

**THE BOARD OF HEALTHCARE FUNDERS of SOUTHERN AFRICA
CONFERENCE**

‘A Meeting of the Minds’

Sun City 22-25 August 2010

**COUNCIL FOR MEDICAL SCHEMES REGISTRAR and CHIEF
EXECUTIVE’S CLOSING ADDRESS: 25 AUGUST 2010**

Programme director, Dr Aquina Thulare Special Advisor to the National Minister of Health, Chairperson of the Board, Managing Director of BHF Dr Humphrey Zokufa, honoured guests, friends and colleagues.

OPENING REMARKS

I would like to welcome everyone back after the 3 days of presentations and deliberation during this conference where there should be ‘A Meeting of the Minds’. A very special word of congratulations to the new BHF Board who have just been elected to join the BHF family – I am confident that you will find the BHF a very challenging and rewarding organisation

whose membership constituency is regulated by the Council for Medical Schemes (CMS) “without fear, favour or interference”

I trust that all colleagues took the opportunity to share views and ideas with friends and colleagues during the conference, and that everyone is energised and enthusiastic about the year ahead because there are many challenges that need your input and more importantly solutions ranging from the NHI to the new term I heard for the first time, “single purchaser multipayer”. I really hope we achieve ‘A Meeting of the Minds’ on many of the issues raised over the past 3 days.

Sadly, we met during a period that was also marred by wide ranging strikes in the public sector, including healthcare workers. I am sure you will join me in expressing my deepest sympathies and condolences to the families affected by losses of their loved ones.

We have heard that 2009 was also in some ways a landmark year for the BHF. We congratulate it for that while we also encourage it to move forward providing leadership publicly praising exceptional achievements, and admonishing poor performance. However, we must not be complacent there is still a Medical Schemes Act to comply with. We must galvanise

the efforts of the “not so good” performers in your midst to build on initial progress, and to face the challenges that lie ahead. The 2009-2010 Annual Report of the CMS will give you a good glimpse of both good and poor performers when the CMS releases it on 2 September 2010. This special edition of our Annual Report also speaks to the first decade of the CMS; we turned 10 on 2 May 2010.

While great strides have been made by some medical schemes in addressing healthcare funding challenges in South Africa, pervasive “hotspots” of non-compliance and poor governance continue to prevail, despite the natural resource base and human potential that exist. It is in these areas that regulatory bodies like the CMS will redouble their efforts to make a meaningful contribution to sustainable, affordable, accessible and quality healthcare towards the betterment of people’s lives.

My Council has put in place a sound vision and strategy to guide the private healthcare funding industry into the future. The organisational structure has also been aligned to support the implementation of the vision and strategy.

I therefore invite you to “Lend me your Ears” and subsequently “Pledge me your Armoury” The ultimate goal of the organisational changes for schemes should be to accelerate affordable quality healthcare. Key principles underpinning the structure include:

- Achieving greater focus and alignment with the NHI mission and vision;
- Nurturing innovation and fostering entrepreneurship by rewarding performance;
- Separating risk-taking from risk management functions;
- Enhancing your role as an efficient administration based institution; and
- Empowering individuals, i.e. beneficiaries, to understand and take care of their own health whenever it is possible.

The implementation of the NHI is going to be one of the most transformational projects that South Africa has ever undertaken. I hope your new organisational culture will be characterised by the appetite to take initiative. Given the dynamic nature of our environment, and our continually evolving organisations and companies that belong to the BHF, it was never envisaged that the organisational challenges of 2010 would be the final chapter in the evolution of your organisation.

If you are to survive and remain on the table and not in the menu the fundamental principles underlying the organisational structure should not remain intact as they were 10 years ago but supportive of the country's mission and vision. The challenge at this juncture is to sustain and enhance the momentum that has been put on the table by the South African government. The changes that you should be announcing from now onwards should take account of the clarity of purpose in your vision and the impressive progress made in the past years towards quality healthcare for all. What I am looking for are:

- Sharpen your focus on “hotspots”, compliance- and governance-challenged areas of the industry;
- Position universal access to healthcare as a leading funding agency for placing Southern Africa on a sustainable development path as envisaged in the NEPAD framework; and
- Allow further scope and opportunity for us to build our human capital and to deploy this in line with our strategic objectives, resources and responsibilities.

If we agree on the above I will suggest that the strategic areas outlined in the Minister's various briefings that the CMS is involved in, be used as a basis for defining strategic priorities that take along the BHF going forward. These can stress the central role the CMS intends playing in establishing problem-solving processes to deal with systemic problems, such as access to risk pools, pricing and health costs, and the incorporation of low-income groups into cover. In addition again the issue of corporate governance needs to be highlighted as major strategic focus. There is a need to implement major changes to how schemes are governed and, at a minimum, should comply with the positions adopted in the King 3 governance codes.

An issue of concern for some of the CMS Units which has not been fully attended to over the past ten years is Governance. We continue to experience major concerns with governance of schemes, where in some instances trustees have abdicated their fiduciary functions to service providers such as the administrator and managed care organisations. During 2006 we embarked on a theme project in the form of research on causes of governance failures within the industry. Certain recommendations were made which were then presented to the industry for comment and recommendation. Some of the recommendations

necessitated a legislative amendment which broadly covers the responsibilities of the Principal Officers; publication by the CMS of guidelines for good corporate governance; and the clarification of the role of the Board of Trustees. Unfortunately the Amendment Bill has not been promulgated yet and I am extending an invitation to all medical schemes to forward their amendments proposals to the CMS.

DIFFICULTIES EXPERIENCED BY MEDICAL SCHEMES

The CMS Annual Report due to be released on 2 September 2010 will indicate that solvency overall fell from in 2008 to 2009 especially for open schemes. Also, it will be shown that the number of schemes below the required 25% solvency increased noticeably.

This is an indication that schemes are having difficulty keeping up with increased claims costs (costs per average beneficiary increased 14,6% when comparing 2009 to 2008).

Further evidence of this is demonstrable via the significantly greater operating losses incurred by open schemes relative to restricted schemes

Another issue that has impacted a number of schemes with financial problems is that due to the subsidy structure of government, pensioners who may qualify are not joining. Younger, low-claiming members are thus leaving open schemes but the pensioners remain behind and are a burden to those schemes. Resultantly, there has been a lot of consolidation in the industry.

The Boards of medical schemes therefore need to carefully consider their reserving policies in light of current circumstances, as well as added challenges such as anti-selection. Other issues for consideration are value-add derived out of contracts entered into, and need for correlation between price, cost and benefits.

REFERENCE PRICE LIST (RPL)

As you are aware the Pretoria High Court struck down the reference price list on procedural grounds. The Court advised that the Department must restart the process of making regulations. This would probably take another six months to conclude before a new set of regulations become effective.

The CMS is concerned that the absence of a price schedule would pose a challenge to medical schemes in developing their benefits for 2011. The CMS must approve the proposed scheme benefits and rules by November 2010. Consequently we will then be in a position to consider the publication of an interim cost of benefits schedule, NOT prices for 2011. The CMS will withdraw all costs schedules from the market when a new pricing system is finally legislated. The current rates registered with the Council by schemes still apply.

An issue that relates to costs in the environment is the absence of initiatives by the industry to try and mitigate cost-escalation. Schemes have predominantly sought to compete through cost-shifting (onto members) and risk-selection rather than improving the cost-effectiveness of care provided to beneficiaries. This has particularly become a problem with regard to managed care initiatives that currently exist in the industry. There is a concern that the majority of these initiatives do not add any value to the general performance of medical schemes. We would like to see schemes taking greater initiative towards implementing cost-containment strategies to minimise the impact of contribution increases on members. These cost-containment strategies will mean that schemes need to get more substantially involved in certain aspects of healthcare delivery.

Another issue I would like to raise is the complexity of the product offering by medical schemes. There is currently an abundance of benefit options which not only confuse members, but also contribute substantially to risk segmentation in the environment. Some benefit options are deliberately designed to attract good risk, leaving those with a poorer health profile with no other choice but to purchase cover in more expensive options. This subverts the community-rating principle as envisaged in the Medical Schemes Act. Whilst risk equalisation would go a long way towards addressing this concern, in the meantime the CMS will have to scrutinise benefit options more closely before they are approved.

CHALLENGES RAISED BY AND ABOUT SCHEMES AND ADMINISTRATORS

There are numerous concerns regarding the conduct of some medical schemes which began in June 2009 when various open schemes began communicating with my Office regarding what was regarded as an irregular movement of members from restricted medical schemes onto other schemes. We have documentation to this effect with evidence that was brought to the attention of my Office.

A central concern was the perception that restricted schemes or alternatively the affected employers were dumping bad risk groups, i.e. members who are older or sicker, onto other schemes. This is unacceptable.

LEGISLATIVE FRAMEWORK AND AMENDMENTS TO THE MEDICAL SCHEMES ACT

There are systemic risks in the medical schemes industry, to mention but a few:

1. Pricing for operating losses
2. Risk Equalisation Fund
3. Low-cost options
4. Anti-selection in relation to movements between options within a scheme
5. Option self-sustainability
6. Price and tariffs
7. Solvency as a measure of risk

In keeping with the theme of good corporate governance as noted above and the increasing complexity of product offerings by medical schemes as stated before, I wish to highlight the importance of transparency in how schemes operate and the obligation which rests on scheme trustees and administrators in ensuring proper, transparent and accurate communication to members in a manner which is clearly understandable to them.

The current pernicious practices which result in members being denied access to benefits, are largely dependent on poor or no communication. Proper communication to members, while being crucial, unfortunately is either extremely opaque or non-existent and in protecting member interests going forward the CMS will increasingly be focusing on this area.

However, the CMS appreciates the response made by some schemes to our invitation to submit documents highlighting concerns relating to specific industry matters and risks. Many of the issues discussed provide insights in terms of possible solutions and interventions. We would appreciate further engagement with the rest of the industry on the legislative matters as we continue to advise the Minister of Health on policy formulation and implementation in the private healthcare sector. We thank you again for your willingness to engage with us; it is much appreciated.

From the benefits design and management perspective, the CMS has seen a rise in the number of schemes considering amalgamating as the landscape has changed and the way in which schemes operated in the past has changed. Schemes which have not managed to keep up with the

challenges in funding for healthcare and in particular those that would have benefited from the Risk Equalisation Fund project have been hardest hit.

Further initiatives, like creating individualised networks and negotiating with providers, have not been realised. Schemes have only recently seen the benefit of these arrangements and further advantages of identifying efficient and effective providers and hence passing these benefits to members, thus having a positive impact on the overall value provided to beneficiaries of medical schemes.

The arguments for economies of scale in driving down non-healthcare costs have not been demonstrated to date in the industry. This is of concern as the CMS has been on a constant drive to improve the protection of beneficiaries of medical schemes by driving non-healthcare related costs down. The Office has been constantly engaging with funders and providers of these services in the pursuit of value for beneficiaries but so far I can say that battle is still ongoing.

CROSS-CUTTING PROJECTS

PMBs

The CMS noted with concern systemic industry-wide non-compliance with prescribed minimum benefits or PMBs; you may recall our Circular 37 of 2009.

We have acknowledged the systemic issues preventing consistent and sustainable implementation of PMB requirements.

We have noted that problems impact on all stakeholders (members, schemes, providers and administrators).

From May the CMS led a task team of various stakeholders to address problems around full compliance with PMBs provisions. I am very encouraged that the task team developed and finalised a Code of Conduct which has now been operational with effect from 1 August 2010.

The approach adopted by the CMS and the Department of Health was to develop a jointly agreed, collaborative process to address these problems giving guidance on:

- access to information on PMBs, including the use of designated service providers (DSPs), the requirements on

marketing information of schemes, and desired educational efforts by stakeholders in respect of PMBs;

- clarity and certainty on entitlements prescribed in PMB regulations;
- the prescribed level of care for PMB conditions;
- access to alternative interventions where prescribed interventions, scheme protocols, or formularies are inadequate or may cause harm;
- conduct required to accurately identify PMB conditions; and
- administrative processes such as pre-registration, pre-authorisation, and mechanisms required to deal with disputes in respect of PMBs.

The “payment in full” provisions in regulation 8 of the Medical Schemes Act, along with the RPL judgment, require strategic interventions by the Office.

The chronic element of PMB-DTPs is to be included in the PMBs.

Therefore, the CMS position on PMBs is as following:

- We are firm on our position regarding contentious issues; we will continue to uphold appeal ruling interpretations.

- Additional work is still outstanding, including benefit definitions and interaction with the National task team on ICD-10.
- The DoH and CMS are grateful for the collaborative efforts and the commitment of stakeholders.

RISK EQUALISATION FUND (REF)

My recommendation to schemes is that they should immediately make available the required data in the prescribed format to the REF registry or template that should be populated by schemes data either on a voluntary basis or under a confidentiality clause even prior to the legislative/regulatory framework. The CMS can then be in a position to consolidate the data as it comes in while at the same time doing the much needed financial transactions in-and-out under the CMS management. That way the future of REF within the CMS will be guaranteed. If we do not plan for this eventuality over the next few months I am afraid the DoH might just start thinking that you do not have the data and therefore do not have a plan for the “single purchaser multipayer system” that some of your speakers presented earlier.

MANAGED CARE: THE SOUTH AFRICAN CONTEXT

At the moment there is no need to draft dedicated or specific legislation for managed care but the changing environment demands accountability for accreditation to be justified. Cost-effectiveness of a technology may change over time and decisions may have to be reviewed as time goes on. However, there is a need to prevent hosting arrangements, inappropriate contracting, and the definition of and need to revisit all capitation products and network arrangements where the MCO becomes the de facto medical scheme. The CMC will continue doing on-site inspections to verify fitness and propriety.

DEMARCATIION PROCESS

The jurisdictional delineation between the regulatory span of control of the CMS and that of the Financial Services Board (FSB) has been an important area of focus in our previous financial year. The effective regulation of medical schemes and the protection of beneficiaries are critically dependent on all entities and products seeking to do the business of a medical scheme being subjected to the rigorous oversight and strict protections contained in the Medical Schemes Act. A serious threat is posed to the sustainability of medical scheme risk pools by the recent

proliferation of insurance products which seek to encroach on the preserve of medical schemes. We continue to participate in the demarcation work group established by National Treasury as part of the process of drafting regulations in support of certain amendments effected to the Long- and Short-Term Insurance Acts of 1998 by the Insurance Laws Amendment Act. The work group has as its purpose consideration of the underlying principles required to inform the drafting of regulations to ensure that a clear delineation of products is achieved so that the purpose of the Medical Schemes Act is not undermined.

FINANCIAL SUPERVISION OF MEDICAL SCHEMES IN SOUTH AFRICA

As mentioned above, the solvency overall fell from 36,6% in 2008 to 32,9% in 2009 (open schemes from 29,8% to 27,4%). The number of schemes below the required 25% solvency increased from 18 (13 open) to 21 (16 open).

This is an indication that schemes are having difficulty keeping up with increased claims costs (costs per average beneficiary increased 14,6% 2009 v 2008).

The industry average age and pensioner levels did not increase very much in the previous year. However, these numbers look very different when you compare the open and restricted schemes. From 2001-2006, restricted schemes were older than open schemes; the trend has changed in recent years after the registration of GEMS.

CONSUMER PROTECTION ACT 68 of 2008

The CMS will be applying to the Minister in terms of section 5(3) for an industry-wide exemption from complying with some of the provisions of the Consumer Protection Act and the application for exemption would include the adjudication of complaints and appeals.

We share the same sentiments raised that there will be duplication and/or conflict in dispute resolution procedures if the Council for Medical Schemes is not exempted from the provisions of the Consumer Protection Act as the Consumer Protection Act also provides for the resolution of disputes arising from the conduct of medical schemes (referred to as suppliers of service in the Consumer Protection Act). There are far-reaching consequences for both organisations if we are not exempted from complying with some of the provisions of the Consumer Protection Act as

there will be no coordination of activities relating to the adjudication of complaints relating to the medical schemes industry.

CONCLUSION

Given the RPL judgment, as Dr Anban Pillay indicated, there is a need to introduce an interim process on determining some form of costs of benefits (NOT provider tariffs). The CMS will be working with the Department of Health and the Minister in this regard in order to allay the anxieties in the market place. We will not rule out an inflator. Alternatively, a formula that sets out exactly how the costs of health benefits increase will be calculated in relation to CPI and published so that schemes can at least make an educated guess of what the increase will be.

In relation to the operations of the CMS during 2009-2010, I urge you to study in detail the Annual Report when it is released in 2 weeks' time, with road shows shortly in the offing.

I have taken note of the schemes and administrators who approached my Office to confirm that they were not compliant with legislation and I promise

to address their challenges in a fair manner that ensures that medical schemes treat their beneficiaries fairly.

We will further continue focusing on several key areas, including the annual process of approving contributions and benefits for 2011. In 2010 we dealt with a number of amalgamations and liquidations of schemes and we will continue our work on containing scheme costs.

We will further continue to monitor the financial soundness of medical schemes and ensure that schemes which fail to meet statutory solvency requirements submit business plans.

I would like to take this opportunity to convey our sincere thanks and appreciation for the continuing support of the work of the CMS by the industry, the Minister and the Department of Health.

Lastly, for as long as the CMS regulates in the interests of the beneficiaries and the public, including their financial resources, the routine monitoring function of the Office of the Registrar shall focus on solvency margins, but also on operating performance in future.

Our real value lies in the wealth of human capital and experience that we have nurtured and developed as the CMS and BHF organisations, and I would encourage everyone to seize the opportunities to empower ourselves to give further effect to our mission and vision of a better life for all.

Thank you.