5 July 2018

Craig Taylor
Principal Officer
Netcare Medical Scheme

Dear Craig

Following the publication of the Health Market Inquiry's (HMI) provisional findings today, we thought it important to share our views on some key aspects of the HMI's findings and recommendations. These are obviously preliminary views, as we are still studying the documents released today (the full 600 page Provisional Report has not yet been published). I have attached the summary documents for your information.

HMI FINDINGS AND RECOMMENDATIONS ON SCHEME BENEFITS AND CONSUMERS AND ROLE OF ADMINISTRATORS

The HMI finds that:

- Scheme options are highly complex, and consumers cannot effectively compare options, and are therefore confused. This is in part due to the incomplete regulatory environment. The HMI does not agree that option complexity reflects innovation by schemes.
- Schemes demand almost no accountability from administrators to manage supply-induced demand and moral hazard.
- Schemes and administrators are not using buying power effectively, although the HMI clearly recognises that DH is the only administrator that does exercise power against hospitals and has achieved lower hospital tariffs than other administrators.
- There is limited evidence of value based contracting by medical schemes.
- Brokers play an important role in assisting members to navigate scheme complexity.
- Anti-selection has adversely affected medical schemes and it is not clear whether current measures provide additional financial offset to schemes.

The HMI recommends that:

- Scheme options be restructured to include a base benefit option which is standard across all schemes, and that this option would be risk equalised across schemes. Schemes would then be free to provide supplementary options which may be risk rated.
- The PMB package for the base benefit option would be regularly reviewed (at least every 3 years) with more detailed information provided to members on accessing PMBs. PMBs need to include more out of hospital cover to reduce incentives for admissions.

- Governance of schemes should be strengthened and Trustees should demand more accountability from their administrators to manage claims inflation.
- Remuneration for scheme officers should be capped and linked to scheme performance.
- There should be public reporting of the outcomes of managed care arrangements in terms of savings achieved.
- Schemes need to be more actively encouraging AGM participation by members and members should be made more aware of the CMS.
- Voting for scheme trustees should take place over a longer period, with electronic voting allowed, and trustee elections should be completed prior to the AGM.
- Brokers should be remunerated on an opt-in basis with full disclosure of fees to members, and schemes should charge a lower premium (net of broker fees) to members who opt out of having a broker.
- A discount to encourage younger members to enter earlier should be considered.

Discovery Health responses

We agree that scheme options are complex and that members are not always clear on how their options work. We maintain our view that the major drivers of this are regulatory – in particular, PMB regulations, and also that product innovation in approaches to manage risk do lead to option complexity (eg network options etc).

In the case of our client schemes, we strongly disagree that schemes demand no accountability from DH to manage healthcare costs including supplier induced demand. We experience significant (and appropriate) pressure from all of our scheme clients to do whatever we can to mitigate claims inflation, and we feel fully accountable for doing so.

We are pleased that the HMI has acknowledged that DH is the only administrator to effectively wield strong countervailing negotiating power with the major hospital groups and other suppliers, which is one key driver of the lower claims costs we are able to achieve for our scheme clients.

The recommendations on restructuring scheme options are not new, and in some respects are consistent with the recently released Draft Medical Schemes Act Amendment Bill. We are generally supportive of this approach, although the detail will be critical.

Anti-selection continue to be a key risk for open schemes in an environment where the social solidarity framework has been incompletely implemented. We will use the opportunity to comment on the HMI Report to push hard for further measures to protect schemes against adverse selection.

HMI FINDINGS AND RECOMMENDATIONS ON DISCOVERY HEALTH MEDICAL SCHEME (DHMS) AND DISCOVERY HEALTH (DH)

We have included some of the HMI's comments on DHMS, just for your information in this section.

The HMI notes that:

- DHMS is the dominant open medical scheme, and there is inadequate competition in the open schemes market.

- There is lack of effective competition in the administrator market. DH and Medscheme between them dominate the administrator market with 76% market share.
- There is some evidence of competition between administrators e.g. DH and Afrocentric and competing for restricted schemes, but no existing players are challenging the existing dominant players, and no competitors are entering to challenge DH.
- That DH has shown sustained profitability, earning profits that are 'multiples higher than its competitors'.
- The HMI notes that much of DH's success can be attributed to competent management but that is not enough to explain the large and persistent gap to competitors.
- This gap may therefore be due to DH charging 'excessive fees' relative to its scale.
- DH is the only administrator that applies some countervailing power to hospital groups (better than Medscheme and MMI), and there is clear evidence that DH (and GEMS) have managed to achieve lower hospital tariffs.
- There are corporate linkages between DH and MMI and Mediclinic, which reduce competition and might affect the decisions of DH to invest in hospitals.

The HMI recommends that:

- Competition in the schemes market should be increased by the introduction of 'regional' schemes, which could be protected from volatile claims risk through reinsurance.
- There were no recommendations making specific reference to DH or its client schemes, nor any specific recommendations regarding the contractual relationship between schemes and administrators.

Discovery Health responses

DHMS market share and competition in the open schemes market

DHMS's large size and market share has been hard earned, with each corporate employer and individual member joining one by one. We do not agree that there is limited competition in the open schemes market – there are 22 open schemes, and competition between the 8 major open schemes is fierce and consistent.

Administrator market competition

We do not agree with the HMI that there is lack of competition in the administrator market. In the open scheme environment, competition occurs at the level of the scheme itself, and competition between the major 8 open schemes is intense. In the restricted scheme market, there is intense competition through tender processes for contracts for closed schemes. Since 2008, DH has competed in 17 such tenders and has won 16 of these. We believe that this is due to our ability to provide a better total administration package, including highly competitive administration fees, lower claims costs and superior service.

Regional schemes to increase competition

This is an interesting proposal which we will need to apply our minds to carefully, as it could pose a competitive threats to some schemes, but possibly also opportunities.

DH profitability and fees

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 consistently disclose a significant amount of segmental information on Discovery Health's financial performance each year as part of the financial results announcement of Discovery Ltd, even though we have no obligation to do so. We are proud of the continued growth and success of our business over the past 26 years, and believe that the revenues and profits we earn reflect an outstanding business which has been grown life by life on an entirely organic basis.

One purpose of the HMI was to assess whether any market players have dominant or unequal market power, allowing them to charge higher prices than competitors and impacting consumers negatively. This raises the question of whether Discovery Health's higher profitability than its competitors is due to it charging materially higher fees to its clients than its competitors do. However, publically available data demonstrate clearly that this is not the case, and we do not agree that DH charges excessive fees relative to the scale of DHMS.

The fees paid by the Discovery Health Medical Scheme ("DHMS") to Discovery Health for administration and managed care fees are almost exactly the same as the weighted average of all 22 open schemes when measured as a percentage of Gross Contribution Income ("GCI"). When measured on Rand per average beneficiary per month (Rpabm), the fees paid by DHMS are 3.8% above the weighted average. When measured on a proportion of GCI basis, the fees paid by DHMS are 0.17% below the average of all open schemes. DHMS administration expenses and managed care fees rank 14th lowest out of 22 when measured on pabpm and 10th lowest out of 22 when measured as a proportion of GCI.

In the open schemes market, the two main local competitors to Discovery Health are Medscheme (administrators of Bonitas and Fedhealth) and MMI Group (administrator of Momentum Health). The weighted average administration expenses and managed care fees charged by Medscheme and MMI are comparable to those charged by Discovery Health.

	pabpm	**% GCI**
DHMS	R175.98	10.58%
All ex DHMS		
- **Excluding adjustment**	R166.33	10.55%
- **Including adjustment**	R169.52	10.75%
DHMS / DH difference		
- **Excluding adjustment**	+5.80%	+0.03 p.p.
- **Including adjustment**	+3.81%	-0.17 p.p.
Medscheme-administered	R172.17	10.65%
Momentum Health		
- **Excluding adjustment**	R135.11	11.30%

	pabpm	% GCI
- **including adjustment**[1]	R162.86	13.62%

In the restricted schemes market, the weighted average administration expenses and managed care fees for all schemes administered by Discovery Health in 2016 are R135.92 papbm, and 8.84% of GCI, whereas the weighted average (excluding GEMS and POLMED) for all other restricted schemes excluding Discovery Health clients is R128.94 pabpm and 9.04% of GCI. Therefore the expenses incurred by Discovery Health clients are 5.42% above the weighted average measured on papbm and 0.20 percentage points below the weighted average measured as a proportion of GCI.

Medscheme-administered restricted schemes have comparable levels of administration expenses and managed care fees when measured per average beneficiary per month (R135.25 pabpm), and lower as a proportion of GCI (7.88%). Restricted schemes administered by MMI Group also have comparable expenses when measured per average beneficiary per month (R136.27 pabpm) and higher as a proportion of GCI (9.42%).

All restricted schemes

	Excluding GEMS and POLMED	
	pabpm	**% GCI**
DH administered	R135.92	8.84%
All ex DH administered	R128.94	9.04%
DH difference	5.42%	-0.20 p.p.
Medscheme-administered	R135.25	7.88%
MMI Group-administered	R136.27	9.42%

Discovery Health's higher profitability relative to competitors is thus not due to it charging higher fees, but is a result of a number of business factors including continuous innovation and greater operational efficiency driven by large investments in advanced systems and customer service technologies.

In our view, the true yardstick for consumers to assess the value they receive from their medical scheme administrator is not the administration fees paid, but the scheme premiums, which is the actual 'exit' price paid by consumers for their benefits and services.

The members of restricted schemes administered by Discovery Health benefit from significant savings and value relative to other restricted schemes. Claims inflation data determined from a sample of 12 in-house

[1] Momentum Health Medical Scheme incurred distribution and marketing fees of R85.7m in 2016. This expense is classified as Acquisition, Marketing and Distribution Costs. The adjustment includes this expense in the total administration expenses and managed care fees

schemes that have been administered by Discovery Health for two or more year's shows that the average claims inflation for these restricted schemes decreased from **13.4%** to **5.7%,** on average.

Similarly, data from a sample of up to 15 in-house schemes indicates that every year, the total savings derived from DH's administration and managed care savings increases. Between 2012 and 2016, total savings doubled from R218m to R440m which amounts to compound annual savings growth of 15.1%. The average savings per life per month increased from R48.56 to R119.04 over the same period, resulting in compound annual growth of 19.6%.

As you know, each year we measure the total managed care savings achieved for your scheme as well as the ratio of these savings to the managed care fees paid to Discovery Health. For 2017, the total savings for your scheme were R22.6m, resulting in a Return on Investment (calculated by Savings/Managed Care fees) of 125%. I do hope that you will agree that this shows clear evidence of the value for money obtained by your scheme for its investment in managed care services carried out on its behalf by Discovery Health.

For your interest, we have included an Annexure which discusses some of the more technical aspects of measuring profitability of medical scheme administrators, and includes some comments on the detailed findings of the HMI.

HMI FINDINGS AND RECOMMENDATIONS REGARDING SUPPLIERS OF HEALTHCARE

The HMI finds that:

- Practitioners are key drivers of health expenditure overall and peer review mechanisms have limited effect.
- There is evidence of specialists acting in collective ways that have driven up costs.
- There has been a failure to properly explore multi-disciplinary models of care delivery and the fee for service model stimulates over servicing.
- There is a lack of accountability in terms of reporting of outcomes.
- There is evidence of supplier induced demand including increases in the number of private hospital beds driving admission rates and inappropriately high rates of ICU admissions. It was also noted that facilities are competing to attract specialists (with factors such as new technology).
- There is not an under supply of specialists but rather an inefficient use of their time.
- The private hospital market is highly concentrated with 3 hospital groups dominant. They have exhibited sustained profitability and there has been a low tendency to adopt alternative modes of delivering hospital care. The NHN exemption appears to have been effective from a competition perspective.
- Provider networks are a promising tool for promoting an effective outcomes based approach.
- There has been inconsistent application of licensing processes across the provinces which has led to an oversupply of hospital beds.
- There is lack of transparency in pricing and lack of reporting on outcomes and the overall lack of publicly available information affects decision-making by consumers and practitioners. This data is also required to facilitate risk adjustment.

The HMI recommends that:

- There are detailed reporting requirements for facilities and a new licensing framework under a Supply Side Regulator for Health (SSRH) which would be established under the National Health Act.
- The SSRH would be an independent public entity and would oversee proper healthcare resource planning and monitoring.
- A moratorium on new beds for the 3 large hospital groups should be considered.
- Practice code numbers for public and private facilities should be managed by the SSRH. Practitioners must also register the facilities at which they operate to allow for inspections and prevent fraud. The OHSC would be incorporated into the SSRH.
- Economic value assessments should be published to stimulate competition, mitigate information asymmetry and facilitate strategic purchasing by funders.
- The Outcomes Measurement and Reporting Organisation (OMRO) should be implemented in a phased way with the first phase being a voluntary measurement and reporting system leading to the establishment of a statutory entity.
- The CMS should include metrics on supplier induced demand in its published reports and work with stakeholders to determine appropriate format and frequency.
- The public sector should be engaged in strategic purchasing from the private sector.
- The HPCSA must undertake a review of its ethical rules to encourage group practices and global fees and consider the competition perspective in general. Specific rule references have been provided and this includes full disclosure of the practioners interest in treatment provided including facility shareholding and financial interests in medicines and products used or dispensed.

Discovery Health responses

Our submissions to the HMI highlighted to challenges of managing supplier induced demand as well as the need to promote alternative reimbursement models to align incentives and promote quality and affordable care.

The proposed amendments to the HPCSA rules are an urgent and necessary measure to get this process underway and deliver immediate value to members. While we are concerned by the proliferation of regulators, the consolidation of functions, particularly with regard to licensing of facilities and monitoring of providers in general, under the proposed SSRH is promising. Industry collaborative initiatives such as the HQA are already acting in a way that is consistent with the recommendations regarding the phased implementation of outcomes measures. This is critical for ensuring that members are receiving value for their medical scheme premiums.

HMI FINDINGS AND RECOMMENDATIONS REGARDING PROVIDER PRICING

The HMI finds that:

- Fee for service tariffs are a reflection of market failure as they do not consider quality of care and they promote supplier induced demand.
- A review of the 2004 Competition Commission order is not required but collective bargaining should be facilitated by the SSRH.

- Provider networks have a net positive impact on competition and are beneficial to consumers in terms of treatment with no balance billing. They also benefit providers due to contractual certainty.
- Selective bilateral contracting between funders and corporate providers on patient volumes, price and quality is required for alternative reimbursement models (ARMs) to be effective.

The HMI recommends that:

- There are two proposals for addressing tariff setting:
    - Regulated pricing: this will require meaningful participation by all stakeholders with submissions on tariffs. The SSRH will then publish FFS tariffs which are only binding on PMBs. There would be an appeal mechanism to an arbitrator for stakeholders.
    - Multilateral forum: this would be managed by the SSRH to determine tariffs. There would be a formal engagement/bargaining process leading to tariffs being set by the multilateral forum, governed by the SSRH, which would also only be binding on PMBs and a reference point for other benefits. There would be provision for appeals to an arbitrator.
- Bilateral negotiation and the development of ARMs should be encouraged. We are not however completely clear on how bilateral negotiation between funders and hospitals would relate to the binding FFS tariffs discussed above, and this matter will need to be clarified.
- Coding systems need to be standardised across the health sector. This will be coordinated by the SSRH.
- Provider network agreements need to promote transparency in terms of pricing, health outcomes and location with reasonable access a key consideration. Contracts need to measure and reward quality care. Balance billing should not be allowed under network contracts.
- Facility and pathology DSP arrangements need to be more competitive and involve open tender processes.

Discovery Health responses

The HMI findings have confirmed that it is utilisation factors rather than simple price escalations that have driven the rising costs of healthcare cover. A key factor has been the requirement to cover PMBs at cost and the challenges in identifying and managing PMBs in general. The proposals with respect to published tariffs as a maximum reimbursement level for PMBs and a reference point for other benefits is consistent with our submission to the PMBs. We also stressed the importance of bilateral negotiations and the need to encourage alternative models for contracting and reimbursement and so we welcome these proposals, although we need to clarify the precise details of where the binding FFS tariffs would apply, vs bilaterally agreed tariffs. In our view, the ideal model would be for binding FFS tariffs to apply to individual providers for PMBs, but not to corporates, where agreements should be reached on a bilateral basis. In terms of the HMI tariff setting proposals we would support a multilateral forum which accommodates broad stakeholder input. DH will continue with initiatives to develop innovative contracting mechanisms that facilitate the sharing of data on quality of care and support best practice in service delivery.

Please feel free to contact me should you wish to discuss any of these matters in more detail.

Kind regards

Jonathan Broomberg
CEO, Discovery Health

Annexure

Technical aspects of measuring profitability of medical scheme administrators

In our view, some of the methods used in the HMI's profitability analysis are inappropriate, and they have produced distorted and inaccurate results which are not a true reflection of the profitability of Discovery Health or other medical scheme administrators. We believe that this distorted information is misleading for members of medical schemes and the wider public and should not be used to inform policy.

We have engaged repeatedly with the both KMPG (which carried out the profitability analysis) and the HMI over the past 2 years in an effort to persuade them to adopt more appropriate methodologies, but have unfortunately failed to persuade them. In the sections below, we set out our key concerns with KMPG's and the HMI's approach, and we show the results of a more appropriate analysis of profitability of a service business such as Discovery Health, as well as provide context for these results.

Return on Sales (ROS) is the appropriate measure of profitability for medical scheme administrators

It is widely accepted that return on sales ("ROS") (essentially, profit divided by revenue) is a more appropriate measure of profitability for service businesses which use limited capital inputs.

Discovery Health's average ROS of 33% well known, as we have consistently published information to this effect. These results are not out of line with those of global service businesses. As shown in the table below, which contains data from a wide range of US services business sectors for 2017, these sectors show a range of ROS of **15%** to **62%**, with an average across all sectors of **33.9%.**

Industry	
Commercial banks	33.3%
Consulting services	24.0%
Consumer financial services	35.4%
Insurance brokerage	37.8%
Investment services	28.9%
Miscellaneous financial services	62.2%
Professional services	15.4%
Average across all industries	**33.9%**

Data from CSIMarket (an independent digital financial media company and provider of integrated financial information and analytical applications to the global investment community), published in 2018.

It is also worth noting that there are some risks in calculating the ROS using the HMI's methodology. The HMI calculated ROS by dividing administrator profits by administration and managed care fees only, rather than by the total premium of the schemes under administration.

We have two concerns with the HMI's approach to ROS. The first is that it assumes that all administrators are administering similar schemes, with similar premium profiles. In fact, this is far from true. Discovery Health administers schemes with materially higher premiums per beneficiary than its competitors, reflecting richer and more complex benefits and requiring higher degrees of service and technology investment. Leaving scheme premiums out of the calculation therefore artificially inflates Discovery Health's ROS relative to its competitors. The second concern is that this approach creates the misleading impression that the profits of the administrator account for a significant proportion of total premiums (in Discovery Health's case, over 30%), when this is not in fact the case.

An approach which avoids these risks would be to use total medical scheme premiums in the denominator of the calculation. When this measure is used, the ROS for Discovery Health is currently 3.6%, which is very much in line with the ROS of international health insurers, including those in the US, UK and Australia, whose ROS's are in the range of 3%-7% of total premiums.

Return on capital based measures are wholly inappropriate for measuring the profitability of service businesses such as medical scheme administrators.

The HMI Draft Report utilizes various return on capital based measures, calculated by KPMG, including Return on Capital Employed (ROCE) and Truncated Internal Rate of Return (TIRR). However, these return on capital based measures are not appropriate for measuring the profitability of service businesses since these do not rely on significant investments in capital assets to develop and operate their businesses. Instead, they rely on intangible assets, such as human capital and intellectual property. The capital values of these intangible elements are notoriously difficult to evaluate and compare accurately, and the values of these assets are typically not reflected on the balance sheet of these companies. Using capital based profitability measures will therefore materially overstate the profitability of service based businesses.

By contrast, hospital companies rely heavily on capital investments in buildings and equipment, and derive their income from it. As a result, return on capital based measures are appropriate for assessing the profitability of hospital companies, since the capital values of their investments are accurately reflected on their balance sheets.

The UK Market Inquiry into statutory audit services[2] explicitly recognized this point and decided not to use capital based profitability measures to evaluate services businesses.

Notwithstanding our arguments and extensive evidence against the use of capital based measures, the HMI and KPMG have insisted on using these measures to assess the profitability of Discovery Health and its competitors, and the HMI Draft report contains commentary to the effect that Discovery Health's ROC and TIRR are significantly higher than its cost of capital and much higher than its competitors.

[2] Competition and Markets Authority. 2013. "Statutory Audit Services market investigation," final report, p. 61 . The UK Competition and Markets Authority, during its market investigation into statutory audit services found that "In the case of large professional services firms, much of the asset base is intangible in the form of clients, reputation, human and intellectual capital….Due to the multiple layers of uncertainty, particularly the difficulty of measuring the appropriate asset base and an appropriate measure of partner cost, we did not undertake detailed economic profitability calculations using return on capital employed (ROCE)….We were unable to conclude, based on analysis of profitability, whether firms had earned profits above the cost of capital on their provision of FTSE 350 audit services."

The inappropriateness of this approach is shown by the fact that if Discovery Health had made the levels of return on capital that KPMG calculated for the HMI, then based on the initial capital investment of R10m in Discovery Health in 1993, Discovery Health would today be worth R402 trillion, more than the entire capital value of all companies on the JSE, or the GDP of South Africa.

In addition to the fundamental inappropriateness of using a capital based profitability measure, the KPMG method used by the HMI has also made critical errors within its application of capital based measures. In particular, the HMI has not taken into account Discovery Health's significant investment in technology, systems and innovation, but instead made the incorrect and simplistic assumption that all administrators made similar levels of investment in these intangible assets. This is patently untrue. Discovery Health has invested hundreds of millions of Rands over the past two decades in building state of the art systems, assets and skills, and is globally recognized as an innovator in health insurance products and service. This is not true for our competitors. In addition, both of our major competitors have grown through significant acquisitions in recent years, and the capital cost of these acquisitions is shown on their balance sheets, thus reducing their returns on capital. By contrast, Discovery Health has grown organically, with the exception of one minor acquisition in 2016, and Discovery Health's return on capital is thus artificially inflated.

This simplistic and inaccurate approach has resulted in inaccurate and distorted comparisons between the returns on capital between Discovery Health and its competitors, and significantly overstates Discovery Health's profitability relative to competitors.