GEMS Commentary on the Provisional Health Market Inquiry Report published on 5 July 2018

Introduction

1. The Health Market Inquiry is deemed to be a critical intervention towards addressing existing problems in the South African healthcare sector and is fully supported by GEMS. The Scheme's approach towards the HMI is to render optimal support as may be needed and the Scheme will continue to work with all relevant role players towards finalising the report and to support implementation in the areas where the Scheme is required to play a role.

Main observations

2. Based on the experience of GEMS, the observations and findings are accurate as to the shortcomings, challenges and harmful practices present in the South African private healthcare sector. The findings overall may also be indicative of a sector that has not fully embraced good corporate governance and integrated thinking as contemplated in the King IV Report on Corporate Governance in South Africa, 2016. The successful implementation of the reforms can be strengthened if underpinned by the King IV Code Principles.
3. The bulk of the recommendations in the Provisional HMI Report are supported fully while there are some recommendations that are supported subject to some variation. Overall, the package approach to reform is supported noting that implementation of complementary recommendations will have to be coordinated to prevent a repetition of the challenges that resulted from the incomplete implementation of regulatory changes. **The Scheme specifically supports the recommendations aimed at standardisation, regulated tariffs, care coordination and supply induced demand**.
4. The Scheme's commentary in the table below is substantiated by the Scheme's relevant experience as well as information on the initiatives implemented by the Scheme that are already aligned to the recommendations.
5. Important elements that are not addressed in the recommendations (Chapter 10 of the Provisional Health Market Enquiry Report) are:
    a. The strengthening of the institutional capacity available to medical schemes to combat fraud, waste and abuse, including law enforcement agencies.
    b. Controls that can be introduced from a regulatory perspective to safeguard medical schemes during the process of switching administrators.
    c. An expanded detailed assessment of the impact of shareholding in medical scheme administrators including the acquisition of significant stakes in administration businesses by trade union investment arms and entities associated with trade unions and the formulation of recommendations to address any findings.

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Recommendations supported

6. The recommendations below are fully supported by the Scheme. In the section below, the Scheme's experience in relation to these matters is discussed:

Recommendation	GEMS View	Implementation Notes	Institution to implement	Timelines
a. The creation of an environment in which medical schemes promote alternative models of care	GEMS supports this recommendation **with the proviso that care coordination (GP Nomination and GP-to-Specialist referral) should be mandatory**. In respect of the alternative models of care listed in the recommendation, the Scheme have implemented the following: 	Section 32I of the Medical Schemes Amendment Bill should be amended to provide for mandatory care coordination.	National Department of Health and CMS.	To be deter-mined.

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	• Investing in models of care where appropriate providers provide primary care and reaffirming and strengthening the care coordinator role of GPs : ○ An update of the results achieved under the GEMS Emerald Value option is attached at **Appendix 1**. ○ Further to the Emerald Value option, the principle of specialist referral is also built into the Sapphire and Beryl options of GEMS, i.e. the two lowest cost options. [redacted]			

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	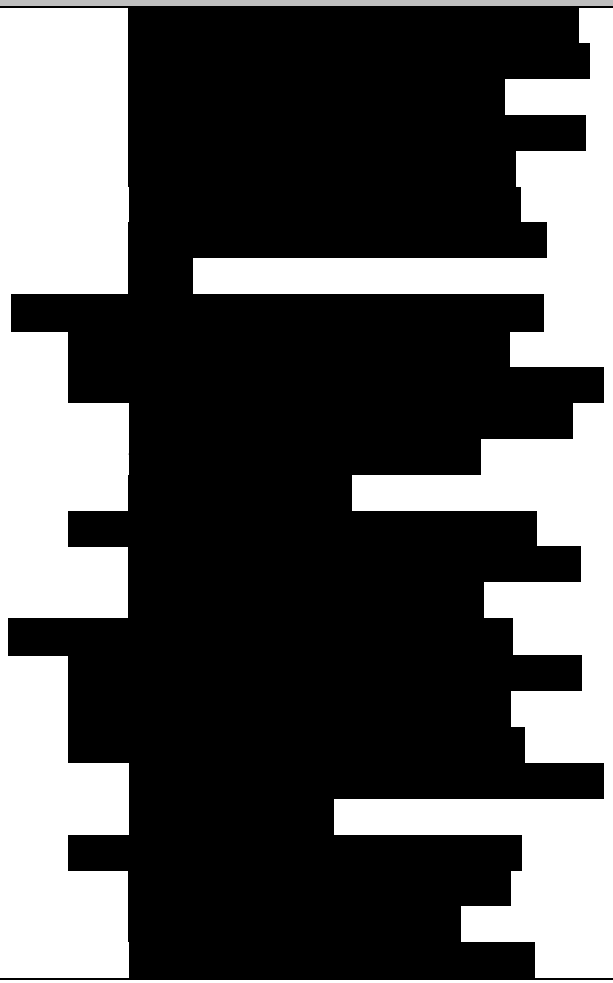			

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	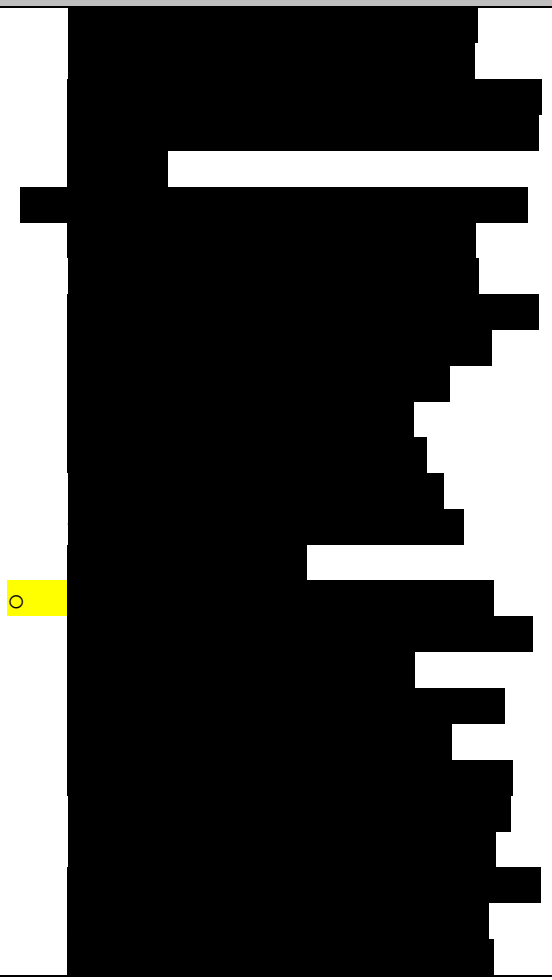			

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	[redacted] It is important to note that the concept of alternative reimbursement and efforts to implement such are not new. The challenges and barriers to the successful implementation of alternative reimbursement should be analysed and addressed by means of industry collaboration.			
b. The introduction of a stand-alone, standardised, obligatory 'base' benefit package that all schemes must offer. The package must include cover for catastrophic expenditure, i.e. Prescribed Minimum Benefits, (including making treatment for PMBs out of hospital); and additionally include primary and preventative care. The base option would include a standard basket of goods and services and will thus be easily comparable across schemes.	The Scheme has acknowledged the adverse impact of too many options and generally supports the standardisation of benefits across medical schemes with a focus on primary healthcare and prevention. Simplification supports access to appropriate care. Stakeholder sentiments conveyed to the Scheme during stakeholder engagements confirmed the need to reduce the number of benefit options available in GEMS. GEMS already has the building blocks in place for a standardised benefit package by means of standardised benefits across the current GEMS benefit options. Please see **Appendix 2.** The development of a stand-alone, standardised, obligatory 'base' benefit package **with**	Phased implementation is advisable. In the current phase of the GEMS' Five-year Strategic Plan covering the period 2017 to 2021, the Scheme is focussed on the simplification of products, services and processes. A reduction in the number of benefit options offered by the Scheme from five to three (medium term) and ultimately two (long term) will be achieved	CMS	To be phased in

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	mandatory care coordination, is further supported as a prelude to the comprehensive service benefits package contemplated in the National Health Insurance Bill. Draft enabling legislation in the form of the Medical Schemes Amendment Bill has been published. Clause 32l (1)(b) (Paragraph 15) of the Bill specifically is seen as a foundation for such a package.	incrementally through the Scheme's Product Development Process. One of the "rationalised" benefit options may be aligned to the NHI service package depending on progress made by the responsible NHI Advisory Committee. The Scheme provided commentary on an incremental approach to achieving a standardised package on 31 May 2016 in response to the draft NHI White Paper as published on 12 December 2015. A copy of the Scheme's commentary is attached as **Appendix 3.** The CMS should develop and implement a plan for the phased consolidation and		

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		reduction of benefit options across the industry under the guidance of the relevant NHI Advisory Committee.		
c. Supplementary care can be provided for care not included in the base package. It is recommended that the CMS develops standards and requirements for all options for supplementary cover.	The Scheme supports standardisation and simplification. The main risk associated with this recommendation is that necessary innovation may be stifled.	Enabling provisions should be incorporated into the Medical Schemes Amendment Bill published on 21 June 2018.	National Department of Health and CMS	To be deter-mined by the CMS
d. To improve regulation and to ensure that the standalone, standardised obligatory base benefit package is appropriate: i. Revising the mandate cover for PMBs to make provision for out of hospital and cost effective care for PMB conditions; ii. Expanding the PMB package to include primary and preventative care which package should make hospital plans obsolete;	The set of recommendations is supported noting that current prescribed minimum benefits are overly hospi-centric and this has contributed to higher cost and poorer outcomes. The expansion of the PMB package is supported **subject to the introduction of compulsory care coordination (GP Nomination and GP-to- Specialist Referral supported by networks)** to fund additional costs of primary and preventative care benefits. In respect of regionally based schemes, the impact of diluting risk pools should be assessed together with the practical implications for members relocating between geographical	As at point b. above		

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iii. Regular review of PMBs; iv. Production of the CMS of a bi-annual report on the value of managed care services including the extent to which risks and benefits are shared between contracting parties and how savings are passed on to medical scheme members; and v. Facilitating the entry of regionally based medical schemes.	regions.			
e. That administrators must report publicly on the value and outcomes of ARMs, PPNs and DSP arrangements they have entered into on an annual basis. These reports must be presented in a simple and accessible way so that it allows consumers to see how much administrators have saved from these arrangements. Linked to this recommendation is the observation that medical schemes should force their administrators to actively manage supply induced demand and that the ability to manage	GEMS supports this recommendation. To be taken into consideration is the fact that a scheme such as GEMS does some of this work and/or manages this work centrally. Administrators should be required to disclose this to prevent misleading reporting. For example, in the case of GEMS, [redacted] With reference to the observation on the management of supply induced demand, GEMS has identified supply induced demand as a significant driver of its adverse claims experience seen in the 2015 and 2016 financial years. The Scheme's response was informed by rigorous	The CMS should require from administrators to report this information in their annual integrated reports as part of the accreditation criteria applicable to administrators. (See point f below relating to the development of the metrics.)	CMS	To be deter-mined by the CMS

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supply induced demand should also be a competitive differentiator for administrators.	investigation by means of: • actuarial data analyses, • internal audit investigations, • operational investigations at the level of the Scheme's contracted Service Provider Network and • forensic investigations targeting specific concerns identified through the aforementioned investigations. As a result, a multifaceted and formal Claims Management Programme was implemented. The programme is based on collaboration between various scheme role players who implement interventions and measure the impact thereof. Importantly, GEMS has changed the working and oversight of administrators as far as claims management is concerned by means of the Claims Management Programme. A write-up of the various interventions implemented under the programme is attached **at Appendix 4**. A summary of the combined impact of the Claims Management Programme on the Scheme's 2017 financial performance is attached **at Appendix 5**.	Contractor responsibilities and performance targets should be included in the Terms of Reference/tender specifications when administration and/or managed care services are purchased by medical schemes. Stringent Service Level management by medical schemes is essential.	Medical schemes	

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f. Administrators' comparative performance on metrics such as non-healthcare costs, the value of PPNs, DSPs and ARMs, claims payment ratio, and the proportion of PMB and non PMB claims paid from risk vs those paid from savings should be published annually for each administrator compared to a national average. This publication should be produced by the CMS.	GEMS supports this recommendation as this promotes accountability and should serve to enhance performance in an administrator market that is deemed to be very complacent. To be taken into consideration is the fact that a scheme such as GEMS does some of this work and/or manages this work centrally. This should be disclosed to prevent misleading reporting. The CMS should obtain independent assurance in respect of the administrator performance information published to promote the reliability of the information. Despite the publication of such information for benchmarking purposes, administrators should still be appointed by means of competitive procurement processes.	The CMS should: • Determine the metrics • Develop definitions for the various metrics to be reported against • Develop requirements for the measurement methodology to be applied • Develop requirements relating to the disclosure of data sources • Prescribe how data/information should be verified before submission to the CMS	CMS	To be deter-mined by the CMS
g. That schemes encourage member participation in its Annual General Meeting, including:	The recommendation is fully supported and already actively pursued by GEMS. The Scheme has been working to increase member	N/A	N/A	N/A

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i. Modifying the requirements for attendance to ensure adequate representation of members (avoiding conflict of interest) ii. Notification of members of the AGM in a timely manner and the AGM must be held at a time convenient for members iii. Making use of technology to facilitate participation of members who are not there in person iv. Review of the criteria for the election of trustees such that sufficient time and appropriate information is available to members to consider and choose trustees and that electronic election of trustees is possible to avoid abuse of proxy votes. Election of trustees must be conducted over an extended period and completed and audited prior to the confirmation of the election results at the AGM.	participation by means of member education. The attached AGM Member Guide and tutorial at **Appendix 6** was developed for this purpose. The GEMS AGM venue is rotated on a provincial basis to enable members to attend. The standard GEMS AGM starting time of 15h00 on a weekday and correspondence is sent to employing departments prior to the AGM to request that employees be released for purposes of attending. The Scheme leverages stakeholder communication channels such as union and employer publications to increase awareness and improve attendance at AGMs. The GEMS Member App has been identified as a potential mechanism to increase member voting on AGM motions and/or to make the submission of proxy forms easier for members. In respect of the criteria for trustee elections, the GEMS Trustee Election governing framework (Rules and trustee election procedure) is already aligned to the HMI recommendation. Although the view is held that the CMS should consider enforcing standards for trustee elections, it is noted that the Medical Schemes Amendment Bill			

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	provides for the election of trustees at Annual General Meetings only, which contradicts the HMI recommendation. The Scheme identified concerns in respect of the Medical Schemes Amendment Bill on this point and will include this information in its commentary to the National Department of Health on the Medical Schemes Amendment Bill.			
h. A set of core competencies for trustees also needs to be developed, taking into account the diversity of expertise required.	The recommendation is fully supported. The GEMS Rules were amended to be in line with the requirements for Board Members in the short term insurance industry. An extract of the GEMS Rules is attached as Appendix 7. Draft enabling legislation in the form of the Medical Schemes Amendment Bill has been published. Clause 56B is specifically aligned to this recommendation and is supported.	Implementation depends on the passing and enactment of the draft legislation.	CMS and medical schemes	Would depend on legislative process
i. The establishment of a dedicated healthcare regulatory authority, i.e. the Supply Side Regulator for Healthcare	The set of recommendations pertaining to the supply side regulation of healthcare are supported overall. There is very little regulation/oversight of the supply side whereas funders are subjected to extensive regulation. This imbalance contributes to the challenges experienced in respect of the funding of PMBs.	The broad implementation process outlined in the Provisional Health Market Inquiry Report is supported noting that this authority would be a public	The entity should resort under the Ministry of Health.	To be deter-mined in accor-dance with processes for

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		entity within the ambit of the Public Finance Management Act.		establish-ing public entities.
j. The requirement to measure quality and outcomes should eventually be legally enforceable. If necessary, by the Supply Side Regulator for Healthcare in partnership with the proposed Outcomes Measurement and Reporting Organisation	The Scheme supports this recommendation. Enhanced and standardised quality measurements will contribute to better outcomes and the sustainability of medical schemes. Disclosure in respect of mortality rates, the incidence of healthcare acquired infections, the incidence of never-events and patient experience scores should be included. Publicly available statistics will empower members to better navigate the healthcare system. In respect of provider profiling, the Scheme also acknowledges the significant positive impact in respect of managing both the cost and quality of care. [redacted].	The broad implementation process outlined in the Provisional Health Market Inquiry Report is supported.		
k. The HPCSA must undertake a review of its ethical rules with a view to: i. Reviewing all rules from a competition perspective; ii. Re-phrasing rules to be more permissive or enabling in	This recommendation is supported. Global fees can contribute to claims management initiatives while simultaneously encouraging the take-up of benefits aimed at prevention.	No specific views are offered	HPCSA and other healthcare regulatory bodies where appropriate.	

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nature including encouraging group practices and promoting the use of global fees.				
l. A set of recommendations are made in respect of Provider Networks. Included in the recommendations is a recommendation that: "Any provider who can match network FFS prices set up by any medical scheme network should be allowed to provide services to the same medical scheme population. However, selective contracting on patient volumes, price and quality must be allowed for ARM agreements to be effective."	GEMS supports the majority of the recommendations. The Scheme has established a number of network providers and these have shown to contribute to lower costs and improved outcomes. GEMS Networks are established using objective and transparent criteria. Two approaches are being used by the Scheme: • Procurement processes conducted in terms of the GEMS Supply Chain Management Policy. Examples of this are the Emerald Value Hospital Network and the Renal Dialysis Network. These networks were established through a tender process, where all providers were given the opportunity to participate in the network. A predetermined methodology (based on cost and quality) was employed to select the highest scoring proposals that would constitute the network. • Contracting with any willing provider, as long as they agree to the terms and conditions of the GEMS network contract	No specific views are offered		

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	(e.g. charge the contracted network rate without balance-billing the member, be subjected to peer review, etc.). Examples of these network agreements are the Family Practitioner, Specialists, Dental and Optical Networks. The Scheme has been challenged at the level of the Competition Commission by an unsuccessful bidder (hospital network for Emerald Value Option) and a bidder who failed to attend a compulsory tender briefing session (renal dialysis network) and who was therefore unable to participate in the procurement process. Participating in tender processes is not necessarily a competency associated with healthcare providers and it may be necessary to empower healthcare providers with the relevant competencies to ensure that procurement processes yield the desired results. In respect of the recommendation regarding allowing providers who are able to match FFS prices to provide services, the Scheme's view is contained in the table at paragraph 7 below.			
m. A set of recommendations in respect of health services pricing is	The Scheme supports the set of recommendations in the current context where	The broad implementation points		

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made. This includes collective bargaining facilitated by the SSRH, to safeguard against collusive behaviour among competitors and foreclosure of new entrants. To remedy the tariff vacuum, a regulatory solution with multilateral inputs and a multilateral price setting-setting mechanism where stakeholders conduct tariff negotiations under a framework determined by the SSRH are recommended.	tariffs are informed by relative negotiating strength of parties and not objective criteria. **Specifically, proposal 1 (paragraph 110 of Chapter 10) where the SSRH assumes responsibility for setting fee-for-service tariffs based on stakeholder inclusivity principles, is supported.** One potential unintended consequence, however, would be "down coding" by healthcare providers as opposed to the current experience of "up coding" so as not to be bound by the FFS tariffs for PMBs. As such, **predetermined tariffs should extend to all benefits and not just the basic benefit package to protect members from co-payments for the treatment of conditions that are actually basic benefit package conditions**.	outlined in the Provisional Health Market Inquiry Report are supported.		

Recommendations partially supported

7. The recommendations discussed below are supported subject to the considerations discussed below:

Recommendation	GEMS View	Implementation	Institution to Implement	Timelines
a. The introduction of the base basket must be accompanied by a system of risk adjustment to remove schemes' incentive to compete on risk factors such as age, and will instead encourage schemes to compete on value for money and innovative models of care.	GEMS acknowledges the need for comprehensive risk equalisation mechanisms in the **open** schemes market. Risk equalisation should be coupled with income cross subsidy to prevent lower income members from being prejudiced. Careful consideration should be given to the application of risk equalisation mechanisms in the restricted medical scheme market to prevent restricted schemes from subsidising open schemes, specifically noting paragraph 25 of Chapter 10 of the Report that discusses the basis for some of the efficiencies achieved in the restricted schemes market. Where risk equalisation is mainly aimed at addressing the unintended consequences of implementing open enrolment and community rating without mandatory membership in the open medical schemes market, it should be a consideration that in the restricted schemes market, especially where schemes are linked	The Council for Medical Schemes previously performed extensive work around the establishment of a Risk Equalisation Fund. As part of this, medical schemes made routine data and other submissions as part of a pilot project, i.e. a "shadow Risk Equalisation Fund". The available work and findings should be reviewed to determine the way forward.	Council for Medical Schemes	To be determined by the CMS

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	to employers, there is an element of mandatory membership present (i.e. employers either compel employees to be members of a employer linked scheme or the payment of a subsidy is made conditional upon joining the employer linked scheme. A consideration could be treat public sector restricted schemes as one pool.			
b. It is proposed that the remuneration package of employees of schemes, especially those of the trustees and principal officers, be linked more explicitly to the performance of schemes. Performance will be measured in terms of the value delivered to members. We propose that the remuneration of Principal Officers and trustees be set at a minimum base level and that the rest of their package be linked to clear defined quantitative objectives of the scheme such as reduction in non-healthcare costs, administration costs etc.	The underlying principle to the recommendation is supported. However, this area falls within the scope of the King IV Report on Corporate Governance for South Africa, 2016 (King IV Code) which is aimed at achieving the good governance outcomes of: • Ethical culture • Good performance • Effective control • Legitimacy. Importantly, in respect of the corporate governance principles, King has moved from "apply or explain" to "apply and explain" in respect of reporting by organisations including medical schemes. In the phrasing of the recommendation at paragraph 32.1 of Chapter 10 of the	The CMS should require from medical schemes to report against the King IV Principles and Business Practices. Furthermore, the reporting disclosures listed in King IV should be enforced in reporting to the CMS, medical scheme members and stakeholders.	CMS	2018 Integrated Reporting

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	Provisional HMI Report, the lines between the members of a governing body (i.e. a Board of Trustees) and schemes employees, including the Principal Officer are blurred. The Scheme's view is that medical schemes should be required to report to the CMS how the King IV Code Principles and Business Practices are applied, including Principle 14 on remuneration: "The governing body should ensure that the organisation remunerates fairly, responsibly and transparently so as to promote the achievement of strategic objectives and positive outcomes in the short, medium and long term"			
c. The CMS proposed remuneration framework that seeks to cap Board of Trustees and Principal Officer remuneration and align remuneration with performance should be implemented. The remuneration framework should take into account concrete indicators of improvements in the scheme's performance which must be linked to the performance of individual trustees.	This recommendation is supported subject to alignment with the King IV Code. Further to this, it is recommended that available practice notes regarding the remuneration of Independent Non-executive Directors be studied and incorporated into the CMS proposed remuneration framework.	Implement as part of the Medical Schemes Amendment Act (currently still draft legislation)	CMS	Linked to effective date of Medical Schemes Amendment Act

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d. Provider Networks: It is recommended that: a. Any provider who can match network FFS prices set up by any medical scheme network should be allowed to provide services to the same medical scheme population. However, selective contracting on patient volumes, price and quality must be allowed for ARM agreements to be effective.	GEMS does not fully support this part of the recommendation relating to networks (i.e. paragraph 155.6 of Chapter 10), in respect of networks set up by means of a tender process. In this context, healthcare providers offer meaningful discounts in return for increased volumes. The inability to exclude providers may severely undermine the value that can be derived from network arrangements. The approach recommended by the HMI links network participation to fee for service price levels. This negates the opportunity to establish networks based on holistic cost efficiencies or the quality of care. It is also noteworthy that network contracts concluded following a tender process place obligations on both the Scheme and the contracted network providers. Schemes will not be able to enforce network contract obligations on such providers.	N/A	N/A	N/A

Recommendations not supported

8. The only recommendation not supported is discussed below:

Recommendation	GEMS View	Possible Alternative
a. The CMS contact number must be included on the medical scheme card, to allow members to have direct access to the CMS.	In view of the sheer number of medical scheme beneficiaries, this recommendation is deemed to be impractical. This is unless the CMS would be able to establish a significant call centre capability.	The CMS should continue publishing articles and guidance notes in plain language to assist members in understanding their rights and obligations. The CMS may consider entering into partnerships with medical schemes to improve member education.

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