



H e a l t h M a r k e t I n q u i r y

Promoting Healthy Competition

CALL FOR SUBMISSIONS AND PARTICIPATION IN SEMINAR

A discussion of the need for and impact of selected interventions to address regulatory gaps within healthcare financing, with the aim of strengthening competition.

The Health Market Inquiry (HMI) invites stakeholders to make submissions and to participate in a seminar on the healthcare financing regulatory framework and the impact it has on competition in the South African private healthcare sector.

Please make submissions by 19th of January 2018. The seminar will take place at the HMI offices on the 1st of February 2018.

1 DECEMBER 2017

INTRODUCTION

1. The South African private healthcare market is operating in a less than optimal regulatory environment particularly in relation to the regulation of healthcare financing. The Medical Schemes Act No 131 of 1998 (MSA) introduced Prescribed Minimum Benefits (PMBs), along with community rating and open enrolment. These social solidarity policies sought to provide protection for older, sicker members. It was envisaged that these policies would be accompanied by further social solidarity principles including mandatory membership and a risk equalisation mechanism. However, the current regulations do not include mandatory membership which would mitigate against adverse selection (meaning people stay out of the system until they need access to expensive care and then “opt in”). Medical schemes can, however, implement underwriting through imposing waiting periods and late joiner penalties. In addition, the Council for Medical Schemes (CMS) continued to work towards a risk equalization fund (REF) and developed a shadow REF process. This work stalled when the country’s focus shifted towards universal health coverage and the National Health Insurance (NHI).
2. Several stakeholders, in their submissions to the Health Market Inquiry (HMI), raised concerns about the piecemeal implementation of the social solidarity principles. They argued that the incomplete regulatory framework is one of the explanatory factors for rising healthcare costs and could be indicative of government failure or being unresponsive to market failure.
3. The HMI’s own research unveiled a regulatory environment that hinders competition within the funder market. Consumers wishing to join an open medical scheme have to select between 185 benefit options ranging in richness of cover.¹ Medical schemes may have introduced the wide range of benefit options as a way to induce clients to self-select, based on their own perceived risks. This is in the current environment of open enrolment and community rating without the complementary effects of mandatory membership and risk equalisation.
4. The wide range of benefit options, however, contributes towards information asymmetries in the market which may result in medical schemes being able to avoid direct price competition. It is nearly impossible for consumers to compare and make

¹ Council for Medical Schemes Annual Report 2016/2017. This figure includes the efficiency discount options.

rational choices based on value (price and quality) between all of these options. Additionally, the regulatory gaps may encourage medical schemes (and their administrators) to compete on factors that attract young and healthy members rather than factors that members derive real health related value from.

5. The HMI is considering the impact that the partially implemented social solidarity policies has on competition. The Terms of Reference allow for the HMI to make recommendations that will encourage competition within the private healthcare market.² The HMI plans to hold a seminar to discuss possible interventions that will lead to greater competition within the medical scheme environment which should drive down prices as the country moves towards the NHI. More specifically:
 - a) What interventions, if any, are required to address anti-selection, if it occurs, so as to increase meaningful competition;
 - b) How to improve risk pooling in the market so as to improve competition; and
 - c) How could changes to medical scheme benefit options improve competition in the market?

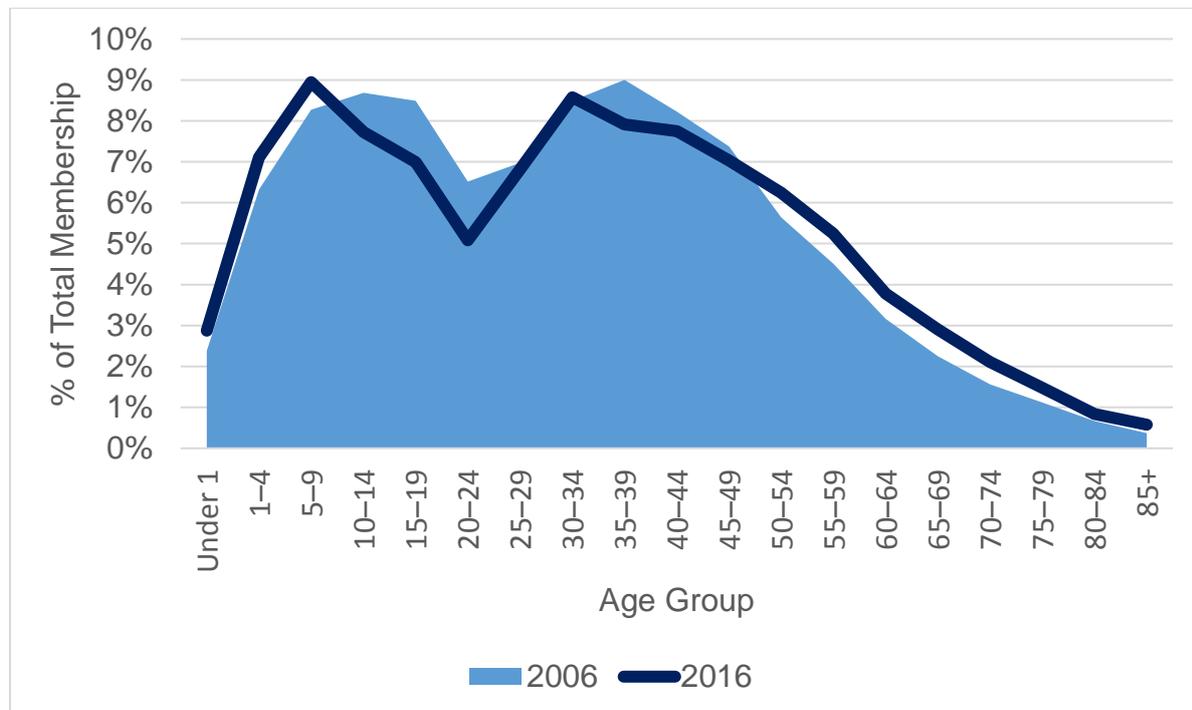
6. This discussion document first looks at anti-selection in relation to medical schemes and then considers risk pooling across and within medical schemes. Finally, this discussion document looks at medical scheme benefit options and the inability of consumers to make meaningful choices based on value. For each section, the HMI sets out the various stakeholders views. We then identify questions that we would like to engage with stakeholders on both through written submissions and in a seminar.

² Terms of Reference for the Market Inquiry into the Private Healthcare Sector, Government Gazette No37062 29 November 2013.

ANTI-SELECTION IN RELATION TO MEDICAL SCHEME MEMBERSHIP

7. Anti-selection refers to the possibility that beneficiaries join medical schemes when they anticipate a need of care or a greater chance to incur healthcare costs. There are differing views amongst stakeholders on the existence and extent of anti-selection. Some stakeholders, including medical schemes and their administrators, are of the view that there is systemic anti-selection against medical schemes. This anti-selection undermines social solidarity and ultimately the viability of medical schemes.
8. The HMI has also heard that the current demographic structure is less a result of anti-selection but more a feature of demographic changes brought about from an increase in membership of those who, historically, were uninsured. Other stakeholders state that the unaffordability of medical schemes incentivizes a level of anti-selection as potential members delay joining a medical scheme until they can afford it, which is typically when they are older.
9. Figure 1 below illustrates the change in demographic structure of medical scheme beneficiaries over a 10-year period. Some stakeholders state that the shape of the figure illustrates anti-selection as individuals leave medical schemes in their teens and twenties when their need for healthcare coverage is low.

Figure 1: Demographic structure of medical schemes for 2006 and 2016



Source: CMS Annual Report 2016/2017

10. If we compare the 2006 demographic structure of medical scheme members in Figure 1 to the 2016 structure, we see there was an increase in membership as a percentage of total membership of those under the age of 9 and those over the age of 54. For both years there is a clear dip in membership for the 20 to 24 year old category. This dip is steeper and the downward trend starts earlier in 2016.
11. Insight Actuaries, in their submission to the HMI, explain that anti-selection is evident as there are a number of people between the age of 20 and 34 that are above the tax threshold but who do not join medical schemes. They provide further analysis on the age and gender profile of medical schemes to illustrate anti-selection through prospective mothers who take up membership to ensure they can access private healthcare for the birth and possible neonatal care.³
12. Some stakeholders refer to the average age of restricted medical schemes to further demonstrate their point of anti-selection in the open medical scheme environment. Usually membership of a restricted medical scheme is a condition of employment and this condition prevents anti-selection. The average age of restricted medical schemes at 30.6 for 2016 is lower than open medical schemes at 34.^{4,5} In 2006, just before the introduction of the Government Employees Medical Scheme (GEMS), the difference in age between open and restricted medical schemes was minimal with the average age of open medical schemes slightly lower at 31.5 compared to restricted at 31.8.⁶ It may be that the decreasing age of restricted medical schemes and the increase in age of the open schemes is due to the introduction of GEMS in 2007 as many of the younger government employees may have moved from open medical schemes to this restricted medical scheme.
13. Stakeholders state that, in addition to (or linked to) the higher age in open medical schemes, these schemes also have higher chronic disease prevalence than restricted medical schemes or compared over time. In addition, there has been a decrease in the number of members who do not claim during a particular year over the last 8 years. This signals a worse risk profile for open medical schemes than restricted medical schemes and is a result of anti-selection in the open medical scheme environment.

³ Insight Actuaries and Consultants, Expert Report of Barry Childs; Prepared for Netcare Limited in relation to the Competition Commission Healthcare Market Inquiry.

⁴ The average age of medical scheme beneficiaries increased in the last five years from 31.6 in 2011 to 32.5 in 2016.

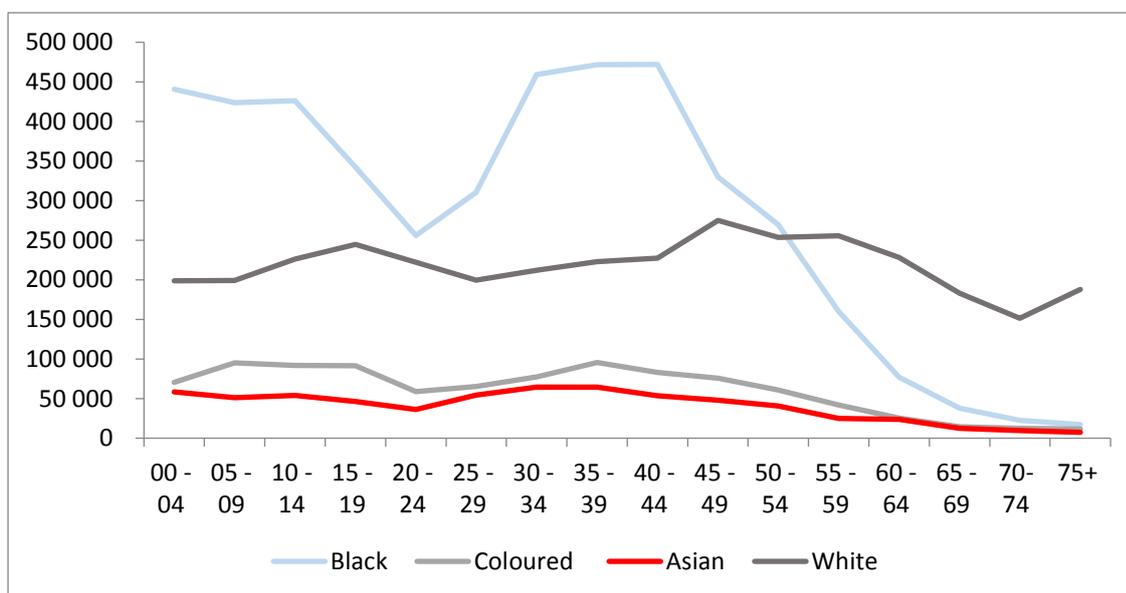
⁵ CMS Annual report 2016/2017.

⁶ CMS Annual report 2006/2007.

14. Some stakeholders question the extent of anti-selection as, while membership is not mandatory, medical schemes can, and do implement underwriting through applying late joiner penalties and waiting periods. In addition, many employers require employees to join a medical scheme as a condition of employment, even if the employer does not have its own restricted scheme, and this eliminates some anti-selection.

15. The HMI has also heard that the double hump in Figure 1 is a result of the historically uninsured population joining medical schemes. Figure 2 provides a breakdown of age of medical scheme beneficiaries by population group for 2014.

Figure 2: Age by population group for beneficiaries of medical schemes



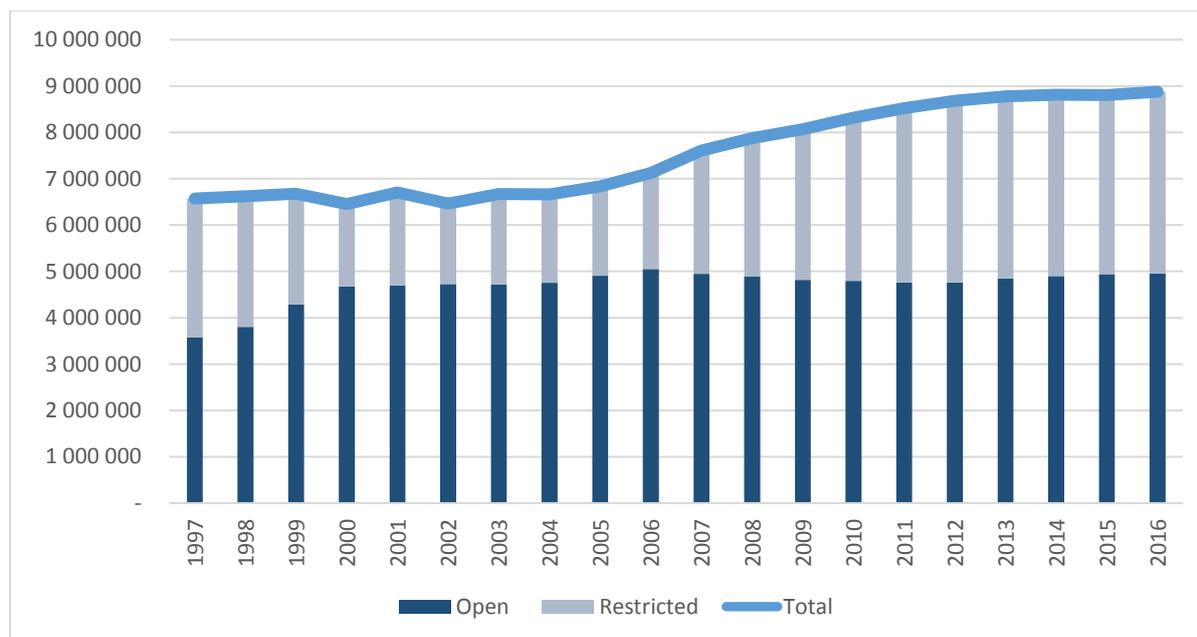
Source: Alex Van Den Heever: Age and population group (submission the HMI) 2016

16. Figure 2 shows that the double hump is most pronounced for the black population and this could be a result of black families joining medical schemes, where previously, their parents were not members. The initial drop off in this category is likely to be income-related. The other population groups experience a milder dip suggesting limited anti-selection. Under this scenario, in time, the bigger dip for the black population will gradually level out as the income related patterns normalise.

17. Stakeholders stating that anti-selection is a result of affordability argue that real growth in the medical scheme environment is constrained by the high level of unemployment

(currently at 27,7%)⁷ and informal employment (with irregular income) in South Africa. Figure 3 below illustrates the growth of medical scheme beneficiaries from 1997 to 2016. The growth rate in the last five years has been particularly slow. The percentage of the total population that belongs to a medical scheme has remained stagnant. In 1996, 15.8% of the total population belonged to a medical scheme and by 2016, the number remained relatively unchanged at 15.9%.⁸

Figure 3 Medical scheme beneficiaries from 1997 to 2016 by scheme type



Source: CMS Annual Reports

18. GEMS provided an example of how affordability affects its membership numbers. The medical scheme experienced negative membership growth in the first 2 quarters of 2015 following its membership fee increase. The number of principal members increased in August that year after the implementation of an increase in subsidy (with last subsidy increase being in 2011).⁹

19. Some stakeholders argue that the dip in Figure 1 above illustrates the inability of young adults to afford medical scheme membership after no longer belonging to their parents' medical schemes. Employment prospects for the youth or young adults is limited with unemployment between at 32% for 25 to 34 year olds. Members join medical schemes at a later age when they can afford it.

⁷ Statistics South Africa 'Quarterly Labour Force Survey' Quarter 3: 2017' 31 October 2017.

⁸ Calculated using figures from the Council for Medical Schemes Annual Reports and Statistics South Africa.

⁹ GEMS Written Submission to the public hearings, 1 March 2016.

20. Given the varying views the HMI has heard, we would like to assess the degree to which anti-selection occurs. In particular, the HMI is interested in the extent to which anti-selection affects medical scheme membership and the viability of the schemes and how this ultimately harms competition and the consumer. To do so, the HMI poses the following questions:

- What evidence, if any, illustrates the extent of anti-selection in the medical scheme market, what are the underlying drivers and how has this changed over time?
- How is this evidence related to developments in income, employment and demographics?
- Is the current level of underwriting effective at discouraging late joiners?
- Assuming that anti-selection is a real and important phenomenon in the South African healthcare market, what mechanisms can be introduced to limit anti-selection (particularly keeping in mind the overall country objective of moving towards a NHI)?
- How would these proposed mechanisms affect the number of beneficiaries and the level of contributions?
- What impact would these mechanisms have on low income earners that may spend unsustainable proportions of income on medical insurance (and in the absence of a low income benefit option)?

RISK POOLING ACROSS MEDICAL SCHEMES

21. In the Revised Statement of Issues, the HMI stated that residual risk pooling failures may affect competition in the private healthcare system in South Africa.¹⁰ The absence of some form of risk adjustment mechanism, particularly for PMBs, in private healthcare may be a structural flaw which harms competition amongst medical schemes. The HMI is interested in risk pooling and the effect it has on price and therefore competition within the private healthcare sector as the country moves towards the NHI. One aspect of an NHI is that that it creates one single risk pool for all South Africans.

22. In stakeholder submissions and public hearings, stakeholders presented mixed views on risk pooling and in particular the REF. Some stakeholders were in favour of a REF. They claim that the lack of a mechanism to equalise on risk drives risk selection failures

¹⁰ Health Market Inquiry 'Revised Statement of Issues' 11 February 2016.

(selection of healthy and young above sick and old). This results in a consolidation of medical schemes with weaker risk pools which may be unrelated to their efficiency or product offering. Other stakeholders are against the development and introduction of risk equalisation mechanisms, not necessarily on material grounds, but rather that the focus of Government should be on the development and implementation of the NHI and not on the REF.

23. Stakeholders in favour of a mechanism to equalise for risk, particularly for PMBs, explain that medical schemes' individual risk pools are small. Smaller risk pools have less predictable healthcare costs and lack the ability to withstand sudden large, unpredictable claims. In addition to this, the risk profiles of the various medical schemes differ which impacts each scheme's cost of care for PMBs per member. With no mechanism to adjust for age or disease burden, medical schemes with older, sicker members will have higher contributions than medical schemes with healthier members. This is in contrast to an industry level risk pool that combines all medical schemes risk pools into a single risk pool which allows medical schemes to share the risk of sicker members and large claims. The lack of a mechanism to standardise for risk limits the ability to achieve the equity goals envisaged under the social solidarity principals and prevents competition based on the efficient delivery of service.
24. Stakeholders state that medical schemes implement a proxy risk rating through benefit¹¹ design. Some medical schemes provide a large number of benefit options to appeal to a wide range of target markets and hence, increases their ability to create more homogeneous risk pools (i.e. proxy risk rating).¹² Members, in essence, self-select between the benefit options based on their own perceived risk. Furthermore, stakeholders told the HMI that medical schemes do not embark on innovative measures to assist high risk individuals through the health system as this will attract additional high risk members to the scheme.
25. The MSA requires that each benefit option must be self-sustaining such that gross contribution income generated from each option should be sufficient to cover members' claims in that benefit option. This means that, in the current regulatory environment, risk pooling should occur at an option level. However, in practice, this

¹¹ Benefit options set out the defined benefits medical schemes offer their members and the resultant contribution rate.

¹² Kaplan J and Ranchod S. 2015. An actuarial perspective on medical scheme benefit design. Presented at the Actuarial Society of South Africa's 2015 Convention 17–18 November 2015, Sandton Convention Centre: Johannesburg.

does not seem to occur as risk pooling occurs at a medical scheme level. Table 1 sets out five open medical schemes beneficiaries by contribution band, with the red figures indicating that the contribution band is cross subsidised. In many cases, medical schemes cross subsidise the higher and lower cost benefit options from the middle cost benefit options.

Table 1: Beneficiaries by contribution band, with the red highlights indicating a cross-subsidised option

Scheme	Options - contribution band	2010	2011	2012	2013	2014
Bonitas	100 – 500		55 119			
	501 – 1000	220 080	184 579	244 183	271 358	219 744
	1001 – 1500	389 533	360 707	349 395	341 435	70 369
	1501 – 2000				28 013	357 120
	2001 – 2500	8 851	8 806			
	2501 – 3000			8 283	9 794	9 294
Discovery	100 – 500				8 894	7 910
	501 – 1000	992 361	716 437	623 832	639 757	659 269
	1001 – 1500	701 115	873 457	1 086 944	1 176 506	1 236 335
	1501 - 2000	75 375	289 002	232 561	238 383	257 709
	2001 - 2500	449 197	447 796	498 042	473 809	46 186
	2501 - 3000	26 846	27 659	27 644		401 095
	3001 - 3500				26 964	26 315
Fedhealth	100 - 500	112	3 239	3 763	8 160	3 721
	501 - 1000	1 328		2 885	4 521	19 427
	1001 - 1500	60 969	45 847	44 517	41 675	38 726
	1501 - 2000	85 393	84 715	78 097	74 966	69 588
	2001 - 2500	7 634	9 304	13 619	13 162	12 918
	3001 - 3500	7 491				
	3501 - 4000		6 213	5 240	2 932	
	4001 - 4500				1 506	3 444
	4501 - 5000	1 048				
	5001 - 6000		835	695	616	521
Medihelp	501 - 1000	98 206	75 367	70 768	74 410	51 205
	1001 - 1500	58 796	92 723	100 212	107 195	137 120
	1501 - 2000	52 705				
	2001 - 2500		42 156	35 551		
	2501 - 3000				30 906	27 822
	4001 - 4500	36 399				
	4501 - 5000		31 957		8 199	6 984
	5001 - 6000			9 684		
Momentum	100 - 500	15 251	20 878	17 611		36 013

	501 - 1000	72 388	77 976	98 169	109 251	89 198
	1001 - 1500	64 595	61 701	36 620	83 971	84 540
	1501 - 2000	10 789	3 506	27 889		
	2001 - 2500	15 120	8 757	5 357		
	2501 - 3000		11 399	12 160	17 223	15 113
	3501 - 4000	3 502				
	4001 - 4500		2 742	2 256		
	4501 - 5000				1 933	1 623
Overall total		3 455 084	3 542 877	3 635 977	3 795 539	3 889 309

Source: Alex Van Den Heever: Industry Overview (Submission to the HMI 2016)

26. Stakeholders told the HMI that medical schemes cross subsidise their benefit options to ensure the sustainability of their scheme as a whole. The higher contribution bands that provide more coverage (comprehensive plans) appear to be cross subsidised from the middle to lower contribution bands. These comprehensive plans typically have the sick and elderly as well as some of the “worried wealthy.” If these plans had to be self-sufficient, then they would become more expensive. This would incentivise members, including the worried wealthy, to *buy down* to cheaper, less benefit rich, options. This results in a decrease in gross contribution income for the medical scheme without an equal decrease in claims which could make the medical scheme unsustainable. Ultimately, it could contribute to what the industry terms the actuarial death spiral.

27. It also appears that some medical schemes subsidise their low cost benefit options. This may suggest that if these options were not being cross subsidised, then they would not be affordable and current members would be eased out of the market.

28. The HMI would like to assess whether the degree to which risk pooling at a medical scheme and benefit option level is adequate in the private healthcare sector and the impact this has on competition. As such, the HMI has the following questions:

- How does the current degree of risk pooling impact competition between medical schemes?
- Why are benefit options that are in financial deficit for consecutive years, allowed to exist?
- What impact does the lack of a medical scheme wide mechanism to equalise for risk have on medical schemes and the cost of cover?
- If there is a need for a risk equalisation mechanism:
 - What are the various mechanisms that can be introduced;
 - How long will it take for them to be fully implemented; and

- What impact will they have on competition? For example, will a mechanism that adjusts for risk across medical schemes allow for variance in price to relate to the different contracts medical schemes have with their service providers?
 - Who will benefit and who will be harmed by introducing these mechanisms to adjust for risk across medical schemes?
 - What costs will be involved to introduce these mechanisms?
 - What impact will an introduction of a risk adjustment mechanism have both on medical schemes and the country as a whole as the country moves towards a NHI?

INCOMPARABILITY OF BENEFIT OPTIONS

29. In well-functioning competitive markets, consumers have sufficient information to compare products based on their price and quality. It is common cause that healthcare markets are riddled with imperfect information. The South African medical scheme market is no different as consumers are unable to make effective choices by comparing contribution rates and the scope of benefits across medical schemes. Consumers, who do not belong to a restricted medical scheme, face the daunting task of choosing between 21 open medical schemes and 185 benefit options¹³ that are neither standardised nor comparable. In some instances, the employer selects the medical scheme or schemes for their employees and then the employees select from the benefit option from within the selected medical schemes.
30. Members should have a robust understanding of the product to determine the benefit option that best suits their healthcare needs by providing access to value for money healthcare. However medical schemes and administrators have told the HMI that consumers typically do not know what their benefit options cover. They tend to only become aware of the details of the products that they purchased (i.e. the particular medical scheme option) when they want to claim or if a claim is partially paid or not paid at all.
31. The MSA requires medical schemes to comply with certain criteria when setting up their benefit options. The MSA requires that all benefit options must include PMBs as part of the benefit design. This is to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have

¹³ Council for Medical Schemes Annual report 2016/2017.

selected. But, beyond PMBs, option cover varies significantly between medical schemes.

32. In the Healthcare Consumer Survey there was consensus among the individuals that the process of selecting a benefit option and the information available from medical schemes is complicated.¹⁴ The complication arises from the substantial amount of information members receive and the terminology medical schemes use to describe the benefits. Individuals tend to narrow their selection to options based on their health status and that fall within their affordability band as individuals face a trade-off between price and richness of cover. Lower income earners, or the young and healthy, for example, will select between the various hospital plans. Higher income earners, or the sick and/or elderly, will select between more comprehensive plans. However, there is no uniformity across medical schemes' benefit options, even within the broad types of categories, such as comprehensive plans or traditional plans.
33. Employers and individuals may rely on brokers to guide them in selecting the appropriate medical scheme and then benefit option. Brokers typically conduct a needs analysis based on the member's healthcare requirements and income level. Although individuals may use a broker, this does not necessarily imply they select the best option as brokers may have their own agenda.
34. The CMS has classified the benefit options into three very broad categories: traditional; new generation; and hospital plans. The traditional plans cover almost all medical expenses and include benefits for in-hospital, day-to-day expenses and chronic medication, subject to the rules of the scheme. This category includes the comprehensive plans. The new generation plans have a savings component and cover almost all medical expenses and include benefits for in-hospital, day-to-day expenses and chronic medication, subject to the rules of the scheme. Some stakeholders are of the view that these medical savings accounts add unnecessary complexities to the market. The hospital plans cover healthcare expenses only for in-hospital treatment. Members are responsible for their own day-to-day medical expenses. It is important to note that although these plans are categorised as hospital plans they must still pay for all PMBs regardless if the treatment occurs in or out of hospital.

¹⁴ Health Market Inquiry 'Summary of Results from the Healthcare Consumer Survey 18 November 2018'.

35. Within each of these broad categories, the benefit options are delineated into narrower options which provide even more choice. Some medical schemes may offer their members hybrid options, which are combinations of traditional and new generation plans. In addition, each of the broad categories also provide network options which stipulate the provider the member can go to. There is no clear list of which benefit options fit in which group and benefit options also change over time. This further adds to the confusion for consumers.
36. Already in 2006 the CMS recognised that the current benefit design structure was inefficient. In Circular 8 of 2006 the CMS proposes a benefit design framework. One of the objectives of the new framework was to ‘improve transparency of scheme designs to aid members in making informed decisions.’ Another objective was ‘to improve price competition between medical schemes’.¹⁵ The proposed benefit design framework included a basic benefit (which would be community rated and subject to REF) and supplementary benefits (which could be risk rated). This proposed framework was incorporated into the 2008 MSA amendments, which have since lapsed in Parliament.
37. The HMI recognises that the large number of benefit options may be a result of medical schemes wishing to remain operational in an environment prone to anti-selection and with risk pooling failures. The role of medical schemes will evolve as South Africa moves towards a NHI. With that in mind, the HMI wishes to make recommendations that will increase competition on value (price/quality) and efficiency of medical schemes’ product offering which will then increase affordability of medical schemes.
38. Successful measures to address anti-selection and risk pooling failures may decrease the need for intervention in the development and design of benefit options. However, there may still be some residual information failure whereby the medical schemes are motivated, in part, by the wish to avoid value comparison. The inability of individuals to compare options effectively provides medical schemes with limited incentive to contract effectively or innovatively with providers with the aim to pass benefits back to members. These benefits include both price and access to higher quality healthcare.
39. The HMI wishes to discuss possible changes to medical scheme benefit options that could improve competition within the market.

¹⁵ CMS Circular 8 of 2006 “*Consultation on a Revised Benefit Design Structure for Medical Schemes.*”

- Is the current level of competition between medical schemes on their benefit options effective, considering the information available and the complexity of the subject?
- What changes would allow members to compare the real value of medical scheme benefit options?
- What is the contribution (if any) of medical savings accounts to the member and to the medical scheme?
- What is the effect of current medical savings accounts on moral hazard,¹⁶ and how can the continued existence of these accounts in the medical schemes industry lower moral hazard, and improve competition between schemes?
- Will a simplification of benefit options improve transparency and accountability? To what extent will this incentivize medical schemes to compete on the merits – that is on value for money and innovative contracting where they can pass the benefits directly onto the members?
- How can benefit options be simplified to allow meaningful comparisons and increased competition? In this regard these are some possible options, but the HMI welcomes others:
 - CMS’s recommendations in Circular 8 of 2006 of an establishment of common benefits across a scheme with a single contribution table (scheme benefits) with buy-up supplementary benefits. In this example, medical schemes will provide common benefits with a single price to the entire membership and members can purchase additional benefits on a voluntary basis. This would result in a single risk pool for each medical scheme for common benefits and distinct risk pools for supplementary benefits. This would require risk equalisation for the pricing of PMBs only.¹⁷
 - Simplify and standardise a mandatory benefit package that all medical schemes must offer. Medical schemes can then sell (a limited number of) complimentary (top-up) benefit options.

¹⁶ In Insurance markets, ‘moral hazard’ describes a situation wherein consumers may change their behaviour because they have insurance. The problem of ‘moral hazard’ arises where one party to a transaction (e.g. the insured) may undertake certain actions (e.g. drive more recklessly) that (a) affect the other party’s valuation of a transaction between them (e.g. the insurance company’s valuation of their insurance contract) but (b) the second party cannot monitor or enforce actions taken by the first party perfectly (adapted from Kreps, D 1990. A course in microeconomic theory, published by Patience Hall).

¹⁷ Council for Medical Schemes Circular 8 of 2006 “*Consultation on a Revised Benefit Design Structure for Medical Schemes.*”

- Each medical scheme must offer a standardized package but can then offer a limited number of other benefit options of their own design, but that meet the requirement of the MSA.
 - Limit the number of benefit options each scheme can offer, and ensure that each meet the requirements of the MSA.
 - No new restrictions on benefit options, but medical schemes must clearly classify each option so that the consumer knows which CMS benefit category it falls in. This will allow the consumer to know and be able to compare options within a particular group such as comprehensive, for example. The CMS will need to review the broad options categories into narrower groupings.
- What prevented the implementation of the revised benefit design structure proposed in Circular 8 of 2006?
 - What are the disadvantages of simplifying the benefit options?
 - What other mechanisms must also be implemented for any simplification of benefit options to result in increased competition?

CALL FOR SUBMISSIONS

40. The HMI requests stakeholders to make submissions specifically in relation to the questions posed in this document. Stakeholders are also welcome to provide the HMI with other information in relation to the topics highlighted above, along with the appropriate research and justification.
41. The HMI will host a seminar to discuss these topics in further detail after reviewing the submissions from stakeholders.
42. Please provide all submissions to the HMI (paulinam@compcom.co.za and pamelah@compcom.co.za) by close of business on 19th January 2018. The HMI will hold a seminar on the 1st of February 2018.

REFERENCES

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