

7 September 2018

Competition Commission of South Africa
The Health Market Enquiry

Via email: paulinam@compcom.co.za

Re: Comments on the Health Market Inquiry Provisional report

Introduction

The Grintek Electronics Medical Aid Scheme (GEMAS), which is a restricted scheme, covering a total of 1 676 lives, welcomes the opportunity to comment on the recommendations contained in the Provisional Report. The Scheme registered on 14 December 1983. As at 31 July 2018 the Scheme's solvency rate is 46% with reserves at R 20 334 461.

General

The Scheme supports the Inquiry's recommendations to improve competition in the private healthcare sector by prioritizing transparency, accountability, curbing supply induced demand and promoting value driven healthcare.

The matters addressed in this submission are most pertinent GEMAS.

Competition in the funders market

17. Overall, the HMI finds that competition in the funders market is neither as vigorous nor as effective as it could, or should, be. This is true of both administration services and medical schemes.

The imbalance in supply and demand has led to medical schemes being unduly prejudiced. It is the GEMAS view that the root cause of the private healthcare sector's adverse effects on competition is the absence of a regulated tariff determination process. The absence of a regulated tariff has resulted in the supply side of the market being able to drive much of the healthcare expenditure in the sector and almost unilaterally being able to determine pricing, as a result of supplier market power and dominance. The size of the scheme is also a factor as the large schemes are able to use their volume in negotiations. It should be noted that with the discontinuation of the National Health Reference Price List (NHRPL) in 2008, as instructed by the Competition Commission, has resulted in the increase of unregulated and unchecked pricing of healthcare services.

Management of supply induced demand

20. The Inquiry has also found that all schemes have failed to adequately manage supply-induced demand. Given that supply-induced demand is known to exist in healthcare markets (and has been shown to exist in South Africa too), we would expect medical schemes to force their administrators to actively manage this in the interest of protecting scheme members' health and the financial sustainability of the scheme. The ability to effectively manage SID should also be a competitive differentiator for administrators. The widespread inability to manage and supply-induced demand suggests a lack of effective competition in the market for administration.

GEMAS agrees that further steps need to be taken to improve the negotiating powers of funders in the industry. Administrators and Managed care organizations currently negotiate preferred fees on behalf of schemes; however the outcome of these negotiations is dependent on the size of the scheme. The limited number of service providers in the industry also restricts the negotiating powers of the schemes.

The Council of Medical Schemes' implementation of Regulation 8 as "Pay in full with no copayments has had a very serious impact of keeping supplier prices high. Despite attempts no Declaratory order has been given by the Courts.

Cost savings passed on to members

27. We find no evidence that schemes demand information on the costs saved by administrators related to, for example, managed care or fraud control and whether the related savings are passed on to scheme members.

GEMAS is in disagreement with the findings of the HMI, all savings generated by GEMAS is passed on to members. Savings generated by either non-health expenses or relevant healthcare costs have a direct impact on the financial performance of the scheme, the savings generated leads to lower contributions or increased benefits in subsequent benefit years.

Improve transparency and promote competition

31. To improve transparency and promote competition we propose:

31.1 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. the current Prescribed Minimum Benefits (including making provision for treating 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.

31.2. The introduction of the base package must be accompanied by a system of risk adjustment (see below), which will remove schemes' incentives to compete on risk factors such as age, and will instead encourage schemes to compete on value for money and innovative models of care.

31.3. Supplementary cover can be provided for care not included in the base package. We recommend that the CMS develop standards and requirements for all options for supplementary cover. This will improve transparency and assist consumers in comparing products, coverage and value across the industry.

31.4. That administrators must report publicly on the value and outcomes of all 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.

In principle GEMAS agrees with the establishment of a base benefit package, but has the view that one size fits all is not the best option given the varying needs of members. More clarity is required regarding the working of the risk adjustment system. A risk equalisation fund mechanism was proposed previously which failed to be implemented. Further consideration is to given to the impact of a risk adjustment system as this may negatively affect smaller, closed schemes that are profitable as a result of their beneficiary base being young and healthy.

Other items relating to funders

The private healthcare industry, by its very nature, is a complex environment, bearing this in mind GEMAS supports the Inquiry's proposals of the improved transparency and governance in medical schemes. Cognisance of the fact that governance standards in restricted schemes is generally high due to the use of various governance tools, including Codes of Conduct, Annual Assessments of Trustees and the Principal Officer and a Remuneration Policy amongst other must be taken into account.

GEMAS supports the introduction of an obligatory base benefit package, which includes an extended range of PMBs, across all schemes; together with a legislated system of risk adjustment is commendable. However the implementation thereof will be challenging, as is evidenced by efforts in the past to introduce a risk equalisation fund.

It is noteworthy, in this regard that the Inquiry has not decided on the most appropriate risk mechanism to use. More detail is accordingly required in this regard.

The prior establishment of an appropriate tariff setting mechanism is an essential pre-condition to the introduction of a base benefit package by schemes. The absence of such a mechanism will be detrimental to costs incurred by the scheme, as is currently the situation with PMBs. It is therefore imperative that the SSRH be established as a matter of urgency.

GEMAS welcomes the proposals that the CMS develop standards and requirements for all options for supplementary cover and that it annually publish administrators' comparative performance.

GEMAS submits that in relation to restricted schemes the Inquiry's proposal that a set of core competencies for trustees must be developed taking into account the diversity of expertise required, may not be practical as the trustees are elected from the existing pool of members of the scheme. More information is required regards the proposal that an incentive be put in place to encourage younger members to join schemes, possibly by way of a regulated discount on medical scheme premium, this will require an amendment to the Act.. In addition thereto more information is required as to whether the current late joiner penalty will be retained and as to the funding of the proposed discount.

A Regulated Tariff Determination Process and the Establishment of the Supply Side Regulator for Healthcare

138. The SSRH can be established through the National Health Act which gives the Minister wide ranging powers. The SSRH should be an independent public entity, with its own executive and a board appointed by the Minister following a transparent, public nomination process. It is recommended that work to set up the SSRH begins immediately with the objective of getting to regulatory body functional within five years of publication of the final Inquiry report.

GEMAS accordingly welcomes the recommendation that a Supply Side Regulator for Healthcare (SSRH) be established. The Scheme does not, however, agree with the proposed timeline of five years from the date of publication of the final Inquiry Report for the introduction of this body. The current unregulated pricing environment has led to high and rising costs of medical care. In the absence of

the introduction of the SSRH, these costs will just continue to rise. The proposed establishment of the SSRH is an important intervention not only for competition purposes, but is in the public interest at large and it is imperative that it be established as a matter of urgency.

Effective and efficient regulatory oversight of the supply side of the healthcare market is essential to curb the ills of the market and is necessary to improve affordability of private healthcare goods and services and to ensure greater access to quality healthcare services. In the absence of an appropriate tariff setting mechanism, it is submitted that there is little that schemes can do to address the supply induced demand and to contain healthcare expenditure.

Of the two tariff setting mechanisms proposed by the Inquiry, the Scheme prefers the regulated option of tariffs being set by the SSRH after input from a multilateral forum. The alternate multilateral price setting mechanism where stakeholders conduct tariff negotiations under a framework and with conditions determined by the SSRH, it is submitted, may be open to abuse as a result of the market dominance of the service providers and facilities. GEMAS welcomes the fact that tariffs for PMBs will be binding and that the tariffs for non-PMBs will have the status of reference tariffs, which may only be exceeded if the patient's informed consent has been obtained, or as a result of negotiations between service providers and funders.

In the event that there is no agreement on a tariff, the proposal is that the decision of an arbitrator will be final and binding on the parties. It is not clear who such an arbitrator will be and which guidelines he will be required to follow in the determination of a dispute as to a tariff. More detail is required in this regard.

Provider networks: The Process of Appointment of DSP Partners

156. Facility and pathology DSP arrangements, in particular, should be far more competitive than they are at present. Some of the recommendations that are worth considering include the following:

156.1. DSP partners should only be appointed after an open tender process and results of the process must be lodged with the SSRH and published.

156.2. Tenders should be advertised broadly through popular media in addition to websites of the SSRH, CMS, affected medical schemes and administrators. Advertisements should remain open for at least one calendar month.

156.3. DSP contract arrangements should not be longer than two years. We make this recommendation to eliminate evergreen contracts while leaving the door open for new entrants to compete. Testing the market regularly in an open manner will have a positive effect on competition as well as expenditure in the long run.

In principle GEMAS supports the appointment of DSP partners after an open tender process and the results of the process are lodged with the SSRH and published, the practicality of this requirement is questioned, especially insofar as it affects restricted schemes. The process is time consuming and cumbersome process and may not be feasible.

The Establishment of an Outcomes Measurement Reporting System

164. The HMI recommends that the outcomes measurement reporting system be implemented in a staged process with two phases.

164.1. The first phase should be a voluntary phase that should be completed within 3 – 4 years from the publication of the HMI's final recommendations. During this phase the participation of doctors and facilities is critical: they must take the lead to form a collaborative body to oversee a voluntary outcomes measurement and reporting system. The body should define standards for South Africa and could draw from existing registries and freely available and tested indicators (such as ICHOM). Funders, patients' organisations and regulators must also be encouraged to participate in this first voluntary phase.

164.2. Providers and funders should take responsibility for financing this first phase of voluntary participation. Initiatives for co-funding formulas in the Netherlands and Scandinavia may serve as a model.

165. The HMI proposes that the data collected in the first phase be released only to participating providers in individual feedback cycles aimed at improving the outcomes measurement and reporting system. Results and experiences from this first phase should then be used as an input towards developing the OMRO in the second phase.

166. In the second phase, an appropriate statutory entity must be established to oversee the outcomes measurement and reporting process. A working title for this entity is the Outcome Measurement and Reporting Organisation ('OMRO'). The National Department of Health, in consultation with relevant stakeholders, must take the lead in drafting the enabling legislation for the OMRO. The industry should aim for OMRO to be fully functional within 6 years of the conclusion of this inquiry.

GEMAS is supportive of the Inquiry's recommendation that standards be developed to measure cost effectiveness in the healthcare sector. The development of the standards will promote value-based pricing decision-making and allow members to choose a medical scheme on the basis of value, rather than on simply affordability.

It is noted in this regard that it is recommended that providers and funders should take responsibility for financing the first phase (3 – 4 years from date of publication of the Inquiry's Final Report) of voluntary participation in the establishment of an outcomes measurement reporting system. It is further proposed that in the second phase (6 years from date of publication of the Inquiry's Final Report) an appropriate statutory entity, the Outcomes Measurement and Reporting Organization (OMRO), be established to oversee the outcomes measurement and reporting process.

It is proposed that Government find a sustainable funding mechanism, but that levies from schemes would be the primary source of funding complemented by Government and voluntary funding. The establishment of three new statutory bodies will obviously have cost implications for schemes. These bodies are the SSRH, the OMRO and the ARM, which is the body that will eventually administer the risk adjustment mechanism and the contributions subsidy, which is proposed to replace the current tax credit regime. Coupled with this, the Inquiry's proposals above, as to the first and second phase funding of an outcomes measurement reporting system, raises issues of affordability, which is of concern to the Scheme. The exact mechanics and extent of the funding that would be required is unclear and needs further elaboration before it can be endorsed.

Conclusion

This comprehensive review of the private healthcare industry and the well-founded recommendations are welcomed. GEMAS is of the view that the adoption of the suggested recommendations will greatly improve competition in the sector and lead to reduced costs, provided that there is a will to implement the recommendations properly and timeously.

Kind Regards,



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