GEMS COMMENTS ON THE COMPETITION COMMISSION'S STATEMENT OF ISSUES AND ADMINISTRATIVE GUIDELINES IN RESPECT OF THE MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

1. INTRODUCTION

1.1 We refer to the above matter and the Draft Statement of Issues: Market Inquiry into the Private Healthcare Sector dated 30 May 2014 issued by The Competition Commission ("the Commission") for public comment ("the Draft Statement").

1.2 As a stakeholder in the Healthcare Sector ("the Sector"), The Government Employees Medical Scheme ("GEMS") has now had an occasion to consider the Draft Statement and submits its views and comments below. GEMS comments contained in this document should not be construed or interpreted as a waiver or admission in any manner whatsoever. GEMS reserves the right to make further submission if required at the appropriate juncture.

1.3 In terms of the Draft Statement, GEMS falls into the category of 'financing of healthcare."[1] As such GEMS comments on the Draft Statement relate to those paragraphs that fall within this category viz, paragraphs 27 to 34 of the Draft Statement. However, to the extent necessary, GEMS also makes comments on the other two categories, as well as on general comments on the framework.

1.4 GEMS does not in this document deal with each and every theory of harm as identified in the Draft Statement. GEMS will however, deal with paragraphs 27 to 34 of the Draft Statement which effectively form the bases of the theories of harm as delineated in paragraph 58 and to the extent necessary paragraph 60, 64, 65 and 67 of the Draft Statement.

2. BACKGROUND INFORMATION ABOUT GEMS

2.1 GEMS is a not-for-profit restricted medical scheme registered as such in terms of the provisions of section 24 of the Medical Schemes Act, 131 of 1998 ("*the MSA"*). GEMS provides assistance in, *inter alia*, defraying expenditure incurred by its members in respect of health care services rendered to such members.

GEMS has operated as a registered medical scheme in the Sector for approximately 9 years, having commenced its operations in 2006. GEMS membership consists of South African government or public sector employees as provided for in terms of section 7 (2) of the Public Service

[1] Paragraph 5 of the Draft Statement

Act,1994. An independent Board of Trustees governs all matters of GEMS and comprises of member elected trustees and employer appointed trustees. The business and day-to-day activities of GEMS are managed by the Principal Officer.

2.2 The Scheme currently has more than 680 000 members distributed throughout South Africa and covers approximately 1 800 000 beneficiaries. This figure changes constantly, particularly as we add new members to the GEMS portfolio. Recent estimates indicate that just more than 50% of our membership-base consists of members who are new to medical schemes. Member contributions are based on the income bands within which members fall. GEMS' membership eligibility rules determine which members of the public sector qualify to become members of GEMS.

2.3 The Managed Care organisation for all of the GEMS benefit options, namely Onyx, Ruby, Emerald, Sapphire and Beryl is Medscheme Health Risk Solutions. Sapphire and Beryl are the low cost options. In addition thereto, GEMS has other service providers in respect of specific managed care services. For instance, in respect of its Dental Managed Care services and HIV/AIDS Disease management services, Primecure Health is the appointed service provider. Universal Health is the appointed service provider in respect of strategic managed care services.

3. COMMENTS ON TECHNIQUES FOR MARKET DEFINITION AND ANALYSIS OF COMPETITION

3.1 It is our understanding that the Draft Statement sets out a framework for approaching the investigation. Furthermore, the Draft Statement indicates that the points raised therein are intended to be topics for investigations. These are the points which the Panel envisages being the most relevant to answering questions arising from the Terms of Reference. It is also indicated that the topics do not represent any settled views or findings of the Panel.[2]

3.2 It is recommended in the Draft Statement that it is important for stakeholders and their appointed experts to engage on this issue mainly because the definition of the relevant product and geographic markets is an important first step in the assessment of the competitive constraints in competition matters. Furthermore, the purpose of undertaking this step is to delineate the market so that instances of market power can be identified and the relevant competitive constraints isolated and their strength assessed.

3.3

[2] Paragraph 6 of the Draft Statement

3.4 Stakeholders have been invited to make submissions on the appropriate techniques to be employed.

3.5 Save for our discussion below relating to GEMS market power and geographic market, we submit that there is already case law defining the market in relation to medical aid schemes,[3] GEMS proffers that it is at this stage premature for it to make such submissions. However, GEMS will be in a position to engage with the Panel to explore alternative techniques if any, with a view to deciding on the most appropriate methods for purposes of the inquiry.

4. COMMENTS ON THE FINANCING OF HEALTHCARE SERVICES

4.1 Annual tariff negotiations

4.1.1 GEMS (assisted by its managed care providers) conducts annual tariff negotiations with each provider group for purposes of reaching an agreement on a tariff schedule that will apply nationally to each hospital that falls within that group. The agreed tariff schedule forms the basis as to how the hospitals within that group will bill GEMS for the services provided by those hospitals to GEMS members and beneficiaries.

4.1.2 GEMS generally conduct its annual tariff negotiations with healthcare providers in the last quarter of each benefit year, a period that falls between October and December. GEMS conducts tariff negotiations with Life, Netcare Limited ("Netcare"), Medi-Clinic Corporation Limited ("Medi-Clinic") and National Hospital Network ("NHN"). Life, Netcare, and Medi-Clinic are considered to be the three major hospital groups in the private hospital sector.

4.1.3 GEMS also deals with other independent hospitals, including the Clinix hospitals, Joint Medical Holdings and a small number of individual independent hospitals on request. However, GEMS does not negotiate a tariff schedule for each benefit year with some of these small hospitals. Instead, we apply the 'GEMS tariff', which is a non-negotiated tariff published by GEMS and adjusted each year. It is not feasible for us to engage with all of the small independent service providers on their own.

4.1.4 Tariff negotiations with each of the large provider groups are conducted in a very professional manner, although both parties will have very distinct interests and objectives. The provider groups typically negotiate for increased funding and an increase in the service tariffs; the Scheme looks to negotiate for the lowest service tariffs.

[3] Refer to the Metropolitan Holdings Limited / Momentum Group Limited Tribunal decision, case number 41/LM/Jul10, and Momentum Group Limited and African Life Health (Pty) Ltd (CT Case no. 87/LM/Sep05)

4.1.5 Provider groups will typically make the first proposals on the desired tariff increases and will make motivations based on a weighted average consideration of CPI, medical inflation, exchange rates, electricity costs, inflation on consumables and anticipated salary increases. Negotiations also take into account the issues that are particularly relevant to the forthcoming benefit year, e.g. public discourse about healthcare costs.

4.1.6 GEMS approaches the negotiations with each provider group with the same percentage tariff increase in mind. It is important to note that the starting point for annual negotiations with each provider group is not from the same base tariff. This is because the Scheme in most cases agrees a different tariff increase in separate negotiations with each provider group for a benefit year and that same agreed tariff schedule will form the basis for negotiations in the subsequent year.

4.1.7 The final tariff increase arrived at with each provider group is likely to differ from the other groups due to the different negotiating strengths of each group. GEMS view is that there are various qualitative aspects that influence the outcome of these negotiations, including the profile of the personalities that participate in the negotiations.

4.1.8 Factors such as the cost-efficiency of individual hospitals usually form part of our quarterly (on-going) consultations with each provider.

4.2 <u>Countervailing buyer power in tariff negotiations</u>

4.2.1 We do not find that we are currently in a position to leave any of the three major hospital groups out of annual tariff negotiations. We also do not feel that we could feasibly choose not to reach an agreement with any of the three major hospital groups. This is primarily because GEMS members are distributed throughout South Africa and neither one of the three major groups is in a position to provide sufficient coverage of each area where our members are situated. It is therefore necessary for us to contract with each of the three major hospital groups in each year.

4.2.2 Our negotiations with the provider groups focus on reaching an agreement on national tariff rates (rate increases). As such, geographic or regional dynamics are not discussed in our negotiations. The extent of coverage offered by each group is assumed and because of the nature of annual tariff negotiations we do not consider that the addition of a few hospitals to the existing hospitals of a group would affect negotiations substantially. We also do not currently 'channel' our beneficiaries and as such we do not consider the distribution of specialists in our annual negotiations with provider groups.

4.2.3 We believe that we are able to exercise some bargaining or countervailing buyer power with hospitals to deter price increases only by virtue of our size and the fact that more than 50% of our members are new to a medical scheme. GEMS is the second biggest medical scheme in south Africa.

4.2.4 As part of GEMS's effort to make access to healthcare affordable for members, GEMS constantly considers innovative ways to reduce healthcare costs as part of its long term product development strategy.

4.3 Preferred provider arrangements

4.3.1 GEMS has not yet negotiated preferred provider arrangements with any private hospitals in South Africa. The only contracts that exist between GEMS and the provider groups are those that govern the relationship between the parties once the annual tariff increases have been agreed. We do have preferred provider arrangements with National Renal Care for Renal dialysis. Medscheme, the Scheme's managed care organisation for all five of our benefit options, manages and has negotiated specific tariffs for the Scheme's low cost options (Beryl and Sapphire) for when these beneficiaries are admitted to private hospitals.

4.3.2 Our designated service provider is the State i.e. State hospitals. The State bills on the basis of the Uniform Patient Schedule Fee (UPFS). The State hospital rate is much lower than other tariffs, including those negotiated with private hospitals.

4.4 The Role of Medical Scheme Administrators

4.4.1 In terms of Section 58(1) of the MSA and concomitant regulations, administrators have to be accredited by the Council for Medical Schemes in order to be able to act as scheme administrators. Administrators are separate legal entities from the schemes they administer.

4.4.2 CMS has published standards and measurement criteria for third-party administrators.[4] The advisory team appointed to assist with the process of defining the functional elements, associated systems, processes and structures required by the administrators to function according to the requirements of the MSA developed a draft set of standards. The standards encompass the following services provided by administrators:

4.4.2.1 General compliance with the MSA;

[4] CMS Accreditation Standards for Third Party Administrators of Medical Schemes: Standards and Measurement Criteria Version 5

4.4.2.2 System assessment;

4.4.2.3 Member record management;

4.4.2.4 Contribution management;

4.4.2.5 Claims management;

4.4.2.6 Financial management reporting;

4.4.2.7 Information management and data control; and

4.4.2.8 Customer services.

4.4.3 The majority of the services rendered by administrators to the schemes they are contracted to centre around the above standards. Administrators are usually for-profit entities whereas medical schemes are not for-profit entities.

4.4.4 GEMS has contracted Metropolitan Health as its Member and Claims Administrator. The MSA requires that there should be an agreement between a medical scheme and its administrator.[5] The agreement between GEMS and MH sets out *inter alia* the nature and extent of the obligations of MH to GEMS, the details of the fees payable by GEMS and undertakings on the part of MH to administer GEMS in compliance with the MSA and GEMS rules.

4.4.5 GEMS employs the services of the administrator and managed care providers to ensure that the risk that it is exposed to with regard to claims is managed.

4.5 <u>The relationship between GEMS and brokers</u>

4.5.1 GEMS does not utilise the services of brokers as its membership is restricted to those employees who meet the eligibility criteria set out in Rule 6 of GEMS Rules.

4.6 <u>The relationship between GEMS and suppliers of consumables</u>

4.6.1 GEMS does not presently have a direct relationship with suppliers of consumables. However, the Scheme's long term strategy is to become an activist purchaser of all healthcare services and this will include getting involved in the sourcing of consumables.

5. CONCLUSION

5.1.1 We hope that our comments will be of some use to you and that they will be incorporated into the final Statement of Issues and Administrative Guidelines.

5.1.2 GEMS is willing to engage with you further and to provide supporting data for its submissions to the extent necessary.

[5] Regulation 18 of MSA Regulations published under GN R1262 in GG 20556 of 20 October 1999