by 32% from R550,00 to R728,000

STRATEGIC PRIORITIES

STRATEGIC PRIORITIES: PRICING HEALTH PROFESSIONALS

Very high real increases were experienced in medicines, specialists and hospitals…

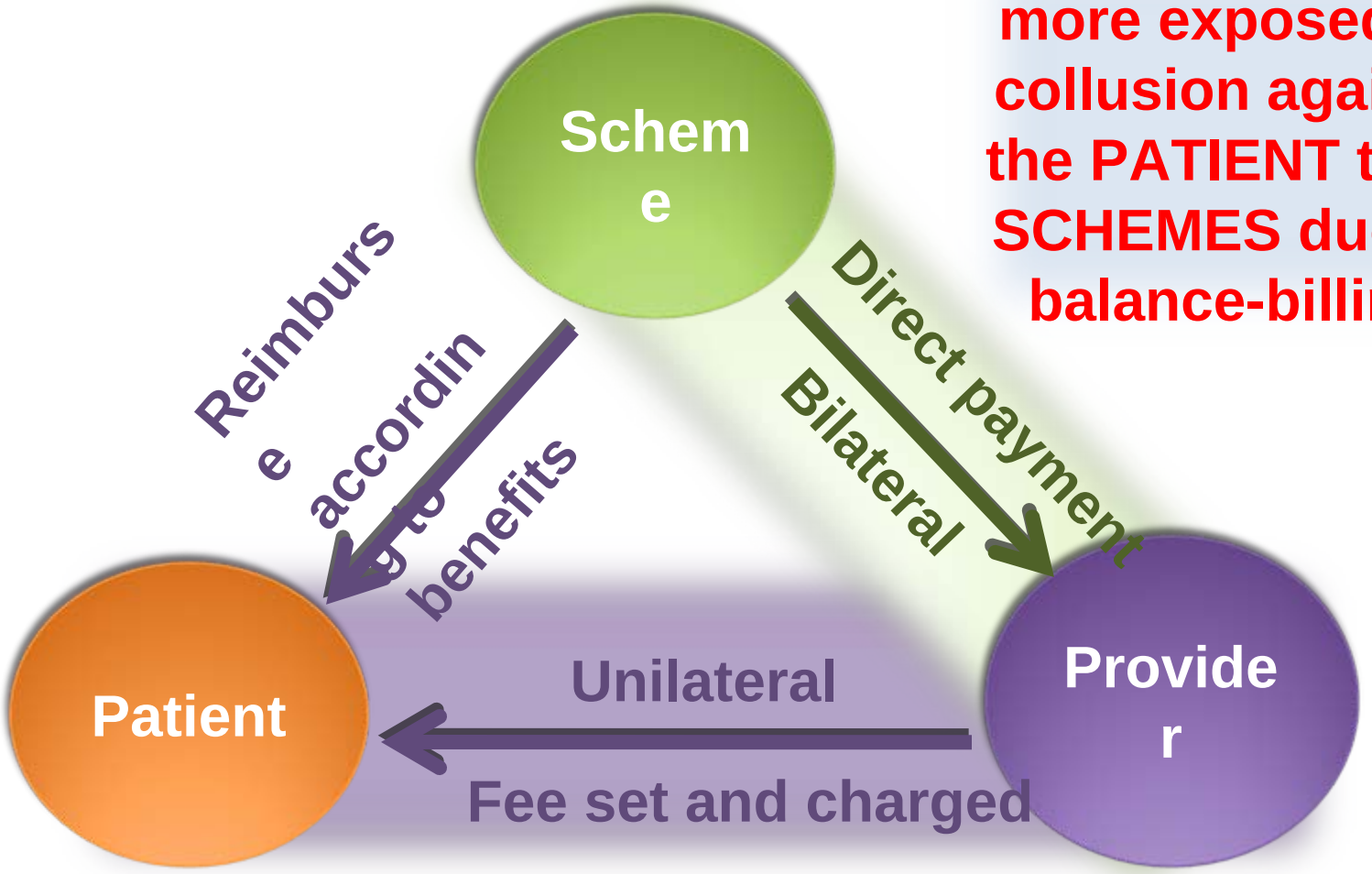


Two types of contract…

- **Bilateral** – direct contracting between parties
- **Unilateral** – provider sets fee for patient and scheme decides independently how much it will reimburse

How does it work?

Private system is more exposed to collusion against the PATIENT than SCHEMES due to balance-billing

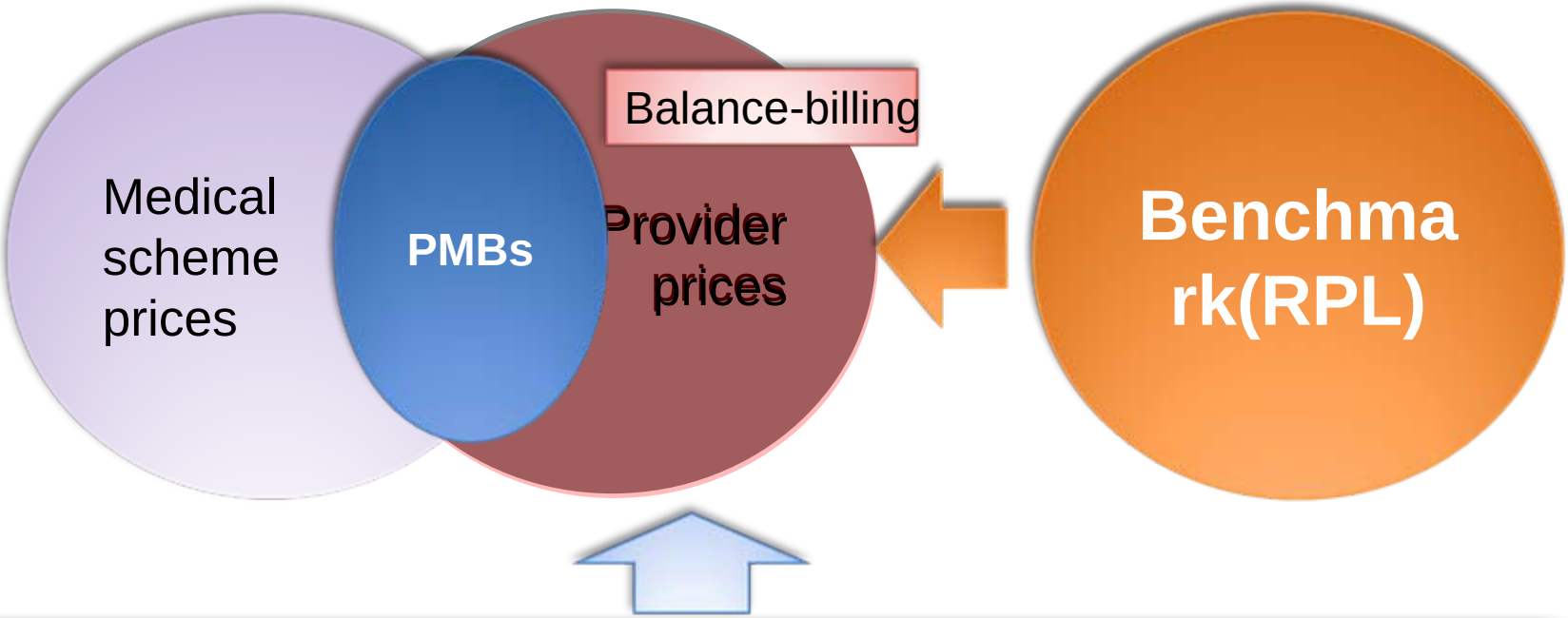


Problem statement

- By allowing providers to sit together to set part of the price, they are actually sitting together to determine the full price
- The RPL process permitted this collusion without consideration of the budget constraint of
  - Medical schemes
  - Private households

- **Even without a final published RPL, the damage has been done**

Elements of a price-setting process…



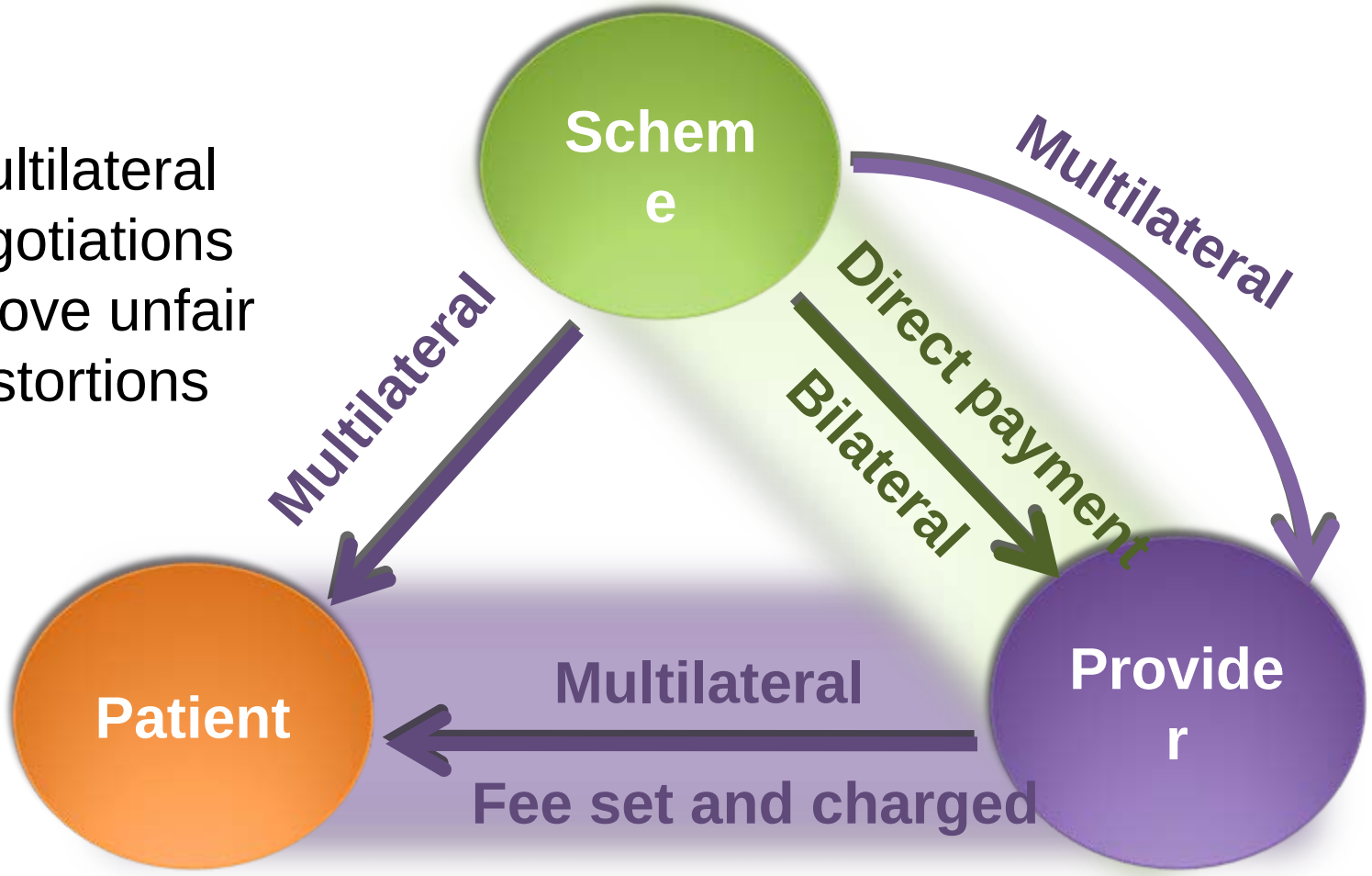
General changes

Code structure

Billing rules

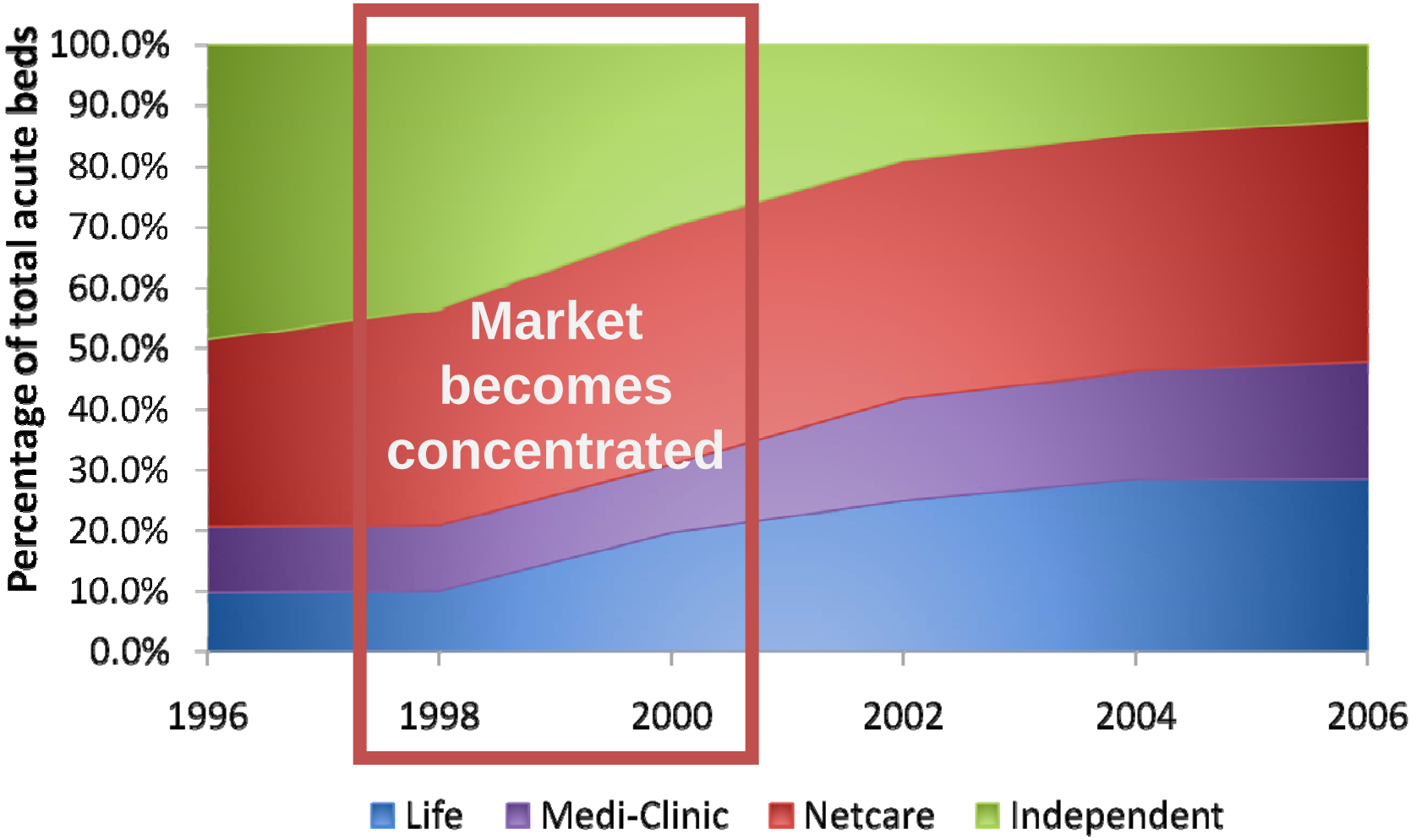
How should it work?

Multilateral negotiations remove unfair distortions



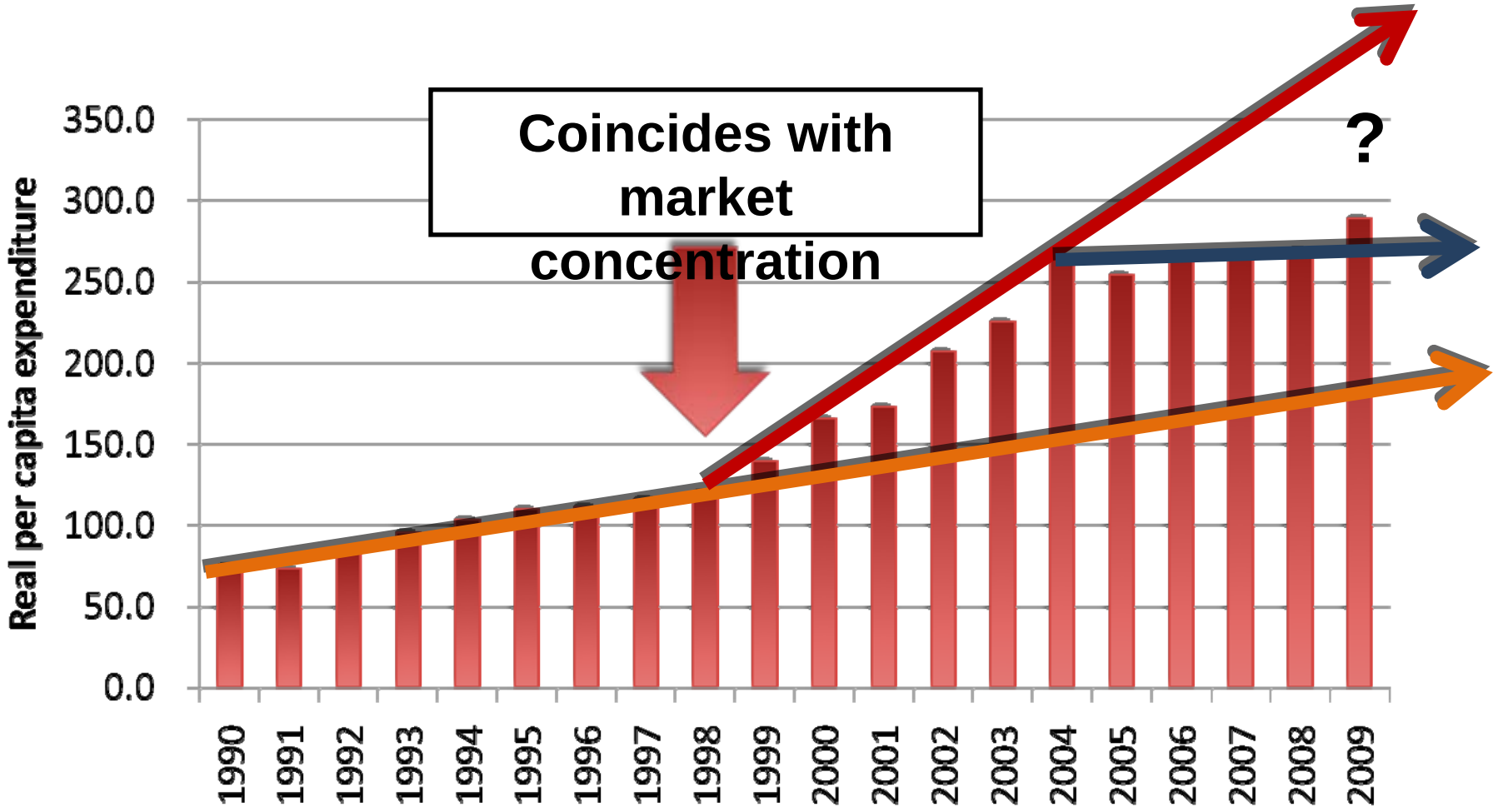
STRATEGIC PRIORITIES: PRICING HOSPITALS

The private hospital market in metropolitan areas (50%+ of medical scheme population) was concentrated by 1999..

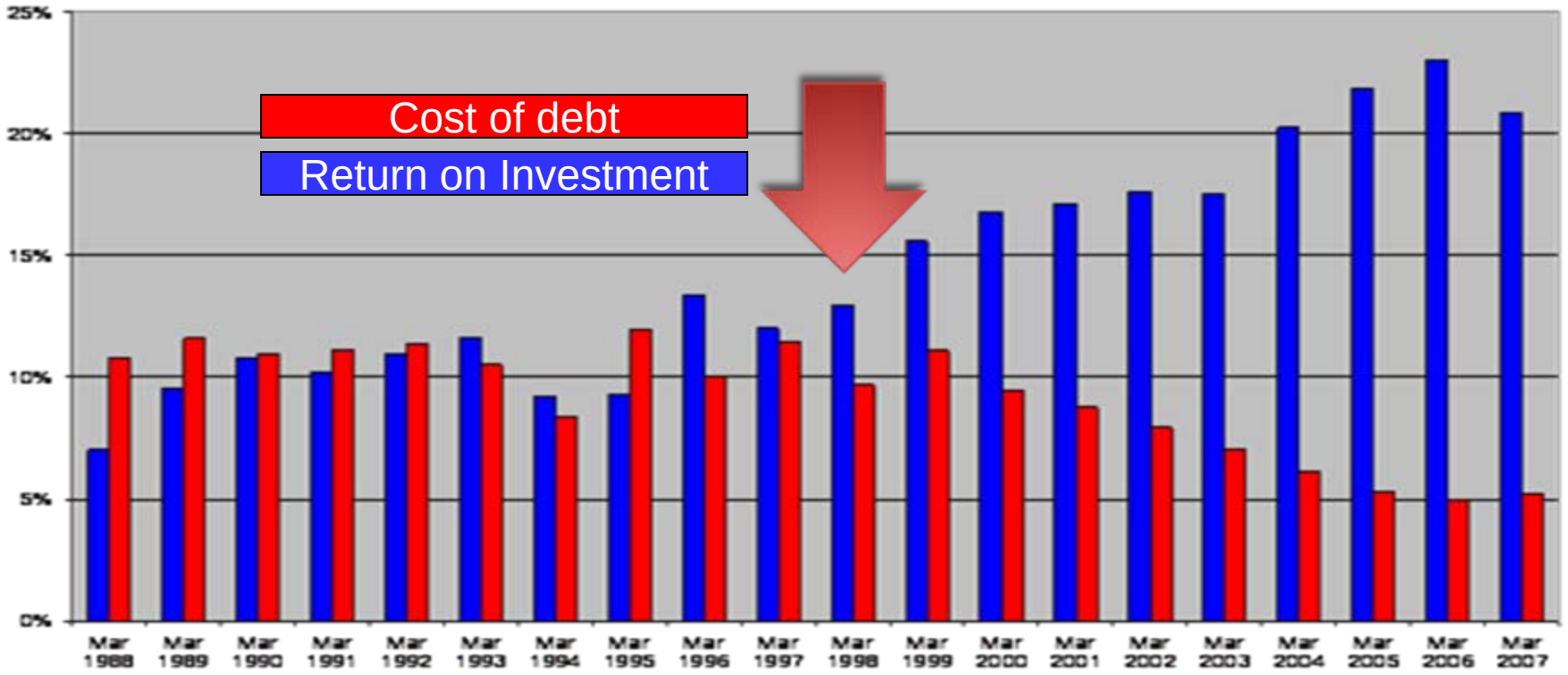


Only 12.3% of private hospital beds were outside three main hospital groups by 2006…

Private hospital real cost trends (2009 prices)



Private Hospital Return on Investment 1988 to 2007



Observations:

- The return on investment has grown from 10% to north of 20%. (Note: The acceleration in returns corresponds to the concentration of the market.)
- The cost of debt has dropped significantly since 1999.
- With the return on investment rising and the cost of debt falling the gap between blue and red has widened significantly. This gap represents the economic value which shareholders have enjoyed in increasing amounts over the last few years.

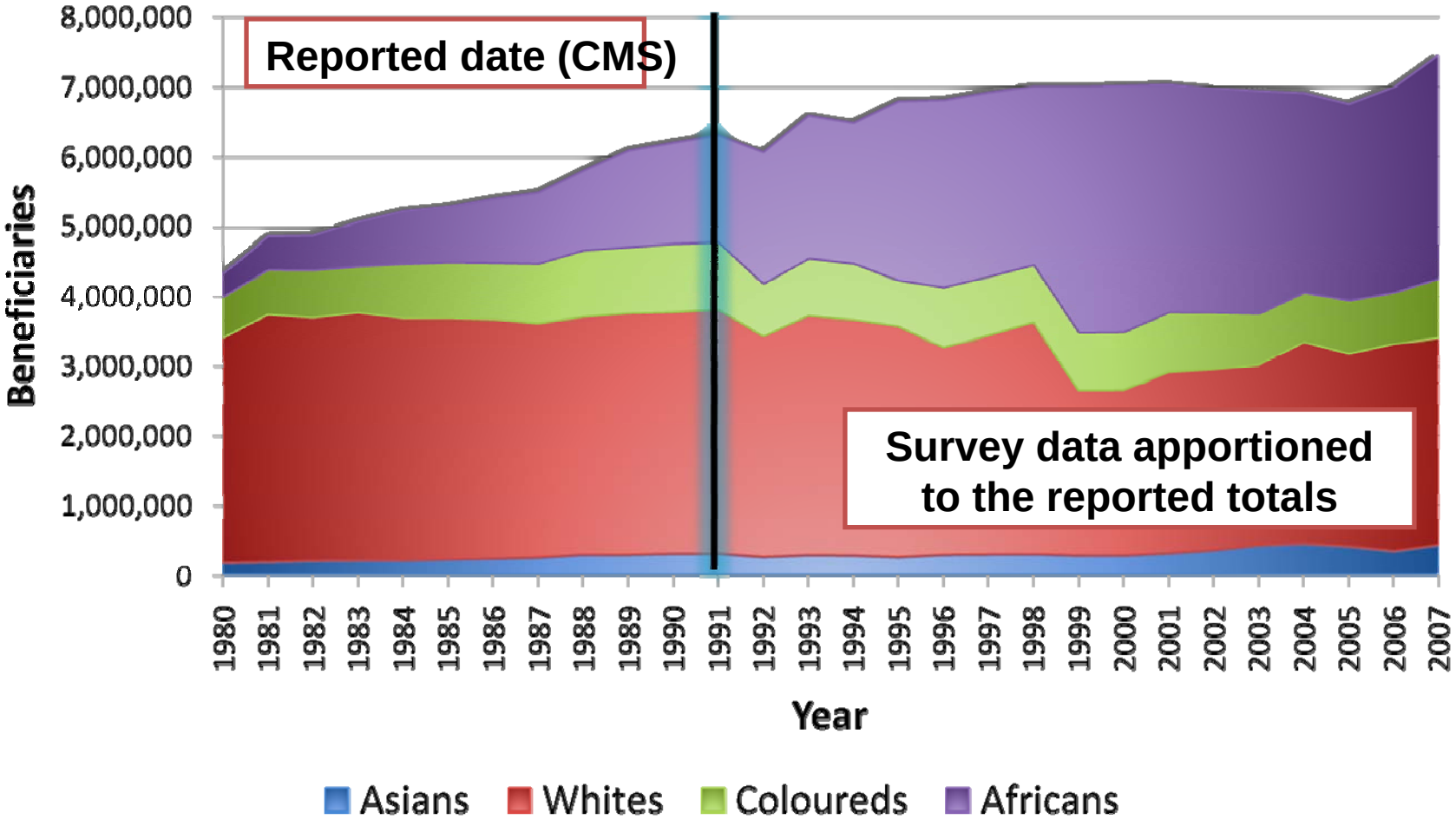
CONCLUSION ON PRICING

What is required?

- Fair process to determine prices set outside of bilateral contracts, that can take into account scheme and household affordability constraints
- Fair processes to set prices where significant market imbalances exist
- Need to protect the system of Prescribed Minimum Benefits
- Hospitals – clear market imbalance which must be addressed

STRATEGIC PRIORITIES: RISK EQUALISATION FUND

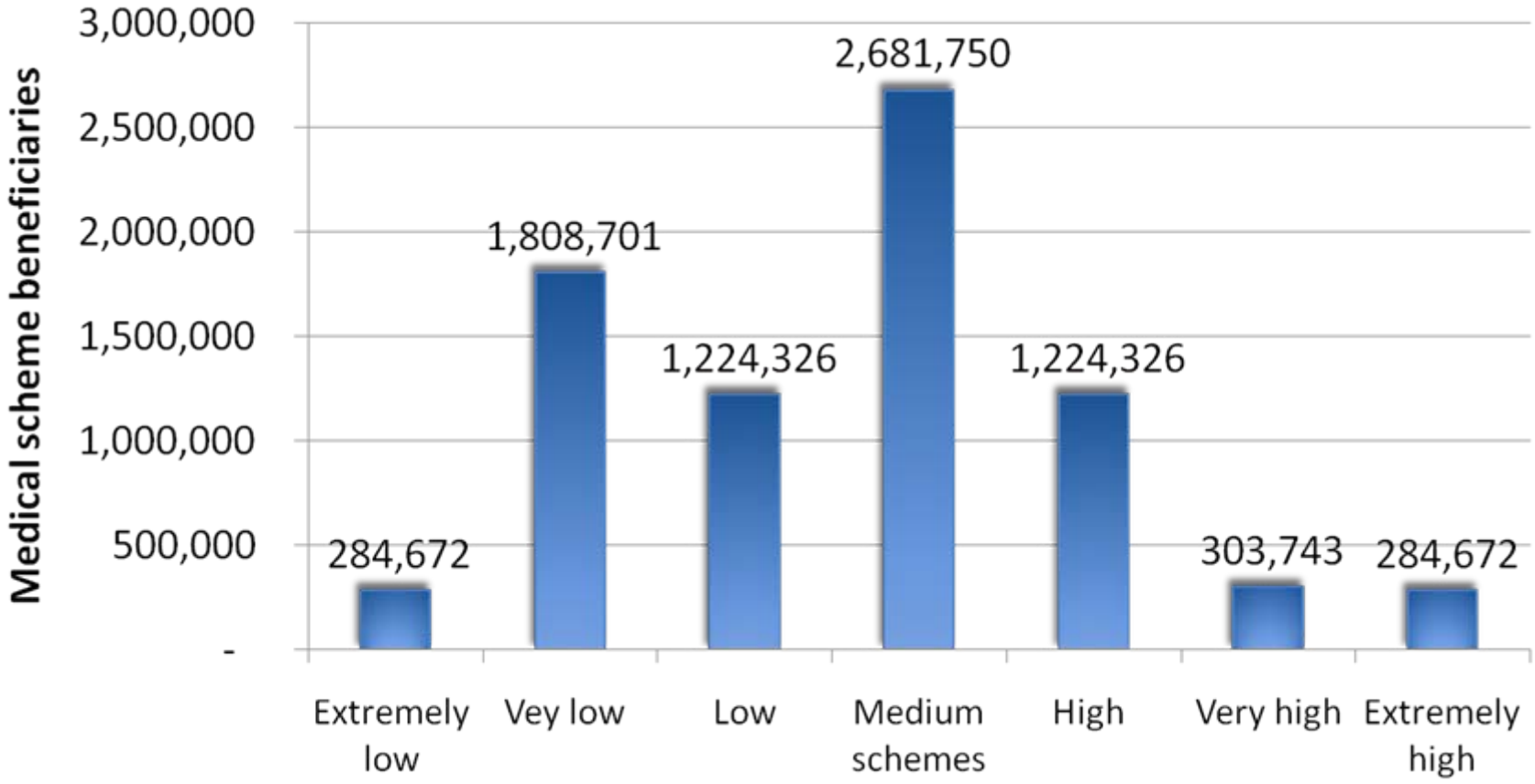
Racial breakdown of medical schemes



Sources: Council for Medical Schemes Annual Reports to 1999 and OHS, GHS and LFS

...the absence of risk equalisation unfairly discriminates against older and sicker members of medical schemes and jeopardises medical scheme cover for almost 600,000 vulnerable beneficiaries...

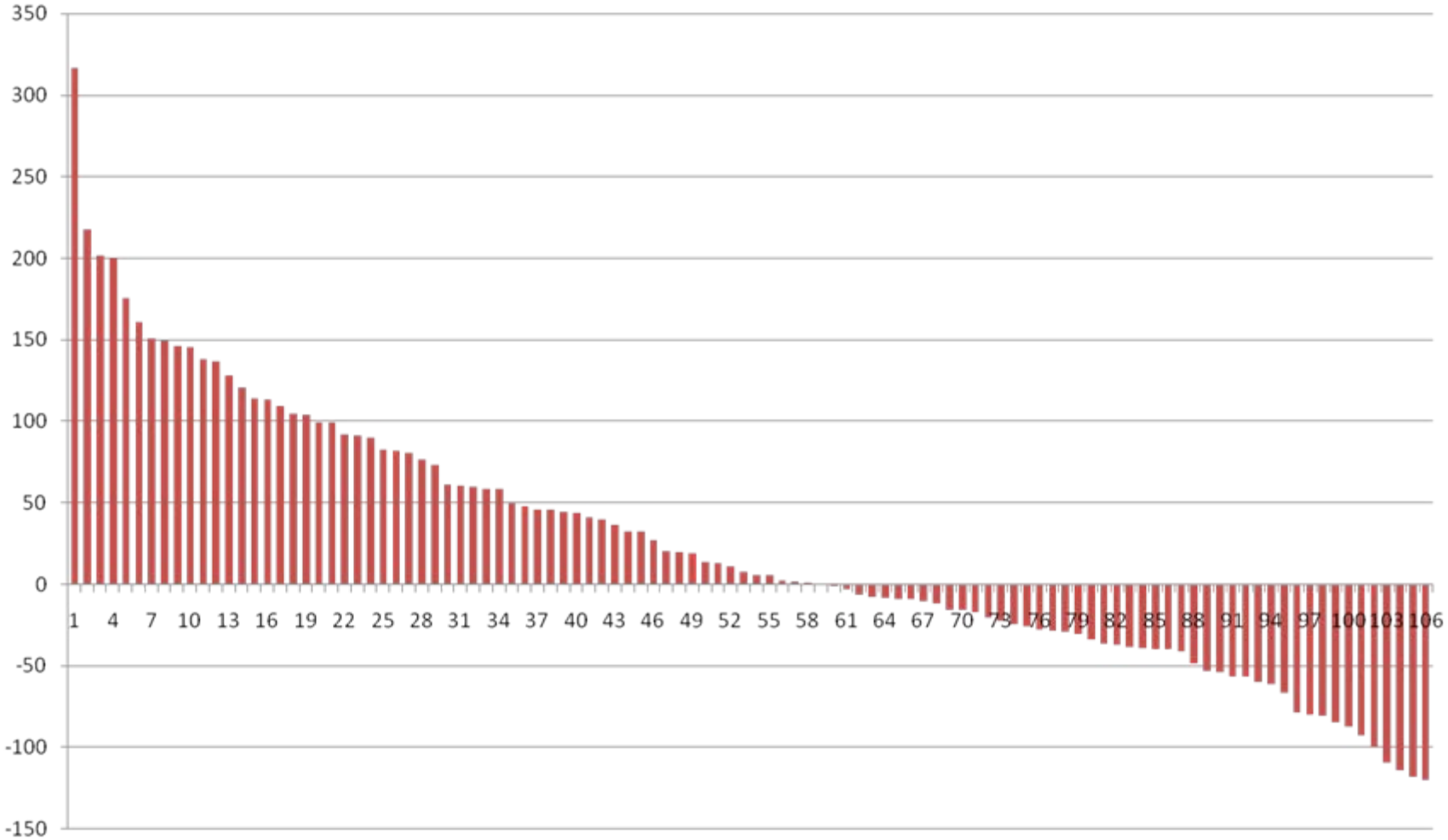
…there are many low risk beneficiaries in the system to cross subsidise the high risk beneficiaries



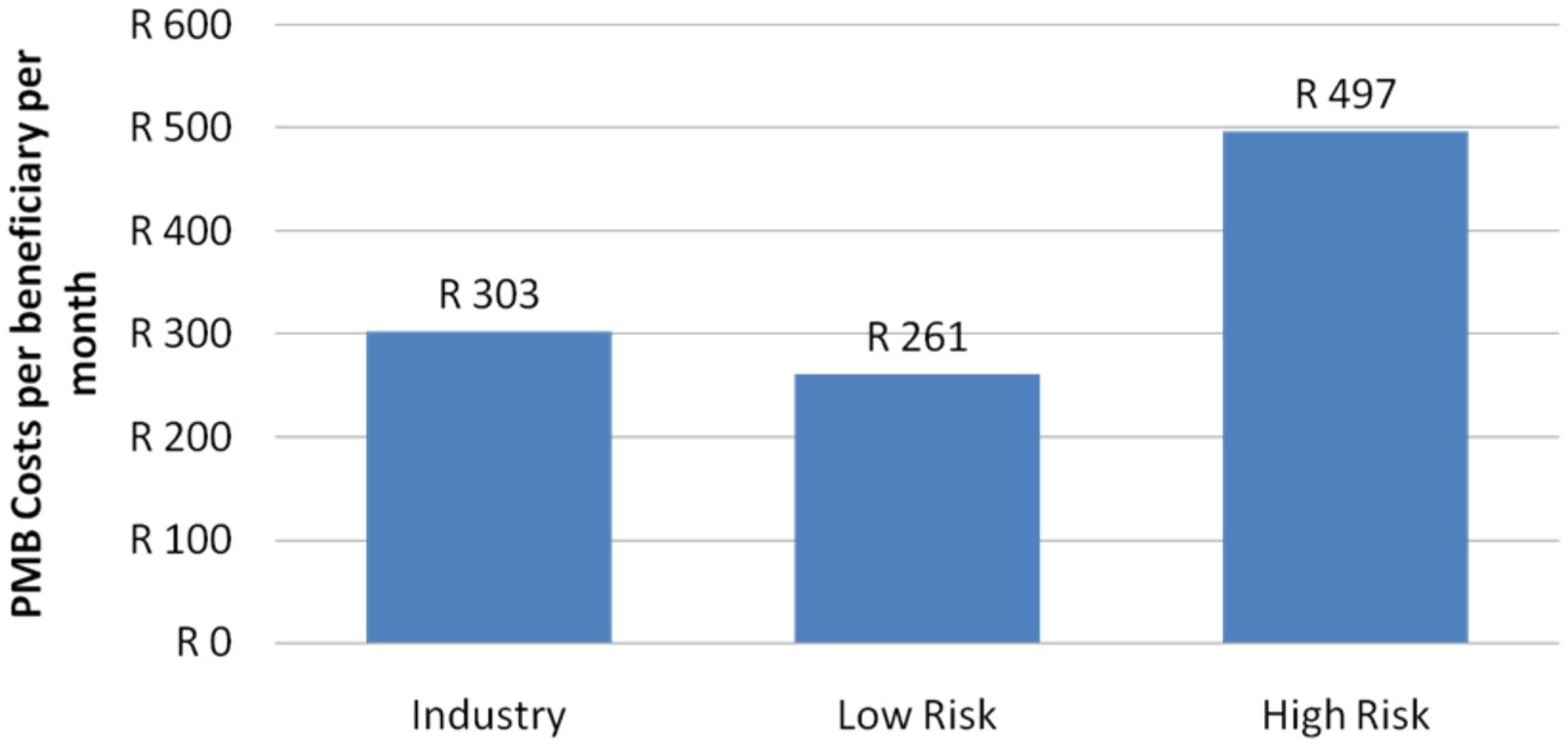
… why a system of risk equalisation is required…

- Age and health status correlates
- Costs largely driven by these factors
- Age structures differ between schemes – either by design or historic
- A risk equalisation system lets everyone pay in accordance with the risk faced by the entire industry
  - everyone pays the same amount

…large differences between the costs of medical schemes…



…the absence of risk equalisation results in an unfair variation of PMB costs faced by members…



…many countries have tried and tested risk equalisation mechanisms…

Australia	New Zealand	Sweden
Belgium	Russian Federation	Chile
Columbia	Switzerland	France
Czech Republic	United Kingdom	Japan
Germany	United States of America	Italy
Ireland	Canada	Denmark
Israel	Finland	Spain
Netherlands	Norway	Taiwan

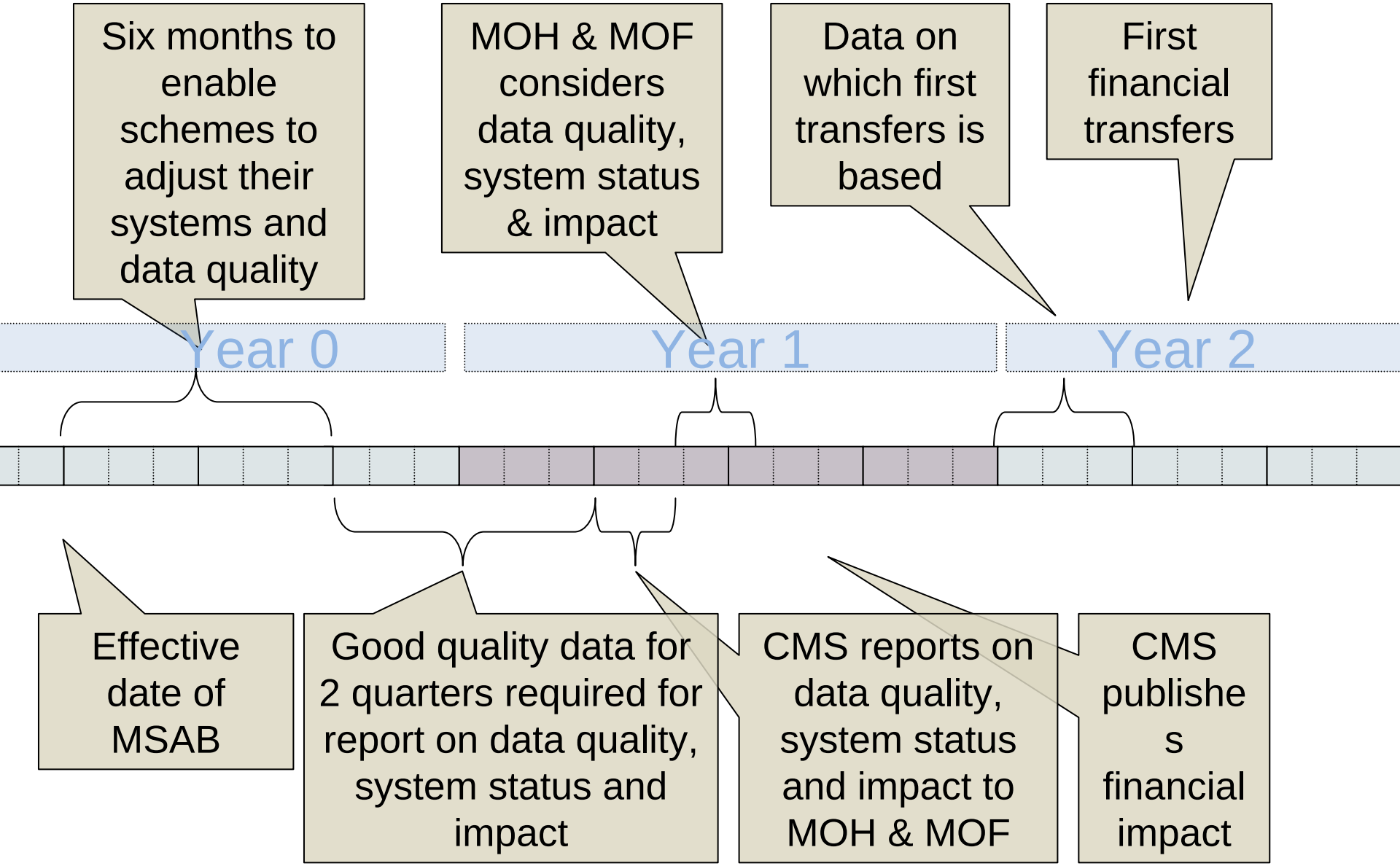
Source:

- Rice, N. and Smith, P.C., (2001) Capitation and Risk Adjustment in Health Care Financing: An International Progress Report, The Milbank Quarterly, Vol. 79, No. 1, 2001. Oxford: Blackwell Publishers. Available on http://www.medicalschemes.com
- Van de Ven, W.P.M.M. and Ellis R.P. (1999). Risk Adjustment in Competitive Health Plan Markets. Prepared for Chapter 17 in Handbook of Health Economics, eds. Culyer, A.J. and Newhouse, J.P. Amsterdam: Elsevier. Published 2000. Available on http://www.medicalschemes.com

... work has continued on a system of risk equalisation over the past seven years...

- DoH and CMS consultative process started in 2003
- An international review panel recommended implementation in 2005
- The Minister instructed the CMS to prepare for a system of risk equalisation
- Cabinet instructed the DoH to prepare legislation in 2005
- Amendment Bill not considered by Parliament in 2007

REF can be implemented quickly and at low cost…



CONCLUSION ON REF

Continued delay in the implementation of the REF harms the industry

- Risk rating continues
- Vulnerable, older and sicker members are at risk of not being able to afford continued membership

This continues while

- Similar problems have been addressed internationally through risk equalisation systems
- In South Africa a shadow system has been in place for 5 years
- REF is a low cost intervention that addresses a major systemic concern

OTHER STRATEGICALLY IMPORTANT MATTERS

... the CMS met with the Minister and is working with the DoH to address important areas of concern...

- Medical scheme governance and compliance
- Demarcation between medical schemes and health insurance products
- Regulation of brokers to address perverse relationships and conflicts of interest
- Recommendations to amend the PMB regulations were submitted in March 2010

CONCLUSION OF PRESENTATION

...the medical schemes industry is structurally sound, but to ensure the continued protection of the public, urgent interventions are required...

- Improved compliance through training and enforcement
- Protection of the PMB framework
- Intervention in price negotiations
- Implementation of the REF
- Strengthened regulation of governance, brokers and managed care