A regulators perspective: evidence of anti-selection and experience in addressing risk pooling failures and benefit design

Council for Medical Schemes
Contents

• Introduction
• Anti-selection evidence
• Experience in risk pool regulation
• Conclusion
In SA there is limited **empirical evidence** on the factors influencing member movement between different options and medical schemes.

- International evidence - Health Insurance (Netherlands, China, Belgium)
- 5 case studies (2004-2014)

These studies describes the **impact of anti-selection** within **particular conditions** and **circumstances**
Introduction

- **Anti-selection** behaviour can be analysed according to the following categories:
  - **Age**: young people defer scheme membership
  - **Gender**: females during child-bearing ages
  - **Disease burden**: people with expensive illnesses to treat or multiple illnesses
  - **Benefit options**: members selecting options with comprehensive benefits only when their likelihood of needing those benefits is high
  - **Voluntary membership** where mandatory participation is not enforced through legislation
  - **Employer group preferences** and **splitting of the risk pools**
• Case study 1 (Chronic Renal Failure)

There is **anecdotal evidence** that older people with **chronic renal failure** needing dialysis are encouraged to join medical schemes in order to get dialysis in the private sector, as there are limited resources in the public sector. The impact on a medical scheme is substantial. **In 2017, the average cost of chronic renal failure was R27 590** per patient per month according the data from the Scheme Risk Measurement (SRM, formerly REF). Such costs have an **impact on contribution increases** for all members within a benefit option and a scheme as a whole.
Anti-selection evidence

• **Case study 2:** (Pregnancy)

“There are instances where medical scheme cover will be taken by couples or single women who are planning to have children. The medical and accommodation costs associated with the pregnancy will be covered by the medical scheme. Because of information asymmetry, plans to start a family are considered privileged information and deliberately not disclosed to the medical scheme.”
Case Study 3: Age specific anti-selection: Polmed

The analysis of Polmed claims data for the years 2006 and 2007 showed that various categories of anti-selection have affected the cost of Polmed options, namely: “Buy-downs” from the higher to the lower plans by older members. This category of anti-selection shows that the number of members in age categories from 35 upwards remained constant or declined in the higher plan, while growing in the lower plan. The data also showed that the level of hospital costs per beneficiary increased markedly with age. This trend was apparent in all the other benefit categories.
Anti-selection evidence

• **Case study 4: Mcleod and Ramjee (2007)**

Undertook a study which compared the relationship between **income**, **age** and **gender** to expose the anti-selection behaviour that occurs in the voluntary medical schemes environment. **This analysis was undertaken in 2007 where CMS’ Risk Equalisation Fund (REF) data** was analysed.

This study showed higher numbers of maternities than expected in the REF pricing each year. Furthermore, unpublished scheme investigations also showed **substantially higher maternities than expected** as well as some evidence of increasing numbers of women who join schemes before giving birth and leaving schemes thereafter (Mcleod & Ramjee, 2007).
### Case study 5: Large scheme experience (2014)

<table>
<thead>
<tr>
<th>Anti-selection evidence</th>
<th>0%</th>
<th>2%</th>
<th>4%</th>
<th>6%</th>
<th>8%</th>
<th>10%</th>
<th>12%</th>
<th>14%</th>
<th>16%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration on Scheme – Musculoskeletal conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14.31% who claimed biologics for musculoskeletal conditions had been on the Scheme for <1 year.

**Medical Scheme presentation to CMS, 2014**
Anti-selection evidence

16.52% who claimed interferon had been on the Scheme for <1 year

Medical Scheme presentation to CMS, 2014
Anti-selection evidence

Duration on the scheme before first maternity admission (2008-2013)

- 34% join within 9 months of the maternity event

<table>
<thead>
<tr>
<th>Duration</th>
<th>Number of Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 months</td>
<td>7,155</td>
</tr>
<tr>
<td>4-6 months</td>
<td>8,933</td>
</tr>
<tr>
<td>7-9 months</td>
<td>9,976</td>
</tr>
<tr>
<td>10-12 months</td>
<td>8,084</td>
</tr>
<tr>
<td>13-18 months</td>
<td>13,424</td>
</tr>
<tr>
<td>19-24 months</td>
<td>9,315</td>
</tr>
<tr>
<td>2-3 years</td>
<td>11,172</td>
</tr>
<tr>
<td>3-4 years</td>
<td>4,742</td>
</tr>
<tr>
<td>4-5 years</td>
<td>1,496</td>
</tr>
<tr>
<td>&gt;5 years</td>
<td>153</td>
</tr>
</tbody>
</table>

Other underwriting categories

<table>
<thead>
<tr>
<th>Duration</th>
<th>Number of Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 months</td>
<td>7,155</td>
</tr>
<tr>
<td>4-6 months</td>
<td>8,933</td>
</tr>
<tr>
<td>7-9 months</td>
<td>9,976</td>
</tr>
<tr>
<td>10-12 months</td>
<td>8,084</td>
</tr>
<tr>
<td>13-18 months</td>
<td>13,424</td>
</tr>
<tr>
<td>19-24 months</td>
<td>9,315</td>
</tr>
<tr>
<td>2-3 years</td>
<td>11,172</td>
</tr>
<tr>
<td>3-4 years</td>
<td>4,742</td>
</tr>
<tr>
<td>4-5 years</td>
<td>1,496</td>
</tr>
<tr>
<td>&gt;5 years</td>
<td>153</td>
</tr>
</tbody>
</table>
**Anti-selection evidence**

*1-year withdrawal rate of lives who joined <12 months before maternity admission*

<table>
<thead>
<tr>
<th>Duration on scheme before first maternity admission</th>
<th>Withdrawal rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 months</td>
<td>29.8%</td>
</tr>
<tr>
<td>4-6 months</td>
<td>32.1%</td>
</tr>
<tr>
<td>7-9 months</td>
<td>29.9%</td>
</tr>
<tr>
<td>10-12 months</td>
<td>25.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Underwriting category A</th>
<th>0.0%</th>
<th>5.0%</th>
<th>10.0%</th>
<th>15.0%</th>
<th>20.0%</th>
<th>25.0%</th>
<th>30.0%</th>
<th>35.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underwriting category A</td>
<td>29.8%</td>
<td>32.1%</td>
<td>29.9%</td>
<td>25.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25% of these leave the scheme within 12 months of the maternity event.
Experience in addressing risk pooling failures
Contents

• Introduction
• Risk pool size
• Case studies
• Benefit option registration
• Regulatory gaps
• Conclusion
Introduction

- Pooling involves the accumulation of health revenues on behalf of a population for eventual transfer to providers
- Core objective for pooling arrangements: maximize redistributive capacity, financial protection and equity in service use relative to need for care
- Size (bigger) and diversity (more) are key characteristics to consider in reform design
Introduction: SA healthcare system

Revenue sources
- General taxation
- Medical schemes (voluntary contribution)

Pooling
- MOH uninsured
- 9 provinces

Purchasing
- VHI
  - 82 medical schemes
  - 287 benefit options

Provision
- private & some public

Population
- poor (84%)
- middle class & rich (16%)
Introduction: SA healthcare system

Revenue sources
- General taxation
- Medical schemes (voluntary contribution)

Pooling
- High unemployment rate
- Medical schemes
- Affordable challenges!

Purchasing
- Poor central bureaucracy
- Line-item budgeting
- Passive purchasing
- Duplicated administrative systems
- Fee-for-service
- Up-coding
- Profit motive

Provision
- RWOPS
- Poorly designed PMBs
- Profit motive

Population
- Poor (84%)
- Middle class & rich (16%)

Fiscal constraints!
Some “signposts” that tell us we have a problem

• Pooling
  – Is pooling highly fragmented and complex?

• Benefit design
  – Population not aware of entitlements and obligations?
## Risk pool size

### Table 1: Minimum Risk Pool Size for Healthcare Providers to Accept Risk

<table>
<thead>
<tr>
<th>Type of Risk</th>
<th>Minimum Member Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician</td>
<td>500 - 1,000</td>
</tr>
<tr>
<td>All Physician Services</td>
<td>20,000 - 30,000</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>60,000 - 100,000</td>
</tr>
<tr>
<td>All Risk</td>
<td>20,000+</td>
</tr>
</tbody>
</table>
Risk pool size

Number of benefit options (2006-2015)

Total number of benefit options

- Open schemes
- Restricted schemes
- All Schemes
Risk pool size

Number of loss making options (2006 -2015)

(231 – 150)
Risk pool size

Option size (number of beneficiaries) categories, 2015

- <=1,000: 27
- >1,000 & <= 6,000: 83
- >6,000 & <= 30,000: 115
- >30,000: 48
Community rate analysis - schemes

Impact analysis

Community rate per m, December 2016

R 745,6
Community rate analysis - options

Impact analysis
Case studies

COMMED (2016):

• Total membership – 7981
• Number of option – 4
• Membership on a per option level:
  – Deluxe – 869
  – Standard – 2195
  – Roots – 4894
  – Shina – 23
Case studies

• **Naspers Medical Fund (2016):**
  – Total membership – 16100
  – Number of option – 3

• Membership on a per option level
  – Option A: 2900
  – Option B: 3500
  – Option C: 9700

• 1 case Gaucher’s disease crippling the schemes
Benefit option registration

• **Deregistration** of an option is normally considered as a **last resort**, such regulatory intervention has a potential of creating pricing uncertainty and can lead to member dissatisfaction.

• **Close monitoring** of loss making options.
Benefit option registration

- If the benefit option continues to be non-compliant as per provisions outlined above, the Registrar reserves the right to deregister those benefit options.
Section 63, Section 24 (2) (d) , Reg 2 (3)

“…Minimum number of members required for the registration of a medical scheme established after these regulations have come into operation is 6000.”

SUREMED case :

• The judge set aside the decisions of the Registrar and the Appeal Board.

• The high court held that it was not competent for the Registrar to confirm the exposition because the parties’ merger agreement was rendered void when Suremed’s members voted against the merger.

• Section 63(11) does not authorise a medical scheme to enter into a transaction that is in conflict with its rules.

• The high court further held that the Registrar did not have the power to confirm an exposition which was not underpinned by a valid and binding agreement.
Regulatory gaps

• **Amendment of the MSA**:  
  – Regulation 2(3) to explicitly state that all registered medical schemes *should always have the minimum of 6000 members* whether or not these medical schemes were registered before the amendment of the 1967 Act.

  – Explicitly state corrective measures to be followed by the Regulator in addressing non-compliance.
Amendment of the MSA:
- Outline of the required membership base at a benefit option level.

- Section 33 (2) (c) does not permit withdrawal of the benefit option if that option is financially sound, even if that benefit option has low membership.
Amendment of the MSA:

- A clear interpretation of “public interest” as outlined within Section 24 (2) (f) is also required.

- Such interpretation needs to take into consideration membership growth requirements, consumer preference and the impact of option selection by employer groups.
Conclusion

• World Health Organisation recommends that health financing reforms **should not only focus on increasing the level of prepayment** funding for the risk pools, but should also **consider policy options to encourage risk pool consolidation**. Implementing such measures without paying proper attention to changes in risk pooling can result in **increased fragmentation and compromised equity and efficiency goals** (WHO 2010).
• FinMark Trust 2009 “Making health insurance work for the low-income market in South Africa :Cost drivers and strategies”