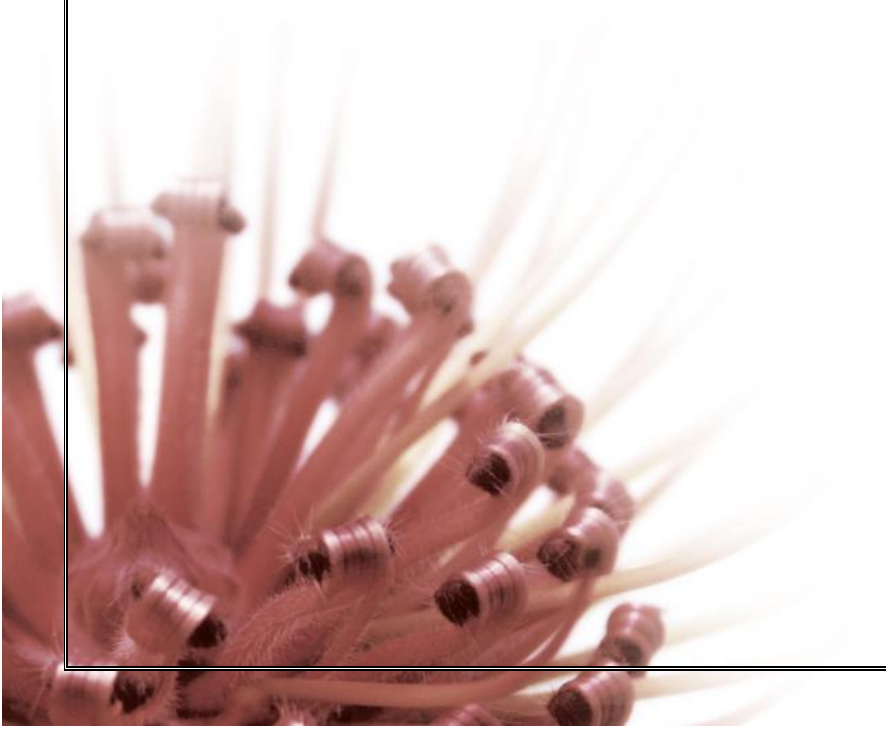
Life Healthcare Group

Report on the HMI regulatory gap discussion paper

January 2018

CADIANT partners
consultants & actuaries



1. Introduction

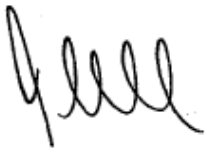
1.1 Introduction

Cadiant Partners Actuarial and Consulting Solutions (Pty) Ltd ('Cadiant Partners') has been requested to provide feedback to Life Healthcare regarding the Health Market Inquiry paper released on 1 December 2017 titled "A discussion of the need for and impact of selected interventions to address regulatory gaps within healthcare financing, with the aim of strengthening competition."

This document responds to the various questions raised in the paper.

1.2 Signatories

This paper has been prepared for Life Healthcare by:



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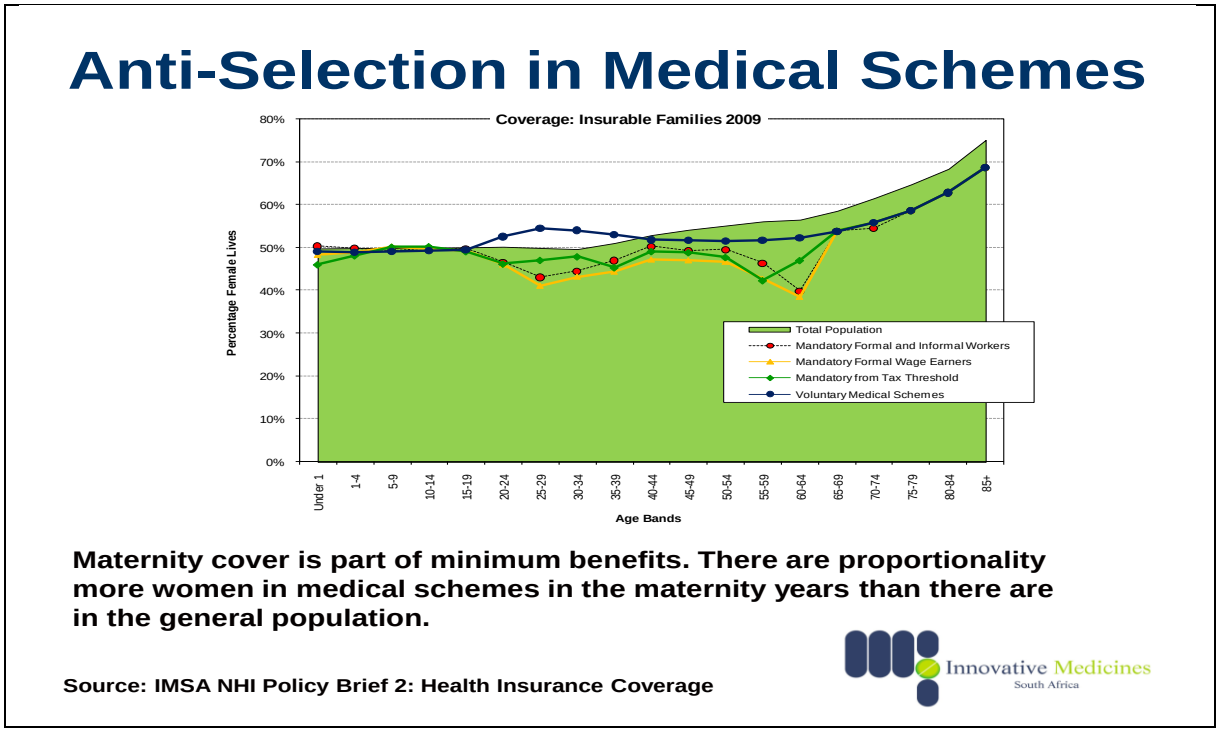
Questions raised by the Health Market Inquiry in some cases query anti-selection and in other cases late joiners. The definition of anti-selection, as provided in point 7 of the HMI report, notes that "anti-selection refers to the possibility that beneficiaries join medical schemes when they anticipate a need of care or a greater chance to incur healthcare costs". This definition would include both anti-selection whereby members join a scheme to access health care cover for a short period of time (hereinafter referred to as "anti-selection") as well as members who join when they anticipate greater healthcare costs over a longer term (hereinafter referred to as "late joiners"). Both of these forms of anti-selection are considered where relevant.

2.1 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?

In a Personal Finance article dated 23 July 2017, Kabelo Khumalo writes that "Anti-selection is when beneficiaries join a medical scheme for a short period to claim for expensive medical care and resign once the scheme has paid for their treatment. GEMS says beneficiaries practising anti-selection claimed R149 million from the scheme, while they contributed R30m in 2015."

A number of medical schemes note that maternity is a big area for anti-selection, particularly in low cost options attempting to attract young, previously uninsured members. This type of anti-selection was noted by Dr Jonathan Broomberg of Discovery Health in the Parliamentary Monitoring Group meeting held on 1 June 2010.

The slide below shows further evidence of anti-selection in medical schemes in relation to maternity. Innovative Medicines South Africa shows in the same presentation that proportionately less males are medical scheme members at these ages than females.



The underlying drivers for anti-selection for maternity cases is as follows:

- The majority of females looking to have children are under the age of 35, where no late joiner penalties ('LJPs') are applied. Even up to age 40 the LJPs are only a 5% contribution loading
- Pregnancies are in many cases planned events and it will take close to 10 months for the event to take place. A one year waiting period is therefore not a deterrent
- Females are able to relatively accurately calculate the cost of childbirth (including pre-natal care) and compare this to the cost of contributions that will be payable to the medical scheme. Any difference where contributions exceed expected costs (which is not always the case) is considered to be insurance against complications that may occur during childbirth.

Both anti-selection and later joiners have a negative impact on claims costs and therefore the affordability of medical schemes.

2.2 How is this evidence related to developments in income, employment and demographics?

Anti-selection is reduced considerably for employees who are employed with large corporates who make membership of a medical scheme a compulsory condition of employment. Even where membership is compulsory for employees, it may not necessarily be compulsory for their families, leading to anti-selection by these individuals in a manner similar to individual member anti-selection.

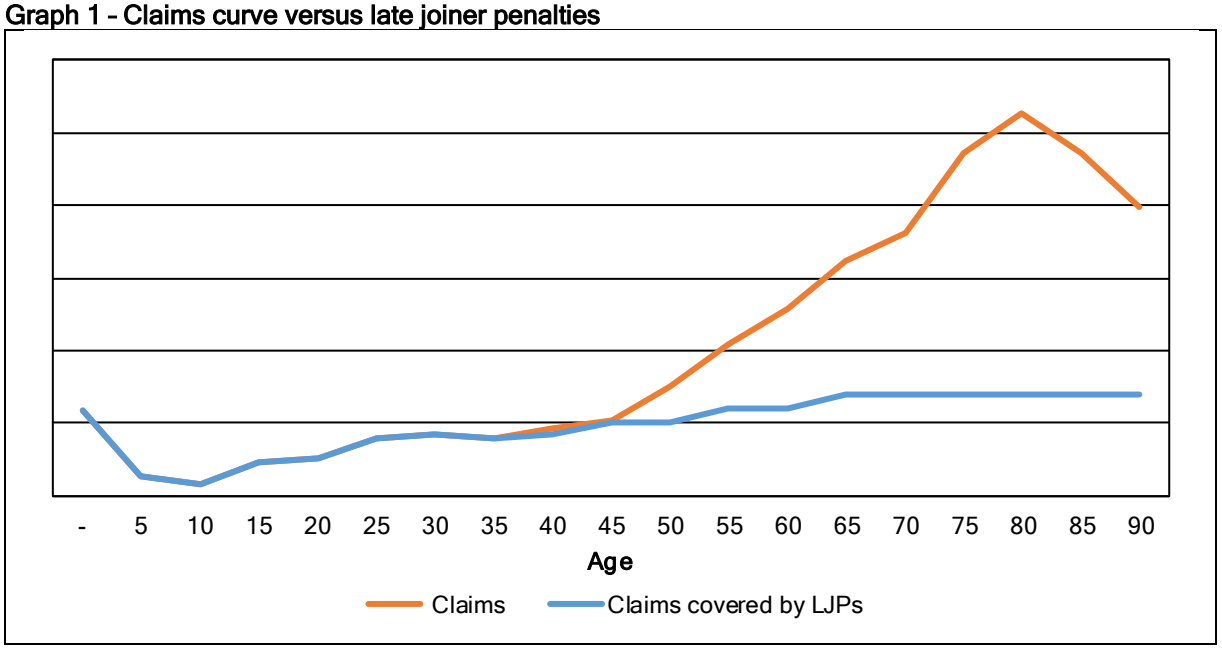
Anti-selection is therefore far more of a risk for unemployed, self-employed or employed by small company individuals where membership of a medical scheme is not compulsory.

2.3 Is the current level of underwriting effective at discouraging late joiners?

Late joiner penalties

The graph below shows a typical claims curve for a medical scheme and the implied claims covered by late joiner penalties assuming that these apply to the base claims for age 35 to 40.

Graph 1 – Claims curve versus late joiner penalties



The graph clearly shows that late joiner penalties are ineffective at covering the additional costs expected by a medical scheme as a result of increased age. This assumes that a member joining later in life has the same expected claims as an average medical scheme member. In reality, members seeking out medical scheme cover later in life are likely to be in poorer than average health, resulting in even higher expected claims and a large differential between the late joiner penalties and expected claims.

Waiting periods

The maximum waiting period that can be imposed on a member is a 12 month condition specific waiting period. This does not protect schemes from:

- Anti-selection in the case of expensive surgeries that can be delayed by the member such as joint replacements. Many members will join an entry level option for the 12 month period and buy up to a more expensive option once the waiting period has lapsed in order to gain access to the required level of benefits.

- Late joiners who have been diagnosed with conditions that require extended periods of treatment (such as cancer) or life-long treatment (including various chronic conditions), the cost of which will well exceed the contributions payable (even if a level of late joiner penalty is applied) after the waiting period has lapsed.

2.4 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)?

There is currently considerable uncertainty regarding when NHI will be fully implemented, at what level it will be implemented and exactly what role medical schemes will play in an NHI environment. It is therefore difficult to provide recommendations specifically taking into account NHI. We therefore consider various scenarios and make recommendations accordingly.

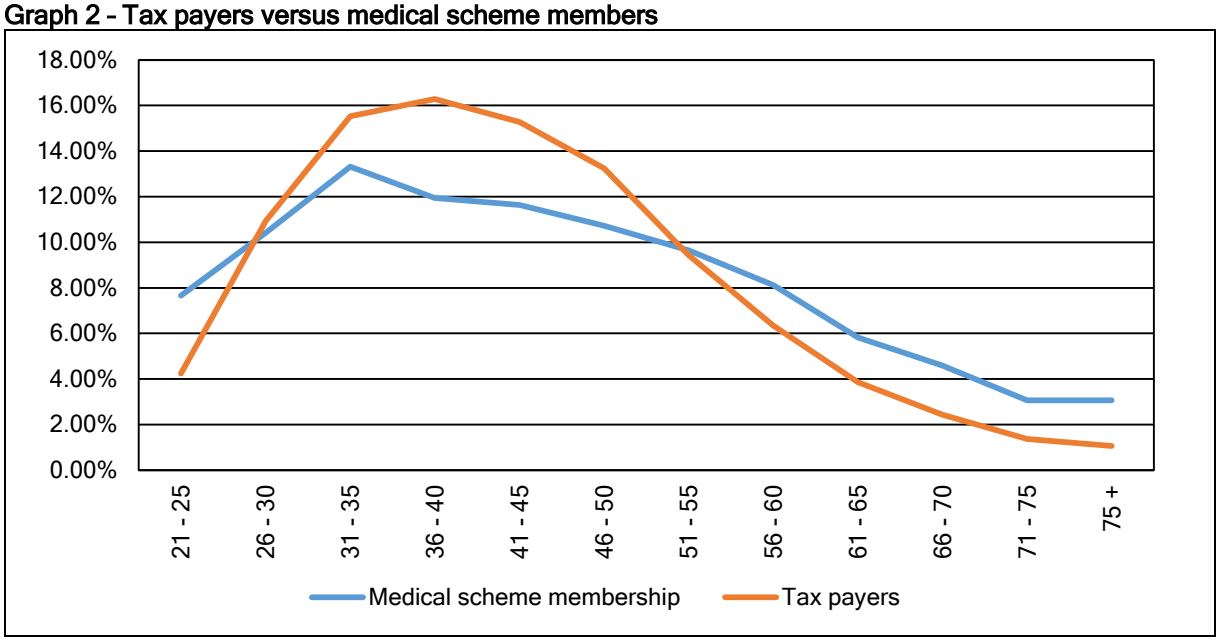
Compulsory membership is by far the most effective way of removing both anti-selection and late joiner effects in the medical scheme industry. Membership could be made compulsory for, for example, individuals or family units earning above a certain income each year. This would be appropriate in the current environment where government is looking to reduce the burden on the public health care system and would benefit from increased medical scheme membership at more affordable prices. The anticipated positive impact on contribution rates of compulsory membership is considered in Section 2.5 below.

The introduction of a full NHI would mean that NHI membership would become compulsory and medical schemes would likely provide supplementary cover. In this case, medical schemes should be allowed to operate on common insurance principles, including the use of life-long pre-existing condition exclusions, contribution rating based on claims and limitation of all benefits (including what is currently included as Prescribed Minimum Benefits).

2.5 How would these proposed mechanisms affect the number of beneficiaries and the level of contributions?

The graph below compares the percentage of tax payers by age category for tax payers over the age of 21[1] to the percentage of medical scheme members by age category[2]. Note that there is a slight difference in the age categories used by Council for Medical Schemes ('CMS') and SARS and the CMS age category 20 – 24 has, for example, been compared to age category 21 – 25 of the SARS report.

Graph 2 – Tax payers versus medical scheme members



[1] SARS 2017 Tax Statistics – Personal Income Tax
[2] These have been estimated using the graph reflected on page 4 of the HMI report, sourced from the CMS Annual Report 2016/2017.

The above demographic profiles combined with the claims curve shown in Graph 1 indicate that claims would reduce by approximately 15% should the medical scheme membership demographic distribution be the same as the personal income tax distribution[3]. This would in turn reduce contributions, which would encourage membership growth. The change in the demographics of medical scheme membership will occur through the introduction of compulsory membership.

We note that current membership of medical schemes far exceeds the number of individuals who pay income tax. Medical scheme membership would include the spouses of income tax payers who are not themselves earning a taxable income as well as the children of tax payers. It would also include individuals who earn an income below the tax threshold who can either afford to pay their medical scheme contributions directly or indirectly through employer and/or family assistance.

2.6 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)?

A reduction in the current level of contributions would benefit all medical scheme members, including low income earners.

Compulsory membership has been recommended for tax payers, thereby setting a minimum level of income required before an individual is required to join a medical scheme. There should therefore be a limited effect on low income earners.

[3] This assumes that non-tax paying medical scheme dependants would have a similar demographic distribution.

3.1 How does the current degree of risk pooling impact competition between medical schemes?

Currently there is no risk pooling between medical schemes. This results in schemes with higher age profiles and higher resulting claims being less competitive. The question is then why all schemes do not have similar age profiles, resulting in similar expected claims across all schemes.

Medical schemes currently compete for two types of members:

- **Corporate members**
  In this case, employers make membership of a medical scheme compulsory for its employees. The employer would offer one or a range of medical schemes from which employees can choose. This removes the ability of members to anti-select against medical schemes in that they are required to be members of the medical scheme whilst they remain employed. The membership of a corporate is usually spread across the various ages of a typical workforce, with a group of pensioners that have retired with the corporate.

  It is useful to note that, due to complaints from employees that medical schemes are expensive, companies have been known to allow employees to join without their dependents. The dependants may then join at a future date, creating a potential for anti-selection similar to that of individual members.

  Medical schemes who relax underwriting for corporate members as a result of the reduced anti-selection risk may well impose underwriting for dependants who join later than the main member.

- **Individual members**
  In this case, individuals are determining whether they require medical scheme cover and can join and exit a medical scheme as they choose.

The two types of members have very different effects on medical scheme risk profiles. This is discussed below.

Whilst there will be turnover of staff within an employer, the staff will typically be replaced by staff of a similar age and risk profile. Staff retiring will be replaced by new young staff, thereby ensuring a relatively stable average age for the group. In comparison, individuals who remain on a medical scheme will age each year. When an individual retires, the scheme does not automatically get a new young member to offset the impact of the older member on expected claims. As a result, schemes with high concentrations of individual members versus corporates usually experience higher levels of ageing.

The positive impact of corporate membership and in particular new employees being employed at younger ages is largely removed for medical schemes with such high concentrations of medical scheme members (such as Discovery Health Medical Scheme) that new employees of corporates are likely to already have been members of the scheme and therefore have no impact on the average age of the option or the scheme.

Corporate membership is largely influenced by brokers who provide advice to the corporates regarding medical scheme membership for its employees. Brokers will encourage corporates to consider medical schemes with larger membership for the following reasons:

- Large schemes are better able to sustain very large unexpected high cost claims without the solvency level of the scheme being significantly influenced.
- Large schemes have larger risk pools, which is likely to result in more predictable claim patterns overall. This means that contribution increases and benefit changes will be less affected on an ongoing basis by “good” and “bad” years.
- Loss of a few small corporates or one or two larger corporates is less likely to impact the age profile of a large scheme and therefore the expected claims for that scheme.
- Growth within a smaller scheme places pressure on solvency requirements, which in turn places pressure on contributions.

Schemes with larger risk pools are therefore at an immediate advantage in terms of gaining new membership, with this membership likely to be of a better overall risk profile (as discussed above).

Schemes with older age profiles will have higher expected claims regardless of the success of health management interventions. The higher expected claims result in higher contribution requirements. The higher contribution requirements result in the following:

- An inability to attract new members unless the Scheme offers an option that is priced at the same level as the market. Whilst this helps to grow the Scheme size, it does not solve the problem of the higher contributions required for the remaining options.

- Buy down of members from higher cost options to lower cost options. Members who buy down are usually older or higher claimants than the average age of the new option (they purchased a higher cost option initially because of their perceived need for the richer benefits, which is usually linked to risk profile including age), but younger than the option that they are leaving (if the benefits needed required that they remained on the previous option then they would not have bought down to an option that would not cover their needs). This results in increased costs for both the option that is being left and the new option joined.

- Members leave the scheme to purchase the same level of cover at a lower contribution level (which is possible for a scheme that has a lower average age). This increases the average age of the scheme even further, resulting in higher claims and contributions. In addition, it reduces membership size, which makes the overall scheme less attractive in the market.

The current lack of risk pooling between medical schemes is therefore resulting in a loss of membership for schemes with higher age profiles, which frequently results in the deterioration of the age profile even further, reduced support from brokers (particularly for corporate clients, which are preferred members) and ultimate potential failure of the scheme.

The Medical Schemes Act only allows risk pooling within each medical scheme's individual options. However, the CMS has, over time, recognised that some level of risk pooling is required between options of a single medical scheme in order to ensure scheme sustainability. This particular aspect is considered further as part of the response to Question 3.2 below.

3.2 Why are benefit options that are in financial deficit for consecutive years, allowed to exist?

Table 1 of the report shows that options in a financial deficit are usually the lower and higher cost options, with the middle-cost options making a profit. It is important to understand why this structure exists before one can consider why it has been allowed to continue.

Medical schemes usually offer a range of benefit options, from a benefit option that looks to provide essential care at an affordable price to a comprehensive option that looks to provide a full range of benefits at a higher price. All of these options would offer comprehensive hospital and chronic disease cover because PMB cover is in itself relatively comprehensive.

Low cost options

The low cost option is ideally looking to attract new entrants to the medical scheme market, i.e. young members with a low risk profile who are looking to obtain insurance at an affordable price. These members would then purchase higher levels of cover as their income (and risk profile!) increases.

In the above scenario, low cost options would have low average ages and low risk profiles, resulting in low costs. However, even low risk profile groups claim and the cost of new born babies alone can often skew the otherwise low claims for a younger group of members.

Low cost options also attract new entrants to the medical scheme market who may not be young but who have recognised that they require medical scheme cover (i.e. late joiners). This often increases the average age and risk profile of the option relative to what was intended. Increased contributions to cover this increase in expected claims would unfairly penalise the lower age, lower risk members for whom the option was intended.

In an effort by medical schemes to continue to provide this low cost option as an "industry need" despite claims potentially exceeding what is considered to be an affordable contribution level, medical schemes make a conscious decision to price the option to make a financial deficit. Increasing contributions on these options to be financially neutral may result in members exiting the medical scheme industry (which has been noticed by medical schemes who have closed such options) and returning as late joiners later in life.

Comprehensive options

Comprehensive options look to provide a full range of benefits to members, which results in a higher contribution payable. The full range of benefits would usually include more comprehensive out of hospital benefits and higher reimbursement rates on chronic medication and for specialists. Comprehensive options would usually attract older age members who recognise that they have higher health care needs. This is clearly evidenced by the average age of members participating on comprehensive options when compared to the overall average age of medical scheme members.

Older members claim more for the same level of benefits when compared to younger members, as evidenced in Graph 1 of this report. Therefore, the comprehensive option is more expensive for two reasons:

- The option pays for more benefits and/or a higher level of benefits
- The members participating on the option claim more because they are older and/or have higher health care needs.

Whilst it is reasonable for members to pay for more and/or higher levels of benefits, one has to question whether it is reasonable for members to pay more because they are older and/or sicker. In the case of comprehensive options, medical schemes must attempt to balance the need to have members on the option pay for the fact that they are older and/or sicker (because the Medical Schemes Act requires financially self-sustaining options) with the ability to pay the higher cost.

Ultimately, members who are simply unable to afford the high contributions may opt to buy down to a lower cost option. This buy down would result in them losing the better benefits. However, they would also lose some of the contribution cost associated with the age profile of the option.

The first members to buy down to lower cost options are usually older than the option that they are joining (which is why they had picked the comprehensive option in the first place) but younger than the option they are leaving. This results in ageing on both the option that they are leaving and the option that they are joining. The ageing on both options increases claims and results in the need to increase contributions on both options. This in turn results in further buy downs. Members also leave the scheme as the scheme overall becomes more expensive.

This continuous effect of buy downs/buy outs and increased contributions can ultimately result in a collapse of the scheme.

Actuaries of many medical schemes have analysed the above effect and the "actuarial death spiral" has been discussed in many industry forums, including the Industry Technical Advisor Panel to the Council for Medical Schemes ('ITAP'). CMS has received many submissions from many medical schemes showing the historical impact of excessive contribution increases on comprehensive options in an attempt to remove financial deficits and has recognised that further pressure on contributions could result in the collapse of schemes. It is for this reason that options with a financial deficit have continued to operate.

It is useful to note that financial deficits on low cost options and comprehensive options are only sustainable for a scheme if the scheme is able to offset these financial deficits from financial surpluses on other options. Schemes who have higher average ages than its competitors across all options will have no choice but to ensure that the scheme overall is financially sound. This results in higher contribution levels relative to competitors, which results in membership losses and unsustainability of the scheme.

3.3 What impact does the lack of a medical scheme wide mechanism to equalise for risk have on medical schemes and the cost of cover?

As noted in the previous section, medical schemes are required to ensure that they are financially sound. This often includes cross-subsidising lower and higher cost options with surpluses generated in the middle-income options. If a scheme has a higher weighting of older members with higher claiming profiles across all of its options then by implication the scheme's overall contribution levels will be higher than a scheme offering the same level of benefits with a younger membership profile and lower claims. The higher contribution levels of the first scheme puts at risk the sustainability of the scheme given that members will opt for the scheme with lower contributions and the same level of benefits.

The scheme can attempt to set its contribution levels at the same level as the scheme with the younger age profile in order to remain competitive and attempt to attract new, younger members. However, this results in financial deficits, which is unsustainable. In addition, brokers are unlikely to recommend that members move from a stable scheme with a lower age profile to a scheme that is producing financial deficits and has a higher age profile.

The result is that the schemes with higher age profiles become unsustainable and are forced to amalgamate with other schemes or liquidate. This has contributed towards the significant reduction in the number of schemes over the past 10 years.

A reduction in the number of medical schemes reduces overall industry competition, which is ultimately likely to reduce innovation in the industry.

3.4 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 variation in price to relate to the different contracts medical schemes have with their service providers?**

A mechanism that equalises across Prescribed Minimum Benefits is required in order to place schemes on a more even playing field in terms of equalising for age and chronicity in the environment of open enrolment and community rating. The industry developed a grid that considered CDL conditions, including an allowance for multiple conditions and maternity. This "Risk Equalisation Fund" ('REF') grid was intended to provide an indication of the level of subsidy that would be paid to each scheme for each beneficiary with the specified conditions.

Significant scheme administration development took place to enable schemes to report the required prevalence statistics to CMS. Implementation of the REF would therefore only require updating of the cost associated with each condition as well as how the distribution between schemes would be undertaken. Given industry willingness to be actively involved in these types of initiatives, the process could be completed in time for 2019 pricing.

There is a concern that some schemes do not encourage members to fully utilise chronic condition benefits available. As a result, these schemes benefit from lower costs than schemes who encourage compliance with medication regimes and care plans. It is therefore important that the reimbursement provided to schemes in terms of the REF grids does not benefit schemes who are not providing the correct level of care to members. At the same time, schemes should continue to be encouraged to negotiate with providers and manage costs. This balance could potentially be achieved as follows:

- By introducing an independent managed care review process whereby medical schemes are allocated a score based on a review of their CDL managed care processes and randomly selected sample cases. The higher the score the higher the level of managed care undertaken by the scheme. Reimbursement of costs from the risk equalisation fund will be dependent on the medical scheme's managed care score.

  These scores can be published and can assist potential members and brokers in understanding the relative value being added by certain medical schemes. This will hopefully assist in improving competition between schemes, not only on contributions and benefits as is currently the case, but on value add.

- Setting the reimbursement of a specific event at a pre-specified percentile (for example, 50%) of the cost distribution, with cost only considered for "well managed" cases. This will encourage schemes to continue to manage costs.

High costs cases can have a significant financial and competitive impact on smaller schemes. It is therefore further recommended that high cost cases be equalised through an industry-wide reinsurance type arrangement. This will also go a long way towards addressing the PMB costs associated with emergency admissions.

3.5 Who will benefit and who will be harmed by introducing these mechanisms to adjust for risk across medical schemes?

Medical schemes who have been successful in attracting younger, healthier members will be required to pay towards the REF whilst older schemes will receive money from the REF. Members currently participating on the younger schemes may therefore experience a contribution increase, with members participating on the older schemes experiencing a contribution decrease.

The above contribution impacts may further result in membership movements between the schemes, with membership moving to the schemes that have experienced contribution decreases. This should result in a reduced average age for the scheme. Market movements between schemes, with contribution adjustments occurring as the age profiles change, should result in the majority of schemes ultimately having similar age and risk profiles, with schemes competing more on other factors such as innovation and managed care.

3.6 What costs will be involved to introduce these mechanisms?

The private health care industry has for many years volunteered time and expertise to develop medical scheme industry initiatives. It is therefore anticipated that a large amount of the work can be undertaken through a task team such as the previous ones set up for the REF and ITAP.

Considerable work was undertaken when the REF was seriously being considered and much of the cost estimates considered at that time, inflation adjusted, could be used to estimate the cost of introducing the proposal provided.

3.7 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?

A risk adjustment mechanism will improve the stability of smaller and/or older age profiled medical schemes, thereby retaining competition within the medical scheme industry. Stability of the medical scheme industry is essential whilst the NHI is established so that current medical scheme members do not place a further burden on public health care resources in the interim.

4.1 Is the current level of competition between medical schemes on their benefit options effective, considering the information available and the complexity of the subject?

No, the current level of competition between medical schemes is not effective. There is significant information asymmetry between medical schemes and members.

4.2 What changes would allow members to compare the real value of medical scheme benefit options?

National Health Reference Price List

Since the removal of the published National Health Reference Price List ('NHRPL') in 2006, medical schemes have been required to set their own tariffs. This has resulted in each scheme specifying how much they will pay for each service rendered by every type of practitioner.

Medical scheme benefit guides note that service providers will be reimbursed at a percentage of the scheme's tariff. It is impossible for the member to know what each of these tariffs would be and how the one scheme's tariff would compare to another. As a result, schemes are able to reduce their claim costs by reducing their scheme tariff, thereby reducing contribution requirements relative to schemes that pay a higher scheme tariff (and possible one that would fully cover the cost of the provider!).

A published list of tariffs allows members to understand what the service provider is likely to charge and how much of the claim will be covered by the medical scheme. Importantly, this information will be available at the time of choosing a medical scheme and not at the time of claiming.

Whilst it is recognised that the initial removal of the NHRPL was as a result of competition concerns, the HMI Report on Analysis of Medical Schemes Claims Data – A Focus on Practitioners shows that there continues to be consistently in terms of what practitioners charge and reintroducing the codes in line with current charging is therefore not expected to have an impact on claims costs.

Chronic medication costs

All schemes are required to cover medication in respect of Chronic Disease List ('CDL') conditions. Schemes are also required to cover medication in respect of PMB conditions where ongoing medicine management is required. Some schemes choose to list the PMB conditions as additional benefits covered, thereby hoping to appear to offer "more comprehensive" cover whilst others only show chronic medication cover as "PMBs only", thereby hoping that members with less knowledge of the CDL benefits available will not claim for the benefits. This asymmetry in information provided to members can result in competition as a result of "clever marketing" as opposed to competition as a result of real value differences.

Whilst members have, over time, become more aware of chronic medication cover available, they assume that all schemes and options cover the conditions at the same level. Terms used by medical schemes such as "reference price lists" do not provide the member with valuable information regarding what will be covered and what will not. Members should be able to understand whether only one medication will be covered for a condition, with no cover if an alternative medication is chosen, or whether any medication can be chosen up to a set Rand value.

Guidelines should be introduced regarding the marketing of scheme cover in terms of CDL and PMB conditions that require ongoing medicine management. All schemes should be required to note how these are covered in a format that is consistent to ensure comparability across schemes. This includes whether the cover differs by option and the level of flexibility available to the member (and his practitioner) to choose the medication required.

Guidelines on benefit option marketing

Medical schemes offer members insurance. The principle behind insurance is to provide cover for unexpected events that may have a significant financial impact on the consumer if the cover were not in place. This definition for insurance is largely applicable to hospital cover provided by medical schemes, particularly in the case of PMBs.

Hospital cover makes up a significant part of the claims and therefore the cover purchased by members. However, members are usually unaware of this fact until they claim for such cover. Members therefore find themselves (often with the help of brokers) comparing medical schemes based on the benefits that they have experienced before. This includes basic out of hospital benefits and possibly chronic medication. The comparisons are therefore skewed to the lower cost items.

Schemes also provide very varied information in their benefit guides, highlighting some aspects of the benefits whilst excluding others. It is almost impossible to create guidelines for schemes in terms of what information should be provided to members in what form given the enormous complexity of medical scheme benefits and the significant number of stakeholders involved. It may therefore be useful to require that schemes provide, for each option, a split of the costs from the previous financial year by main benefit category and expenses. This allows members to see how much of the benefits that they are using to make comparisons actually comprise of the total costs.

4.3 What is the contribution (if any) of medical savings accounts to the member and to the medical scheme?

Medical savings accounts ('MSA') provide the following advantages to members:

- Members are not treated as cash patients by all service providers. Cash patients are not necessarily charged the scheme-agreed tariff and in many cases will find themselves paying more. The same applies to scheme-agreed dispensing fees at pharmacies. (We note that a number of specialists treat medical scheme members as cash patients regardless of their medical scheme membership, with patients being required to claim back from the scheme.)

- Members receive their full allocation of the medical savings account annually upfront. This provides members with access to more funds that may be required for more expensive health care requirements, such as optometry or orthodontics. The upfront allocation is provided interest-free.

- Members do not have to have cash immediately available should they need to access the health care system. This is particularly important for families who, for example, rely on relatives to access the health care system on their children's behalf.

- Medical savings accounts provide members with the flexibility to manage their outpatient health care needs. For example, in one year the member may recognise that there is a need to spend a large allocation of the MSA on optometry, with the next year spend being required on dentistry. This flexibility is not available in a traditional option where outpatient benefits are restricted through limits. Many members see these limits as targets and seek to spend as much as possible "because they have paid for it". This requires that the medical schemes restrict benefits potentially to levels that are lower than an average family would require in any specific year.

Medical schemes are intended to provide insurance for unexpected events that may result in significant financial strain to the member if the insurance were not in place. Outpatient care does not meet this insurance definition.

Members do not necessarily see value in the in-hospital insurance aspect of their medical scheme cover because it may be many years before they are required to utilise the insurance (if ever). This perceived lack of value places schemes at risk of further anti-selection and late joiners. In order to mitigate this risk, schemes look to provide cover for outpatient benefits that almost all medical scheme members will access over the course of a benefit year. This continues to remind the member that the medical scheme is there to cover health care needs (even if the outpatient cover is actually just a storage of the member's own money).

4.4 What is the effect of current medical savings accounts on moral hazard, and how can the continued existence of these accounts in the medical schemes industry lower moral hazard, and improve competition between schemes?

Traditional options that provided specified limits for listed outpatient benefits are often exposed to moral hazard. This is because certain types of outpatient care is discretionary. Members look to maximize their perceived value from the medical scheme by spending as much as possible of the limits available for the various outpatient benefits. The use of the benefits is often not strictly necessary and is almost impossible for the medical scheme to control. Examples include:

- Members may seek treatment from a physiotherapist for sore muscles after intensive exercise. The treatment is not medically necessary but is useful, particularly if the member does not have to pay.

- Members may look to purchase new spectacles every year or every second year even if their current spectacles remain suitable because the medical scheme pays for these. This may include more expensive frames than the member would otherwise have purchased if he/she were using his/her own money.

Medical savings accounts remove this moral hazard because the outpatient benefit allocation is effectively the member's money and the member can choose what to purchase, recognising that the one purchase will reduce the funds available for other purchases.

Unfortunately members still attempt to access benefits through hospitals in order to avoid having to pay for the services as an outpatient benefit (such as radiology). Over the past years this has resulted in significant increases in casualty/emergency visits at hospitals for diagnoses that could otherwise have been dealt with through a general practitioner. Medical schemes have consequently been forced to reduce this moral hazard by specifying that certain levels of casualty/emergency visits will be funded from outpatient benefits (including medical savings accounts).

Medical savings accounts remove the outpatient benefits from benefit comparisons and leave the majority of hospital and chronic medication benefits as part of the "risk benefit" package. This allows members to appreciate more what part of the contribution is being used for benefits that better meet the definition of insurance and allows better comparability across medical schemes.

4.5 Will a simplification of benefit options improve transparency and accountability? To what extent will this incentivize medical schemes to compete on merits – that is on value for money and innovative contracting where they can pass the benefits directly onto the members?

Medical schemes provide cover for a significant number of health care events using a wide range of service providers. It is therefore difficult to see how the cover provided by benefit options could be simplified.

4.6 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:

4.6.1 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…This would require risk equalisation for the pricing of PMBs only.

The general principles of Circular 8 of 2006 were valuable.

However, one of the disadvantages of this structure is that age and chronicity is not fully addressed through the cost of PMBs. In particular, if one looks at a claims curve by age, both PMB and non-PMB claims increase with age. Therefore, a common benefit across a scheme with a single contribution will still result in higher contributions for schemes with older members. This does not improve competition.

This said, schemes should be required to show the CMS that the profit and loss-making options are overall financially sound for common benefits. This assists the CMS in ensuring that cross-subsidies across options is not for additional benefits but rather for the age and chronicity differences between options.

4.6.2 Simplify and standardise a mandatory benefit package that all medical schemes must offer. Medical schemes can then sell (a limited number of) complementary (top-up) benefit options.

This option creates the same risks as the previous option.

4.6.3 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.

It is unclear whether "meet the requirement of the MSA" suggests that each of the other benefit options must then be financially sound on a stand-alone basis. If this is the case, then the same problems as have been considered throughout this paper exist, namely that older options cannot be financially sound whilst still being competitive and affordable.

If schemes are allowed to continue to subsidise between options, then the purpose of requiring a standardised package is defeated because medical schemes will be able to price the standardised option at a level that can be afforded based on subsidies between options and the age profile of the members who have joined that option.

4.6.4 Limit the number of 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 option categories into narrower groupings.

It would be very useful for the CMS to create categories into which all benefit options should fit. Schemes should be restricted from providing certain types of benefits within certain categories to ensure that the industry is able to compare similar benefit options in a category.

As noted previously, it may be useful for medical schemes to provide members with a pie chart breakdown of certain categories of benefit claims to enable members to understand how their contribution is being spent. This allows the members to question the importance of benefits that may be highlighted by, for example, medical schemes and brokers, as part of their marketing strategy.

4.7 What prevented the implementation of the revised benefit design structure proposed in Circular 8 of 2006?

The CMS's Circular 8 of 2006 could not be implemented without some form of risk equalisation across medical schemes. The risk equalisation was intended to take place across PMBs only and work undertaken by the REF initially suggested that the cost should be determined based largely on the cost of the CDLs. The problem at the time was that there was very little clarity regarding what should and should not be covered as part of PMBs. Very few PMB treatment plans had been designed for outpatient care and medical schemes were debating what inpatient codes should be reimbursed as a PMB. These concerns remain until today, with the CMS continuing to issue guidelines on PMB conditions and how these should be managed. The CMS continues to deal with complaints from members, service providers and medical schemes regarding the reimbursement of PMB claims.

The industry requires better uniformity in terms of dealing with PMB claims and the reimbursement thereof before a risk equalisation mechanism can be introduced.

4.8 What are the disadvantages of simplifying the benefit options?

The reality is that administering and managing a benefit option is never likely to be "simple" and requiring that medical schemes market a "simplified" product provides the opportunity for medical schemes to be more innovative in how they manage the aspects of the benefit option that members do not see. This is not the type of innovation that the industry should be looking to encourage.

4.9 What other mechanisms must also be implemented for any simplification of benefit options to result in increased competition?

We have no further proposals.